Florida Network for Youth and Family Services
Compliance Monitoring Report for

Lutheran Services Florida Southeast - Lippman Youth Shelter

221 NW 43rd Court
Oakland Park, Florida 33309

Compliance Monitoring Services Provided by

FOREFRONT

EXECUTIVE SUMMARY

Forefront LLC conducted a joint Quality Improvement (QI) and Florida Network of Youth and Family Services (FNYFS) monitoring visit for Lutheran Services Florida Southeast (LSF Southeast), for FY 2020-2021. The agency has two program locations: 1) Lippman Youth Shelter located at 221 NW 43rd Court, Oakland Park, Florida, and 2) Administrative office located at 4185 North State Road 7 in Lauderdale Lakes, 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 Southeast is contracted with the Florida Network of Youth and Family Services (FNYFS) to provide direct services to Children/Families in Need of Services (CINS/FINS). The services to be provided are identified in Contract Section A - Descriptions and Specifications and Section B - Delivery and Performance, and are funded with General Revenue Funds effective for July 2020 through June 30, 2021.

The review was conducted by Marcia Tavares, Consultant for Forefront LLC and Peer Reviewer(s). Agency representatives from LSF Southeast present for the entrance interview were: Raymond Ballinger, Regional Director; Scoundrel Oliver, Shelter Manager; Kali Fabal, Clinical Director; Ivonne Fusco, Executive Administrative Assistant; and Laura Saldana, Outreach Liaison. The last onsite QI visit was conducted February 5-6, 2020.

In general, the Reviewer found that Lutheran Services Florida Southeast is in compliance with specific contract requirements. **LSF Southeast received an overall compliance rating of 100% for achieving full compliance with all 12 applicable indicators** of the CINS/FINS Monitoring Tool. One of the indicators was not applicable because the provider does not have any outstanding corrective action item(s) cited by an external funding source. There were no corrective actions or recommendations made as a result of the monitoring visit.

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

2020-2021 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 04-14-2020-2021

Agency Name: Lutheran Services Florida Southeast	**Monitor Name: Marcia Tavares, Lead Reviewer**
Contract Type : CINS/FINS	**Region/Office: 221 NW 43 Ct., Oakland Park, FL 33309**
Service Description: Comprehensive Compliance Monitoring I	**Site Visit Date(s): April 14-15, 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.	☐	☐	☒	☐	☐	Documentation/Interview: The provider currently has six (6) certified DJJ-QI Peer Reviewers: Raymond Ballinger; Kali Fabal; Ivonne Fusco; Scoundrel Oliver; Laura Saldana; and Diana Davila. Both Mr. Ballinger and Ms. Fabal have participated in QI Peer Reviews during the current FY.	
Additional Contracts a. Provider shall provide a listing of all current federal, state, or local government contracts, as well as other contracts entered into with for profit and not-for-profit organizations. Such listing shall identify the awarding entity and contract start & end dates. **PTV**	☐	☐	☒	☐	☐	Documentation: A list of three additional contracts, Childcare Food Program, ChildNet, and HHS for FY2020- 2021 was provided for LSF Southeast region. The list includes: awarding entity, amount funded, type of service provided and award term. The program also maintains interagency agreements and Memorandums of Agreement (MOUs)	

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						with schools, mental health, and substance abuse providers.	
Limits of Coverage a. Provider shall provide and maintain during this contract, the following minimum kinds of insurance: Worker's Compensation and Employer's liability insurance as required by Chapter 440, F.S. with a minimum of $100,000 per accident, $100,000 per person and $500,000 policy aggregate. Commercial General Liability with a limit of $500,000 per occurrence, and $1,000,000 policy aggregate. Automobile Liability Insurance shall be required and shall provide bodily injury and property damage liability covering the operation of all vehicles used in conjunction with performance of this contract, with a minimum limit for bodily injury of $250,000 per person; with a minimum limit for bodily injury of $500,000 per accident; with a minimum limit for property damage of $100,000 per accident and with a minimum limit for medical payments or $5,000-$10,000 per person. Florida Network is listed as payee or co-payee. **PTV**	☐	☐	☐	☒	☐	General Liability through Markel Global Insurance Company, for limits of coverage $1,000,000 each $3,000,000 aggregate, and medical expense for $10,000, effective 6/01/2020 – 6/01/2021 Automobile insurance through Markel Global Insurance Company for combined limits of liability/property damage for $1,000,000. Policy effective date 6/01/2020 – 6/01/2021 Workers Compensation through United WI Insurance Company with limits of $1,000,000 each/aggregate, effective 6/01/2020 – 6/01/2021 Umbrella liability through Markel Global Insurance Company with limits of $5,000,000 each/aggregate, effective 6/01/2020 – 6/01/2021	

