Florida Network for Youth and Family Services
Compliance Monitoring Report for

LSF NW – Hope House
18377 Clinton Blvd.
Crestview, Florida 32506

Compliance Monitoring Services Provided by

EXECUTIVE SUMMARY

Forefront LLC conducted a joint Quality Improvement (QI) and Florida Network of Youth and Family Services (FNYFS) monitoring visit for the LSF NW – Hope House for the FY 2020-2021 at its program office located at 18377 Clinton Blvd., Crestview, 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. LSF NW – Hope House is contracted with the Florida Network of Youth and Family Services (FNYFS) to provide direct services to Children/Families in Need of Services (CINS/FINS). The services to be provided are identified in Contract Section A - Descriptions and Specifications and Section B - Delivery and Performance and are funded with General Revenue Funds effective for July 2020 through June 30, 2021.

The review was conducted by Ashley Davies, Consultant for Forefront LLC and Peer Reviewer(s). Agency representatives from LSF NW – Hope House present for the entrance interview were: Beth Deck, Regional Director; Sherri Swanson, Clinical Director; and Cynthia Freshour, Quality Services Manager. The last onsite QI visit was conducted October 2 – 3, 2019.

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

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

2020-2021 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 3-3-2021

Agency Name: LSF NW – Hope House	**Monitor Name: Ashley Davies, Lead Reviewer**
Contract Type : CINS/FINS	**Region/Office: 18377 Clinton Blvd., Crestview, FL 32506**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): March 3 – 4, 2021**

Major Programmatic Requirements	Explain Rating: Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable	Ratings Based Upon: I = Interview; O = Observation; D = Documentation; PTV = Submitted Prior To Visit; (List Who and What)	Notes: Explain Unacceptable or Conditionally Acceptable: (Attach Supportive Documentation)
I. Administrative and Fiscal							
DJJ Quality Improvement Peer Reviewer a. Provider shall demonstrate that a minimum of two (2) staff members have been trained to be certified as DJJ QI Peer reviewers. Provider shall participate in a minimum of one (1) on-site quality assurance review of a similar type program in another judicial circuit during each 12-month period of the contract, if requested.	☐	☐	☒	☐	☐	Interview: The program currently has two staff members certified as DJJ QI Peer reviewers. Both of these staff have participated as a peer reviewer this season.	**No recommendation or Corrective Action.**
Additional Contracts a. Provider shall provide a listing of all current federal, state, or local government contracts, as well as other contracts entered into with for profit and not-for-profit organizations. Such listing shall identify the awarding entity and contract start & end dates. **PTV**	☐	☐	☒	☐	☐	Documentation: A list of additional contracts for FY 2020- 2021 was provided by the provider. The list includes name, funding source, contract amount, and beginning date. The program also maintains interagency agreements and Memorandums of Agreement (MOUs) with schools, substance abuse, mental health partners, and other treatment providers. All of the agreements reviewed had recent contract/agreement dates.	**No recommendation or Corrective Action.**
Limits of Coverage	☐	☐	☒	☐	☐	Documentation:	**No recommendation or Corrective Action.**

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Major Programmatic Requirements	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable		
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**						Provided by Market Global Reinsurance Company. The provider's General Liability insurance provides limits of coverage of $1,000,000 each/$3,000,000 aggregate and $10,000 each for medical expenses. The providers Automobile insurance provides limits of coverage of $1,000,000 combined for each accident. The providers Excess/Umbrella Liability insurance provides limits of coverage of $1,000,000 each/aggregate. The provider's Professional Liability insurance provides limits of coverage of $1,000,000 each/$3,000,000 aggregate. The provider's Abuse/Molestation insurance provides limits of coverage of $1,000,000 each/$3,000,000 aggregate.	

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						Coverage for the above policies is in effect for the current FY 2020-2021, 6/1/2020 – 6/1/2021. The certificate does list the Florida Network on the consolidate certificate of liability as a certificate holder.	
External/Outside Contract Compliance a. Provider has corrective action item(s) cited by an external funding source (Fiscal or Non-Fiscal). **ON SITE**	☐	☐	☐	☐	☒	**N/A –** During the Entrance Conference, the provider indicated that there are no outstanding corrective action item(s) cited by an external funding source.	**No recommendation or Corrective Action.**
Fiscal Practice a. Agency must have employee and fiscal policy/procedures manuals that are in compliance with GAAP and provide sound internal controls. Agency maintains fiscal files that are audit ready. **PTV**	☐	☐	☒	☐	☐	Documentation: Fiscal policies are in place signed by the VP of Finance and the CFO with a revision date of 4/27/2017. The procedures reviewed appear to be consistent with GAAP and provide for limited internal controls. Procedures are included for general ledger, cost accounting, payroll, petty cash, computer backup, and other relevant financial processes.	**No recommendation or Corrective Action.**
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	☐	☐	☒	☐	☐	Documentation: Detailed General Ledger for the current FY2020-2021, as of 7/1/2020	**No recommendation or Corrective Action.**

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(standard account numbers / separate funds for each revenue source, etc.). **PTV**						to 12/31/2020. Agency maintains a detailed general ledger that is structured to track all funding sources as well as activities for the CINS/FINS, ICMS, and SNAP programs separately. The ledgers showed current balances and differences.	
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 and Documentation: No change in practice was reported for the agency since the last onsite program review. Reviewed petty cash Policy and Procedure. The Petty Cash fund does not exceed the established minimum. Petty cash is stored in a secure locked location in the building. The agency produced past documentation of monthly petty cash reconciliations. Petty cash is reconciled on a consistent basis (monthly/quarterly) by designated staff and reviewed by the Supervisor. Disbursements and invoices are approved by the Program Supervisor as required.	**No recommendation or Corrective Action.**
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.	☐	☐	☒	☐	☐	Documentation: Reviewed Bank Statements and Bank Reconciliations for the past six months for one account with Bank of America.	**No recommendation or Corrective Action.**

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(Disbursements/invoices are approved & monitored by management). **ON SITE**						Bank reconciliations are conducted each month for the activities and bank statements for the preceding month and are signed by two parties. Checks disbursed are signed by two parties. Invoices are submitted on a monthly basis with supporting documentation. The agency maintains individual vendor files which are kept in secure file cabinets in the Program Administration office.	
e. Agency maintains inventory in accordance with a written policy and FNYFS contractual requirements. If over $1,000 inventory has DJJ Property Inventory Number/Tag. In the event the provider has purchased computer equipment an Informational Resources Request (IRR) been submitted to DJJ. **PTV/ON SITE**	☐	☐	☐	☐	☒	N/A – The agency has not purchased any items with FNYFS monies since the last time on-site.	**No recommendation or Corrective Action.**
f. Agency submits payroll taxes and deposits (and retirement deposits as applicable), Employee IRS Form W-2 and Independent Contractors IRS Form 1099 forms prior to federal requirements. **ON SITE**	☐	☐	☒	☐	☐	Documentation: Provider submitted evidence of payroll taxes and deposits for quarters three and four of 2020. A Collection Details report showed funds deposited every two weeks and an EFTPS Paid Tax report showed all payments made.	**No recommendation or Corrective Action.**

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g. Budget to actual reports prepared and reviewed by appropriate management. Variance from the budget are investigated and explained. **PTV/ON SITE**	☐	☐	☒	☐	☐	Documentation: Agency provided a Budget Report including the current fiscal year to 12/31/2020. The report tracks all budget categories by current period actual and current period contract separately. Variances if applicable are identified. CINS/FINS, ICMS, and SNAP are tracked separately. The program budget is reviewed and approved by the agency's Pres/CEO, Board, and Regional Director B. Deck.	**No recommendation or Corrective Action.**
h. A Single Audit is performed as part of the annual audit if expenses are greater than $500,000. The agency must submit a Corrective Action Plan for findings cited in the management letter and single audit. An annual financial audit was completed within 120 days after the previous fiscal year/calendar year and that a copy was provided to the Network unless and extension has been requested and approved in writing. Copy of Audit is submitted to the FNYFS by December 31st. **Obtain from FNYFS**	☐	☐	☒	☐	☐	Documentation: Financial audit was conducted for the fiscal year beginning June 30, 2020 – 2019 by RSM US LLP. A letter dated December 28, 2020 stated no corrective action was needed. A copy was submitted directly to the Florida Network of Youth and Family Services.	**No recommendation or Corrective Action.**
i. Agency maintains confidentiality policy with written policies and procedures to ensure the security and privacy of all employee and client data. Personal information is not easily accessible. Agency maintains a backup system in case of accidental loss of financial information. Security procedures are in place to protect laptops. Obsolete	☐	☐	☒	☐	☐	Documentation: The agency provided multiple Policies and Procedures. No changes in Confidentiality and Security protocols. The policies have been applied consistently across the required areas	**No recommendation or Corrective Action.**

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documents are shredded and computer hard drives are wiped prior to discarding. **ON SITE**						that include Data Back Up Systems; Information Security; and Confidentiality. Policies are signed by the Regional Director with a revision date of 4/27/2017.	

