Florida Network for Youth and Family Services
Compliance Monitoring Report for

CDS Interface East
2919 Kennedy Street
Palatka, FL 32177

Compliance Monitoring Services Provided by

EXECUTIVE SUMMARY

Forefront LLC conducted a joint Quality Improvement (QI) and Florida Network of Youth and Family Services (FNYFS) monitoring visit for CDS Family and Behavioral Health Services, Inc. – Interface East for the FY 2020-2021 at its program office located at 2919 Kennedy Street, Palatka, 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 East is contracted with the Florida Network of Youth and Family Services (FNYFS) to provide direct services to Children/Families in Need of Services (CINS/FINS). The services to be provided are identified in Contract Section A - Descriptions and Specifications and Section B - Delivery and Performance and are funded with General Revenue Funds effective for July 2020 through June 30, 2021.

The review was conducted by Marcia Tavares, Consultant for Forefront LLC and Peer Reviewer(s). CDS Family and Behavioral Health Services, Inc. – Interface East present for the entrance interview were: Tracey Ousley, COO; Cynthia Starling, Regional Coordinator; Alex Culbreth, Residential Supervisor, Monica Heinecker, Senior Youth Care Worker, and Lytinia McCullough, community counseling Counselor. The last onsite QI visit was conducted March 4-5, 2020.

In general, the Reviewer found that CDS Family and Behavioral Health Services, Inc. – Interface East is in compliance with specific contract requirements. **CDS Interface East received an overall compliance rating of 100% for achieving full compliance with all eleven applicable indicators** of the CINS/FINS Monitoring Tool. There were no corrective actions or recommendations made as a result of the monitoring visit.

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

2020-2021 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 5-05-2020-2021

Agency Name: CDS Family and Behavioral Health Services, Inc. – Interface East	**Monitor Name: Marcia Tavares, Lead Reviewer**
Contract Type : CINS/FINS	**Region/Office: 2919 Kennedy St., Palatka, FL**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): May 5-6, 2021**

Major Programmatic Requirements	Explain Rating: Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable	Ratings Based Upon: I = Interview; O = Observation; D = Documentation; PTV = Submitted Prior To Visit; (List Who and What)	Notes: Explain Unacceptable or Conditionally Acceptable: (Attach Supportive Documentation)
I. Administrative and Fiscal							
DJJ Quality Improvement Peer Reviewer a. Provider shall demonstrate that a minimum of two (2) staff members have been trained to be certified as DJJ QI Peer reviewers. Provider shall participate in a minimum of one (1) on-site quality assurance review of a similar type program in another judicial circuit during each 12-month period of the contract, if requested.	☐	☐	☒	☐	☐	Interview: The program currently has at least two staff members certified as DJJ QI Peer reviewers, Cindy Starling and Alex Culbreth. Both staff members have participated as peer reviewer during the current FY.	
Additional Contracts a. Provider shall provide a listing of all current federal, state, or local government contracts, as well as other contracts entered into with for profit and not-for-profit organizations. Such listing shall identify the awarding entity and contract start & end dates. **PTV**	☐	☐	☒	☐	☐	Documentation: The agency provided a list of six additional current contracts for FY2020- 2021. The list includes: the contract #, the agency, contact info, service, start and end dates, date executed, annual amount, any changes to the contract. The program also maintains interagency agreements and Memorandums of Agreement (MOUs) with schools, mental health, and substance abuse providers. All of the agreements	

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						reviewed had current contract/agreement dates.	
Limits of Coverage a. Provider shall provide and maintain during this contract, the following minimum kinds of insurance: Worker's Compensation and Employer's liability insurance as required by Chapter 440, F.S. with a minimum of $100,000 per accident, $100,000 per person and $500,000 policy aggregate. Commercial General Liability with a limit of $500,000 per occurrence, and $1,000,000 policy aggregate. Automobile Liability Insurance shall be required and shall provide bodily injury and property damage liability covering the operation of all vehicles used in conjunction with performance of this contract, with a minimum limit for bodily injury of $250,000 per person; with a minimum limit for bodily injury of $500,000 per accident; with a minimum limit for property damage of $100,000 per accident and with a minimum limit for medical payments or $5,000-$10,000 per person. Florida Network is listed as payee or co-payee. **PTV**	☐	☐	☐	☒	☐	Documentation: General Liability through Berkshire Hathaway Specialty Insurance Company, for limits of coverage $1,000,000 each $3,000,000 aggregate, $20,000 individual medical expense, $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. Policy effective for 1/10/2021-1/10/2022.	

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						Workers Compensation through Bridgefield Employers Insurance Company for $500,000 each accident. Effective 5/1/21 – 5/1/22. 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.	
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, property and equipment, debt and other liabilities. The procedures reviewed appear to be consistent with GAAP and provide for sound internal	

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						controls. These polices were last reviewed in October 2019.	
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 3/31/2021, as of 4/26/2021. 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.	
c. Petty cash ledger system is balanced and all cash disbursements are compliant with financial policies and allowable under the contract. (Disbursements/invoices are approved & monitored by management.) –**ON SITE**	☐	☐	☒	☐	☐	Observation/Documentation: No change in practice was reported for the agency since the last onsite program review in March 2020. Reviewed petty cash Policy and Procedure was conducted. 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.	

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d. Financial records and reports are current. Includes bank statements reconciled within 6 weeks of receipt. Vendor invoices past 6 months. Invoices are submitted on a monthly basis with supporting documentation. (Disbursements/invoices are approved & monitored by management). **ON SITE**	☐	☐	☒	☐	☐	Documentation and Observation: Reviewed Bank Statements and Bank Reconciliations for the past six months for one account held with Center State Bank. Bank reconciliations during the monitoring period are documented by two signatures and status of reconciliation is noted including corrections/adjustments. All but one of the six bank reconciliations reviewed was conducted within 6 weeks of receipt of the bank statement for the preceding month. Invoices are submitted monthly with supporting documentation.	
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.	
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 Form 941 documentation for the 4th quarter 2020 and 1st quarter 2021 supporting payment of payroll taxes each payroll	

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						period to the IRS, for the last six months.	
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 Revenues 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.	
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 & Co., P.L. A report was issued on December 9, 2020. 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.	

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i. Agency maintains confidentiality policy with written policies and procedures to ensure the security and privacy of all employee and client data. Personal information is not easily accessible. Agency maintains a backup system in case of accidental loss of financial information. Security procedures are in place to protect laptops. Obsolete documents are shredded and computer hard drives are wiped prior to discarding. **ON SITE**	☐	☐	☒	☐	☐	Documentation: Policies and procedures for Back-up, IT Confidentiality Standards, Data Integrity, Record Elimination, Uses and Disclosures of Confidential and Protected Health Information Youth Case Record, and Security. 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 day to USB drive. 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 East 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, **the 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.

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 East CINS/FINS Program

May 5-6, 2021

Compliance Monitoring Services Provided by

FOREFRONT

Quality Improvement Review

CDS Family & Behavioral Health Services, Inc. – Interface East – May 5-6, 2021
Lead Reviewer: Marcia Tavares

CINS/FINS Rating Profile

Standard 1: Management Accountability

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

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

Standard 2: Intervention and Case Management

2.01 Screening and Intake	Satisfactory
2.02 Needs Assessment	Satisfactory
2.03 Case/Service Plan	Satisfactory
2.04 Case Management & Service Delivery	Satisfactory
2.05 Counseling Services	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)	N/A

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

Standard 3: Shelter Care & Special Populations

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

Percent of indicators rated Satisfactory: 85.71%
Percent of indicators rated Limited: 14.29%
Percent of indicators rated Failed: 0.00%

Standard 4: Mental Health /Health Services

4.01 Healthcare Admission Screening	Satisfactory
4.02 Suicide Prevention	Satisfactory
4.03 Medications	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: 96.43%
Percent of indicators rated Limited: 3.57%
Percent of indicators rated Failed: 0.00%

Rating Definitions

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

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

Reviewer

Members

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

Warren Garrison - Department of Juvenile Justice

Isabel Fernandes – Youth and Family Alternatives Inc.