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						Professional Liability/Abuse Molestation through Markel Global Insurance Company for $1,000,000 each and $3,000,000 aggregate, effective through 6/01/2020 – 6/01/2021 Florida Network is listed as certificate holder.	
External/Outside Contract Compliance a. Provider has corrective action item(s) cited by an external funding source (Fiscal or Non-Fiscal). **ON SITE**	☐	☐	☐	☐	☒	Interview: During the Entrance Conference, the provider indicated that there are no outstanding corrective action item(s) cited by any external funding source.	
Fiscal Practice a. Agency must have employee and fiscal policy/procedures manuals that are in compliance with GAAP and provide sound internal controls. Agency maintains fiscal files that are audit ready. **PTV**	☐	☐	☒	☐	☐	Documentation: Fiscal Policies and Procedures. Agency maintains an Accounting Procedures Manual that is consistent with GAAP and provides for limited internal controls. Policies and procedures were last approved 4/12/2017 by the Chief Financial Officer and are updated as necessary with revised policies showing a revision/approval date.	

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b. Agency maintains a general ledger and the corresponding source documents. General ledger must be set up to track the activity of the grant separately (standard account numbers / separate funds for each revenue source, etc.). **PTV**	☐	☐	☒	☐	☐	Documentation: Expanded General Ledger – Detail GL for July 1, 2020 – February 2021. The agency maintains a detailed general ledger with corresponding source documents. General ledger is structured to track all funding sources separately for the Lutheran Services Florida Southeast CINS/FINS program.	
c. Petty cash ledger system is balanced and all cash disbursements are compliant with financial policies and allowable under the contract. (Disbursements/invoices are approved & monitored by management.) –**ON SITE**	☐	☐	☒	☐	☐	Observation/Documentation: Reviewed petty cash Policy and Procedure 4.32 included in section 4 of the Fiscal Manual. There are two separate funds, one for the Nonresidential program ($500) and the other for the shelter which does not exceed $1000. Petty cash is maintained by the Administrative Assistant (Non-Res) and the Residential Manager (Shelter) and are stored in secured cash boxes. Petty cash is reconciled at least monthly by the custodians, approved by management, and submitted to the corporate office for refunding as	

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						needed. Disbursements and invoices are approved by the program manager or designee.	
d. Financial records and reports are current. Includes bank statements reconciled within 6 weeks of receipt. Vendor invoices past 6 months. Invoices are submitted on a monthly basis with supporting documentation. (Disbursements/invoices are approved & monitored by management). **ON SITE**	☐	☐	☒	☐	☐	Documentation: Reviewed Bank Statements for Bank of America Bank's operating account and the corresponding Bank Reconciliations for the period September 2020-February 2021. Bank reconciliations are processed by the finance department in the Tampa Corporate office. Successful bank reconciliations were conducted within 1 week of receipt of bank statements. All of the reconciliation worksheets were reviewed by a second party in addition to the preparer. Vendor payments are distributed through the corporate office in Tampa, Florida through check requisitions by the Broward office. Vendor files are maintained locally with copies of the invoices and check requisitions.	

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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**	☐	☐	☒	☐	☐	Documentation: Provider maintains an inventory for computer and periphery equipment purchased from 12/2002. Inventory was last updated on 4/7/21 but no additional items were purchased with FN funds within the last year.	
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: ADP is contracted by LSF to process payroll. ADP is responsible for submitting information for W2s, Quarterly 941 reports, and payroll taxes. The Collection Details for 3rd and 4th Qtr. 2020 were reviewed. These reports demonstrate submission of payroll taxes biweekly.	

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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: Statement of Revenues and Expenditures for FY to date as of 3/16/21 for the CINS/FINS Program was reviewed. A program surplus was observed per the statement. The provider has a monthly process for reviewing and explaining variances.	
h. A Single Audit is performed as part of the annual audit if expenses are greater than $750,000. The agency must submit a Corrective Action Plan for findings cited in the management letter and single audit. An annual financial audit was completed within 120 days after the previous fiscal year/calendar year and that a copy was provided to the Network unless and extension has been requested and approved in writing. Copy of Audit is submitted to the FNYFS by December 31st. **Obtain from FNYFS**	☐	☐	☒	☐	☐	Documentation: The provider submitted a copy of the financial audit conducted for year ending June 30, 2020 and 2019 for the review. The audit was completed by RSM US, LLP and was dated December 28, 2020. No management letter was stated as issued in the audit.	
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 of policy and procedures regarding data back-up contained in the Agency P&P Section 11 (11.12 Information Technology and 11.09 IT Security); Policy and Procedure for Records Retention;	

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documents are shredded and computer hard drives are wiped prior to discarding. **ON SITE**						Policy Section 1 (1.09 – client confidentiality); and policy 9.5.01 (Case Records) and G11.4 (Confidentiality of Client Information).	

