FLORIDA NETWORK
of youth and family services

Florida Network for Youth and Family Services
Compliance Monitoring Report for

CDS – Interface Central
1400 Northwest 29th Road
Gainesville, FL 32605
Compliance Monitoring Services Provided by

FOREFRONT

EXECUTIVE SUMMARY

Forefront LLC conducted a joint Quality Improvement (QI) and Florida Network of Youth and Family Services (FNYFS) monitoring visit for CDS Family and Behavioral Health Services, Inc. – Interface Central for the FY 2020-2021 at its program office located at 1400 Northwest 29th Road, Gainesville, 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. CDS Family and Behavioral Health Services, Inc. – Interface Central 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 CDS Family and Behavioral Health Services, Inc. – Interface Central present for the entrance interview were: Tracey Ousley, COO; Jessica Bechold, Regional Coordinator; Evelitza Soto, SNAP Supervisor; Gonzellas Whitter, Residential Supervisor; Cassandra Mccray, Regional Coordinator; and Naomi Thompson, Residential Counselor. The last onsite QI visit was conducted February 5 – 6, 2020.

In general, the Reviewer found that CDS Family and Behavioral Health Services, Inc. – Interface Central is in compliance with specific contract requirements. **CDS Family and Behavioral Health Services, Inc. – Interface Central 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 04-13-2021

Agency Name: CDS Family and Behavioral Health Services, Inc. – Interface Central						**Monitor Name: Ashley Davies, Lead Reviewer**	
Contract Type : CINS/FINS						**Region/Office: 1400 NW 29th Rd., Gainesville, FL**	
Service Description: Comprehensive Onsite Compliance Monitoring						**Site Visit Date(s): April 13 – 14, 2021**	
	Explain Rating						
Major Programmatic Requirements	**Unacceptable**	**Conditionally Unacceptable**	**Fully Met**	**Exceeded**	**Not Applicable**	**Ratings Based Upon:** **I = Interview** **O = Observation** **D = Documentation** **PTV = Submitted Prior To Visit** **(List Who and What)**	**Notes** **Explain Unacceptable or Conditionally Acceptable:** **(Attach Supportive Documentation)**
I. Administrative and Fiscal							
DJJ Quality Improvement Peer Reviewer a. Provider shall demonstrate that a minimum of two (2) staff members have been trained to be certified as DJJ QI Peer reviewers. Provider shall participate in a minimum of one (1) on-site quality assurance review of a similar type program in another judicial circuit during each 12-month period of the contract, if requested.	☐	☐	☒	☐	☐	Interview: The program currently has at least two staff members certified as DJJ QI Peer reviewers. One of the staff members has participated as peer reviewer this season.	**No recommendation or Corrective Action.**
Additional Contracts a. Provider shall provide a listing of all current federal, state, or local government contracts, as well as other contracts entered into with for profit and not-for-profit organizations. Such listing shall identify the awarding entity and contract start & end dates. **PTV**	☐	☐	☒	☐	☐	Documentation: The agency provided a list of eleven contracts for FY2020 - 2021. The list includes: the contract #, the agency, the contact, the address, service, start and end dates, date executed, and annual amount. The program also maintains interagency agreements and Memorandums of Agreement (MOUs) with schools, mental health, and substance abuse providers. All of the agreements reviewed had current contract/agreement dates.	**No recommendation or Corrective Action.**
Limits of Coverage	☐	☐	☒	☐	☐	Documentation:	**No recommendation or Corrective Action.**

Agency Name: CDS Family and Behavioral Health Services, Inc. – Interface Central						Monitor Name: Ashley Davies, Lead Reviewer	
Contract Type : CINS/FINS						Region/Office: 1400 NW 29th Rd., Gainesville, FL	
Service Description: Comprehensive Onsite Compliance Monitoring						Site Visit Date(s): April 13 – 14, 2021	
	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)
a. Provider shall provide and maintain during this contract, the following minimum kinds of insurance: Worker's Compensation and Employer's liability insurance as required by Chapter 440, F.S. with a minimum of $100,000 per accident, $100,000 per person and $500,000 policy aggregate. Commercial General Liability with a limit of $500,000 per occurrence, and $1,000,000 policy aggregate. Automobile Liability Insurance shall be required and shall provide bodily injury and property damage liability covering the operation of all vehicles used in conjunction with performance of this contract, with a minimum limit for bodily injury of $250,000 per person; with a minimum limit for bodily injury of $500,000 per accident; with a minimum limit for property damage of $100,000 per accident and with a minimum limit for medical payments or $5,000-$10,000 per person. Florida Network is listed as payee or co-payee. **PTV**						General Liability through Berkshire Hathaway Specialty Insurance Company, for limits of coverage $1,000,000 each $3,000,000 aggregate, $20,000 individual medical, $1,000,000 personal & adv injury, and $1,000,000 employee benefits, effective 1/10/21-1/10/22. Automobile insurance through Berkshire Hathaway Specialty Insurance Company, for combined single limits of $1,000,000, and PIP Basic for $10,000. Policy effective for 1/10/2021-1/10/2022. An umbrella liability policy through Berkshire Hathaway Specialty Insurance Company, for $1,000,000 each/aggregate. Workers Compensation through Bridgefield Casualty Insurance Company for $500,000 each accident. Effective 5/1/2020 – 5/1/2021. Abuse and Molestation coverage through Berkshire Hathaway Specialty	

Agency Name: CDS Family and Behavioral Health Services, Inc. – Interface Central						Monitor Name: Ashley Davies, Lead Reviewer	
Contract Type : CINS/FINS						Region/Office: 1400 NW 29th Rd., Gainesville, FL	
Service Description: Comprehensive Onsite Compliance Monitoring						Site Visit Date(s): April 13 – 14, 2021	
	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)**
						Insurance Company for $1,000,000 each and $3,000,000 aggregate. Effective 1/10/21 – 1/10/22. Professional Liability Coverage through Berkshire Hathaway Specialty Insurance Company for $1,000,000 each and $3,000,000 aggregate. Effective 1/10/21 – 1/10/22. 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: The agency had a set of Accounting Policies and Procedures in place for: fiscal management, cash, petty cash, support, program service fees, revenue, and receivables, expenses for program and supporting services and accounts payable, payroll and related liabilities, governmental financial assistance programs,	**No recommendation or Corrective Action.**

Agency Name: CDS Family and Behavioral Health Services, Inc. – Interface Central						Monitor Name: Ashley Davies, Lead Reviewer	
Contract Type : CINS/FINS						Region/Office: 1400 NW 29th Rd., Gainesville, FL	
Service Description: Comprehensive Onsite Compliance Monitoring						Site Visit Date(s): April 13 – 14, 2021	
	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)**
						property and equipment, debt and other liabilities. The procedures reviewed appear to be consistent with GAAP and provide for sound internal controls.	
b. Agency maintains a general ledger and the corresponding source documents. General ledger must be set up to track the activity of the grant separately (standard account numbers / separate funds for each revenue source, etc.). **PTV**	☐	☐	☒	☐	☐	Documentation: Detailed General Ledger for the current FY, through 4/7/2021. Agency maintains a detailed general ledger that is structured to track all funding sources as well as activities for the shelter and each program separately.	**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: Reviewed the petty cash policy and procedure. The petty cash fund does not exceed the established minimum. Petty cash is stored in a locked box in the administrative assistant's office. All receipts are submitted to the main office for reimbursement as needed. Reimbursement comes in the form of a check made out to the Administrative Assistant, who will then cash it and place money in petty cash box.	**No recommendation or Corrective Action.**