Sudonna Harris – Orange County Youth Shelter

Shirley Moon – Thaise Educational & Exposure Tours

Quality Improvement Review

CDS Family & Behavioral Health Services, Inc. – Interface East – May 5-6, 2021
Lead Reviewer: Marcia Tavares

Methodology

This review was conducted in accordance with FDJJ-1720 (Quality Assurance Policy and Procedures), and focused on the areas of (1) Management Accountability, (2) Intervention and Case Management, and (3) Shelter Care/Health Services, which are included in the Children/Families in Need of Services (CINS/FINS) Standards (July 2020/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
0 # Healthcare Staff
N/A # 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
4 # MH/SA Records
6 # Personnel /Volunteer Records
7 # Training Records
19 # Youth Records (Closed)
7 # Youth Records (Open)
0 # Other: _____

Surveys

4 # Youth
12 # Direct Care Staff
0 # Other: **N/A**

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**.

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

CDS Family & Behavioral Health Services, Inc. is a private 501(c)(3) non-profit social services agency that has provided services in North Central Florida for over 40 years and has offices in Gainesville, Lake City, and Palatka, Florida. CDS Interface East is the Palatka location that provides residential and community counseling services in three counties, Bradford, Putnam, and Union, across Circuits 7 and 8.

The Regional Coordinator oversees both programs. The residential counseling program consists of one master's level counselor. The non-residential counseling program is housed on-site. The non-residential program consists of two, bachelor's level, counselor/case managers. Funding through CINS/FINS allows the agency to serve both male and female youth up to seventeen years old that are locked out, runaway, ungovernable and/or truant, homeless, abuse, neglected, or at-risk. The agency also provides services to special populations who meet the criteria for Staff Secure shelter, Domestic Minor Sex Trafficking (DMST), and youth referred by the Juvenile Justice Court System for domestic violence, probation respite, and Family and Youth Respite Aftercare services (FYRAC). CDS Interface East is not currently contracted to provide Intensive Case Management services and is not a SNAP provider. The youth census during the QI visit was 4 youth. The agency is currently accredited by the CARP through April 30, 2021 and is scheduled for reaccreditation in the summer of 2021.

The global pandemic has had a tremendous impact on all programs that serve children, youth and families. Despite the challenges presented, the agency focused heavily on a heightened level of safety for their staff and participants. CDS implemented sanitizing and cleaning schedules, temperature logs, essential visitor COVID questionnaires, and social distancing markers throughout the building. The agency also made numerous purchases related to the pandemic to include the following: three air scrubber purification systems, hands-free pumps for sanitizer, additional cleaning supplies, personal protective equipment, additional thermometers for staff, youth, and essential visitors. Other challenges related to the pandemic included maintaining contact and excellent counseling services with its youth and families. However, the programs adjusted by setting up virtual learning for youth, Zoom family sessions, and later in the year were able to meet parents outside for sessions. It also purchased new outside

chairs and tables to accommodate more outside visitors at the shelter. Unfortunately, the program had two periods where the shelter temporarily closed due to staff or youth who tested positive for COVID-19. The periods of temporary closure were: September 16-20, 2020 and December 18-27, 2020. Both closures were reported to DJJ Central Communication Center and CCC reports were submitted for the QI review.

Due to the pandemic, the program has struggled with the hiring and retention of Youth Care Workers especially for the weekend shifts. It has also had a significant number of staff turnover during the past year. The Residential Supervisor recently resigned, as did one of its registered nurses. Additionally, the Bradford/Union County non-residential counselor position has remained vacant since January 2021. Several youth care workers resigned after a very brief period of employment. However, there has been some internal promotions including a Residential Counselor to Residential Supervisor, a Senior YCW filled the vacant Administrative Assistant position and one of the program's outstanding YCW was promoted to Senior YCW.

Some additional good news is that the agency was awarded a three-year Basic Center grant effective 9/30/20 through 9/30/23. The grant allows the agency to add two new positions. In February 2021, it hired an Outreach/Safe Place Specialist and a Life Skills Educator.

Narrative Summary

CDS Interface East is under the leadership of a Regional Coordinator who oversees both residential and community counseling programs. The residential counseling program consists of one master's level counselor which was recently vacated with the promotion of said staff to the residential supervisor's position. The community counseling program is housed on-site and consists of two, bachelor's level, counselor/case managers, one of which was a vacant position. Per the organization chart, the residential program employs a senior youth care worker, 9.5 youth care FTEs, a part time house manager, and 2 part time registered nurses, one of which was vacant during the review. At the time of the review, the program had three total vacant positions as previously reported: 1 shelter Counselor, 1 community counseling position, and a part time nurse. The program has not reported any major challenges critical incidents, administrative review, or current external investigation outside the scope of the pandemic.

The overall findings for the QI review for CDS Interface East are summarized as follows:

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

Standard 2 has a total of ten indicators that relate to intervention and case management. One of the indicators, SNAP, is not applicable as CDS East is not a SNAP provider. Eight of the nine applicable indicators were rated satisfactory with no exceptions (2.01-2.04, 2.06, and 2.07), and one was rated satisfactory with exceptions (2.05).

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

Standard 4, Mental Health and Health Services, is comprised of five indicators. All five indicators were rated satisfactory with no exceptions (4.01 - 4.05).

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

Standard 3:
Indicator 3.06 – Limited

Staff during bed checks, on April 18th, did not physically check on the youths but documented completed bed checks for the times: 1:41 am – 1:49 am, 2:00am – 2:09 am, 2:20 am – 2:29 am and 2:29am – 3:02 am. Instead, staff scanned a piece of paper located on top of the table in the boy's day room and did not get up to physically check on the youth in their sleeping rooms.

CINS/FINS QUALITY IMPROVEMENT TOOL

Quality Improvement Indicators	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable	Review Based Upon Document Source *For example: Interview/Surveys, Observation, and/or Type of Documentation*	Notes Explain any items that have any deficiencies, exceptions or are not applicable.
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 agency has the required policies and procedures P-1025 and P-1285 that were approved by the Chief Operating Officer (COO) on 1/20/2021.	
Agency utilizes an employee suitability prescreening assessment with a passing rate criterion prior to an offer of hire for direct care staff working with youth or the agency has provided an explanation to for staff hired with a non-passing/low score.	**X**					The agency uses the Criteria Score Report pre-assessment tool. All three new hire staff documented a pre-employment suitability assessment was completed prior to hire using the Criteria assessment. All three staff documented an overall rating of medium or high.	
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**					Three new staff were hired since the last on-site Quality Improvement review. All three staff were background screened with eligible ratings received prior to the staff members' hire date. The program did not utilize any applicable volunteers or interns during the review period.	
Five-year re-screening completed every 5 years from initial date of hire	**X**					There were three eligible five-year re-screenings during this review period. Clearinghouse background screening documentation demonstrated current/active retained prints for all three staff.	
Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed	**X**					The agency submitted an Affidavit of Annual Compliance with Level 2 Screening Standards to the Department of Juvenile Justice Background Screening Unit via email on January 7, 2020.	