CONCLUSION

LSF Southeast has met the requirements for the CINS/FINS contract as a result of full compliance with 12 applicable indicators of the Administrative and Fiscal Contract Monitoring Tool. One of the thirteen indicators was not applicable because the provider does not have any outstanding corrective action item(s) cited by an external funding source. Consequently, t**he overall compliance rate for this contract monitoring visit is 100%.** There are no corrective actions cited or recommendation made as a result of the contract monitoring visit. Overall, the provider is performing satisfactorily in meeting the fiscal and administrative terms of its contract. In addition, the majority of indicators reviewed were carried out in a manner which meets the standard as described in the report findings.

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

Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Lutheran Services Florida Southeast
CINS/FINS Program

April 14-15, 2021

Compliance Monitoring Services Provided by

FOREFRONT

Quality Improvement Review

Lutheran Services Florida – April 14-15, 2021
Lead Reviewer: Marcia Tavares

CINS/FINS Rating Profile

Standard 1: Management Accountability

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

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

Standard 2: Intervention and Case Management

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

Percent of indicators rated Satisfactory: 88.89%
Percent of indicators rated Limited: 11.11%
Percent of indicators rated Failed: 0.00%

Standard 3: Shelter Care & Special Populations

3.01 Shelter Environment	Satisfactory
3.02 Program Orientation	Satisfactory
3.03 Room Assignment	Satisfactory
3.04 Log Books	Satisfactory
3.05 Behavior Management Strategies	Satisfactory
3.06 Staffing and Youth Supervision	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	Limited
4.04 Medical/Mental Health Alert Process	Satisfactory
4.05 Episodic/Emergency Care	Satisfactory

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

Overall Rating Summary

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

Rating Definitions

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

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

Reviewer

Members

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

Gabriel Medina - Department of Juvenile Justice

Pierre Bandoo – Crosswinds Youth Services

Alana Corradi – Florida Keys Children Shelter

Mark Shearon – Arnette House

Quality Improvement Review

Lutheran Services Florida – April 14-15, 2021
Lead Reviewer: Marcia Tavares

Methodology

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

Persons Interviewed

☐ Chief Executive Officer
☐ Chief Financial Officer
☐ Chief Operating Officer
☐ Executive Director
☒ Program Director
☒ Program Manager
☐ Program Coordinator
☒ Clinical Director
☐ Counselor Licensed

☐ Case Manager
☒ Counselor Non-Licensed
☐ Advocate
☒ Direct – Care Full time
☐ Direct – Part time
☐ Direct – Care On-Call
☐ Intern
☐ Volunteer
☒ Human Resources

☐ Nurse – Full time
☒ Nurse – Part time
0 # Case Managers
1 # Program Supervisors
0 # Food Service Personnel
1 # Healthcare Staff
N/A # Maintenance Personnel
0 # Other (listed by title): _____

Documents Reviewed

☐ Accreditation Reports
☒ Affidavit of Good Moral Character
☒ CCC Reports
☒ Logbooks
☒ Continuity of Operation Plan
☐ Contract Monitoring Reports
☐ Contract Scope of Services
☒ Egress Plans
☒ Fire Inspection Report
☒ Exposure Control Plan

☒ Table of Organization
☒ Fire Prevention Plan
☒ Grievance Process/Records
☐ Key Control Log
☒ Fire Drill Log
☒ Medical and Mental Health Alerts
☒ Precautionary Observation Logs
☒ Program Schedules
☒ List of Supplemental Contracts
☒ Vehicle Inspection Reports

☐ Visitation Logs
☒ Youth Handbook
4 # Health Records
3 # MH/SA Records
15 # Personnel /Volunteer Records
7 # Training Records
13 # Youth Records (Closed)
9 # Youth Records (Open)
0 # Other: _____

Surveys

5 # Youth

11 # Direct Care Staff

0 # Other: **N/A**

Observations During Review

☐ Intake
☐ Program Activities
☐ Recreation
☐ Searches
☒ Security Video Tapes
☐ Social Skill Modeling by Staff
☐ Medication Administration
☒ Census Board

☒ Posting of Abuse Hotline
☐ Tool Inventory and Storage
☒ Toxic Item Inventory and Storage
☐ Discharge
☐ Treatment Team Meetings
☐ Youth Movement and Counts
☐ Staff Interactions with Youth

☐ Staff Supervision of Youth
☒ Facility and Grounds
☒ First Aid Kit(s)
☐ Group
☐ Meals
☒ Signage that all youth welcome

Comments

Due to COVID-19, this review was conducted **Hybrid/Virtually**.