Agency Name: CDS Family and Behavioral Health Services, Inc. – Interface Central						Monitor Name: Ashley Davies, Lead Reviewer	
Contract Type : CINS/FINS						Region/Office: 1400 NW 29th Rd., Gainesville, FL	
Service Description: Comprehensive Onsite Compliance Monitoring						Site Visit Date(s): April 13 – 14, 2021	
	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)
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, 8/2020 – 1/2021, for one account held with Center State Bank. 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 and are documented by two signatures. Invoices are submitted on a monthly basis with supporting documentation.	**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.**
f. Agency submits payroll taxes and deposits (and retirement deposits as applicable), Employee IRS Form W-2 and Independent Contractors IRS Form 1099 forms prior to federal requirements. **ON SITE**	☐	☐	☒	☐	☐	Documentation: Agency provided documentation in bank statements that payroll taxes are paid each payroll period to the IRS, for the last six months.	**No recommendation or Corrective Action.**

Agency Name: CDS Family and Behavioral Health Services, Inc. – Interface Central						Monitor Name: Ashley Davies, Lead Reviewer	
Contract Type : CINS/FINS						Region/Office: 1400 NW 29th Rd., Gainesville, FL	
Service Description: Comprehensive Onsite Compliance Monitoring						Site Visit Date(s): April 13 – 14, 2021	
	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)
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 year-to-date report for the current fiscal year. The report shows Actual, Budget, and Variance with Total Revenue Over Expense. A review of these documents was conducted. Variances in budget are monitored on a regular basis and are discussed with the Board by the Budget and Financial Committee. If changes need to be made to the budget, then the individual shelter is notified.	**No recommendation or Corrective Action.**
h. A Single Audit is performed as part of the annual audit if expenses are greater than $750,000. The agency must submit a Corrective Action Plan for findings cited in the management letter and single audit. An annual financial audit was completed within 120 days after the previous fiscal year/calendar year and that a copy was provided to the Network unless and extension has been requested and approved in writing. Copy of Audit is submitted to the FNYFS by December 31st. **Obtain from FNYFS**	☐	☐	☒	☐	☐	Documentation: Financial audit conducted for year ending June 30, 2020 and 2019 was completed by James Moore. A separate Management Letter requiring a Corrective Action Plan was not issued by the auditor. A copy of the audit was submitted to the FNYFS.	**No recommendation or Corrective Action.**
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	☐	☐	☒	☐	☐	Documentation: Policies and procedures for Back-up, IT Confidentiality Standards, Virus Protection, Data Integrity, Record Elimination, Uses and Disclosures of Confidential and Protected Health	**No recommendation or Corrective Action.**

Agency Name: CDS Family and Behavioral Health Services, Inc. – Interface Central						Monitor Name: Ashley Davies, Lead Reviewer	
Contract Type : CINS/FINS						Region/Office: 1400 NW 29th Rd., Gainesville, FL	
Service Description: Comprehensive Onsite Compliance Monitoring						Site Visit Date(s): April 13 – 14, 2021	
	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)
documents are shredded and computer hard drives are wiped prior to discarding. **ON SITE**						Information. The Medical Manager performs daily back-ups at 2am and prints summary receipt. Back-up tape is replaced every morning. Accounting data files are backed-up every night. Other critical servers, microcomputers and laptops complete scheduled back-ups on a secured portable hard drive.	

CONCLUSION

CDS Family and Behavioral Health Services, Inc. – Interface Central 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 CDS Family and Behavioral Health Services, Inc.–
Interface Central
CINS/FINS Program

April 14 – 15, 2021

Compliance Monitoring Services Provided by

FOREFRONT

CINS/FINS Rating Profile

Standard 1: Management Accountability

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

Percent of indicators rated Satisfactory: 85.72%
Percent of indicators rated Limited: 14.28%
Percent of indicators rated Failed: 0.00%

Standard 2: Intervention and Case Management

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

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

Standard 3: Shelter Care & Special Populations

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

Percent of indicators rated Satisfactory: 85.72%
Percent of indicators rated Limited: 14.28%
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: 93.12%
Percent of indicators rated Limited: 6.88%
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

Tara Gilligan – Regional Monitor, Department of Juvenile Justice

Kim Stone – SMA Beach House

Krizia Santana – Center for Family & Child Enrichment, Inc.

Tamika Gloston – Youth Crisis Center

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
- **7** # Personnel /Volunteer Records
- **8** # Training Records
- **6** # Youth Records (Closed)
- **4** # 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 **hybrid (virtually and on-site)**.

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 pandemic created change in all aspects of the residential program as they created their own "new normal" for service delivery. The staff at the program were able to respond quickly to the adjustments needed to be Covid-19 ready. Implementing daily and hourly action steps to keep everyone as safe as possible. A few of the major changes at the program included replacing fabric upholstered furniture with items that could be sanitized easily, each area of the building was sanitized after use, and a general mass spraying of all areas occurred three times a day, once during each shift. They purchased and installed a Plexiglas type material that was placed on one side of each bunk bed, creating a barrier between the beds to assist in social distancing during sleeping hours. The program reduced their overall population to ensure social distancing throughout the day. They adjusted the physical entrance to separate the community from staff and implemented a screening process as visitors entered. They did temperature readings of staff and youth on each shift. They did not directly feel the impact of the virus infecting them until around mid- June, when a staff person tested positive. Thus far they have had five staff test positive and be quarantined. They have had two youth test positive, testing after they were discharged from the program, and being symptom free in the program. A third youth ran while on a furlough and tested positive when recovered.

When school started in the fall, they focused on having all youth do digital learning instead of brick and mortar. They kept close contact with the schools and teachers to ensure the youth were on target in all areas.

The program was able to maintain some of their community contacts/services in spite of the pandemic. They have continued their partnership with Planned Parenthood, and they lead a weekly group for the youth via Zoom. The Sickle Cell Foundation and a faith-based group doing Hear Hope continued providing information groups via speaker phone. Youth with counselors in the community were able to meet virtually with them while in the program, most via Zoom. They continued doing Why Try groups and introduced pandemic information groups. Individual sessions did not see any change. The residential counselors switched from on-site, family sessions to doing them over the phone.

Narrative Summary

Standard 1

CDS Family and Behavioral Health Services, Inc. –Interface Central is managed by a Chief Executive Officer and Chief Operating Officer who oversee a Coordinator and Residential Supervisor. The Coordinator and Residential Supervisor are responsible for the day-to-day operations at the shelter. Due to Covid-19 the program has had challenges with retention of staff. Since January 2020 they have had thirteen Youth Care Workers resign. Three of the employees worked three-quarters to full-time. They have had a difficult time getting applicants

to fill the open positions. At the time of the review, they had made some progress. There were two new hires and four additional people identified as candidates for hire and were set to begin training by the end of April 2020. There was also a Counselor position vacant in the Family Action community counseling program. The Stop Now and Plan (SNAP) program was fully staffed.