and sent to BSU by January 31st?							
Proof of E-Verify for all new employees obtained from the Department of Homeland Security	X					All three new hires had proof of E-Verify being completed from the Department of Homeland Security with authorization to work.	
1.02: Provision of an abuse free environment to ensure safety and abuse free environment for youth in care							
Provider has a written policy and procedure that meets the requirement for Indicator 1.02						**YES X NO (explain)** The agency has multiple written policies and procedures in place to address an abuse-free environment that include: P1032 Behavioral Expectations(staff), P1044 Abuse Reporting, P1105 Complaint/Grievance Process, P1128 Rule Violations, and P1212 Standards of Conduct (participants). The policies were last reviewed on January 20, 2021 and approved by the COO.	
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 agency has a written code of conduct policy (P-1212) that is a part of the agency's personnel policy and procedures and is signed and dated by each employee during their initial orientation.	
Child Abuse Registry telephone number is visible to youth and posted common areas of the facility	X					The Florida Abuse Hotline number was observed to be posted in common areas of the facility.	
Youth were informed of the Abuse and Contact Number (see youth survey results)		X				The Abuse Hotline contact number is included in the Resident Handbook that is given and reviewed with youth during intake. Four youth surveys were completed. All 4 youth indicated staff is respectful towards them and they feel safe in the program. Two of the 4 youth stated they were aware of the abuse hotline number but none reported knowing the location of the hotline number in the facility.	**Exception** Four surveys completed with youth indicated two of the four youth were not familiar with the abuse hotline number and all four stated they did not know the location(s) of the abuse hotline number in the facility.
Management takes immediate action to address any incidents of threats or abuse			X			No incident of threats or abuse by staff requiring management action was reported during the review period.	
Grievance Process							
Agency has a formal grievance process	X					The agency has a formal grievance process. Policy (P1105) was last reviewed and approved January 20, 2021 by the Chief Operating Officer.	
Locked box accessible to only management and available to youth in a common area	X					Two locked grievance boxes were observed to be located in both the male and female day rooms	

						accessible to youth. The residential supervisor has possession of the keys to the grievance boxes.	
Direct care does not handle the complaint/grievance unless assistance is asked for by the youth. Program director/supervisor will have access to and manage grievances unless it is towards themselves.	X					Per the residential supervisor, the grievance boxes are only accessed by the residential supervisor and direct care staff do not handle grievances.	
72-hour resolution requirement by management. If this does NOT occur within the 72 hour period, there is sufficient documentation explaining the cause for the delay in resolution.			X			The grievance procedure outlines how participants may file a grievance and actions to be taken to address grievances fairly and expeditiously (within the 72-hour time frame). No grievances were reported during this review period.	
1.03: Incident Reporting							
Provider has a written policy and procedure that meets the requirement for Indicator 1.03						**YES X NO (explain)** The agency has two written policies in place to address incident reporting titled P-1045 Incident Reporting Procedures and P-1051 Unusual Event Report Internal. The policies were last reviewed on January 20, 2021 and approved by the COO.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
During the past 6 months, the program notified the Department's CCC (Central Communication Center) no later than two hours after any reportable incident occurred or within two hours of the program learning of the incident	X					The Central Communications Center Incidents Detail Report was reviewed indicating 16 reportable residential incidents were called in to the CCC during the review period. All 16 incidents were reported within the 2-hour time frame of the incident and/or staff's knowledge.	
The program completes follow-up communication tasks/special instructions as required by the CCC	X					Six of the 16 incidents required follow up tasks. All were documented with notes to the tasks required and outcome of the incidents reported. Ten of the incidents were information only related to the COVID19 Pandemic.	
Incidents are documented in the program logs and on incident reporting forms	X					All 16 incidents are documented on the agency's incident reporting forms. Seven of 16 incidents were recorded on the agency's log by staff on duty. Nine incidents were COVID19 related and were not recorded in the agency's log due to HIPPA.	

All incident reports are reviewed and signed by program supervisors/directors	X					All 16 incidents were reviewed and signed by program supervisors	
1.04: Training Requirements (Staff receives training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions)							
Provider has a written policy and procedure that meets the requirement for Indicator 1.04						**YES X NO (explain)** The agency has required policy and procedure (P1030) to address the requirements of this indicator. The policy was approved on January 20, 2021 by the COO.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
First Year Direct Care Staff							
All staff completed the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days from date of hire. *(Staff hired before January 1st were required to complete no later than December 31, 2020)*	X					The one first year training files reviewed for two staff hired prior to January 1, 2021 completed the DOJ Civil Rights & Federal Funds prior to December 31, 2020. One new hire file reviewed for staff hired February 2021 completed the DOJ Civil Rights & Federal Funds within 30 days of hire.	
All staff receives all mandatory training during the first 90 days of employment from date of hire.		X				A review of three new staff members training files was conducted. One of three did not receive all mandatory training during the first 90 days of employment from date of hire.	**Exception** One first year staff hired 2/2/2021 did not complete Youth Development Training during the first 90 days as required.
All staff completes all mandatory Florida Network and SkillPro training during the first-year employment.	X					The training file for the three first year staff provided documentation of the completion of all mandatory Florida Network and Skill Pro training during the first-year employment.	
Non-licensed Mental Health Clinical Shelter Staff (within first year of employment)							
Non-licensed mental health clinical shelter staff Assessment of Suicide Risk Training			X			The agency did not have any applicable non-licensed mental health clinical staff during the review period.	
Documentation of non-licensed mental health clinical staff person's training in Assessment of Suicide Risk form or written confirmation by a licensed mental health professional of training (includes date, signature and license number of the licensed			X				

mental health professional supervisor).							
In-Service Direct Care Staff							
Direct care staff completes 24 hours of mandatory refresher Florida Network, SkillPro, and job-related training annually *(40 hours if the program has a DCF child caring license).*		**X**				All four in-service direct care training files reviewed demonstrated the staff were in compliance with training requirements by completing all required hours 40 hours of training annually but not all required topics. A review of four in-service staff training files was conducted. One of the four staff members completed all required annual trainings but three did not complete one training topic each by the due dates.	**Exception** • One in-service staff training record was missing the MAB training required every 2 years. • One in-service staff was late completing MAB training (due by completed 3/20/2021) • One in-service staff had not yet completed Sexual Harassment Training (due date was 11/28/2020)
Required Training Documentation							
The program maintains an individual training file for each staff, which includes an annual employee training hours tracking form and related documentation, such as certificates, sign-in sheets, and agendas for each training attended.	**X**					All seven training files reviewed were maintained in individual training files for each staff that included a training plan/log and supporting documentation. Training is maintained annually based on the fiscal year of hire.	
Provider has a written policy and procedure that meets the requirement for Indicator 1.05						**YES X NO (explain)** The agency has the required policy and procedure P-1049 Risk Management Plan, Data Integrity, and Data Collection that addresses the requirements of this indicator. The policy was last reviewed on January 20, 2021 by COO.	
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**					Record reviews were conducted October and December 2020 and March 2021. A total of 11 residential records and 11 community counseling records were reviewed during the period.	
The program conducts reviews of incidents, accidents, and grievances quarterly, at a minimum	**X**					Monthly data is collected for incidents, accidents, and grievances. These trends are reviewed and were documented on staff meeting agendas and minutes. Meetings were held in September and December 2020 and February and March 2021.	
The program conducts an annual review of customer satisfaction data	**X**					The program collected and reviewed customer satisfaction survey data quarterly for FY2019-2020.	