Quality Improvement Review

Lutheran Services Florida – April 14-15, 2021
Lead Reviewer: Marcia Tavares

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

Lutheran Services Florida is a statewide, non-profit, human services agency with its headquarters located in Tampa, Florida. LSF Southeast (LSF SE) contracts with the Florida Network of Youth and Family Services (Florida Network) to operate Children In Need of Services/Families In Need of Services (CINS/FINS) residential and non-residential services to youth and families in Broward County. The program operates out of two locations: 1) the Lippman Youth Shelter, located in the City of Oakland Park, Florida, and 2) the administrative office and non-residential program also known as Broward Family Center, is located on the second floor of the Lakes Medical Center Building at 4185 North State Road 7 in Lauderdale Lakes. Funding through CINS/FINS allows the agency to serve both male and female youth up to seventeen years old that are locked out, runaway, ungovernable and/or truant, homeless, abuse, neglected, or at-risk. The agency also provides services to special populations who meet the criteria for Staff Secure shelter, Domestic Minor Sex Trafficking (DMST), and youth referred by the Juvenile Justice Court System for domestic violence respite. LSF SE is not currently contracted to provide Probation Respite, Intensive Case Management, or Family and Youth Respite Aftercare services (FYRAC) and is not a SNAP provider. The youth census during the QI visit was 9 youth. LSF SE is currently accredited by the Council of Accreditation (COA) and was recently re-accredited through February 28, 2022.

The following programmatic updates since the last Quality Improvement review in February 2020 were reported to the QI team during the visit:

The global pandemic has had a tremendous impact on all programs that serve children, youth and families. Despite the challenges presented, LSF has continued to provide services uninterrupted. Staff who work directly in the shelter have performed their jobs with a level of compassion and professionalism that has made the agency proud. The Residential Services Manager, Ms. Scoundrel, continues to provide steady leadership for youth and staff. Her leadership capabilities have been on full display during the pandemic. The program has implemented pandemic protocols across all program areas in accordance with CDC guidelines.

In the last year, the program promoted from within at the shelter. Ms. Fordhan was promoted to YCS III, Shelter Supervisor and Ms. Medrano was promoted to YCS II Lead (position vacated by Ms. Fordhan) after many years of service.

Under the leadership of Clinical Director, Kali Fabal, LSF SE employed a very aggressive outreach strategy to meet the needs of the communities and support the families during the pandemic. Outreach efforts were made to inform clients and stakeholders of the alternate methods of service provision. Outreach efforts have proven to be successful as the community counseling program continues to thrive. Dellanira Calvet-Noda joined the community counseling team in May of 2020.

In August of 2020, the LSF development team organized a committee to embark on a capital campaign to raise $250,000 for renovations at Lippman Youth Shelter. The undertaking of the capital campaign was to bring beauty and operational integrity to the facility. The mission of the campaign was to significantly enhance the aesthetics and programing capabilities for the most vulnerable youth who come through the doors, providing the optimal environment for program objectives to succeed. As of March 25, 2021, the goal of $250k has been reached with an official presentation of the check scheduled for April 27, 2021.

In September 2020, LSF SE was awarded funding through the Family and Youth Services Bureau's (FYSB) Runaway and Homeless Youth (RHY) Program to implement, enhance, and/or strengthen strategies that provide a runaway and/or homeless youth, under the age of 18, access to emergency shelter, reunite with their families, offer connections to school and employment, enhance social and emotional well-being, self-sufficiency, and help them build permanent connections with families, communities, schools, and other positive social networks.

Narrative Summary

LSF SE is under the leadership of a management team that consists of a regional director; a shelter services manager; a licensed clinical director; and a senior administrative assistant. At the time of the review, the program had one vacant Counselor II (Shelter Counselor) position at Lippman and 3 fulltime youth care positions. The program has not reported any major challenges, critical incidents, administrative review, or current external investigation.

The overall findings for the QI review for LSF SE are summarized as follows:

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

Standard 2 has a total of ten indicators that relate to intervention and case management. One of the indicators, SNAP, is not applicable as LSF SE is not a SNAP provider. Four of the nine applicable indicators were rated satisfactory with no exceptions (2.02, 2.06, and 2.07), four were rated satisfactory with exceptions (2.01, 2.03, 2.04, 2.08, and 2.09), and one received a limited rating (2.05).