CONCLUSION

LSF NW – Hope House 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.

SUMMARY OF RECOMMENDATIONS

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

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

Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Lutheran Services Florida/Northwest – Hope House
CINS/FINS Program

March 3 – 4, 2021

Compliance Monitoring Services Provided by

FOREFRONT

CINS/FINS Rating Profile

Standard 1: Management Accountability

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

Percent of indicators rated Satisfactory: 57.14%
Percent of indicators rated Limited: 42.86%
Percent of indicators rated Failed: 0.00%

Standard 2: Intervention and Case Management

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

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

Standard 3: Shelter Care & Special Populations

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

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

Standard 4: Mental Health /Health Services

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

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

Overall Rating Summary

Percent of indicators rated Satisfactory: 89.29%
Percent of indicators rated Limited: 10.71%
Percent of indicators rated Failed: 0.00%

Rating Definitions

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

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

Reviewer

Members

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

Tara Frazier – Department of Juvenile Justice

Shanna Baker – Thaise Educational and Exposure Tours

Fatima Rodgers – Thaise Educational and Exposure Tours

Janessa Hart – Anchorage Children's Home

Methodology

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

Persons Interviewed

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

0# Case Managers
1 # Program Supervisors
0 # Food Service Personnel
1 # Healthcare Staff
0 # Maintenance Personnel
1 # Other (listed by title): **Regional Director**

Documents Reviewed

- ☐ Accreditation Reports
- ☒ Affidavit of Good Moral Character
- ☒ CCC Reports
- ☒ Logbooks
- ☐ Continuity of Operation Plan
- ☐ Contract Monitoring Reports
- ☐ Contract Scope of Services
- ☒ Egress Plans
- ☒ Fire Inspection Report
- ☐ Exposure Control Plan
- ☒ Table of Organization
- ☒ Fire Prevention Plan
- ☒ Grievance Process/Records
- ☒ Key Control Log
- ☒ Fire Drill Log
- ☒ Medical and Mental Health Alerts
- ☒ Precautionary Observation Logs
- ☒ Program Schedules
- ☐ List of Supplemental Contracts
- ☐ Vehicle Inspection Reports
- ☐ Visitation Logs
- ☒ Youth Handbook

5 # Health Records
5 # MH/SA Records
9 # Personnel /Volunteer Records
7 # Training Records
5 # Youth Records (Closed)
5 # Youth Records (Open)
0 # Other: _____

Observations During Review

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

Comments

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

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

COVID-19 has had a major impact on everyone, and HOPE House has had their share of difficulties. The shelter shut down for the first two weeks of November because of exposure. Two staff and the Counselor tested positive along with some of the clients. One of the staff and the Counselor were out for a long period of time, creating longer hours for the remaining staff. One staff member had a kidney transplant in October and is hopefully going to be back on board in March. In December, the Shelter Supervisor who had been with the program for almost ten years left for another job. Shortly after the Shelter Supervisor leaving, the new YCS II went on medical leave for several weeks and the Quality Services Manager was out for five weeks with COVID-19. The Regional Director and Shelter Supervisor from Currie House kept the program running.

Because of COVID-19, all clients in the shelter are doing online school. That has worked out very well and eliminated a potential source of infection. Crestview High School is reported to have a very large number of COVID-19 cases so shelter (home) schooling has helped keep the clients safer. They have also seemed to enjoy it and have done a good job of applying themselves to their schoolwork.
The program has adjusted the client's activities because of COVID-19. They have increased their number of events for the clients on-site in order to keep them safer.
Also because of COVID-19, they have seen an increase in the numbers of people who are in need of food in the community. The food distribution program has grown approximately by 100 more people each month receiving food. Most of this increase comes from people who have lost their jobs because of businesses shutting down.

Narrative Summary
Lutheran Services Florida NW Hope House is managed by a Regional Director who oversees a Quality Services Manager and a Clinical Director. At the time of the review, there were three vacant Youth Care Specialist (YCS) positions, a full-time, a part-time, and a temporary position.

Lutheran Services Florida NW Hope House provides residential and non-residential counseling and case management services over four counties, Walton, Escambia, Santa Rosa, and Okaloosa, across Circuit 1.
The Clinical Director, who is a Licensed Mental Health Counselor (LMHC), oversees both programs. The residential counseling program consists of one master's level counselor. The non-residential counseling program also consists of one master's level counselor. The non-residential program also offers Intensive Case Management (ICM) services. ICM services are provided by an ICM Coordinator and a part-time ICM Case Manager. The Clinical Director oversees ICM services.
This location does not offer Stop Now and Plan (SNAP) services. SNAP services for this circuit are provided at a sister shelter operated by the agency in the same circuit. The program has provided domestic violence and ICM services this review period. At the time of the review, the program had not provided any staff secure, domestic minor sex trafficking, probation respite, or

Family and Youth Respite Aftercare (FYRAC) services since the last QI review. The agency is currently maintaining paper files.

Lutheran Services Florida NW Hope House residential program is led by a Quality Services Manager and a Youth Care Specialist (YCS) III. The shelter runs three shifts. The YCS III oversees each shift. The first shift has three YCS I staff. The second shift has three YCS I staff and one vacant YCS I and YCS II positions. The third shift has two YCS I and one YCS II staff and has one vacant YCS I position.
The youth shelter is a residential home that has been converted into a shelter. There are three bedrooms upstairs, one bedroom sleeps four youth and the other two bedrooms sleep two youth each. The one-bedroom that sleeps four youth, is primarily used for the boys' room and the other two bedrooms are primarily used for the girls.
There are eight beds licensed for CINS/FINS services. At the time of the review, there were four CINS/FINS youth in the shelter.

The residential counseling services in the shelter are overseen by the Clinical Director who is a Licensed Mental Health Counselor (LMHC). Services are provided by one master's level counselor. All youth are screened for suicide at intake using the six approved questions on the CINS Intake Assessment form and the Suicide Risk Evaluation (SRE). If youth receive a positive screening they are placed on sight and sound supervision until seen and assessed by a qualified mental health professional. All staff receives training on suicide prevention.
Health services are overseen by a part-time Registered Nurse (RN). All newly hired staff are trained on the medication distribution process and the Pyxis Med-Station4000 Medication Cabinet. Refresher training is provided as needed. All medications in the facility are stored in the Pyxis Med-Station4000 Medication Cabinet. YCS staff completes shift-to-shift inventories of all controlled medications and maintains perpetual inventories of all other medications.

<u>The overall findings for the QI Review for Lutheran Services Florida/Northwest – Hope House are summarized as follows:</u>

<u>Standard 1</u>: This standard has a total of seven indicators regarding management accountability. Four of the seven indicators were rated satisfactory. Indicators 1.03 Incident Reporting, 1.04 Training Requirements, and 1.07 Outreach Services were rated limited. There were exceptions noted in indicators 1.01 Background Screening and 1.06 Client Transportation. The exception noted in 1.01 was due to the program's policy not stating the pass rate, score, or measure for the pre-assessment tool being used. The exception noted in 1.06 was due to being unable to determine if three single client transport had supervisor approval prior to the transport taking place.

<u>Standard 2:</u> This standard has a total of ten indicators that relate to intervention and case management. Nine applicable indicators were rated satisfactory. Indicator 2.10 Stop Now and Plan (SNAP) was not applicable as this program does not provide SNAP services. There was an exception noted in indicator 2.06 Adjudication/Petition Process due to the family and case staffing committee being notified less than five working days prior to the staffing in all four files reviewed.

Standard 3: This standard has a total of seven indicators regarding shelter care. All seven indicators were rated satisfactory. There was an exception noted in indicator 3.04 Log Books due to the Clinical Director, staff, and supervisors not indicating the dates reviewed when reviewing the log book.

Standard 4: This standard has a total of five indicators regarding mental health and health services. All five indicators were rated satisfactory. There were exceptions noted in indicators 4.02 Suicide Prevention and 4.05 Episodic/Emergency Care. The exception noted in 4.02 was due to a suicide risk assessment being completed outside the twenty-four hour requirement. The exception noted in 4.05 was due to two staff not having a current CPR and First Aid certification.

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

Standard 1: Indicators 1.03 Incident Reporting, 1.04 Training Requirements, and 1.07 Outreach Services were rated limited.