The program suspended the use of volunteers at the beginning of the pandemic and have yet to reintroduce this component of services. They did accept a student intern form Walden University; however, this is the only volunteer/intern they have used since the pandemic began.

The program recently experienced damage to the fence in the recreational area from a tree that fell during a storm. They are hoping the city will assist them with the repair/replacement of the fence.

The program collects and reviews data from various sources on a monthly basis. All data collection is shared and reviewed with management and staff during monthly meetings. Any improvements or corrective actions needed are implemented at this time. The agency also submits a monthly packet to the Board of Directors. The packet includes all outcome data and a review of any incidents that happened at the shelter during that month. The program also provides the Board with a summary of program updates for the month. This packet is reviewed during the monthly Board meeting. Data entry and collection is reviewed monthly during the management team meetings. The Data Department for the agency will print out monthly JJIS and NETMIS reports. These reports are reviewed with all management staff during the meeting to ensure data accuracy. Due to Covid-19 all meetings have been conducted via Zoom since the pandemic began.

Standard 2

CDS Family & Behavioral Health Services, Inc. –Interface Central provides residential and non-residential counseling and case management services over three counties, Alachua, Gilchrest, and Levy, across Circuit 8.

The Regional Coordinator, who is a Licensed Mental Health Counselor (LMHC), oversees both programs. The residential counseling program consists of two master's level counselors.

The community counseling program is housed off-site. The program consists of four counselors with one of those positions being vacant at the time of the review. Out of the three remaining counselors one is a bachelor's level counselor, one is an associate level counselor, and one is a Doctor of Philosophy.

The community counseling program offers Stop Now and Plan (SNAP) services. SNAP services are provided by a SNAP Supervisor, SNAP in Schools Lead, and SNAP Facilitators. The Regional Coordinator oversees SNAP services. The program has provided Domestic Violence services. The program has not had any examples of Staff Secure, Probation Respite, Domestic Minor Sex Trafficking, or Family and Youth Respite Aftercare Services (FYRAC) in the last year. This site also does not provide Intensive Case Management Services. The program is currently maintaining paper files.

Standard 3

CDS Family & Behavioral Health Services, Inc. –Interface Central residential program is led by a Regional Coordinator and a Residential Supervisor. A Senior Youth Care Worker oversee' s twelve Youth Care Workers. The shelter runs three shifts. At the time of the review there were four Youth Care Worker positions vacant; however, candidates had been identified for the positions and were set to begin training at the end of April 2021. Due to the staff shortage the program has been closing every Saturday since February 13, 2021 and furloughing any youth that were in the program that day. During the week, the program was able to cover all shifts by current staff working extra hours or being held over from the previous shift. The Regional Coordinator reported, with the recent new hires, the program should be fully staffed and able to operate seven days a week by the beginning of May 2021.

The shelter follows a daily schedule that allows time for school, homework, reading, meals, recreation, and sleeping. The schedule is posted in all common areas throughout the shelter.

The shelter utilizes the FACE System (Facilitating Activity & Communication Effectively) with the intent of increasing youth involvement in the program. Behavioral Expectation forms are reviewed between staff and youth so there is a clear plan designed for each youth to progress. The FACE System is comprised of three phases: Assessment, Daily, and Achievement. The youth are able to maneuver through the phases, gaining privileges based on their compliance with rules and through demonstrating that they are mastering their targeted skills. Youth are provided with an orientation packet at intake explaining in detail the Behavior Management System (FACE).

CDS Family & Behavioral Health Services, Inc. - Interface Central is licensed by the Department of Children and families for twenty beds. The agency serves both CINS/FINS and DCF program participants. At the time of the review the shelter had four CINS/FINS youth.

Standard 4

The residential counseling services in the shelter are overseen by the Regional Coordinator who is a Licensed Mental Health Counselor (LMHC). Services are provided by two, master's level, residential Counselors.

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

Health services are overseen by a part-time registered nurse (RN). The RN is on-site seven days a week for a total of twenty hours a week. The RN will distribute all medications when on-site and trained youth care workers will distribute medications when the RN is not on-site. The RN provides various trainings for staff, including Medication Administration. All staff are CPR and first aid certified.

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

inventories of all other medications. The shelter does not maintain any over-the-counter medications.

The overall findings for the QI Review for CDS Family and Behavioral Health Services, Inc.– Interface Central are summarized as follows:

Standard 1: This standard has a total of seven indicators regarding management accountability. Six of the seven indicators were rated satisfactory. Indicator 1.04 Training Requirements was rated limited. The reasonings for this limited rating are listed below. With the exception of indicator 1.04 all other indicators in this standard were rated satisfactory with no exceptions.

Standard 2: This standard has a total of ten indicators that relate to intervention and case management. All ten indicators were rated satisfactory with no exceptions noted.

Standard 3: This standard has a total of seven indicators regarding shelter care. Six of the seven indicators were rated satisfactory. Indicator 3.06 Staffing and Supervision was rated a limited. The reasonings for this limited rating are listed below. There was an exception noted in indicator 3.07 Video Surveillance System due the camera views being off by one or more hours, making the system time consuming and difficult to use.

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.

Summary of Deficiencies resulting in Limited or Failed Rating:

Standard 1: Indicator 1.04 Training Requirements was rated a limited due two staff not completing the DOJ Civil Rights and Federal Funds training and one staff completing the training late. Also, one newly hired staff did not complete all required trainings in the first 90 days of employment. Lastly, four staff training files reviewed for annual training requirements did not complete the required trainings or hours for the last completed training cycle.

Standard 3: Indicator 3.06 Staffing and Supervision was rated a limited due to the review the program not being sufficiently staffed to be able to operate seven days a week. Since February 13, 2021 until the date of the review the program was closing on Saturdays and furloughing any youth who were at the program that day. The remainder of the week the program was able to cover shifts by staff working extra hours or staff being held over from the previous shift. Also, there were eleven instances in the last six months when bed checks exceeded the fifteen minute requirement.

CINS/FINS QUALITY IMPROVEMENT TOOL

Quality Improvement Indicators:	Satisfactory	Non-compliant	No Eligible Items for Review (N)	No Practice (NP)	Not Applicable	Review Based Upon Document Source	Notes
Standard One – Management Accountability							
1.01: Background Screening and compliance with DJJ OIG statewide procedures regarding BS of employees, contractors and volunteers							
Provider has a written policy and procedure that meets the requirement for Indicator 1.01						YES **X** NO (explain) The program has two policies in place to address background screening requirements, P-1025 Background Check, Reference Check, Fingerprinting for Personnel, Volunteers, or Interns, and P-1285 Pre-employment Suitability Assessment. The policies were last reviewed on January 20, 2021 by the Chief Operations Officer.	
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 seven new staff were hired since the last QI review. Four of the staff met the criteria for a pre-screening assessment. The agency uses the Criteria Assessment. All four staff had a Criteria Assessment completed and documented a passing rate.	
Background screening completed prior to hire/start date or exemption obtained prior to working with youth (if rated ineligible) for new hires, volunteers/interns, and contractors	**X**					A total of seven new staff were hired since the last QI review. All seven staff were background screened prior to hire.	
Five-year re-screening completed every 5 years from initial date of hire	**X**					There were a total of five staff applicable for a five-year rescreening during this review period. All five staff had a re-screening completed prior to the initial date of hire.	