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

Standard 4, Mental Health and Health Services, is comprised of five indicators. Four of the five indicators were rated satisfactory with no exceptions (4.01, 4.02, 4.04, and 4.05) and indicator 4.03 received a limited rating.

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

Standard 1:
Indicator 1.04 – Limited

- Three of the four first year staff were out of compliance for completing the DOJ Civil Rights training. Two of the three staff completed the training after the December 31, 2020 deadline date and the third staff had not yet completed the DOJ training as of the onsite QI visit.
- None of the four new staff completed all mandatory trainings required during the first 120-days.
- One of the three in-service staff did not complete the 40 training hours required annually.

- All three in-service staff missed completing some of the SkillPro trainings required. Two were missing Human Trafficking training and two missed Child Abuse training during their annual training year.

Standard 2:
Indicator 2.05 – Limited

- Out of 6 months of group data reviewed, groups were conducted five times per week (counting every 7 days) for two of the six months only. Only eighteen of all house meetings held could be counted as groups since the remainder did not meet group criteria.
- Many of the house meetings did not meet group criteria due to lasting less than 30 minutes and not having clear/relevant topic for the activity itself.

Standard 4:
Indicator 4.03 – Limited

- Five of the six new non-licensed staff did not receive EpiPen training
- Perpetual inventory and shift-to-shift counts of controlled medication were not consistently done on all three shifts as required in the two applicable randomly selected records reviewed.
- The nurse and staff were logging over the counter (OTC) medication distribution to youth but did not maintain a perpetual or weekly inventory of OTC medication.
- No evidence of monthly review of knowledge portal reports run by the agency was observed for the review period.
- A total of 38 medication discrepancies occurred between 11/1/2020 and 3/31/2021. Twenty-seven of the 38 discrepancies were not cleared at the end of the shift where it was discovered as required.

CINS/FINS QUALITY IMPROVEMENT TOOL

Quality Improvement Indicators	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable	Review Based Upon Document Source *For example: Interview/Surveys, Observation, and/or Type of Documentation*	Notes Explain any items that have any deficiencies, exceptions or are not applicable.
Standard One – Management Accountability							
1.01: Background Screening and compliance with DJJ OIG statewide procedures regarding BS of employees, contractors and volunteers							
Provider has a written policy and procedure that meets the requirement for Indicator 1.01						**YES X NO (explain)** The agency has the required policy and procedure # 1.01 in place that was approved December 28, 2020 by the Regional Director.	
Agency utilizes an employee suitability prescreening assessment with a passing rate criterion prior to an offer of hire for direct care staff working with youth or the agency has provided an explanation to for staff hired with a non-passing/low score.	X					The agency has been using Predictive Index (PI) pre-employment assessment since July 2018. The tool was administered prior to the hiring of six (6) applicable new staff during the review period. All six employees obtained passing scores greater than/equal to 7 on a scale of 1-10.	
Background screening completed prior to hire/start date or exemption obtained prior to working with youth (if rated ineligible) for new hires, volunteers/interns, and contractors	X					A total of seven new staff were hired since the last onsite QI visit and four interns provided volunteer services. All eleven background screenings were initiated prior to hire/start dates with eligibility documented on the Clearinghouse results. No exemptions were applicable.	
Five-year re-screening completed every 5 years from initial date of hire	X					The program had four eligible staff who met the criteria for 5-year re-screening. A review of the agency's clearinghouse staff list shows all four staff have valid retained prints in the clearinghouse.	
Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is	X					The program had a signed and notarized Annual Affidavit of Compliance with Level 2 Screening Standards that was completed, notarized, and emailed to the Background Screening Unit on	

completed and sent to BSU by January 31st?						January 19, 2021 prior to the January 31st deadline.	
Proof of E-Verify for all new employees obtained from the Department of Homeland Security	X					Proof of the 7 new employees' employment authorization from the Department of Homeland Security was obtained through E-verify and filed in their personnel files.	
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 the required policy and procedure # 1.02 in place that was approved December 28, 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 agency has a code of conduct that prohibits that use of physical abuse, profanity, threats or intimidations. Documentation of receipt and acknowledgement of the agency's code of conduct is maintained in each staff's personnel file.	
Child Abuse Registry telephone number is visible to youth and posted common areas of the facility	X					The Abuse Registry Number is posted in each youth bedroom, the common area, counselor's office, and the hallways of the shelter as well as posted in the community counseling office building.	
Youth were informed of the Abuse and Contact Number (see youth survey results)	X					Each youth receives a handbook upon admission and a review of youth rights, grievance procedures, Florida Abuse Hotline telephone number. Five youth surveys were completed. All 5 youth indicated staff is respectful towards them and they feel safe in the program. The 5 youth also stated they were aware of the abuse hotline number and its location in the facility.	
Management takes immediate action to address any incidents of threats or abuse			X			There were no incidents that required management to take immediate action to address incidents of physical and/or psychological abuse, verbal intimidation, use of profanity, and/or excessive use of force.	
Grievance Process							
Agency has a formal grievance process	X					The agency has a clear policy and procedure talking about the grievance process and that information is shared with the youth during the intake process and it also is available in their youth handbook and posted in a binder in each bedroom. Five youth surveyed stated they know about the grievance process.	