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 includes monthly analysis of performance and outcomes data, utilization, outreach, and missing data. Monthly reports were reviewed for July 2020 – March 2021.	
The program conducts a monthly review of NetMIS data reports.	**X**					NetMIS reports are shared and reviewed with management and staff monthly as documented in meeting minutes and agendas reviewed.	
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 entered into JJIS and NETMIS is reconciled by data staff and reviewed during staff and manager's meetings monthly.	
There is documentation that findings are regularly reviewed by management and communicated to staff and stakeholders.	**X**					Management meets to review all data areas including safety trends, peer record review, data reconciliation, incidents, grievances, consumer surveys, and risk management. Corrective actions plans are implemented to address areas of concern which are also addressed at monthly staff meetings.	
There is evidence that strengths and weaknesses are identified, improvements are implemented or modified, and staff are informed and involved throughout the process.	**X**					Data reviewed during the QI period was found to have documentation of information discussed regarding trends/quality improvement, FN Netmis data, policies and procedures, reports, and areas identified as needing improvements or changes needed from analysis.	
Provider has a written policy and procedure that meets the requirement for Indicator 1.06						**YES X NO (explain)** The agency has a written policy (P-1013) in place that addresses the requirements of this indicator titled, Client Transportation. The policy was last reviewed on January 20, 2021 and approved by the Chief Operating Officer.	

Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	X					Provider maintains a list of 12 staff approved to transport client(s) in agency approved vehicle. The drivers were approved after conducting motor vehicle checks.	
Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	X					Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance (Berkshire Hathaway).	
Agency's Transportation policy prohibit transporting a client without maintaining at least one other passenger in the vehicle during the trip and include exceptions in the event that a 3rd party is NOT present in the vehicle while transporting	X					Policy#1013 prohibits transporting a client without maintaining at least one other passenger in the vehicle, an approved volunteer, intern, agency staff, or other youth.	
In the event that a 3rd party cannot be obtained for transport, the agency's supervisor or managerial personnel consider the clients' history, evaluation, and recent behavior	X					In the event a 3rd party is not present, the supervisor considers the client's history, evaluation, and recent behavior before giving approval for transport.	
The 3rd party an approved volunteer, intern, agency staff, or other youth	X					Policy#1013 requires that the 3rd party must be an approved volunteer, intern, agency staff, or other youth. The use of staff or other youth was observed on the transportation logs.	
There is documentation of use of vehicle that notes name or initials of driver, date and time, mileage, number of passengers, purpose of travel and location.	X					A review of the program's travel logs for the past six months documented name and/or initials of youth (showing number of youth), staff driver name, date, time, mileage, purpose of the travel, and location.	
Provider has a written policy and procedure that meets the requirement for Indicator 1.07						**YES X NO (explain)** The agency has two policies to address the requirements of the indicator, P-1050 Outreach Plan for Targeting Youth for Program Services, and P-1053 Roles and Responsibilities – Prevention Outreach. The policies were last reviewed by the Chief Operating Officer on January 20, 2021.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		

The program has a lead staff member designated to participate in local DJJ board and council meetings with evidence that includes minutes of the event or other verification of staff participation	X					The agency provided verification of attendance to meetings with DJJ Circuit Advisory Board (CAB7) and Putnam County Juvenile Justice Counsel.	
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 agency provided documentation of various outreach activities conducted during the last six months. The outreach activities were conducted at local schools, church, and virtual or on-site community events.	
The program maintains written agreements with other community partners which include services provided and a comprehensive referral process.	X					Documentation of outreach services for the past six months was reviewed. The documentation included several cooperative service agreements, collaboration agreements, meeting agendas, and minutes, and information sharing with other community service agencies. The program has nine interagency agreements with local schools, mental health providers, hospitals, and sheriff's office. The agreements were all current and included services provided and a referral process.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.01						**YES X NO (explain)** The agency has the required policy and procedure P-1112 that was last reviewed January 20, 2021 by the Chief Operating 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					A total of ten files were reviewed. Of the ten files, five were residential and five were non- residential. Out of the five residential files two were open and three were closed. Out of the five non-residential files two were open and three were closed. All five of the residential files meet the requirements of having the eligibility screening completed timely for all shelter placement inquiries.	
Community counseling: Eligibility screening is completed within 3 business days of referral	X					Eligibility screenings were completed within three business days of receiving the referral in four of the five community counseling files reviewed. One	

by a trained staff using the NetMIS form						of the screenings was not completed within the three days but reason was noted in the file.	
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 supported all youth and parents received, in writing, documentation about service options, rights and responsibilities of the youth and parents/guardians.	
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**					The parents are provided an informed consent form, packet, and CINS/FINS brochure at intake that includes information about case staffing and grievance procedures.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.02						**YES X NO (explain)** The agency has the required policy and procedure P-1019 that was last reviewed January 20, 2021 by the Chief Operating 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**					All five of the residential files reviewed met the requirement of a Needs Assessment being initiated within 72 hours.	
Non-Residential youth: Needs Assessment is done within 2 to 3 face-to-face contacts after the initial intake **OR** updated, if most recent assessment is over 6 months old	**X**					All five non-residential needs assessments were 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 in the ten files reviewed were conducted by a bachelor's or master's level staff member and included a supervisor's signature upon completion.	
Needs Assessment includes a supervisor's review signature upon completion	**X**					All ten Needs Assessments in the ten files were signed by a supervisor.	
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 ten files reviewed were identified with an elevated risk of suicide as a result of the Needs Assessment.	
If yes, the youth was referred for an Assessment of Suicide Risk conducted by or under the direct supervision of a licensed mental health professional					X	N/A	
Provider has a written policy and procedure that meets the requirement for Indicator 2.03						**YES X NO (explain)** The agency has the required policy and procedure P-1162 that was last reviewed January 20, 2021 by the Chief Operating 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					All ten of the files had a Case/Service Plan developed within 7 working days of the Needs Assessment.	
Case plan service Plan includes: 1. Individualized and prioritized need(s) and goal(s) identified by the Needs Assessment 2. Service type, frequency, location 3. Person(s) responsible 4. Target date(s) for completion and Actual completion date(s) 5. Signature of youth, parent/ guardian, counselor, and supervisor 6. Date the plan was initiated	X					All ten files reviewed documented the individualized plan, goals, frequency, target dates, completion dates, signature of counselor and signature of the supervisor. There was a non-residential file that could not be signed by the parents due to COVID-19 Exposure. However, progress notes indicated the case plan was reviewed with the parent/guardian over the phone.	
Case/service plans are reviewed for progress/revised by counselor and parent (if available) every 30 days for the first three months and every 6 months after	X					All case plans were reviewed by the counselors and parents at the required timeframes and frequency.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.04						**YES X NO (explain)** The agency has the required policy and procedure P-1163 that was last reviewed January 20, 2021 by the Chief Operating Officer.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Counselor/Case Manager is assigned	X					All ten reviewed files had a counselor or case manager assigned.	