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 1/7/2021.	
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 seven 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 X NO (explain)** The program has four policies in place to address the Provision of an Abuse Free Environment. The policies are P-1044 Florida Abuse Reporting, P-1105 Complaint/Grievance Process for Participants or Companions with Disabilities, P-1128Rule Violations, and P-1212 Standards of Conduct. The policies were last reviewed on January 20, 2021 Chief Operations Officer.	
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 maintains a code of conduct which prohibits the use of physical abuse, profanity, threats, or intimidation that all staff must adhere to. This is reviewed with staff at hire.	
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 in the lobby, the hallway, in both the boys and girls dayrooms, and in the dining area of the shelter.	
Youth were informed of the Abuse and Contact Number (see youth survey results)	**X**					A review of five shelter 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 identified and/or 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 two accessible grievance boxes that are	

						locked and located in the dayrooms of the boys' and girls' dorms. The Lead Case Manager has a key to the boxes, and they are checked daily.	
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**			The program reported there have been no grievances files since the last QI review.	
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**			The program reported there have been no grievances files since the last QI review.	
1.03: Incident Reporting							
Provider has a written policy and procedure that meets the requirement for Indicator 1.03						**YES X NO (explain)** The program has a policy for Incident Reporting, P-1045 Incident Reporting Procedures. The policy was last reviewed January 20, 2021 by the Chief Operation 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 than two hours after any reportable incident occurred or within two hours of the program learning of the incident	**X**					There were six CCC reports reviewed during the last six months. All six incidents were reported to the CCC 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 six reports documented follow-up communication and tasks were completed as required and the reports were successfully closed.	
Incidents are documented in the program logs and on incident reporting forms	**X**					All six reports were documented in the programs logbook and also documented on incident reporting forms.	
All incident reports are reviewed and signed by program supervisors/directors	**X**					All incident reports reviewed were signed by the person completing the report and by a supervisor and director.	

1.04: Training Requirements (Staff receives training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions)							
Provider has a written policy and procedure that meets the requirement for Indicator 1.04						**YES X NO (explain)** The program has a policy in place titled P-1030 Training Policy to address the requirements of this indicator. The policy was last reviewed on January 20, 2021 by the Chief Operations Officer.	
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 were eight staff training files reviewed. Five of the eight staff completed the DOJ Civil Rights and Federal Funds training in the required time frames.	**Exception:** Two of the eight staff training files reviewed did not document the staff completed the DOJ Civil Rights and Federal Funds training. One staff completed the training; however, it was completed late and not within the staff's first 30 days of hire.
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. Two of the three staff were still within their first 90 days of employment and were on track to receive all required trainings within the first 90 days. Both staff still had approximately one month left to receive five trainings.	**Exception:** The remaining staff had completed their first 90 days; however, did not complete four required trainings.
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. Two of the three staff were still within their first 90 days of employment and were on track to receive all required trainings within the first year. The remaining staff had completed their first year of employment and documented 122.5 training hours. This staff also documented all required DJJ SkillPro trainings.	**Exception:** One staff did not complete four required 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 five staff training files reviewed for in-service training requirements. One staff documented more than the required 40 hours of annual training and all required trainings for their last completed training cycle and the current training cycle.	**Exception:** The remining four staff were not on track to receive all required trainings and hours for the current training cycle. The staff were in the last quarter of the current training cycle and had received 10, 5.5, 6, and 23 hours and all still needed to complete more than half of the required trainings. These same four staff also did not complete 40 hours of training for the last competed cycle. The staff received 18.5, 12, 27.5, and 19.5 of the required 40 hours and did not complete all required trainings.
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 eight 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 X NO (explain)** The program has a policy in place titled P-1049 Risk Management Plan that addresses the requirements of this indicator. The policy was last reviewed on January 20, 2021 by the Chief Operations Officer.	
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 program conducts quarterly participant, peer, and supervisor reviews on two open and two closed files. A report is created from this data and shared with program staff.	
The program conducts reviews of incidents, accidents, and grievances quarterly, at a minimum	X					There was documentation provided to show incidents, accidents, and grievances are reviewed monthly at the staff meetings.	
The program conducts an annual review of customer satisfaction data	X					The annual CDS performance and risk management report from the past fiscal year was reviewed. The report included performance analysis data from participant satisfaction surveys, demographics of all participants, performance and projections, monthly shelter utilization, outreach, risk, and issue distribution. Other areas addressed included annual data collection of screenings, admissions, discharges, emergency shelter participants, NetMIS data entry, medical emergencies, incident summary report, and personnel summaries.	
The program conducts an annual review of outcome data and (if applicable) there is evidence of annual reconciliation that occurs through communication from the Florida Network via email or phone call when corrections are needed and the information is corrected and submitted within the requested timeframes.	X					The annual CDS performance and risk management report from the past fiscal year was reviewed. The report included performance analysis data from participant satisfaction surveys, demographics of all participants, performance and projections, monthly shelter utilization, outreach, risk, and issue distribution. Other areas addressed included annual data collection of screenings, admissions, discharges, emergency shelter participants, NetMIS data entry, medical	

						emergencies, incident summary report, and personnel summaries. The program reported they had completed their annual reconciliation with the Florida Network and all corrections were made.	
The program conducts a monthly review of NetMIS data reports.	X					NetMIS data reports are reviewed monthly during the management team meetings.	
The Florida Network conducts monthly reconciliation by comparing NetMIS data to JJIS data. Agency has evidence that they have reconciled any differences noted.	X					Data entry and collection is reviewed monthly during the management team meetings. The Data Department for the agency will print out monthly JJIS and NETMIS reports. These reports are reviewed with all management staff during the meeting to ensure data accuracy. Any changes that need to be made are made at that time.	
The program has a process in place to review and improve accuracy of data entry & collection	X					Data entry and collection is reviewed monthly during the management team meetings. The Data Department for the agency will print out monthly JJIS and NETMIS reports. These reports are reviewed with all management staff during the meeting to ensure data accuracy. Any changes that need to be made are made at that time.	
There is documentation that findings are regularly reviewed by management and communicated to staff and stakeholders.	X					All findings are shared and reviewed with management and staff during monthly staff meetings. Meeting minutes reviewed confirmed this information is reviewed. The agency also submits a monthly packet to the Board of Directors for each program operated by the agency. The packet includes all outcome data and a review of any incidents that happened at the shelter during that month. Each program also provides the Board with a summary of program updates for the month. This packet is reviewed during the Board meeting as evidenced by meeting minutes.	
There is evidence that strengths and weaknesses are identified, improvements are implemented or modified, and staff are informed and involved throughout the process.	X					Any improvements or corrective actions needed are implemented when the issues are discussed at the monthly staff meetings. Meeting minutes also confirmed that strengths and weaknesses are identified.	

Provider has a written policy and procedure that meets the requirement for Indicator 1.06						**YES X NO (explain)** The program has a policy in place for client transportation requirements titled P-1013 Vehicle Use and Safety Inspection. The policy was last reviewed on January 20, 2021 by the Chief Operations Officer.	
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 P-1013 Vehicle Use and Safety Inspection 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**					A review of vehicle logs for the last six months documented all single client transports had a supervisor's approval obtained prior to the transport taking place.	
The 3rd party an approved volunteer, intern, agency staff, or other youth	**X**					The 3rd party present 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**					All vehicle logs reviewed included the name and initials of the driver, the date and time, mileage, number of passengers, purpose of the travel, and location. Logs reviewed for the last six months were filled out in their entirety.	