Indicator 1.03 was rated limited due to one of six CCC reports not being reported within the two-hour time frame, two of the seven reports were not documented in the program's log book, and none of the seven reports were signed by the Shelter Manager/Clinical Director.

Indicator 1.04 was rated limited due to two staff missing required trainings during the first 90 days of employment and also documented trainings that were completed outside the required time frame.

Indicator 1.07 was rated limited due to the program not documenting any outreach activities in the last six months.

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	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 NO (explain) X** The agency has a policy in place titled 1.01 Background Screening of Employees and Volunteers that addresses the requirements of this indicator. The policy was last reviewed on December 15, 2020 by the Regional Director.	**Exception:** The policy did not state the pass rate, score, or measure for the pre-assessment tool being used.
Agency utilizes an employee suitability prescreening assessment with a passing rate criterion prior to an offer of hire for direct care staff working with youth or the agency has provided an explanation to for staff hired with a non-passing/low score.	**X**					A total of six new staff were hired since the last QI review. Five of the staff met the criteria for a pre-screening assessment. The agency uses the Predictive Index. All staff had a Predictive Index completed.	
Background screening completed prior to hire/start date or exemption obtained prior to working with youth (if rated ineligible) for new hires, volunteers/interns, and contractors.	**X**					A total of six new staff and one intern were hired since the last QI review. All seven staff were background screened prior to hire.	
Five-year re-screening completed every 5 years from initial date of hire	**X**					There were a total of three staff applicable for a five-year rescreening during this review period. All three staff had a re-screening completed prior to the initial date of hire.	

Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?	**X**					The agency submitted the Annual Affidavit of Compliance with Level 2 Screening via fax to the Background Screening Unit on 1/07/2021.	
Proof of E-Verify for all new employees obtained from the Department of Homeland Security	**X**					Documentation of approval of E-Verify work eligibility was provided for all six new staff hired.	
1.02: Provision of an abuse free environment to ensure safety and abuse free environment for youth in care							
Provider has a written policy and procedure that meets the requirement for Indicator 1.02						**YES X NO (explain)** The agency has a policy in place titled 1.02 Provision of an Abuse Free Environment that addresses the requirements of this indicator. The policy was last reviewed on December 15, 2020 by the Regional Director.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Abuse Free Environment							
Agency has a code of conduct of policy and there is evidence that staff are aware of agency's code of conduct.	**X**					The program maintains a code of conduct which prohibits the use of physical abuse, profanity, threats, or intimidation that all staff must adhere to. This is reviewed with staff at hire.	
Child Abuse Registry telephone number is visible to youth and posted common areas of the facility	**X**					Child Abuse telephone number was observed during the virtual tour to be posted on a bulletin board in the dayroom of the shelter.	
Youth were informed of the Abuse and Contact Number (see youth survey results)	**X**					A review of five residential files confirmed youth were informed of the Abuse Hotline number during orientation. The youth initialed and signed the orientation checklist documenting a review of the Abuse Hotline information.	
Management takes immediate action to address any incidents of threats or abuse	**X**					The program reported there were no incidents of abuse or threats identified and/or reported during the review period needing management action.	
Grievance Process							
Agency has a formal grievance process	**X**					A review of the program's policy confirmed the agency has a formal grievance process in place.	
Locked box accessible to only management and available to youth in a common area	**X**					During the virtual tour it was observed that the program has an accessible grievance box that is locked and located in the dayroom. The Quality Services Supervisor has a key to the box, and it is	

						checked daily. The box was opened during the tour and was empty.	
Direct care does not handle the complaint/grievance unless assistance is asked for by the youth. Program director/supervisor will have access to and manage grievances unless it is towards themselves.			**X**			The program has had no grievances filed since the last QI review.	
72-hour resolution requirement by management. If this does NOT occur within the 72 hour period, there is sufficient documentation explaining the cause for the delay in resolution.			**X**			The program has had no grievances filed since the last QI review.	
1.03: Incident Reporting							
Provider has a written policy and procedure that meets the requirement for Indicator 1.03						**YES X NO (explain)** The agency has a policy in place titled 1.03 Incident Reporting that addresses the requirements of this indicator. The policy was last reviewed on December 15, 2020 by the Regional Director.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
During the past 6 months, the program notified the Department's CCC (Central Communication Center) no later than two hours after any reportable incident occurred or within two hours of the program learning of the incident		**X**				There were seven CCC reports reviewed. Six of the seven reports were reported within the required two-hour time frame.	**Exception:** Staff became aware of a reportable incident on October 12, 2020 at 7:30pm; however, it was not reported to the CCC until October 13, 2020 at 2:10pm.
The program completes follow-up communication tasks/special instructions as required by the CCC	**X**					All CCC incidents that required followed up documented it was completed and the report was successfully closed.	
Incidents are documented in the program logs and on incident reporting forms		**X**				All seven CCC reports were documented on incident reporting forms. Five out the seven reports were documented in the program's log book.	**Exception:** Two out of the seven CCC reports reviewed were not documented in the program's log book.

All incident reports are reviewed and signed by program supervisors/directors		**X**				All seven incident reports reviewed were signed by the staff member completing the report.	**Exception:** None of the seven incident reports reviewed were signed by the Shelter Manager/Clinical Director.
1.04: Training Requirements (Staff receives training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions)							
Provider has a written policy and procedure that meets the requirement for Indicator 1.04						**YES X NO (explain)** The agency has a policy in place titled 1.04 Training Requirements that addresses the requirements of the indicator. The policy was last reviewed on December 15, 2020 by the Regional Director.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
First Year Direct Care Staff							
All staff completed the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days from date of hire. *(Staff hired before January 1st were required to complete no later than December 31, 2020)*	**X**					There was a total of seven staff training files reviewed. All seven staff were hired prior to January 1, 2021 and had the DOJ Civil Rights and Federal Funds training completed prior to December 31, 2020.	
All staff receives all mandatory training during the first 90 days of employment from date of hire.		**X**				There were three staff training files reviewed for first year training requirements.	**Exceptions:** Two staff were missing seven trainings required in the first 90 days and one staff was missing six. Also, two staff documented three required trainings that were completed late, outside the 90 day time frame.

All staff completes all mandatory Florida Network and SkillPro training during the first-year employment.			X			All three staff still had time remaining in their first year training cycle to receive all required trainings, two staff had six months left and staff had approximately one month left.	
Non-licensed Mental Health Clinical Shelter Staff (within first year of employment)							
Non-licensed mental health clinical shelter staff Assessment of Suicide Risk Training					X	There were no non-licensed clinical staff requiring this training during this review period.	
Documentation of non-licensed mental health clinical staff person's training in Assessment of Suicide Risk form or written confirmation by a licensed mental health professional of training (includes date, signature and license number of the licensed mental health professional supervisor).					X	There were no non-licensed clinical staff requiring this training during this review period.	
In-Service Direct Care Staff							
Direct care staff completes 24 hours of mandatory refresher Florida Network, SkillPro, and job-related training annually *(40 hours if the program has a DCF child caring license).*		X				There were four staff training files reviewed for in-service training requirements. Two of the four staff documented more than the required 40 hours of annual training and all required trainings for 2020.	**Exception:** Two staff did not document all required training hours or trainings for 2020. One staff only documented 26.5 of the required 40 hours and was missing Skill Pro Suicide Prevention Part 2, Skill Pro Human Trafficking, and Fire Safety. The other staff documented 35.75 of the required 40 hours and was missing CPR, First Aid, and Skill Pro Human Trafficking.
Required Training Documentation							

The program maintains an individual training file for each staff, which includes an annual employee training hours tracking form and related documentation, such as certificates, sign-in sheets, and agendas for each training attended.	X					All seven training files reviewed contained a spreadsheet documenting all trainings, date completed, and hours. Also, training files included any related documentation such as training certificates, sign-in sheets, and training worksheets.	
Provider has a written policy and procedure that meets the requirement for Indicator 1.05						**YES X NO (explain)** The agency has a policy in place titled 1.05 Analyzing and Reporting Information that addresses the requirements of the indicator. The policy was last reviewed on December 15, 2020 by the Regional Director.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Case record review reports demonstrate reviews are conducted quarterly, at a minimum	X					The agency reviews case records monthly. These monthly reports were provided for the last six months.	
The program conducts reviews of incidents, accidents, and grievances quarterly, at a minimum	X					Incidents, accidents, and grievances are reviewed monthly during the committee meetings.	
The program conducts an annual review of customer satisfaction data	X					Customer satisfaction data is reviewed monthly during the committee meetings.	
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					Outcome data is reviewed during monthly staff meetings. The program reported an annual reconciliation was just completed with the Florida Network in January 2021.	
The program conducts a monthly review of NetMIS data reports.	X					NetMIS data reports are reviewed monthly by the Clinical Director.	
The Florida Network conducts monthly reconciliation by comparing NetMIS data to JJIS data. Agency has evidence that	X					The Clinical Director reviews information in JJIS and NetMIS monthly to ensure accuracy of data entry and collection. Any differences are reconciled at that time by the Clinical Director.	