Locked box accessible to only management and available to youth in a common area	X					There is a locked grievance box located in the hallway between the common area and youth rooms. The grievance forms are kept right above the box for the youth to access.	
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 shelter manager is the only person that handles the key to the grievance box.	
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					Eleven grievances were filed since the last onsite QI visit. All eleven grievances reviewed were handled in the required time frame and it is clearly documented that grievances are resolved by the shelter manager.	
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 the required policy and procedure # 1.03 in place that was approved December 28, 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					In the last six months there were 15 incidents reported to the CCC and all of them were reported within the 2hr time frame.	
The program completes follow-up communication tasks/special instructions as required by the CCC	X					All Incidents that required follow-up with the CCC were all completed within the required time frame**.**	
Incidents are documented in the program logs and on incident reporting forms	X					All Incidents are documented in the logbook and highlighted appropriately**.**	
All incident reports are reviewed and signed by program supervisors/directors	X					The supervisor signs off on all the incident reports.	
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 the required policy and procedure # 1.04 in place that was approved December 28, 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**				Four first year staff training records were reviewed. All four staff were hired prior to January 1, 2021 and needed to complete the DOJ Civil Rights training by December 31, 2020.	**Limited Exception** Three of the four first year staff were out of compliance for completing the DOJ Civil Rights training. Two of the three staff completed the training after the December 31, 2020 deadline date and the third staff had not yet completed the DOJ training as of the onsite QI visit.
All staff receives all mandatory training during the first 90 days of employment from date of hire.		**X**				Staff training was rated based on the previous 120-day QI training requirement applicable to all 4 staff hired prior to implementation of 90-day requirement effective January 1, 2021. All four staff completed an excess of 80 training hours ranging from 106 to 129 hours. None of the four staff completed all mandatory trainings required during the first 120-days.	**Limited Exception** • One staff was late completing MAB and a second staff (DOH 6/8/2020) did not complete the training. • One staff was late completing Suicide Prevention and a second staff (DOH 6/8/2020) did not complete the training. • One staff was late completing CINS/FINS Core and a second staff (DOH 6/8/2020) did not complete the training. • Two staff were late completing Mental Health/Substance Abuse and a third staff (DOH 6/8/2020) did not complete the training. • Two staff were late completing Behavior Management training. • Two staff were late completing Universal Precaution training.

All staff completes all mandatory Florida Network and SkillPro training during the first-year employment.	X					All four staff met all 1st year mandatory SkillPro training requirements and two of four had time remaining to complete Florida Network trainings required.	
Non-licensed Mental Health Clinical Shelter Staff (within first year of employment)							
Non-licensed mental health clinical shelter staff Assessment of Suicide Risk Training			X			The agency did not have any new non-licensed mental health clinical shelter staff hired during the review period or dating back to the last QI review.	
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				
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				Two of the three in-service training records reviewed exceeded the 40 annual hours required. The third staff only completed 27 of the 40 hours. All 3 staff completed the Florida Network mandatory refresher training but all three were missing one or more mandatory annual SkillPro training.	**Limited Exception** • One of the three in-service staff did not complete the 40 annual training hours required during their training year. • All three in-service staff missed completing some of the SkillPro trainings required. Two were missing Human Trafficking training and two missed Child Abuse training during their annual training year.
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					The program maintains a staff training sheet for each employee that lists all their trainings for the year; however, they are not in any order and are randomly placed on the sheet. The sheet does give the total number of hours earned for the year. Supporting documentation of training including sign in sheets and certificates is maintained in each training file.	