Provider has a written policy and procedure that meets the requirement for Indicator 1.07						**YES X NO (explain)** The program has two policies in place to address the requirements of outreach services, P-1050 Outreach Plan for Targeting Youth for Program Services and P-1053 Roles and Responsibilities –Prevention Outreach. The policies were last reviewed on January 20, 2021 by the Chief Operations Officer.	
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					There was documentation through emails to show a representative from the program attends the Alachua County Juvenile Justice Council meetings and the Circuit 8 Board Meetings. Due to Covid-19 these meetings have been held virtually so there were no sign-in sheets available.	
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 evidence of outreach events by providing the NetMIS outreach report which includes title of event, date of event, number of youth and adults in event, purpose of event, and what area event took place in the community. 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 current, up-to-date, Cooperative Service Agreements with Meridian Behavioral Healthcare, Alachua County Coalition Against Human Trafficking, Alachua County Health Promotion and Wellness Coalition, Child Advocacy Center of Gainesville, Alachua County Sheriff's Office, Levy County Prevention Coalition, Gilchrist County Schools, The School Board of Alachua County to participate in the implementation of the Too Good for Drugs and Too Good for Violence programs, and a Universal Agreement for Emergency Disaster Shelter for Florida Network Member Agencies.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.01						**YES X NO (explain)** The program has three different policies to address the requirements of this indicator. The policies titled P-1112 Intake/Assessment, P-1113 Screening for Eligibility and Target Population, and P-1115 24-Hour Telephone Access were all last reviewed on January 20, 2021 by the Chief Operations Officer.	

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, two open and three 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 program has a policy titled P-1019 Needs Assessment that addresses the requirements of the indicator. The policy was last reviewed January 20, 2021 by the Chief Operations 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, two open and three 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**					All ten Needs Assessments were signed by a supervisor upon completion.	
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**			None of the files reviewed documented 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**			None of the files reviewed documented the youth identified with an elevated risk of suicide as a result of the Needs Assessment.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.03						**YES X NO (explain)** The program has a policy titled P-1162 Individual Plan that addresses the requirements of the indicator. The policy was last reviewed January 20, 2021 by the Chief Operations 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, two open and three 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	**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, six files include actual goal completion dates while two shelter file and two community counseling files are still open. All ten	

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						Service Plans had the signature of the counselor, supervisor, youth, and 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**					All five community counseling files were applicable for 30 day reviews. All of the 30 day reviews in these files were completed as required. The five shelter 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 X NO (explain)** The program has a policy titled P-1163 Case Management, Counseling, and Service Delivery to address the requirements of the indicator. The policy was last reviewed on January 20, 2021 by the Chief Operations Officer.	
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, two open and three 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	**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. None of the files were applicable for referring the youth and family to the case staffing committee. None of the files were applicable for accompanying youth/guardian to court hearings and related appointments. All ten files were applicable and referred the youth/family for additional services. All ten files provided case monitoring and reviews. All six applicable files provided case termination documentation. There were six files applicable for providing follow-up after 30 days of exit and four files after 60 days of exit. All follow-up calls were completed as required.	

parent/guardian to court hearings and related appointments 8. Refers the youth/family for additional services when appropriate 9. Provides case monitoring and reviews court orders 10. Provides case termination notes 11. Provides follow-up after 30 days of exit 12. Provides follow-up after 60 days of exit							
The program maintains written agreements with other community partners that include services provided and a comprehensive referral process	**X**					The program has current, up-to-date, Cooperative Service Agreements with Meridian Behavioral Healthcare, Alachua County Coalition Against Human Trafficking, Alachua County Health Promotion and Wellness Coalition, Child Advocacy Center of Gainesville, Alachua County Sheriff's Office, Levy County Prevention Coalition, Gilchrist County Schools, The School Board of Alachua County to participate in the implementation of the Too Good for Drugs and Too Good for Violence programs, and a Universal Agreement for Emergency Disaster Shelter for Florida Network Member Agencies.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.05						**YES X NO (explain)** The program has a policy titled P-1163 Case Management, Counseling, and Service Delivery to address the requirements of the indicator. The policy was last reviewed on January 20, 2021 by the Chief Operations Officer.	
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, two open and three 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 b. Opportunity for youth engagement c. Clear and relevant topic (informational/developmental/ educational) d. Clear leader or facilitator	**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.	
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**					The program conducts quarterly participant, peer, and supervisor reviews on two open and two closed files. 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 program has three different policies in place to address this indicator, P-1157 Case Staffing Committee: Plan of Services, P-1159 Case Staffing Committee: Review and Committee Composition, and P-1160 Case Staffing Committee: Parent/Guardian Request. The policies were reviewed on January 20, 2021 by the Chief Operations 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			The program has not conducted any case staffing's since the last QI review.	
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			The program has not conducted any case staffing's since the last QI review.	
Case Staffing Committee							
Must include: a. DJJ rep. or CINS/FINS provider b. Local school district representative			X			The program has not conducted any case staffing's since the last QI review.	
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			The program has not conducted any case staffing's since the last QI review.	
The program has an established case staffing committee, and has regular communication with committee members	X					The program has an established case staffing committee that can meet when needed.	
The program has an internal procedure for the case staffing process, including a schedule for committee meetings	X					The program has a policy and procedures in place for the case staffing process. The committee can meet whenever needed.	

As a result of the Case Staffing							
The youth and family are provided a new or revised plan for services			**X**			The program has not conducted any case staffing's since the last QI review.	
Written report is provided to the parent/guardian within 7 days of the case staffing meeting, outlining recommendations and reasons behind the recommendations			**X**			The program has not conducted any case staffing's since the last QI review.	
If applicable, the program works with the circuit court for judicial intervention for the youth/family			**X**			The program has not conducted any case staffing's since the last QI review.	
Case Manager/Counselor completes a review summary prior to the court hearing			**X**			The program has not conducted any case staffing's since the last QI review.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.07						**YES X NO (explain)** The program has a policy in place titled P-1046 Youth Case Records that addresses the requirements of the indicator. The policy was last reviewed on January 20, 2021 by the Chief Operations 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 locked file cabinet that was marked confidential located in the administrative office.	
When in transport, all records are locked in an opaque container marked "confidential"	**X**					The program uses a locked, black, opaque case that is marked confidential 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 program has a policy titled P-1284 Sexual Orientation, Gender Identity, Gender Expression that addresses the requirements of the indicator. The policy was last reviewed on January 20, 2021 by the Chief Operations 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 b. Youth's preferred name and gender pronouns are used in logbook and on all outward-facing documents and census boards			**X**			A review of the Florida Network's SOGIE Report as of March 8, 2021 and an interview with program staff confirmed there have been no youth who have fallen under the requirements of this indicator since the last Quality Improvement review.	
Youth in need of specialized support is referred to qualified resources (as applicable)			**X**			A review of the Florida Network's SOGIE Report as of March 8, 2021 and an interview with program staff confirmed there have been no youth who have fallen under the requirements of this indicator since the last 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**			A review of the Florida Network's SOGIE Report as of March 8, 2021 and an interview with program staff confirmed there have been no youth who have fallen under the requirements of this indicator since the last Quality Improvement review.	
Youth is provided hygiene products, undergarments and clothing that affirms their gender identity or gender expression			**X**			A review of the Florida Network's SOGIE Report as of March 8, 2021 and an interview with program staff confirmed there have been no youth who have fallen under the requirements of this indicator since the last 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, hallways, and both dayrooms of the facility.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.09						**YES X NO (explain)** The program has six policies addressing the requirements of special populations, P-1249 Staff Secure Shelter –Program Overview, P-1248 Staff Secure Shelter Services, P-1282 Domestic Minor Sex Trafficking, P-1267 Domestic Violence Respite, P-1279 Probation Respite, P-1283 Family/Youth Respite Aftercare Services (FYRAC). These policies were last reviewed on January 20, 2021 by the Chief Operations Officer.	
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: 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	**X**					The program's policy titled P-1248 Staff Secure Shelter Services covers all requirements for staff secure services.	
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			**X**				