they have reconciled any differences noted.							
The program has a process in place to review and improve accuracy of data entry & collection	**X**					The Clinical Director reviews information in JJIS and NetMIS monthly to ensure accuracy of data entry and collection. Any differences are reconciled at that time by the Clinical Director.	
There is documentation that findings are regularly reviewed by management and communicated to staff and stakeholders.	**X**					There was documentation through meeting minutes that findings are communicated to staff and stakeholders.	
There is evidence that strengths and weaknesses are identified, improvements are implemented or modified, and staff are informed and involved throughout the process.	**X**					There is evidence in monthly YCS meeting minutes that strengths and weaknesses are identified, improvements are implemented, and staff are informed and involved throughout the process.	
Provider has a written policy and procedure that meets the requirement for Indicator 1.06						**YES X NO (explain)** The agency has a policy in place titled 1.06 Client Transportation that addresses the requirements of the indicator. The policy was last reviewed on December 15, 2020 by the Regional Director.	
Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	**X**					The program provided a list of staff approved to transport youth.	
Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	**X**					There was documentation all drivers had a valid Florida driver's license and are covered under the agency's insurance policy.	
Agency's Transportation policy prohibit transporting a client without maintaining at least one other passenger in the vehicle during the trip and include exceptions in the event that a 3rd party is NOT present in the vehicle while transporting	**X**					The programs policy titled 1.06 Client Transportation prohibits transporting a youth without another passenger in the vehicle. There are provisions in place in case a 3rd party is not present in the vehicle.	
In the event that a 3rd party cannot be obtained for transport, the agency's supervisor or		**X**				Transportation Logs and logbook entries were reviewed for the last six months. There were ten single client transports reviewed. There was	**Exception:** There were three single client transports not

managerial personnel consider the clients' history, evaluation, and recent behavior						documentation for seven of the ten single client transports of supervisor approval, prior to the transport taking place, documented on the Transportation Logs and also in the log book.	documented in the log book so it was unable to be determined if supervisor approval occurred prior to the transport happening. The supervisor signature on the Transportation Log did not have a date or time of approval.
The 3rd party an approved volunteer, intern, agency staff, or other youth	**X**					The 3rd party present on transports reviewed for the last six months was either an agency staff member or another youth.	
There is documentation of use of vehicle that notes name or initials of driver, date and time, mileage, number of passengers, purpose of travel and location.	**X**					Transportation Logs were reviewed for the last six months and documented the date, time, mileage, number of passengers, destination, and drivers initials. All Transportation Logs were filled out in their entirety.	
Provider has a written policy and procedure that meets the requirement for Indicator 1.07						**YES X NO (explain)** The agency has a policy in place titled 1.07 Outreach and Interagency Agreements that addresses the requirements of this indicator. This policy was last reviewed on December 15, 2020 by the Regional Director.	
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**					Meeting minutes and agendas were provided to show a staff member from the program attends the local DJJ Board and Council Meetings. These meetings have been held bi-monthly.	
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**				NetMIS Outreach Reports were reviewed and an interview with Quality Services Manager was conducted.	**Exception:** There was no documentation of any outreach activities conducted by the program in the last six months.

The program maintains written agreements with other community partners which include services provided and a comprehensive referral process.	**X**					The program provided fourteen interagency agreements. The agreements included services provided.	**Exception:** Although the agreements were not expired due to not having an expiration date, the agreements were all signed between 2008 and 2014. The agreements have not been updated or reviewed since they were signed.
Provider has a written policy and procedure that meets the requirement for Indicator 2.01						**YES X NO (explain)** The agency has a policy in place titled 2.01 Screening and Intake that addresses the requirements of the indicator. The policy was last reviewed on December 15, 2020 by the Regional Director.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Shelter youth: Eligibility screening is completed immediately for all shelter placement inquiries. If staff on duty cannot complete the screening, an on-call supervisor is contacted and eligibility is determined within 30 minutes from initial inquiry.	**X**					There were five shelter files reviewed, two open and three closed. All five files documented an eligibility screening was completed immediately.	
Community counseling: Eligibility screening is completed within 3 business days of referral by a trained staff using the NetMIS form	**X**					There were five community counseling files reviewed, three open and two closed. All five files documented an eligibility screening was completed within three days of the referral.	
Youth and parents/guardians receive the following in writing: a. Available service options b. Rights and responsibilities of youth and parents/guardians	**X**					All ten files documented the youth and parent/guardian received, in writing, available services options, rights and responsibilities, and brochure.	

The following is also available to the youth and parents/guardians: a. Possible actions occurring through involvement with CINS/FINS services (case staffing committee, CINS petition, CINS adjudication) b. Grievance procedures	**X**					All ten files documented the youth and parent/guardian were provided information on possible actions occurring through involvement with CINS/FINS services and the grievance procedure.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.02						**YES X NO (explain)** The agency has a policy in place titled 2.02 Needs Assessment that addresses the requirements of the indicator. The policy was last reviewed on December 15, 2020 by the Regional Director.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Completion of Needs Assessment							
Shelter Youth: Needs Assessment initiated within 72 hours of admission	**X**					There were five shelter files reviewed, two open and three closed. All five files documented the Needs Assessment was initiated within 72 hours of admission.	
Non-Residential youth: Needs Assessment is done within 2 to 3 face-to-face contacts after the initial intake **OR** updated, if most recent assessment is over 6 months old	**X**					There were five community counseling files reviewed, three open and two closed. All five files documented the Needs Assessment was completed within two to three face-to-face contacts.	
Needs Assessment is conducted by a bachelor's or master's level staff member	**X**					All ten Needs Assessments were completed by a bachelor's or master's level staff member.	
Needs Assessment includes a supervisor's review signature upon completion	**X**					One Needs Assessment reviewed included a supervisor's signature upon completion. Due to Covid-19, the remaining nine Needs Assessments contained documentation in the progress notes they were reviewed virtually with the supervisor upon completion and the supervisor signed the Needs Assessments the next time on-site. These nine Needs Assessments were signed approximately one month after they were completed.	
Suicide Risk as a Result of the Needs Assessment							

Youth was identified with an elevated risk of suicide as a result of the Needs Assessment			X			None of the files reviewed documented the youth identified with an elevated risk of suicide as a result of the Needs Assessment.	
If yes, the youth was referred for an Assessment of Suicide Risk conducted by or under the direct supervision of a licensed mental health professional			X			None of the files reviewed documented the youth identified with an elevated risk of suicide as a result of the Needs Assessment.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.03						**YES X NO (explain)** The agency has a policy in place titled 2.03 Case/Service Plan that addresses the requirements of the indicator. The policy was last reviewed on December 15, 2020 by the Regional Director.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Case/Service plan is developed within 7 working days of Needs Assessment	**X**					There were ten files reviewed, five shelter files reviewed, two open and three closed, and five community counseling files, three open and two closed. All ten files had a Service Plan developed within seven working days of the Needs Assessment.	
Case plan service Plan includes: 1. Individualized and prioritized need(s) and goal(s) identified by the Needs Assessment 2. Service type, frequency, location 3. Person(s) responsible 4. Target date(s) for completion and Actual completion date(s) 5. Signature of youth, parent/ guardian, counselor, and supervisor 6. Date the plan was initiated	**X**					All ten Service Plans reviewed included individualized and prioritized needs and goals identified by the Needs Assessment, service type, frequency and location, persons responsible, and target dates for completion. Of the ten files reviewed, five files include actual goal completion dates while two shelter files and three community counseling cases are still open. All ten Service Plans had the signature of the counselor, supervisor, and youth. Seven of the ten Service Plans had the signature of the parent. Three shelter files were reviewed virtually with the parent.	
Case/service plans are reviewed for progress/revised by counselor and parent (if available) every 30 days for the first three months and every 6 months after	**X**					All five community counseling files were applicable for 30 day reviews. All of the 30 day reviews in these files were completed as required. The five shelter files reviewed were not applicable for 30 day reviews due to not being in the program long enough.	