The Counselor/Case Manager completes the following as applicable: 1. Establishes referral needs and coordinates referrals to services based upon the on-going assessment of the youth's/family's problems and needs 2. Coordinates service plan implementation 3. Monitors youth's/family's progress in services 4. Provides support for families 5. Monitors out-of-home placement (if necessary) 6. Makes referrals to the case staffing to address problems and needs of the youth/family 7. Accompanies youth and parent/guardian to court hearings and related appointments 8. Refers the youth/family for additional services when appropriate 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	**X**					All youth files established referral needs to service based upon the ongoing assessment of youth family, needs for service based on the need's assessment. Support was provided to the families. The families are referred out for additional services as needed and copies of referrals were maintained in the files. Discharge plans were completed on clients with closed files. None of the ten files reviewed were applicable for a case staffing.	
The program maintains written agreements with other community partners that include services provided and a comprehensive referral process	**X**					Written agreements with community partners include local schools, mental health providers, hospitals, and sheriff's office. The agreements were all current and included services provided and a referral process.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.05						**YES X NO (explain)** The agency has the required policy and procedure P-1163 that was last reviewed January 20, 2021 by the Chief Operating 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					All of the files reflected coordination of services for the youth/family through completion of the need's assessment and service plan. Case notes are maintained for all client files.	
Shelter Program							
Shelter programs provides individual and family counseling	X					Documentation supported youth and families received individual and family counseling as needed in accordance with the Case Plan.	
Group counseling sessions held a minimum of five days per week		X				Groups were held on a consistent basis a minimum five times per week during the review period with the exception of one week.	**Exception** There was a gap in provision of group counseling during the period 1/31/2021 to 2/6/2021.
Group counseling sessions consist of: a. Length of at least 30 minutes b. Opportunity for youth engagement c. Clear and relevant topic (informational/developmental/ educational) d. Clear leader or facilitator	X					The groups had specific relevant topics to help address some of the needs of the youth. The topics were relevant and groups last at least 30 minutes.	
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					There were five non-residential files reviewed. All the files reviewed provided services in locations convenient to the family. The services were therapeutic to meet the individual needs of the family.	
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 10 files reviewed provided counseling services. There was a coordination of services based on individual needs of the family.	
Maintain individual case files on all youth and adhere to all laws regarding confidentiality	X					The program maintained individual case files marked confidential in locked areas labeled confidential and secure.	
Case notes maintained for all counseling services provided and documents youth's progress	X					All files maintain progress notes that document services provided and progress.	

On-going internal process that ensures clinical reviews of case records and staff performance	X					Documentation in the files supported an ongoing process of internal reviews by the clinical supervisor of case records and staff performance.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.06						**YES X NO (explain)** The agency has the required policies and procedures P-1159 and P-1160 that were last reviewed January 20, 2021 by the Chief Operating Officer.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Case Staffing Initiation and Notifications							
If parent/guardian initiates, staffing is held within 7 days			X			There were no case staffing meetings held during the review period where a staffing was requested.	
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				
Case Staffing Committee							
Must include: a. DJJ rep. or CINS/FINS provider b. Local school district representative	X					The program has a DJJ and local school representative as a part of the committee in the event of a staffing.	
Other members may include: a. State Attorney's Office b. Others requested by youth/ family c. Substance abuse representative d. Law enforcement representative e. DCF representative f. Mental health representative			X			There were no case staffing meetings held during the review period where a staffing was requested requiring participation of other representatives.	
The program has an established case staffing committee, and has regular communication with committee members	X					Agency's policy and procedure addresses establishment of the case staffing committee and communication regarding staffing.	
The program has an internal procedure for the case staffing	X					Agency's policy and procedure addresses procedure for case staffing process and schedule.	

process, including a schedule for committee meetings							
As a result of the Case Staffing							
The youth and family are provided a new or revised plan for services			X			There were no case staffing meetings held during the review period where a staffing was requested.	
Written report is provided to the parent/guardian within 7 days of the case staffing meeting, outlining recommendations and reasons behind the recommendations			X			There were no case staffing meetings held during the review period where a staffing was requested.	
If applicable, the program works with the circuit court for judicial intervention for the youth/family			X			There were no case staffing meetings held during the review period where a staffing was requested.	
Case Manager/Counselor completes a review summary prior to the court hearing			X			There were no case staffing meetings held during the review period where a staffing was requested.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.07						**YES X NO (explain)** The agency has the required policy and procedure P-1046 that was last reviewed January 20, 2021 by the Chief Operating Officer.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
All records are clearly marked 'confidential'.	X					All ten records reviewed were observed to be marked confidential.	
All records are kept in a secure room or locked in a file cabinet that is marked "confidential"	X					During the tour of the facility, a locked area for case files was observed and also secured container for transporting files. The file cabinets and files were marked confidential.	
When in transport, all records are locked in an opaque container marked "confidential"	X					The locked container used for transporting files is marked confidential.	
All records are maintained in a neat and orderly manner so that staff can quickly and easily access information	X					The files are maintained in the respective counselors' offices for easy access and files appear to be organized and maintained in a consistent manner.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.08						**YES X NO (explain)** The agency has the required policy and procedure P-1284 that was last reviewed January 20, 2021 by the Chief Operating 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					One eligible youth was served during the review period. This youth was addressed by their preferred name and pronoun and preferred name and pronoun was used in the logbook, on the census board, and on all outward facing documents.	
Youth in need of specialized support is referred to qualified resources (as applicable)	X					Specialized support was provided to the youth and family including counseling services.	
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					This youth was able to choose sleeping arrangement and was assigned boy's bed #2 as noted in the program logbook and on the census board.	
Youth is provided hygiene products, undergarments and clothing that affirms their gender identity or gender expression	X					The youth was able to dress in clothing and use hygiene products that affirmed their gender identity.	
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					The shelter has signage located throughout the shelter including in the hallways, lobby, staff offices, and boys and girl's dayroom indicating the program is a safe space for all youth regardless of actual or perceived sexual orientation, gender identity, and gender expression.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.09						**YES** **NO (explain) X** The agency has the required policies and procedures as follows: 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, and P-1283 Family/Youth Respite Aftercare Services (FYRAC) Non-Residential Services. The policies and procedures were last reviewed January 20, 2021 by the Chief Operating Officer.	The current policy P-1283 Family/Youth Respite Aftercare Services (FYRAC) does not include the requirement for youth and families to participate in services for thirteen (13) sessions or ninety (90) consecutive days of services as required by the indicator.
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Staff Secure							

Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? **(If no, select rating "No eligible items for review")**	**YES**	**NO** **X**	**N/A**			The program has not served any Staff Secure youth since the last onsite QI visit and has no eligible items for review.	
Staff Secure policy and procedure outlines the following: a. In-depth orientation on admission b. Assessment and service planning c. Enhanced supervision and security with emphasis on control and appropriate level of physical intervention d. Parental involvement e. Collaborative aftercare			**X**				
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 program has not served any Domestic Minor Sex Trafficking (DMST) youth since the last onsite QI visit and has no eligible items for review.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Agency has evidence that the FNYFS was contacted for approval prior to admission for all Domestic Minor Sex Trafficking (DMST) placements			**X**				
Services provided to these youth specifically designated services designed to serve DMST youth			**X**				
Did the placement of DMST youth require additional supervision for the safety of the youth or the program? If so, did the agency provide the appropriate level of supervision and safety measures?			**X**				
Length of Stay: a. Youth in program do not have length of stay in DMST placement that exceeds seven (7) days b. Agency has approval for stays and support beyond seven (7) days for DMST placements that are obtained on a case-by-case basis? (If applicable.)			**X**				
Agency has evidence that staff assigned to DMST youth under this provision are to enhance the regular services available through direct engagement in positive activities designed to encourage the youth to remain in shelter			**X**				