all other general CINS/FINS program requirements							
Domestic Violence							
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? **(If no, select rating "No eligible items for review")**	**YES** **X**	**NO**	**N/A**				
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Youth admitted to DV Respite placement have a pending DV charge and have evidence of being screened by JAC/Detention, but do not meet criteria for secure detention	**X**					There was one closed file available for review for the last six months. The file had a face sheet indicating a pending DV charge and the youth was 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**					There was evidence of data entry within three business days of intake and discharge.	
Youth in program do not have length of stay in DV Respite placement that exceeds 21 days. If more than 21 days, documentation exists in youth file of transition to CINS/FINS or Probation Respite placement, if applicable.	**X**					The youth did not stay in the program longer than 21 days.	
Case plan in file reflects goals focusing aggression management, family coping skills, or other intervention design to reduce reoccurrence of violence in the home	**X**					The Service Plan 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**					The 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	**YES**	**NO** **X**	**N/A**			The provider has not served any youth meeting the criteria for Probation Respite since the last QI review.	

last onsite QI review was conducted? **(If no, select 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**				
Probation Respite Referral come from DJJ Probation and are all youth referred on probation regardless of adjudication status			**X**				
Data entry into NetMIS and JJIS within (3) business days of intake and discharge			**X**				
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**				
All case management and counseling needs have been considered and addressed			**X**				
All other services provided to Probation Respite youth are consistent with all other general CINS/FINS program requirements			**X**				
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**			This program does not 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							
Services for youth and family include:							

a. Four (4) direct contacts per month b. Four (4) collateral contacts per month							
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)							
Case plan demonstrates a strength-based, trauma-informed focus							
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							
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.	
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			**X**				

household member, and/or the youth is on probation regardless of adjudication status and at risk of violating							
Agency has evidence that all FYRAC referrals have documented approval from the Florida Network office			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 b. Shall be no more than eight (8) youth at one (1) time and shall be for a minimum of sixty (60) minutes per session			X				
Youth and family participate in services for thirteen (13)			X				

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							
2.10: STOP NOW AND PLAN (SNAP)							
Provider has a written policy and procedure that meets the requirement for Indicator 2.10						**YES X NO (explain)** The program has five policies to address SNAP services, P-1286 SNAP Intake, P-1287 SNAP Group Delivery, P-1288 SNAP Fidelity Adherence Monitoring, P-1289 SNAP Discharge Requirements, and P-1290 SNAP in Schools. All policies were reviewed on January 20, 2021 by the Chief Operations Officer.	
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**					There were four files reviewed, two open and two closed. All four files had the NetMIS Screening form and SNAP Brief Intake Screening form.	
Needs assessment is completed at initial intake, or within two face-to-face sessions	**X**					Needs Assessment was initiated at intake in all four files.	
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**					A pre CBCL was completed in all four files. A post CBCL was completed in one of the closed files. The second closed file documented the family withdrew from services a few weeks after they began so no post assessment forms were completed. A pre TRF was sent to the teacher to complete in all four files. A completed TRF was not returned in any of the files; however, a follow-up email was sent to the teachers in an attempt to have the forms completed and returned. A post TRF was emailed to the teacher to complete in one closed file. The form was not returned; however, an email was sent to the teacher to attempt to have the form completed and returned. The second closed file documented the family withdrew from services a few weeks after they began so no post assessment forms were completed. A pre TOPSE was completed in all four files. A post TOPSE was completed in one closed file. The second closed file documented the family withdrew from services a few weeks after they	

						began so no post assessment forms were completed. A pre PAT was completed in all four files. A post PAT was completed in both closed files.	
SNAP discharge report summary	**X**					Both closed files had a SNAP discharge report summary.	
SNAP Boys/SNAP Girls **Parent** Group Evaluation Form	**X**					One closed file had a Parent Group Evaluation Form. The second closed file documented the family withdrew from services a few weeks after they began so the Parent Group Evaluation Form was not completed.	
SNAP Boys/SNAP Girls **Child** Group Evaluation Form	**X**					One closed file had a Child Group Evaluation Form. The second closed file documented the family withdrew from services a few weeks after they began so the Child Group Evaluation Form was not completed.	
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**					All 13 weekly attendance sheets were present with youth names and teacher and facilitator signatures.	
"Class Goal" sheet	**X**					"Class Shoot for Your Goal" sheet was completed.	
Measure of Classroom Environment (MoCE) (Pre and Post) is used to identify baseline and treatment outcomes of reported classroom dynamics.	**X**					There was a pre and post MoCE completed.	
Pre and Post Evaluations	**X**					Pre and post evaluations were present for all youth and the teacher.	
One SNAP® Fidelity Adherence Checklist completed per classroom in a 13 – week SNAP in Schools group and uploaded to Dropbox	**X**					There was one Fidelity Adherence Checklist completed during the 13-week group.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.01						**YES X NO (explain)**	

						The program has two policies in place to address the requirements of the indicator P-1122 Leisure Activities Program (LEAP), and P-1137 Faith Based Activities. The policies were reviewed on January 20, 2021 by Chief Operating 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 were secured with key access required. Egress plans were posted in several locations. The client rules, abuse hotline information, and DJJ incident reporting information was posted on a bulletin board in each dayroom and the hallway. Blank grievance forms were available located next to the locked grievance box in each dayroom. The program has two vans used for transporting youth which were equipped with major safety equipment as required. Interior areas of the vans 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. A current DCF license was displayed with an effective date of April 1, 2021. Each youth has their own individual bed with clean, covered mattress, pillow, and sufficient linens. The program has a locked cabinet that serves as a safe place for youth to keep their personal belongings.	
Fire and Safety Health Hazards	**X**					The annual fire inspection was completed on March 25, 2021. The annual fire sprinkler inspection was March 24, 2021. The annual fire extinguisher inspection was January 27, 2021. The annual fire alarm inspection was April 9, 2021. A review of drills indicated the program conducted on average three fire drills per month. The program also completed mock emergency drills, including at a minimum, one per shift per quarter. Residential Group Care inspection was completed on March 10, 2021 and Food	