Provider has a written policy and procedure that meets the requirement for Indicator 2.04						**YES X NO (explain)** The agency has a policy in place titled 2.04 Case Management and Service Delivery that addresses the requirements of the indicator. The policy was last reviewed on December 15, 2020 by the Regional Director.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Counselor/Case Manager is assigned	**X**					There were ten files reviewed, five shelter files, two open and three closed, and five community counseling files, three open and two closed. All ten files had a counselor assigned.	
The Counselor/Case Manager completes the following as applicable: 1. Establishes referral needs and coordinates referrals to services based upon the on-going assessment of the youth's/family's problems and needs 2. Coordinates service plan implementation 3. Monitors youth's/family's progress in services 4. Provides support for families 5. Monitors out-of-home placement (if necessary) 6. Makes referrals to the case staffing to address problems and needs of the youth/family 7. Accompanies youth and parent/guardian to court hearings and related appointments 8. Refers the youth/family for additional services when appropriate 9. Provides case monitoring and reviews court orders 10. Provides case termination notes 11. Provides follow-up after 30 days of exit	**X**					All ten files establish referral needs and coordinated referrals to services based upon the ongoing assessment of the youth's/family's problems and needs, coordinated service plan implementation, monitored youth's/family's progress in service, and provided support to families. Five out of ten files were applicable and documented monitoring out-of-home placement. No files were applicable for referrals to case staffing committee or accompanying youth/guardian to court hearings and related appointments. All ten files were applicable and referred the youth/family for additional services. All ten files provided case monitoring and reviews. All five applicable files provided case termination documentation. There were five files applicable for providing follow-up after 30 days of exit and three files after 60 days of exit. All follow-up calls were completed as required.	

12. Provides follow-up after 60 days of exit							
The program maintains written agreements with other community partners that include services provided and a comprehensive referral process	**X**					The program has written agreements with Okaloosa Walton First Call for Help, Healthy Families Santa Rosa/Walton, C.O.P.E. Center, Big Brothers/Big Sisters, Children's Home Society, Bridgeway Center Emergency Services Unit, and various local police departments. Agreements included services provided and a comprehensive referral process.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.05						**YES X NO (explain)** The agency has a policy in place titled 2.05 Counseling Services that addresses the requirements of the indicator. The policy was last reviewed on December 15, 2020 by the Regional Director.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Youth and families receive counseling services, in accordance with the youth's case/service plan, to address needs identified during the assessment process	**X**					There were ten files reviewed, five shelter files, two open and three closed, and five community counseling files, three open and two closed. Service plans and case notes maintained demonstrated all ten youth received counseling services to address needs identified during the assessment process.	
Shelter Program							
Shelter programs provides individual and family counseling	**X**					All five shelter files reviewed demonstrated individual and/or family counseling was offered.	
Group counseling sessions held a minimum of five days per week	**X**					All five shelter files reviewed documented group sessions at least five days per week.	
Group counseling sessions consist of: a. Length of at least 30 minutes b. Opportunity for youth engagement c. Clear and relevant topic (informational/developmental/ educational) d. Clear leader or facilitator	**X**					All groups reviewed were at least 30 minutes in length, had an opportunity for engagement, had a clear and relevant topic, and had a clear leader.	
Community Counseling							
Community counseling programs provide therapeutic community-based services designed to	**X**					All five community counseling files reviewed documented therapeutic services were provided by agency staff and were documented in the case notes.	

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.						Referral needs were established and provided to all five youth.	
Counseling Services							
Reflect all case files for coordination between presenting problem(s), psychosocial assessment, case/service plan, case/service plan reviews, case management, and follow-up	**X**					All ten files reviewed documented coordination between presenting problems, the needs assessment, service plan, service plan reviews, case management, and follow-up.	
Maintain individual case files on all youth and adhere to all laws regarding confidentiality	**X**					An individual youth file was maintained for all ten youth files reviewed.	
Case notes maintained for all counseling services provided and documents youth's progress	**X**					All ten youth files included case notes that documented services provided including counseling and the youth's progress.	
On-going internal process that ensures clinical reviews of case records and staff performance	**X**					A sample of case records are reviewed quarterly. A supervisor also signs all screening, assessment, and treatment paperwork in each file to ensure staff performance is adequate.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.06						**YES X NO (explain)** The agency has a policy in place titled 2.06 Adjudication/Petition Process that addresses the requirements of the indicator. The policy was last reviewed on December 15, 2020 by the Regional Director.	
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 four case staffings reviewed. None of the staffings were initiated by the parent.	
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		**X**				There were four case staffings reviewed.	**Exception:** All four case staffings documented the family and committee were notified less than five working days prior to the staffing.

b. Notification to committee no less than 5 working days prior to staffing							
Case Staffing Committee							
Must include: a. DJJ rep. or CINS/FINS provider b. Local school district representative	**X**					All four staffings included a DJJ representative, the CINS/FINS provider, and a school representative.	
Other members may include: a. State Attorney's Office b. Others requested by youth/ family c. Substance abuse representative d. Law enforcement representative e. DCF representative f. Mental health representative	**X**					There were other members present at the staffings as needed or requested.	
The program has an established case staffing committee, and has regular communication with committee members	**X**					The program has an established committee that meets on a regular basis.	
The program has an internal procedure for the case staffing process, including a schedule for committee meetings	**X**					The program has policy 2.06 Adjudication/Petition Process in place and has a committee that meets on a regular basis.	
As a result of the Case Staffing							
The youth and family are provided a new or revised plan for services	**X**					In all four cases the youth and family were provided a revised plan for services.	
Written report is provided to the parent/guardian within 7 days of the case staffing meeting, outlining recommendations and reasons behind the recommendations	**X**					In all four cases a written report was provided to the parent on the day of the staffing outlining recommendations and reasons for the recommendations.	
If applicable, the program works with the circuit court for judicial intervention for the youth/family					**X**	None of the four files reviewed were applicable for judicial intervention.	
Case Manager/Counselor completes a review summary prior to the court hearing					**X**	None of the four files reviewed were applicable for judicial intervention.	

Provider has a written policy and procedure that meets the requirement for Indicator 2.07						**YES X NO (explain)** The agency has a policy in place titled 2.07 Youth Records that addresses the requirements of the indicator. The policy was last reviewed on December 15, 2020 by the Regional Director.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
All records are clearly marked 'confidential'.	X					All ten youth files reviewed were marked confidential.	
All records are kept in a secure room or locked in a file cabinet that is marked "confidential"	X					All files were maintained in a locked file cabinet that was marked confidential located in the Youth Care Specialist office area.	
When in transport, all records are locked in an opaque container marked "confidential"	X					The program uses a locked, black, opaque case that is marked confidential to transport files.	
All records are maintained in a neat and orderly manner so that staff can quickly and easily access information	X					All files were maintained in a consistent manner and were neat and orderly making information easy to access.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.08						**YES X NO (explain)** The agency has a policy in place titled 2.08 Sexual Orientation, Gender Identity, Gender Expression that addresses the requirements of this indicator. This policy was last reviewed on December 15. 2020 by the Regional Director.	
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			There have been no youth who have fallen under the requirements of this indicator since the last Quality Improvement review.	
Youth in need of specialized support is referred to qualified resources (as applicable)			X			There have been no youth who have fallen under the requirements of this indicator since the last Quality Improvement review.	

Youth preference is considered and documented for room assignment and youth is not roomed in isolation due to sexual orientation, gender identity, or gender expression			**X**			There have been no youth who have fallen under the requirements of this indicator since the last Quality Improvement review.	
Youth is provided hygiene products, undergarments and clothing that affirms their gender identity or gender expression			**X**			There have been no youth who have fallen under the requirements of this indicator since the last Quality Improvement review.	
The agency has signage and brochures/publication placed in common areas indicating that all youth are welcome regardless of sexual orientation, gender identity, and gender expression	**X**					A virtual tour of the facility showed signage posted in the lobby area, offices, hallways, and dayroom of the facility.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.09						**YES X NO (explain)** The agency has a policy in place titled 2.09 Special Populations that addresses the requirements of this indicator. The policy was last reviewed on December 15, 2020 by the Regional Director.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Staff Secure							
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? **(If no, select rating "No eligible items for review")**	**YES**	**NO** **X**	**N/A**			The provider has not served any youth meeting the criteria for staff secure since the last QI review.	
Staff Secure policy and procedure outlines the following: a. In-depth orientation on admission b. Assessment and service planning	**X**					The program's policy titled 2.09 Special Populations covers all requirements for staff secure services.	