All other services provided to DMST youth are consistent with all other general CINS/FINS program requirements			**X**				
Domestic Violence							
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? **(If no, select rating "No eligible items for review")**	**YES**	**NO** **X**	**N/A**			The program has not served any Domestic Violence Respite eligible youth since the last onsite QI visit and has no eligible items for review.	
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**				
Data entry into NetMIS and JJIS within (3) business days of intake and discharge			**X**				
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**				
Case plan in file reflects goals focusing aggression management, family coping skills, or other intervention design to reduce reoccurrence of violence in the home			**X**				
All other services provided to Domestic Violence Respite youth are consistent with all other general CINS/FINS program requirements			**X**				
Probation Respite							

Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? **(If no, select rating "No eligible items for review")**	**YES**	**NO** **X**	**N/A**			The program has not served any Probation Respite eligible youth since the last onsite QI visit and has 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**			CDS Interface East is not contracted to provide Intensive Case Management services.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Youth receiving services was court ordered or referred by case staffing committee					**X**		

Services for youth and family include: a. Four (4) direct contacts per month b. Four (4) collateral contacts per month					**X**		
Assessments include: a. A Child Behavior Checklist (CBCL) is completed within 14 days of intake and at discharge (if applicable) b. An approved self-report assessment that was completed at intake c. An approved self-report assessment that was completed every 90 days following intake and at discharge (if applicable)					**X**		
Case plan demonstrates a strength-based, trauma-informed focus					**X**		
Agency has evidence that ICMS has a strength-based perspective in one or more of the following areas; engaging the family, advocating on their behalf, initiating change agent activities, helping to access supports in the community, teaching problem solving skills, modeling productive behaviors, and/or successful completion of youth and family developmental milestones					**X**		
Family and Youth Respite Aftercare Services (FYRAC)– Non-residential Only							
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? **(If no, select rating "No eligible items for review")**	**YES**	**NO** **X**	**N/A**			The program has not served any FYRAC eligible youth since the last onsite QI visit and has no eligible items for 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 household member, and/or the youth is on probation regardless of adjudication status and at risk of violating			X				
Agency has evidence that all FYRAC referrals have documented approval from the Florida Network office			X				
Intake and initial assessment sessions meets the following criteria: a. Face-to-face gathering of family history and demographic information b. Includes development of the service plan and is documented through signature of the youth and his/her parent/guardian as well as orientation to the program			X				
Life Management Sessions meets the following criteria: a. Sessions are face-to-face, sixty (60) minutes in length and focus on strengthening the family unit b. Individual Sessions are with the youth and family and focus to engage, identify strengths and needs of each member that help to improve family functioning			X				
Group Sessions: a. Focus on the same issues as individual/family sessions with the overall goal of strengthening relationships and prevention domestic violence b. Shall be no more than eight (8) youth at one (1) time and shall be for a minimum of sixty (60) minutes per session			X				

Youth and family participate in services for thirteen (13) sessions or ninety (90) consecutive days of services, or there is evidence in the youth's file that an extension is granted by DJJ circuit Probation staff			**X**				
2.10: STOP NOW AND PLAN (SNAP)							
Provider has a written policy and procedure that meets the requirement for Indicator 2.10						**YES NO (explain) N/A X**	CDS Interface East is not contracted to provide SNAP services.
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**	CDS Interface East is not contracted to provide SNAP services at this location.	
Needs assessment is completed at initial intake, or within two face-to-face sessions					**X**		
SNAP Assessments a. Child Behavior Checklist (CBCL) is completed by the caregiver (pre & post) b. Teacher Report Form (TRF) completed by the teacher (pre & post) c. Tool for Parenting Self Efficacy (TOPSE) completed by the caregiver (pre & post) d. Prevention Assessment Tool (PAT) (pre & post)					**X**		
SNAP discharge report summary					**X**		
SNAP Boys/SNAP Girls **Parent** Group Evaluation Form					**X**		
SNAP Boys/SNAP Girls **Child** Group Evaluation Form					**X**		
SNAP in Schools							
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		

Weekly attendance sheet with youth names and/or identifying number completed with signatures of teacher and facilitator(s) (For a total of 13 attendance sheets)					**X**		
"Class Goal" sheet					**X**		
Measure of Classroom Environment (MoCE) (Pre and Post) is used to identify baseline and treatment outcomes of reported classroom dynamics.					**X**		
Pre and Post Evaluations					**X**		
One SNAP® Fidelity Adherence Checklist completed per classroom in a 13 – week SNAP in Schools group and uploaded to Dropbox					**X**		
Provider has a written policy and procedure that meets the requirement for Indicator 3.01						**YES X NO (explain)** The agency has multiple policies to address the requirements of the indicator as follows: P-1122 Leisure Activities Program (LEAP), P-1137 Faith Based Activities, and P-1210 Shelter Environment. The policies were last reviewed by the Chief Operating Officer on January 20, 2021.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		

Facility Inspection	**X**					A tour of the facility was provided by the Residential Supervisor. The facility is well kept and free of any insect infestation, hazards, and debris. During the walk through of the shelter it was observed furnishings were in good repair and the building was free of insect infestation. Each youth beds were clean and each bed was provided with sheets and pillows. Bathrooms, bedrooms, and common areas were free of any contraband and hazardous objects. Showers were clean and functional and the lighting in the shelter was adequate to perform tasks. Both vehicles had doors locked, with first aid kit, fire extinguisher up to date, flashlight, glass breaker, seat belt cutter, and air bag deflator. Facility had no dumpster but had a trash can with a cover located in the front. Map and egress plans of the facility, general client rules, grievance forms, abuse hotline information, DJJ Incident reporting number and other related notices were posted in the girls and boys day room and rooms, in multiple hallways, kitchen and lobby. All chemicals are listed, approved for use, inventoried, stored securely in the kitchen and in Regional Director's office. Per policy and procedures of the shelter, inventory is done on a monthly basis. Washer and dryer are operational and the general area/lint receptacle are clean.	
Fire and Safety Health Hazards	**X**					The following inspections were reviewed and are noted as follows: • County fire inspection: 12.10.20 - passed • Fire Extinguisher Inspection: 8.4.2020- passed with findings (Failed on emergency light needing to replace battery) • Annual fire Alarm: 10.19.20 - passed • Fire Alarm System Inspection and Testing: 10.19.20 - passed • Department of Health: 11.10.20 - passed • Range Hood Systems: 11.20.20 – passed • The agency current DCF Child Care License was located in the front lobby with an updated	

						date, April 1, 2021 and enforced March 31, 2022.	
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**					Youths are being engaged in meaningful activities. Staff is provided for life skills, and counseling services during awake hours. At least one hour, 6pm – 7pm youths are having physical activity daily. Every Sunday's program has a local pastor (Christian) interacting with the youths if the youth is requesting. If there are any other faith-based activities per program manager the youths can watch it on tv or the guardian can take the youth. The youth have the opportunity to complete their homework and access variety of age-appropriate program approved books in the girls/boy day rooms. Daily programming schedule is located in both day rooms boy/girls. The daily program for staff is located in a notebook in the control room.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.02						**YES X NO (explain)** The agency has the required policy and procedure P-1114 that was last reviewed 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**					Evidence of a formal orientation and receipt of handbook was observed in the five youth records reviewed.	
Orientation includes the following:	**X**					Youth is given a list of contraband during intake; youth sign off as youth was given explanation by staff. Disciplinary action is explained during intake	