						Establishment Inspection was completed on September 23, 2020. The kitchen exhaust inspection was November 2, 2020. Menus were posted and signed by a licensed dietician on January 23, 2021. Cold food was properly stored, marked, and labeled, and dry storage/pantry areas were clean. Refrigerators/freezers were clean, and temperatures were 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**					Youth are engaged in meaningful structured activities seven days a week during awake hours. The youth receive at least one hour per day of physical activity. Youth are given the opportunity to participate in a variety of faith-based activities. Daily programming includes opportunities for youth to complete homework and access a variety of age appropriate, program approved books for reading. Daily programming schedule is posted throughout the program in common areas, dining area, and hallways.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.02						**YES X NO (explain)** The program has a written in place titled P-1114 Admission/Intake and Participation Orientation to address the requirements of the indicator. The policy was last reviewed on January 20, 2021 by the Chief Operating 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 shelter files reviewed, two open and three closed. An 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 orientation process is thorough, including a handbook given to each youth and an explanation of disciplinary actions, grievance, and emergency procedures. Rules regarding contraband, dress code, procedures for visitation, mail, and telephone calls were outlined. Access to medical and mental health services were explained as well as suicide prevention (alerting staff of their own feelings or awareness of others having suicidal thoughts). Youth were given a tour of the facility and each youth was assigned an appropriate bed and introduced.	
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					Documents of each component of orientation including orientation topics and the date presented were present in each file. Initials and the signatures of both staff and youth were noted in each file reviewed.	

Provider has a written policy and procedure that meets the requirement for Indicator 3.03						**YES X NO (explain)** The program has a policy in place titled P-1116 Youth Room Assignment that addresses the requirements of the indicator. The policy was last reviewed on January 20, 2021 by the Chief Operating Officer.	
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 shelter files reviewed, two open and three closed. Each file indicated a process for the youth room assignment including initial classification of the youth, with consideration given to potential safety and security concerns. The youth intake form includes a review of youth history, exposure to trauma, age, gender, gender identification, physical stature, disabilities, and history of violence, gang affiliation, sexually aggressive behavior, and suicide risk. Collateral contacts were documented as well as initial interactions and observations of youth.	
An alert is immediately entered into the program's alert system when a youth is admitted with special needs and risks such as risk of suicide, mental health, substance abuse, physical health or security risk factors	**X**					Alerts are immediately documented in youth files at intake including the following: special needs and risks, risk of suicide, mental health, substance abuse, physical health, and security risk factors.	

Provider has a written policy and procedure that meets the requirement for Indicator 3.04						**YES X NO (explain)** The program has a policy in place titled P-1149 Log Books that addresses the requirements of the indicator. The policy was last reviewed on January 20, 2021 by the Chief Operating Officer.	
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 October 1-7, 2020, November 8-14, 2020, December 13-19, 2020, January 24-30, 2021, February 1-9, 2021, and March 7-13, 2021. 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**					Any errors were corrected properly with one line drawn and marked with initials.	
The program director or designee reviews the facility logbook(s) every week and makes a note chronologically in the logbook indicating the dates reviewed and if any correction, recommendations and follow-up are required and sign/date the entry	**X**					The Residential Supervisor reviews the logbook weekly documenting a note which indicates dates reviewed and any corrections needed.	
All staff review the logbook of the previous two shifts and makes an entry signed and dated into the	**X**					Direct care staff are reviewing the log for the previous two shifts at the start of their shift and make an entry into the logbook indicating dates reviewed.	

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**					Supervisors and counselors are reviewing the logbook of all shifts since their last log entry to become aware of any unusual occurrences, problems, etc. They sign and date the logbook indicating the dates reviewed.	
Logbook entries include: a. Supervision and resident counts b. Visitation and home visits	**X**					Supervision and youth counts were documented clearly at the beginning of each shift, including the youth's first and last name. Visitation and home visits were documented clearly.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.05						**YES X NO (explain)** The program has several policies in place to address Behavior Management Strategies. Policies P-1222, P-1123, P-1125, P-1126, P-1127 and P-1128 were last reviewed on January 20, 2021 by the Chief Operating Officer.	
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**					Youth are provided with an orientation packet at intake that clearly explains the Behavior Management System (FACE). There were two open files and three closed files reviewed. Documentation was found in each file that the youth signed indicating that they were given information on the Behavior Management System during the intake process.	
Behavior Management Strategies MUST include: a. Supervisors are trained BMS is designed to teach youth new behaviors and help youth understand the natural consequences for their actions b. Behavioral interventions are applied immediately, with	**X**					The FACE System consists of three phases: Assessment, Daily, and Achievement. The Assessment phase is entry level lasting for three days designed to give the youth the opportunity to become familiar with the system. The Daily phase is where the youth is expected to understand the system and demonstrate the appropriate life skill behaviors and accumulates points assigned by staff towards privileges. The Achievement phase differs from the	

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, services, exercise, or correspondence privileges						Daily phase in that youth have the opportunity to engage with staff in negotiating their points to obtain their privileges for the next 24 hours. Youth earn points by demonstrating specifically defined life skills. Privileges are acquired by earning the expected number of points. Points are documented and tracked on the Point Sheet form in 24-hour intervals. Staff provide feedback to the youth on why points are earned or not earned. Advancement through the phases is determined by the youth's progress towards reaching different milestones of the system. The system prohibits group discipline and room restriction. Youth are never denied any basic rights.	
Program's Use of the BMS							
All staff are trained in the theory and practice of administering BMS rewards and consequences	**X**					All staff are trained on the Behavior Management System (FACE) during the orientation period. A review of three newly hired staff training files confirmed this practice.	

There is a protocol for providing feedback and evaluation of staff regarding their use of BMS rewards and consequences	**X**					All staff receive supervision regarding their implementation of the system both individually and during staff meetings.	
Supervisors are trained to monitor the use of rewards and consequences by their staff	**X**					Supervisor's monitor the use of rewards and consequences by their staff by reviewing the Point Sheet forms.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.06						**YES X NO (explain)** The program has two policies to address Staffing and Youth Supervision. Policies P-1121and P-1133 were last reviewed on January 20, 2021 by the Chief Operating Officer.	
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, March 6, 2021 from 12am - 1am, March 30, 2021 from 2am - 3am, April 3, 2021 from 4am - 5am, April 7, 2021 from 1am - 2am, and April 10, 2021 from 3am – 4am. A review of the program schedules for the last six months indicated that all shifts were covered appropriately with at least two staff on each shift until Saturday February 13, 2021. From February 13, 2021 and on, the staff schedules did not consistently show two staff on each shift and Saturdays showed no staff scheduled. The Regional Director explained that the program has been short staffed, so the schedule has been confirmed at the last minute by staff working extra shifts or staff being held over and not written in on the schedule. Also, due to the staff shortage the program has been closing every Saturday since February 13th until the date of the review due to not having enough staff to cover the shifts. This is why the schedule showed no staff on those Saturdays. A more thorough review of the program logbook, the above listed video surveillance sample, and an on-site visit and interview with program staff confirmed there was sufficient coverage for each shift. The agency has hired four more staff, with three of those staff beginning training on April 16, 2021 and the fourth	**Exception:** At the time of the review the program was not sufficiently staffed to be able to operate seven days a week. Since February 13, 2021 until the date of the review the program was closing on Saturdays and furloughing any youth who were at the program that day. The remainder of the week the program was able to cover shifts by staff working extra hours or staff being held over from the previous shift.