Provider has a written policy and procedure that meets the requirement for Indicator 1.05						**YES X NO (explain)** The agency has the required policy and procedure # 1.05 in place that was approved December 28, 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**					A review of record reviews the period October 2020 through March 2021 was conducted. The record reviews were conducted separately monthly for shelter and family counseling programs. A total of 45 residential records were reviewed and 87 community counseling records during the period. Twenty-nine of the record reviews were conducted by the assigned staff and not a peer. The program documents compliance for each record as well as deficiencies.	
The program conducts reviews of incidents, accidents, and grievances quarterly, at a minimum	**X**					Incident reports are reviewed regularly by the Safety Squad Committee and reported/analyzed based on incident total by program; agency-wide incident totals by type; and incident type by program. Evidence supported the Safety squad met at least once each quarter (September 2020, October 2020, and March 2021 during the review period.	
The program conducts an annual review of customer satisfaction data	**X**					The programs collect customer satisfaction survey data monthly and enter the number completed each month by program into the PQI Monthly Spreadsheet Companion Report. Survey results are reviewed monthly at both staff and manager's meetings and documentation of meeting agendas/minutes for October 2020 through January 2021 were reviewed.	
The program conducts an annual review of outcome data and (if applicable) there is evidence of annual reconciliation that occurs through communication from the Florida Network via email or phone call when corrections are needed and the information is corrected and submitted within the requested timeframes.	**X**					The provider has established program outcomes and collects performance measures data monthly on the PQI Monthly Spreadsheet Companion Report by program. Data collected includes benchmarks and performance measures such as: client satisfaction; client functioning; staff turnover; incidents/accidents; grievances; care days; data entry; service completion and status at discharge, 30 and 60-day follow-up; and exits. PQI, outcomes, and NetMIS data is reviewed and discussed at monthly staff meetings and monthly	

						management meetings and are documented in the meeting minutes.	
The program conducts a monthly review of NetMIS data reports.	X					NetMIS data is reviewed and discussed at monthly staff meetings and monthly management meetings and are documented in the meeting minutes.	
The Florida Network conducts monthly reconciliation by comparing NetMIS data to JJIS data. Agency has evidence that they have reconciled any differences noted.	X					Program provided email dated 4/29/2020 to support completion of annual 2020 data reconciliation for Lutheran Services Florida – SE indicating all names, dates of intake/discharge, and reason for discharged matched their records and there were only two youth that did not show up in DJJ when searched for (one youth in each program) but the name, dates and reason for discharge do accurately reflect the data in Netmis.	
The program has a process in place to review and improve accuracy of data entry & collection	X					Data entered into JJIS and NETMIS is reconciled by program staff and reviewed during staff and manager's meetings monthly.	
There is documentation that findings are regularly reviewed by management and communicated to staff and stakeholders.	X					Management meets to review all data areas including safety trends, peer record review, data reconciliation, incidents, grievances, consumer surveys, and committee updates. Corrective actions plans are implemented to address areas of concern which are also addressed at quarterly CINS team meetings.	
There is evidence that strengths and weaknesses are identified, improvements are implemented or modified, and staff are informed and involved throughout the process.	X					Data reviewed during the QI period was found to have documentation of information discussed regarding trends/quality improvement, FN Netmis data, policies and procedures, reports, and areas identified as needing improvements or changes needed from analysis.	
Provider has a written policy and procedure that meets the requirement for Indicator 1.06						**YES X NO (explain)** The agency has the required policy and procedure # 1.06 in place that was approved December 28, 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					Agency provided a list of 21 approved drivers approved to drive in agency's vehicles.	
Approved agency drivers are documented as having a valid Florida driver's license and are	X					All drivers named on the approved drivers' list have current driver's licenses and are covered under the agency's insurance policy. The	

covered under company insurance policy						agency's auto insurance policy was also provided for review.	
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 agency's policy outlines the importance of avoiding single youth transports. In the event of a single transport of youth, transports are approved by the Residential Supervisor.	
In the event that a 3rd party cannot be obtained for transport, the agency's supervisor or managerial personnel consider the clients' history, evaluation, and recent behavior	**X**					Six incidents of one-on-one transport and all were approved by supervisor prior to transport of youth.	
The 3rd party an approved volunteer, intern, agency staff, or other youth	**X**					Transportation logs for the review period showed third party was agency staff or other 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**					The Agency clearly documents the staff in the van, the youth, where they are going, the time they left and the mileage.	
Provider has a written policy and procedure that meets the requirement for Indicator 1.07						**YES X NO (explain)** The agency has the required policy and procedure # 1.07 in place that was approved December 28, 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**					The agency's Regional Director or designee attends all Circuit Advisory Board meetings. Meetings are being held via Zoom platform currently, but agenda was provided for review.	
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**					Program provided a list of outreach activities that staff attended including list of Zoom activities that they have been attending and has provided agendas supporting those meetings.	