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						and youth must sign off indicating the staff has explained the disciplinary rules. Dress code is also reviewed during intake as well as access to medical and mental health services. Procedures for visitation mail and telephone are explained during intake. Both youth and parent must sign off as staff has explained to both youth and guardian. Grievance procedures are explained during intake and box is located in the girl's day room and forms are located in the girls/boy's day room. Residential supervisor has the key to the grievance box. Disaster preparedness instructions are included in the facility manual but fire drills are reviewed with youth during orientation. Egress plans are posted in the lobby, hallways and boys and girl's rooms and include the physical layout of the facility. During the tour of the facility, youth are shown their sleeping room assignment and are introduced to staff. Youth are also made aware of suicide prevention procedures such as alerting staff of feelings or awareness of others having suicidal thoughts.	
Documentation of each component of orientation, including orientation topics and dates of presentation, as well as signatures of the youth and staff involved is maintained in the individual youth record	**X**					All five files reviewed included a Client Orientation Checklist with specific areas of orientation documented on the list and initialed by the youth.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.03						**YES X NO (explain)** The agency has the required policy and procedure P-1116 that was last reviewed 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		**X**				A total of five residential files were reviewed. Two of the five residential files reviewed were open and three were closed. All five files had a process a place that include an initial classification of the youths to include youth's history, trauma, age, gender, history of violence, disabilities, physical size/strength, gang affiliation, suicide risk, sexually	**Exception:** Two of the five youth files did not indicate any sexual orientation or gender identification of 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						aggressive, acute health symptoms requiring quarantine or isolation, alerts are documented, phone list and initial interactions and observations.	
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**					All alerts were entered into the program's alert system when youth is admitted with special needs and risks such as risk of suicide, mental health, substance abuse, physical health or security risk factors	
Provider has a written policy and procedure that meets the requirement for Indicator 3.04						**YES X NO (explain)** The agency has the required policy and procedure P-1149 that was last reviewed 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**					The program has a process in place to document daily activities, events, and other major occurrences to include safety and security issues that could impact the youth and program highlighted information.	.
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	**X**					Randomly selected timeframes during the review period were reviewed for the following weeks: January 2-8, January 9-15, and January 17-23. All entries entered in the logbook were brief and legibly written in ink.	

• Name and signature of person making the entry							
Recording errors are struck through with a single line. The staff person must initial and date the correction. The use of whiteout and erasures is prohibited.	**X**					All recording errors are struck through with a clear line with staff signature but there were 8 errors struck through in which the date of the correction was not noted.	
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**				Reviews of the logbook are done and documented weekly by the program director.	**Exception:** During weekly reviews of the logbook, corrections, recommendations, and follow-ups needed are not being documented in the logbook and there is no clear evidence of discussion with staff.
All staff review the logbook of the previous two shifts and makes an entry signed and dated into the logbook indicating the dates reviewed	**X**					All direct staff review the logbook at the beginning of each shift for the previous two shifts (at a minimum).	
At the beginning of their shift, oncoming supervisor and shelter counselor reviews the logbook of all shifts since their last log entry and makes a signed and dated entry and into log book indicating the dates reviewed.	**X**					Oncoming supervisor and shelter counselor reviews the logbook of all shifts since their last log entry and makes a signed and dated entry into the logbook indicating the dates reviewed.	
Logbook entries include: a. Supervision and resident counts b. Visitation and home visits	**X**					Staff reports all visitations in the logbook including the time they arrived to the time the visitation was over.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.05						**YES X NO (explain)** The agency 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					The behavior management process in place includes a detailed written description of the system which is explained to youth during program orientation.	
Behavior Management Strategies MUST include: a. Supervisors are trained BMS is designed to teach youth new behaviors and help youth understand the natural consequences for their actions b. Behavioral interventions are applied immediately, with certainty, and reflect the severity of the behavior c. BMS uses a wide variety of awards/incentives to encourage participation and completion of the program d. Appropriate consequences and sanctions are used by the program and consequences for behavior are logical and designed to promote skill-building for the youth e. Counseling, verbal intervention and de-escalation techniques are used prior to physical intervention (Only techniques approved by the 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	X					The written description of the behavioral management strategies included a wide variety of positive incentives used by the program, appropriate interventions are used by the program to teach youth new behaviors and help youth understand the natural consequences for their actions, and behavioral interventions are applied immediately, with certainly, and reflect the severity of the behavior. The behavior management strategy includes consequences for violation of the program rules and the program uses a variety of rewards that are located in Residential Supervisor office to encourage participation. All staff are trained by Residential Supervisor on BMS. The program provides feedback to all the youth every night before bedtime discussing the "Facebook" behavior. The program does not deny the youth any regular meals and snacks, clothing, sleep, physical or mental health services, educational services, exercises correspondence privileges, or contact with parents/ guardians, attorney of record, juvenile probation officer or clergy.	

youth who are physically and/or emotionally out of control h. Youth should never be denied basic rights such as meals, clothing, sleep, services, exercise, or correspondence privileges							
Program's Use of the BMS							
All staff are trained in the theory and practice of administering BMS rewards and consequences	**X**					All seven training files reviewed demonstrated staff were trained in the agency's Behavior Management system.	
There is a protocol for providing feedback and evaluation of staff regarding their use of BMS rewards and consequences	**X**					Every night staff speaks with the youths regarding there points on the Facebook method.	
Supervisors are trained to monitor the use of rewards and consequences by their staff	**X**					Residential supervisor trains all staff members on BMS.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.06						**YES X NO (explain)** The agency has the required policy and procedure P- 1121 and P-1133 that were last reviewed 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**					Reviewed four random samples of video surveillance for the following dates and times: 4/6/21 (12am – 2am), 4/10/21 (2am – 4am), 4/16/21 (4am-6am), and 4/18/21 (1am – 2am). A review of the above video surveillance samples, staff schedules, and logbook entries documented the required staffing ratios were met for the awake hours and sleeping hours.	
All shifts must always provide a minimum of two staff present	**X**					All shifts consistently maintain a minimum of two staff present except shifts 8-4 due to no youths being present during that time; all youths in school.	
Program staff included in staff-to-youth ratio includes only staff that are background screened and properly trained youth care	**X**					All staff included on the schedule were background screened and received direct care staff training.	

workers, supervision staff, and treatment staff							
The staff schedule is provided to staff or posted in a place visible to staff	X					Program staff schedule is located in the control room/main office.	
There is a holdover or overtime rotation roster which includes the telephone numbers of staff who may be accessed when additional coverage is needed	X					The program has an overtime rotation roster that includes home telephone numbers of staff who may be available when additional coverage is needed in a binder located in the control room/main 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				**Document any observed inconsistencies in documentation of bed checks:** Video footage was reviewed to observe the 15-minute (program 10 mins) bed checks. The following dates were reviewed: • April 6, Girls Day Room 12:07am -12:47am • April 10, Boys Day Room 2:05am-2:46am • April 16, Girls Day Room 4:13am-5:00am • April 18, Boys Day Room 1:00am-3:02 am • April 25, Boys Day Room 3:00 am – 4:51am	**Limited Exception:** Staff during bed checks, on April 18th, did not physically check on the youths but documented completed bed checks for the times: 1:41 am – 1:49 am, 2:00am – 2:09 am, 2:20 am – 2:29 am and 2:29am – 3:02 am. Instead, staff scanned a piece of paper located on top of the table in the boy's day room and did not get up to physically check on the youth in their sleeping rooms.
Provider has a written policy and procedure that meets the requirement for Indicator 3.07						**YES X NO (explain)** The agency has the required policy and procedure P- 1280 that was last reviewed 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	X					• The agency has a system in operation 24 hours a day 7 days a week. • A written notice is conspicuously posted on premises for the purpose of security located in the entrance lobby. • Cameras are located within the shelter in the following locations: hallways, lobby, boys' day room, kitchen, girls' day room, conference room, Entrance/Exit, recreation area, and parking lot.	