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

Services provided to these youth specifically designated services designed to serve DMST youth			X				
Did the placement of DMST youth require additional supervision for the safety of the youth or the program? If so, did the agency provide the appropriate level of supervision and safety measures?			X				
Length of Stay: a. Youth in program do not have length of stay in DMST placement that exceeds seven (7) days b. Agency has approval for stays and support beyond seven (7) days for DMST placements that are obtained on a case-by-case basis? (If applicable.)			X				
Agency has evidence that staff assigned to DMST youth under this provision are to enhance the regular services available through direct engagement in positive activities designed to encourage the youth to remain in shelter			X				
All other services provided to DMST youth are consistent with all other general CINS/FINS program requirements			X				
Domestic Violence							
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? **(If no, select rating "No eligible items for review")**	**YES** **X**	**NO**	**N/A**				
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		

Youth admitted to DV Respite placement have a pending DV charge and have evidence of being screened by JAC/Detention, but do not meet criteria for secure detention	X					There were two closed files reviewed. Both files had a face sheet indicating a pending DV charge and both were screened by the JAC and did not meet criteria for secure detention.	
Data entry into NetMIS and JJIS within (3) business days of intake and discharge	X					A review of the Data Entry Lag Report during the time frame of these two files revealed no lags in data entry.	
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					Neither file exceed 21 days in the program.	
Case plan in file reflects goals focusing aggression management, family coping skills, or other intervention design to reduce reoccurrence of violence in the home	X					Both files had Service Plans that focused on anger management and family coping skills.	
All other services provided to Domestic Violence Respite youth are consistent with all other general CINS/FINS program requirements	X					Both youth received all other general CINS/FINS required services.	
Probation Respite							
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? **(If no, select rating "No eligible items for review")**	**YES**	**NO** **X**	**N/A**			The provider has not served any youth meeting the criteria for Probation Respite since the last QI 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			X				

probation regardless of adjudication status							
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** **X**	**NO**	**N/A**				
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Youth receiving services was court ordered or referred by case staffing committee	**X**					There were four open ICM files reviewed. All four youth were referred by the case staffing committee.	
Services for youth and family include: a. Four (4) direct contacts per month b. Four (4) collateral contacts per month	**X**					All four files documented at least four direct contacts and four collateral contacts each month.	
Assessments include: a. A Child Behavior Checklist (CBCL) is completed within 14 days of intake and at discharge (if applicable)	**X**					All four files documented a Child Behavior Checklist was completed within fourteen days of intake. All had evidence of a Youth Self-Report assessment completed at intake and the three applicable files had one completed every 90 days. One youth had not yet been in the program 90 days. All the files were open	

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)						so none were applicable for any assessments being completed at discharge.	
Case plan demonstrates a strength-based, trauma-informed focus	**X**					All case plans demonstrated a strength-based, trauma-informed focus.	
Agency has evidence that ICMS has a strength-based perspective in one or more of the following areas; engaging the family, advocating on their behalf, initiating change agent activities, helping to access supports in the community, teaching problem solving skills, modeling productive behaviors, and/or successful completion of youth and family developmental milestones	**X**					All four files contained an abundance of documentation of engaging the family, advocating on behalf of the family, helping access support in the community, teaching problem solving skills, and modeling productive behavior.	
Family and Youth Respite Aftercare Services (FYRAC)– Non-residential Only							
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? **(If no, select rating "No eligible items for review")**	**YES**	**NO** **X**	**N/A**			The provider has not served any youth meeting the criteria for FYRAC since the last QI review.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Youth is referred by DJJ for a domestic violence arrest on a 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) X** The agency does not provide SNAP services at this location.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
SNAP Clinical Groups							
Youth are screened to determine eligibility of services					**X**		
Needs assessment is completed at initial intake, or within two face-to-face sessions					**X**		
SNAP Assessments a. Child Behavior Checklist (CBCL) is completed by the caregiver (pre & post) b. Teacher Report Form (TRF) completed by the teacher (pre & post) c. Tool for Parenting Self Efficacy (TOPSE) completed by the caregiver (pre & post) d. Prevention Assessment Tool (PAT) (pre & post)					**X**		
SNAP discharge report summary					**X**		
SNAP Boys/SNAP Girls **Parent** Group Evaluation Form					**X**		
SNAP Boys/SNAP Girls **Child** Group Evaluation Form					**X**		
SNAP in Schools							
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		

Weekly attendance sheet with youth names and/or identifying number completed with signatures of teacher and facilitator(s) (For a total of 13 attendance sheets)					**X**		
"Class Goal" sheet					**X**		
Measure of Classroom Environment (MoCE) (Pre and Post) is used to identify baseline and treatment outcomes of reported classroom dynamics.					**X**		
Pre and Post Evaluations					**X**		
One SNAP® Fidelity Adherence Checklist completed per classroom in a 13 – week SNAP in Schools group and uploaded to Dropbox					**X**		
Provider has a written policy and procedure that meets the requirement for Indicator 3.01						**YES X NO (explain)** The agency has a policy in place titled 3.01 Shelter Environment that addresses the requirements of the indicator. The policy was last reviewed on December 15, 2020 by the Regional Director.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Facility Inspection	**X**					A virtual tour of the facility revealed furnishings were in good repair. The program was free of insect infestation. Grounds were landscaped and maintained. Bathrooms were clean and functional. No graffiti was observed. Lighting was adequate. Exterior areas were free of debris and grounds were free of hazards. Dumpster and garbage cans were covered. Doors were secured with key access required. Egress plans were posted in several locations. The client rules, abuse hotline information,	

						and DJJ incident reporting information was posted on a bulletin board in the dayroom. Blank grievance forms were available located next to the locked grievance box in the dayroom. The program has two vans used for transporting youth which were equipped with major safety equipment as required. Interior areas of the vans did not contain contraband and were free of hazardous items. Chemicals were stored behind locks and inventories and MSDS were maintained. The washers and dryers were operational and clean of lint. A current DCF license was displayed. Each youth has their own individual bed with clean, covered mattress, pillow, and sufficient linens. The program has a locked cabinet that serves as a safe place for youth to keep their personal belongings.	
Fire and Safety Health Hazards	**X**					The annual fire inspection was completed on September 30, 2020. A Fire Safety Equipment inspection was completed on May 12, 2020 and documenting satisfactory compliance. A review of drills indicated the program conducted on average three fire drills per month. The program also completed numerous mock emergency drills, including at a minimum, one per shift per quarter. Residential Group Care and Food Service inspection was completed on September 23, 2020. Menus were posted and signed by a licensed dietician. Cold food was properly stored, marked, and labeled, and dry storage/pantry areas were clean. Refrigerators/freezers were clean, and temperatures were maintained.	
Youth Engagement							
a. Youth are engaged in meaningful, structured activities (e.g., education, recreation, counseling services, life and social skill training) seven days a week during awake hours. Idle time is minimal. b. At least one hour of physical activity is provided daily. c. Youth are provided the opportunity to participate in a	**X**					The daily schedule reveals that youth are engaged in meaningful, structured activities seven days a week. The schedule also provides for at least one hour of physical activity. Youth are given the opportunity to participate in faith-based activities with non-punitive activities offered for those who choose not to participate in those activities. Youth are given the time and opportunity to do homework and read. The program has a library with a variety of books for the youth to read. The schedule was observed posted on	

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.						the bulletin board in the dayroom during the virtual tour.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.02						**YES X NO (explain)** The agency has a policy in place titled 3.02 Program Orientation that addresses the requirements of the indicator. The policy was last reviewed on December 15, 2020 by the Regional Director.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Youth received a comprehensive orientation and handbook provided within 24 hours	**X**					There were five shelter files reviewed, three closed and two open. An orientation checklist was observed in all five files reviewed and completed on the day of admission. All five files documented the youth received a handbook.	
Orientation includes the following: a. Youth is given a list of contraband items b. Disciplinary action is explained c. Dress code explained d. Review of access to medical and mental health services e. Procedures for visitation, mail and telephone f. Grievance procedure	**X**					The orientation checklist was completed in all five files reviewed and documented all required topics were covered.	