						staff still in the screening process. By the beginning of May 2021, the program should be fully staffed and able to operate seven days a week.	
All shifts must always provide a minimum of two staff present	**X**					The program had a minimum of two staff present for all shifts reviewed that the program had youth on-site.	
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**					Program staff included in staff-to-youth ratio, only includes properly trained and background screened Youth Care Workers, Supervision Staff and Treatment Staff.	
The staff schedule is provided to staff or posted in a place visible to staff	**X**					The program has the staff schedule posted in the staff office, accessible to all staff.	
There is a holdover or overtime rotation roster which includes the telephone numbers of staff who may be accessed when additional coverage is needed	**X**					There is protocol in place to ensure there is coverage in the event staff call out or there is a vacancy in the schedule. The roster that includes phone numbers of staff is located in a binder in the staff office.	
Staff observe youth at least every 15 minutes while they are in their sleeping room, either during the sleep period or at other times, such as during illness or room restriction		**X**				Bed checks are done by two methods. The program uses hand-held scanners. Staff scan the barcodes, located in the dorm rooms and it is electronically entered into the program's system. Reports of these recorded scans are printed and signed by staff. If the scanners are not used, staff record bed checks manually in the bed check log and signs the bottom when completed. The video surveillance system was reviewed for the random samples listed above, as well as reports from the hand-held scanners, for the last six months. For the most part youth were observed every fifteen minutes while they are sleeping with a few exceptions.	**Exception:** There were eleven instances in the last six months when the bed checks exceeded fifteen minutes.
Provider has a written policy and procedure that meets the requirement for Indicator 3.07						**YES X NO (explain)** The program has a policy in place to address the Video Surveillance System. Policy P-1280 was last reviewed on January 20, 2021 by the Chief Operating Officer.	

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 b. System can capture and retain video photographic images which must be stored for a minimum of 30 days c. System can record date, time, and location; maintain resolution that enables facial recognition d. Back-up capabilities consist of cameras' ability to operate during a power outage e. Have cameras placed in interior and exterior general locations of the shelter where youth and staff congregate and where visitors enter and exit. Cameras are never placed in bathrooms or sleeping quarters. f. All cameras are visible		X				Observed cameras and written notices during the virtual and on-site tour. System can capture and retain video images for up to thirty 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 in case of power outage. All cameras were visible, and no cameras were located in the bathrooms or sleeping rooms.	**Exception:** At the time of the review the camera views were off by one or more hours, making the system time consuming and difficult to use.
A list of designated personnel who can access the video surveillance system is maintained (includes off-site capability per personnel)?	X					The program maintains a list of staff who can access the video surveillance system. The list consisted of 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. The reviews included a random sample of overnight shifts and assessed the activities of the facility and included any corrections needed.	
Grant the requesting of video recordings to yield a result within	X					The program has procedures in place to handle requests of video recordings within 24 – 72 hours.	

24-72 hours from program quality improvement visits and when an investigation is pursued after an allegation of an incident							
Camera service order/requests will be made within 24 hours of discovery of camera malfunctioning or being inoperable. All efforts made to obtain repairs are documented and maintained	**X**					The program provided evidence of a work order submitted to the camera company after discovering the camera views were off between one and four hours. The work order was submitted shortly after the company had already been on-site, on 4/12/2021, to address the problem and stated the cameras had been recalibrated to synchronize and be accurate and exact in terms of time. At the time of the review the program was still waiting on the company to come back and address the problem.	
Provider has a written policy and procedure that meets the requirement for Indicator 4.01						**YES X NO (explain)** The program has a policy titled P-1117 Preliminary Physical Health Screening and a policy titled P-1119 Medical Follow-Up, to address the requirements of this indicator. These policies were last reviewed on January 20, 2021 by the Chief Operating Officer.	
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 shelter files reviewed, two open and three closed. 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 five youth presented with chronic conditions requiring a referral to ensure medical care.	
All medical referrals are documented on a daily log.			X			None of the five youth presented with chronic conditions requiring a referral to ensure medical care.	
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 program has a policy titled P-1144 Suicide Assessment and a policy titled P-1247 Mental Health, Substance Abuse, and Suicide Risk Screening to address the requirements of this indicator. These policies were last reviewed on January 20, 2021 by the Chief Operating 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 shelter files reviewed, two open and three closed. 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	X					Two out of the five youth were placed on sight-and-sound supervision until assessed by a mental health professional. A suicide risk assessment was	

based on the results of the suicide risk assessment.						completed by a licensed professional or non-licensed professional under the direct supervision of the licensed professional within 24 hours in both files. Both youth were appropriately removed from suicide precautions.	
Staff person assigned to monitor youth documented youth's behavior at 30 minute or less intervals	**X**					In both 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**					Both youth were removed from sight-and-sound supervision after a suicide risk assessment 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 X NO (explain)** The program has a policy to address Medication. Policy P-1120 was last reviewed on January 20, 2021 by the Chief Operating Officer.	
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 was completed. The Pyxis Med-Station is located in the staff office 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 the secured medication. The program has two 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 RN 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. This was confirmed in the eight staff training files reviewed.	
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. The program does not maintain syringes or sharps on site, so there is no inventory documentation. It is also noted the program does not keep, or distribute, over-the-counter medications.	
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 each shift. The RN also runs a weekly discrepancy report via the Knowledge Portal. Staff are aware that discrepancies should be cleared at the end of each shift.	
Provider has a written policy and procedure that meets the requirement for Indicator 4.04						**YES X NO (explain)** The program has a policy in place to address the Medical/Mental Health Alert Process. Policy P-1119 was last reviewed on January 20, 2021 by the Chief Operating 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 shelter files reviewed, two open and three closed. Three of the 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 the three applicable 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**					All eight staff training files reviewed confirmed staff are provided training on emergency medical care. Staff are also provided information and instructions on how to respond to each individual youth's medical/mental health problems on that 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. Alerts are also noted on the spine of the youth's file, and on the census board in the staff office. The agency has twenty-one coded alerts that include Sight & Sound, limited contact with parents, no contact allowed, runaway history, bed assignment concerns, allergies, diet restrictions, medication, medical conditions, mental health condition, physical limitations, mental limitations, fire setting history, suicide risk history, sexual acting out history, substance use history, staff secure, DV Respite, self-harm behaviors, and sleeping arrangements. 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 program has a policy in place to address Episodic/Emergency Care. Policy P-1166 was last reviewed on January 20, 2021 by the Chief Operating 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 off-site emergency care events reviewed. The shelter maintains an Emergency and Episodic Care Log that documents the date, youth involved, service needed, if the parent was notified, notification to the CCC, and discharge instructions. There was also an incident report completed for each event that documented a more detailed explanation of the incident, all notifications, and discharge instructions. Each incident was also found documented in the program logbook.	
All staff are trained on emergency medical procedures	**X**					There were eight staff training files reviewed. All eight staff had current First Aid and CPR certifications.	

The program has a Knife-for-life and wire cutters accessible to staff in a secure location(s)	**X**					The shelter has both a knife for life and wire cutters in the staff office.	
First aid kit/supplies are fully equipped and inventoried	**X**					First aid kits are located in the staff office and in both of the vans. The kits are checked weekly for expiration dates and replenished as needed.	