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						• System can record date, time, location and maintain resolution that enables facial recognition. • Cameras can operate during a power outage due to program having a backup battery located next to the monitor in the office. • A list of designated personnel that can access the video surveillance system is hanging on the wall in the office room	
A list of designated personnel who can access the video surveillance system is maintained (includes off-site capability per personnel)?	**X**					Program maintains a list of designated personnel that can access the video surveillance system on the wall in the office room.	
Supervisory review of video is conducted a minimum of once every 14 days and timeframes reviewed are noted in the logbook. The reviews assess the activities of the facility and include a review of random sample of overnight shifts	**X**					The shelter supervisor conducts a review of overnight bed checks a minimum of once every fourteen days.	
Grant the requesting of video recordings to yield a result within 24-72 hours from program quality improvement visits and when an investigation is pursued after an allegation of an incident	**X**					Per agency's policy titled 3.07, the program will grant request of video recordings within 72 hours if requested after an allegation or for investigative purpose.	
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**			All of the cameras were operational during the visit and no technical issues during the review period were reported; however, the shelter supervisor will call in a service request immediately upon notice of malfunction.	

Provider has a written policy and procedure that meets the requirement for Indicator 4.01						**YES X NO (explain)** The agency has the required policy and procedure P- 1117 and P-1118 that were last reviewed 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**					One open and four closed records were reviewed. Initial healthcare screening was completed on each youth on the day of admission. The screening addressed all required elements. The nurse completed each screening. Alerts were identified, as applicable. The program has procedures in place for follow-up medical care if it is needed.	
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 records reviewed indicate youth had a chronic medical condition needing immediate referral.	
When needed, the parent is involved with the coordination and scheduling of follow-up medical appointments			**X**			No eligible medical referrals applicable to the sample records reviewed.	
All medical referrals are documented on a daily log.			**X**			No eligible medical referrals applicable to the sample records reviewed.	
The program has a thorough referral process and a mechanism for necessary follow-up medical care as required and/or needed	**X**					The program does have a policy in place for referral of youth and notification of parent/guardian.	

						YES X NO (explain) The agency has four policies to address the requirements of the indicator, P-1144 Mental Health, Substance Abuse and Suicide Risk Screening (Residential), P1247 Suicide Assessment (Residential), P1262 Suicide Assessment (Non-Residential), and P-1152 Mental Health, Substance Abuse and Suicide Risk Screening (Non-Residential). The polices were last reviewed by the Chief Operating Officer January 20, 2021.	
Rating Criteria	**Satisfactory**	**Non-compliant**		**No Practice**	**Not Applicable**		
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**					One open and three closed records were reviewed. Initial suicide screenings were completed for each youth.	
The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	**X**					The current suicide risk assessment tool used by the program was approved by the Florida Network.	
Supervision of Youth with Suicide Risk							
Youth are placed on the appropriate level of supervision based on the results of the suicide risk assessment.	**X**					Each of the youth were placed on sight and sound supervision. Each of the youth were seen and assessed, by a master's level counselor, within twenty-four hours. All five youth documented a suicide risk assessment was completed by a master's level counselor and documented consultation with the LMHC and Residential Supervisor. Both the LMHC and Residential Supervisor signed the assessments prior to the youth being removed from suicide precautions.	
Staff person assigned to monitor youth documented youth's behavior at 30 minute or less intervals	**X**					Staff monitored each youth and documentations included 30-minute intervals.	
Supervision level was not changed/reduced until a licensed professional or a non-licensed mental health professional under	**X**					The supervision level was not changed/reduced until a licensed professional or a non-licensed mental health professional under the supervision	

the supervision of a licensed professional completed a further assessment OR Baker Act by local law enforcement						of a licensed professional completed a further assessment.	
Provider has a written policy and procedure that meets the requirement for Indicator 4.03						**YES X NO (explain)** The agency has the required policy and procedure P-1120 that was last reviewed 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 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	**X**					The program stores youth medication in a Pyxis Med-Station Medication Cabinet or a secured refrigerator. Staff permitted access to medications are identified in writing, and each staff on the list received training on distributing medication, including use of an Epi-Pen. Temperature logs for the refrigerator showed it is maintained at the required temperature range. The area where the Med-station and refrigerator are located is not accessible to youth unless accompanied by staff.	
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	**X**					An observation determined the agency maintains a minimum of 2 super users for the med station Training determined only designated staff had access to secure medication.	

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						Medication distribution logs for each youth showed perpetual and weekly inventories for non-controlled prescription medications and over-the-counter medications taken on a regular basis. An interview determined the nurse on duty conducts the medication process. The agency reported they do not accept youth who are prescribed injectable medication. Non-licensed staff had documentation of receiving training in the use of epi-pens.	
Medication Inventory							
a. For controlled substances, a perpetual inventory with running balances is maintained as well as a shift-to shift count verified by a witness and documented 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	**X**					Controlled medications are stored in the Med-Station. Three closed youth and one open youth files were reviewed. Documentation determined a perpetual inventory was maintained and shift-to-shift inventories were documented for controlled medications with two staff initialing each shift inventory. Observations determined syringes and sharps have a designated location; however, it is the practice of the agency to not store any sharps or syringes.	
There are monthly reviews of medication management practice	**X**					Monthly documentation of reviews determined it is the practice of the agency to utilize Knowledge Portal or Pyxis.	

via Knowledge Portal or Pyxis Med-Station Reports.							
Medication discrepancies are cleared after each shift.	X					Discrepancies in medication counts and medications errors were cleared by the end of the shift and training was documented for staff when errors or discrepancies occurred.	
Provider has a written policy and procedure that meets the requirement for Indicator 4.04						**YES X NO (explain)** The agency has the required policy and procedure P-1119 that was last reviewed 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					The program maintains an alert board for all alerts and a section in each youth records for food and medication allergies. Five youth records were reviewed. Each youth had alerts, either medical or a food allergy. The alerts were accurately reflected in the records and alert board.	
Alert system includes precautions concerning prescribed medications, medical/mental health conditions	X					The alert system included precautions.	
Staff are provided sufficient training, information and instructions to recognize/respond to the need for emergency care for medical/mental health problems	X					Documentation determined staff were provided sufficient training.	
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					Five youth records were reviewed. Each youth record had documentation of medical or mental health alert in the file. Information included concerns, allergies, side effects, and other pertinent information.	
Provider has a written policy and procedure that meets the requirement for Indicator 4.05						**YES X NO (explain)** The agency has the required policy and procedure P-1166 that was last reviewed 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					Three records reviewed determined off-site emergency medical care was provided. Upon each of the three youth's return, documentation included a receipt of medical clearance and instruction for discharge. The parent/guardian was notified in each instance. The daily log was maintained documentation emergency care was provided.	
All staff are trained on emergency medical procedures	X					Documentation determined staff are trained in the emergency medical procedures	
The program has a Knife-for-life and wire cutters accessible to staff in a secure location(s)	X					Observations determined the program has a knife-for-life and wire cutters accessible to staff.	
First aid kit/supplies are fully equipped and inventoried	X					Observations determined first aid kits were fully equipped and inventoried.	