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							
Documentation of each component of orientation, including orientation topics and dates of presentation, as well as signatures of the youth and staff involved is maintained in the individual youth record	**X**					The Youth Orientation Checklist was completed in all five files reviewed and signed and dated by the youth and staff.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.03						**YES X NO (explain)** The agency has a policy in place titled 3.03 Room Assignment that addresses the requirements of the indicator. The policy was last reviewed on December 15, 2020 by the Regional Director.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
A process is in place that includes an initial classification of the youths, to include:							
a. Review of available information about the youth's history, status and exposure to trauma b. Initial collateral contacts, c. Initial interactions with and observations or the youth d. Separation of younger youth from older youth, e. Separation of violent youth from non-violent youth f. Identification of youth susceptible to victimization g. Presence of medical, mental or physical disabilities	**X**					There were five shelter files reviewed, three closed and two open. The program utilizes the Shelter Intake Assessment Form to document the initial classification process and room assignment. All five files included this form completed in its entirety and signed by a staff member and supervisor. This form documented all required elements.	

h. Suicide risk i. Sexual aggression and predatory behavior j. Sexual orientation gender identity/ expression k. Acute health symptoms requiring quarantine or isolation							
An alert is immediately entered into the program's alert system when a youth is admitted with special needs and risks such as risk of suicide, mental health, substance abuse, physical health or security risk factors	**X**					Reviewed the Shelter Intake Assessment Forms for the five shelter files. Alerts for the youth were documented on the intake forms and the applicable color-coded dots were placed on the file, in all five files.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.04						**YES X NO (explain)** The agency has a policy in place titled 3.04 Log Books that addresses the requirements of the indicator. The policy was last reviewed on December 15, 2020 by the Regional Director.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Log book entries that could impact the security and safety of the youth and/or program are highlighted	**X**					Logbook entries were reviewed for September 3-5, 2020, December 20-21, 2020, January 3-7, 2021, and February 7-13, 2021. The program utilizes the NoteActive electronic log book. Entries that impacted the safety and security of the youth or program were observed highlighted.	
All entries are brief, legibly written in ink and include: • Date and time of the incident, event or activity • Names of youth and staff involved • Brief statement providing pertinent information • Name and signature of person making the entry	**X**					All entries were brief and legible, included the date and time of the event, included names of youth and staff involved, provided a brief statement, and included the name and signature of the person making the entry.	
Recording errors are struck through with a single line. The staff person must initial and date the correction. The use of	**X**					Errors were observed struck through with a single line and initialed.	

whiteout and erasures is prohibited.							
The program director or designee reviews the facility logbook(s) every week and makes a note chronologically in the logbook indicating the dates reviewed and if any correction, recommendations and follow-up are required and sign/date the entry		**X**				The program director designee reviewed the logbook every week and made a note chronologically with recommendations and signed the entry.	**Exceptions:** The reviews documented by the program director designee did not indicate the dates reviewed.
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**				On-coming staff would make an entry in the log book stating they reviewed the previous two shifts.	**Exceptions:** The reviews documented by the staff did not indicate the dates reviewed.
At the beginning of their shift, oncoming supervisor and shelter counselor reviews the logbook of all shifts since their last log entry and makes a signed and dated entry and into log book indicating the dates reviewed.		**X**				The on-coming supervisor and shelter counselor would document reviews of the logbook and make a signed entry.	**Exceptions:** The reviews documented by the supervisor and counselor did not indicate the dates reviewed.
Logbook entries include: a. Supervision and resident counts b. Visitation and home visits	**X**					Entries were observed for counts, visitation, and home visits.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.05						**YES X NO (explain)** The agency has a policy in place titled 3.05 Behavior Management Strategies that addresses the requirements of the indicator. The policy was last reviewed on December 15, 2020 by the Regional Director.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
The program has a detailed written description of the BMS, and it is explained during program orientation	**X**					The program has a written description of the behavior management system that is given to the youth at intake. This was confirmed in all five shelter files reviewed.	
Behavior Management Strategies MUST include:	**X**					The program has a detailed written description of the behavior management motivation system	

a. Supervisors are trained BMS is designed to teach youth new behaviors and help youth understand the natural consequences for their actions b. Behavioral interventions are applied immediately, with certainty, and reflect the severity of the behavior c. BMS uses a wide variety of awards/incentives to encourage participation and completion of the program d. Appropriate consequences and sanctions are used by the program and consequences for behavior are logical and designed to promote skill-building for the youth e. Counseling, verbal intervention and de-escalation techniques are used prior to physical intervention (Only techniques approved by the Florida Network and DJJ are used if physical intervention is required) f. Only staff discipline youth. Group discipline is not imposed g. Room restriction is not used as part of the system or for youth who are physically and/or emotionally out of control h. Youth should never be denied basic rights such as meals, clothing, sleep, services, exercise, or correspondence privileges						(BMMS) in the youth's handbook, which is explained during orientation. The program uses appropriate interventions to teach youth new behaviors and help them understand natural consequences for their actions, as well as a wide variety of positive incentives and rewards to encourage participation to complete the program. Behavioral interventions are applied immediately, with certainty, and reflect the severity of the behavior. Consequences for a violation of program rules are applied logically and consistently. BMMS provides constructive discipline that encourages youth to meet behavior expectations. It provides for positive reinforcement and recognition, minimizing separation of youth from the general population. Disciplinary measures never deny the youth their basic rights. Overall, BMMS, promotes order, safety, security, respect, fairness, and protection of resident rights.	

Program's Use of the BMS							
All staff are trained in the theory and practice of administering BMS rewards and consequences	**X**					All staff are provided a five day training on the BMMS at hire. A review of seven staff training files confirmed this practice.	
There is a protocol for providing feedback and evaluation of staff regarding their use of BMS rewards and consequences	**X**					Staff are provided feedback regarding their use of the BMMS at monthly staff meetings. Supervisors address their concerns with staff regarding their use of the BMMS both formally and informally. A review of staff meeting minutes confirmed the BMMS is discussed with staff during each meeting.	
Supervisors are trained to monitor the use of rewards and consequences by their staff	**X**					The supervisors are trained to monitor the use of interventions by their staff during monthly staff meetings.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.06						**YES X NO (explain)** The agency has a policy in place titled 3.06 Staffing and Youth Supervision that addresses the requirements of the indicator. The policy was last reviewed on December 15, 2020 by the Regional Director.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
The program maintains minimum staffing ratios as required by Florida Administrative Code and contract. • 1 staff to 6 youth during awake hours and community activities • 1 staff to 12 youth during the sleep period	**X**					There were five random samples of video surveillance reviewed, February 1, 2021 from 12am – 1am, February 6, 2021 from 2am – 3am, February 12, 2021 from 4am – 5am, February 21, 2021 from 3am – 4am, and February 24, 2021 from 1am to 2am. A review of the above video surveillance sample, staff schedules, and log book entries documented required staffing ratios were met for awake hours and sleeping hours.	
All shifts must always provide a minimum of two staff present	**X**					The random sample above, log book entries, and staff schedules reviewed for the last six months documented at least two staff were present on all shifts.	
Program staff included in staff-to-youth ratio includes only staff that are background screened and properly trained youth care	**X**					All staff that were included in staff-to-youth ratios had an eligible background screening completed and had been appropriately trained.	

workers, supervision staff, and treatment staff							
The staff schedule is provided to staff or posted in a place visible to staff	**X**					During the virtual tour, the schedule was observed posted in the YCS office area.	
There is a holdover or overtime rotation roster which includes the telephone numbers of staff who may be accessed when additional coverage is needed	**X**					There is a roster, listing staff and their contact information in case additional staff coverage is necessary. This information is also located in the "Pass Down" folder.	
Staff observe youth at least every 15 minutes while they are in their sleeping room, either during the sleep period or at other times, such as during illness or room restriction	**X**					A review of the video surveillance system for the five random samples listed above showed consistent fifteen-minute checks by staff. These checks were done by opening the door and looking inside the room with a flashlight. The log book also confirmed staff were constantly observing the youth every fifteen minutes and documenting observations in real time.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.07						**YES X NO (explain)** The agency has a policy in place titled 3.07 Video Surveillance System that addresses the requirements of the indicator. The policy was last reviewed on December 15, 2020 by the Regional Director.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Surveillance System							
The agency, at a minimum, shall demonstrate: a. A written notice that is conspicuously posted on the premises for the purpose of security b. System can capture and retain video photographic images which must be stored for a minimum of 30 days c. System can record date, time, and location; maintain resolution that enables facial recognition	**X**					Observed cameras and written notices during the virtual tour. System can capture and retain video images for up to thirty days. A review of random samples of overnight video surveillance revealed system records date, time, and location, and enables facial recognition. Cameras have back-up capabilities in case of power outage. All cameras were visible, and no cameras were located in the bathrooms or sleeping rooms.	

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							
A list of designated personnel who can access the video surveillance system is maintained (includes off-site capability per personnel)?	**X**					The programs maintains a list of staff who can access the video surveillance system. The list consisted of supervisory staff.	
Supervisory review of video is conducted a minimum of once every 14 days and timeframes reviewed are noted in the logbook. The reviews assess the activities of the facility and include a review of random sample of overnight shifts	**X**					Supervisory reviews were conducted at least every 14 days for the last 6 months and documented in the log book. The reviews included a random sample of overnight shifts and assessed the activities of the facility and included any corrections needed.	
Grant the requesting of video recordings to yield a result within 24-72 hours from program quality improvement visits and when an investigation is pursued after an allegation of an incident	**X**					The program has procedures in place in policy 3.07 Video Surveillance System to handle requests of video recordings within 24 – 72 hours.	
Camera service order/requests will be made within 24 hours of discovery of camera malfunctioning or being inoperable. All efforts made to obtain repairs are documented and maintained	**X**					The program has procedures in place in policy 3.07 Video Surveillance System to ensure service orders are made within 24 hours of discovery and includes documentation requirements.	

Provider has a written policy and procedure that meets the requirement for Indicator 4.01						**YES X NO (explain)** The agency has a policy in place titled 4.01 Healthcare Screening Admission that addresses the requirements of the indicator. The policy was last reviewed on December 15, 2020 by the Regional Director.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Preliminary Healthcare Screening							
Screening includes : a. Current medications b. Existing (acute and chronic) medical conditions c. Allergies d. Recent injuries or illnesses e. Presence of pain or other physical distress f. Observation for evidence of illness, injury, physical distress, difficulty moving, etc. g. Observation for presence of scars, tattoos, or other skin markings h. Acute health symptoms requiring quarantine or isolation	**X**					There were five shelter files reviewed, two open and three closed. The health screening section of the CINS/FINS Intake Form was completed in all five files and included all required elements. The program had implemented procedures to take the youths temperatures at intake and screen youth for COVID-19 related symptoms. All health screenings were reviewed by a Registered Nurse (RN) within five business days.	
Referral and Follow-up							
Youth with chronic medical conditions have a referral to ensure medical care (e.g. diabetes, pregnancy, seizure disorder, cardiac disorders, asthma, tuberculosis, hemophilia, head injuries, etc.)			**X**			None of the five youth presented with chronic conditions requiring a referral to ensure medical care.	
When needed, the parent is involved with the coordination and scheduling of follow-up medical appointments			**X**			None of the youth required follow-up medical appointments.	
All medical referrals are documented on a daily log.	**X**					Any medical referrals are documented in the log book and the Episodic Care Log.	
The program has a thorough referral process and a mechanism	**X**					There are procedures in place to involve the parent in any follow-up medical care or referrals needed.	

for necessary follow-up medical care as required and/or needed							
Provider has a written policy and procedure that meets the requirement for Indicator 4.02						**YES X NO (explain)** The agency has a policy in place titled 4.02 Suicide Prevention that addresses the requirements of the indicator. The policy was last reviewed on December 15, 2020 by the Regional Director.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Suicide Risk Screening and Approval							
Suicide risk screening occurred during the initial intake and screening process. Suicide screening results reviewed and signed by the supervisor and documented in the youth's case file.	**X**					There were five shelter files reviewed, two open and three closed. All five files contained a suicide risk screening completed during the initial intake screening process that was signed by a supervisor.	
The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	**X**					The program's suicide risk assessment tool was reviewed, and it was reported it had been previously approved by the Florida Network.	
Supervision of Youth with Suicide Risk							
Youth are placed on the appropriate level of supervision based on the results of the suicide risk assessment.		**X**				Four out of the five youth were placed on sight-and-sound supervision until assessed by a mental health professional. A suicide risk assessment was completed by a licensed professional or non-licensed professional under the direct supervision of the licensed professional within 24 hours in three of the four files. Those three youth were appropriately removed from suicide precautions.	**Exception:** In one file the youth was placed on suicide precautions on February 14, 2021 and the suicide risk assessment was completed on February 17, 2021. It was not completed within 24 hours as required.
Staff person assigned to monitor youth documented youth's behavior at 30 minute or less intervals	**X**					In all four files the observation logs documented the youth were monitored at least every thirty minutes while on sight-and-sound supervision.	
Supervision level was not changed/reduced until a licensed professional or a non-licensed mental health professional under	**X**					All four youth were removed from sight-and-sound supervision after a suicide risk assessment was completed by or reviewed with the licensed professional.	

the supervision of a licensed professional completed a further assessment OR Baker Act by local law enforcement							
Provider has a written policy and procedure that meets the requirement for Indicator 4.03						**YES X NO (explain)** The agency has a policy in place titled 4.03 Medication that addresses the requirements of the indicator. The policy was last reviewed on December 15, 2020 by the Regional Director.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Medication Storage							
a. All medications are stored in a Pyxis Med-Station 4000 Medication Cabinet that is inaccessible to youth (when unaccompanied by authorized staff) b. Pyxis machine is stored in accordance with guidelines in FS 499.0121 and policy section in Medication Management c. Oral medications are stored separately from injectable epi-pen and topical medications d. Medications requiring refrigeration are stored in a secure refrigerator that is used only for this purpose, at temperature range 2-8 degrees C or 36-46 degrees 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**					A virtual tour of the Pyxis Med-Station was completed. The Pyxis Med-Station is located in Youth Care Specialist office area and is inaccessible to youth. All medications are stored in the Pyxis Med-Station 4000 medication cabinet. Oral medications are stored separately from topical medications in the locked medical cabinet. There is a secure refrigerator used only for medical purposes and maintained at 36 degrees F. The temperature of the refrigerator is checked weekly by the RN. All narcotic and controlled medications are stored in the Pyxis Med-Station 4000 medication cabinet.	
Medication Distribution							
a. Agency maintains a minimum of 2 Super Users for the Med-Station	**X**					A list of Super Users was provided, and a list of designated staff delineated to have access to secured medication. The program has two Super Users for the Med-Station, the RN and shelter	

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

secured, and counted and documented weekly							
There are monthly reviews of medication management practice via Knowledge Portal or Pyxis Med-Station Reports.	**X**					The RN runs weekly and monthly reports via the knowledge portal.	
Medication discrepancies are cleared after each shift.	**X**					At the time of the review there were no open discrepancies. The RN reported all discrepancies are cleared out at the end of shift. The RN also runs a weekly discrepancy report via the Knowledge Portal.	
Provider has a written policy and procedure that meets the requirement for Indicator 4.04						**YES X NO (explain)** The agency has a policy in place titled 4.04 Medical/Mental Health Alert Process that addresses the requirements of the indicator. The policy was last reviewed on December 15, 2020 by the Regional Director.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Youth with a medical, mental health, or food allergy was appropriately placed on the program's alert system	**X**					There were five shelter files reviewed, two open and three closed. All five files documented the youth had alerts had were placed in the program's alert system.	
Alert system includes precautions concerning prescribed medications, medical/mental health conditions	**X**					In all five files reviewed precautions concerning prescribed medications and medical/mental health conditions were documented on intake and screening forms and on the youth's MDL's.	
Staff are provided sufficient training, information and instructions to recognize/respond to the need for emergency care for medical/mental health problems	**X**					In all five files the alerts included sufficient information concerning the youth's medical condition, allergies, common side effects to medications, food and medications that are contraindicated, and other pertinent mental health treatment information, documented on the youth's screening forms, assessments, and MDL's.	
A medical and mental health alert system is in place that ensures information concerning a youth's medical condition, allergies, common side effects of prescribed medications, foods and medications that are contraindicated, or other pertinent mental health treatment	**X**					Alerts are documented on all intake and screening forms in the youth's file and then the applicable color-coded dot is placed on the youth's file. The alerts are then documented on two dry erase boards located upstairs and downstairs in the shelter as well as documented in the NoteActive electronic log book. Any dietary alerts are located on a form in the kitchen. The alert system includes precautions concerning prescribed medications and medical/mental health conditions. Staff can find this	

information, is communicated to all staff						information documented in the youth's file and on the youth's individual MDL's.	
Provider has a written policy and procedure that meets the requirement for Indicator 4.05						**YES X NO (explain)** The agency has a policy in place titled 4.05 Episodic/Emergency Care that addresses the requirements of the indicator. The policy was last reviewed on December 15, 2020 by the Regional Director.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Off-site Emergency Services							
a. If off-site emergency medical or dental care was provided, an incident report was submitted for the medical or dental care b. Upon youth return, there is a verification receipt of medical clearance via discharge instructions with follow-up is present in file c. Youth's parent/guardian was notified d. A daily log is maintained for emergency care provided	**X**					There were two closed shelter files reviewed for off-site emergency medical or dental care. Both incidents were reported to the CCC and an incident report was completed. Both youth were released to the parent from the emergency room and did not return to the program. In both cases the youth's parent was notified, and the incident was documented on the daily episodic care log and in the NoteActive electronic log book.	
All staff are trained on emergency medical procedures		**X**				There were seven staff training files reviewed. Five of the seven staff had current First Aid and CPR certifications.	**Exception:** Two of the seven staff training files reviewed revealed the staff did not have a current CPR and First Aid certification.
The program has a Knife-for-life and wire cutters accessible to staff in a secure location(s)	**X**					The shelter has two sets of knife-for-life and wire cutters. One set in located in a box, in the closet of the nurse's office. The second set is located in a box, in a drawer in the upstairs YCS office.	
First aid kit/supplies are fully equipped and inventoried	**X**					There are first aid kits located in the kitchen, YCS office upstairs and downstairs, and the vehicles. The contents of all first aid kits are checked monthly by the nurse. All first aid kits were fully equipped.	