The program maintains written agreements with other community partners which include services provided and a comprehensive referral process.	X					Agency has written agreements with Community Partners. They have agreements with 2 Mental Health Services, 3 Substance Abuse Centers, 1 Truancy, 2 Safe Place Agencies, 4 CINS/FINS Groups, 1 Employment Services, 7 Educational Facilities, 3 Medical Treatment Facilities, and 7 Support agencies. These Agreements were last updated on January 2021.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.01						**YES X NO (explain)** The agency has the required policy and procedure # 2.01 in place that was approved December 28, 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					A total of five residential records were reviewed (3 open, 2 closed). All five records contained screenings that had been prior to or immediately upon admission to shelter.	
Community counseling: Eligibility screening is completed within 3 business days of referral by a trained staff using the NetMIS form	X					A total of community counseling records were reviewed (2 open, 3 closed). All five records contained screenings that had been completed within 3 business days of referral and prior to intake.	
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 records reviewed contained verification that the youth and parents/guardians were provided with information related to available service options and rights and responsibilities of youth and parents/guardians.	
The following is also available to the youth and parents/guardians: a. Possible actions occurring through involvement with CINS/FINS services (case staffing committee, CINS petition, CINS adjudication)		X				All five community counseling records contained documentation to support CINS/FINS brochure was discussed by way of a form that stated the brochure and handbook were reviewed. All ten records included documentation grievance procedures were provided/reviewed with youth and parents/guardians.	**Exception** None of the five residential records contained documentation to prove the parent/guardians were given a CINS/FINS brochure or educated about possible actions resulting from involvement with CINS/FINS services.

b. Grievance procedures							
Provider has a written policy and procedure that meets the requirement for Indicator 2.02						**YES X NO (explain)** The agency has the required policy and procedure # 2.02 in place that was approved December 28, 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**					All 5 residential records reviewed had the Needs Assessment 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**					All 5 community counseling records reviewed demonstrated Needs Assessments were completed within 2 to 3 face-to-face contacts.	
Needs Assessment is conducted by a bachelor's or master's level staff member	**X**					All 10 files reviewed had the Needs Assessment competed by a bachelor's or Master's level staff and licensed mental health interns volunteering in the shelter program.	
Needs Assessment includes a supervisor's review signature upon completion	**X**					All 10 files had supervisor's signatures.	
Suicide Risk as a Result of the Needs Assessment							
Youth was identified with an elevated risk of suicide as a result of the Needs Assessment			**X**			None of the ten youth were identified as a suicide risk based on the screening questions on the CINS/FINS Intake Assessment form.	
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**			No eligible youth from selected sample.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.03						**YES X NO (explain)** The agency has the required policy and procedure # 2.03 in place that was approved December 28, 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**					All ten treatment plans reviewed were developed within 7 days of completion of the Needs Assessment.	

Case plan service Plan includes: 1. Individualized and prioritized need(s) and goal(s) identified by the Needs Assessment 2. Service type, frequency, location 3. Person(s) responsible 4. Target date(s) for completion and Actual completion date(s) 5. Signature of youth, parent/ guardian, counselor, and supervisor 6. Date the plan was initiated		X				All ten files were found to have individualized and prioritized needs and goals, service type, frequency, location, target date(s) for completion and person(s) responsible. Actual completion dates were noted in closed records for goals achieved. Signature of youth and parent/ guardian were observed in 7 of the 10 records, mostly noted as consent given virtually on the service plans with corresponding progress notes indicating participating parties and review of goals. All ten records included counselor and supervisor's signatures. All ten files included the date the service plans were initiated and noted as "todays date".	**Exception** Three of the five residential treatment plans reviewed indicated parent/guardian gave virtual consent; however, no supporting documentation was provided in the progress notes to indicate parent/guardian participated in the review of service plans and offered consent.
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				Four out of 5 community counseling records reviewed demonstrated timely reviews for progress by the counselor during the required timeframes with the exception of one that was completed late.	**Exception** There was one service plan completed late.
Provider has a written policy and procedure that meets the requirement for Indicator 2.04						**YES X NO (explain)** The agency has the required policy and procedure # 2.04 in place that was approved December 28, 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					All ten records were assigned a counselor/case manager.	
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		X				All 10 records were observed to establish referral needs, coordinate service plans, provide various types of support, make referrals, provide case management and overall support and follow up.	**Exception** No documentation 30 and 60 day follow-up after case closure was found in 1 residential and 1 community counseling record.

5. Monitors out-of-home placement (if necessary) 6. Makes referrals to the case staffing to address problems and needs of the youth/family 7. Accompanies youth and parent/guardian to court hearings and related appointments 8. Refers the youth/family for additional services when appropriate 9. Provides case monitoring and reviews court orders 10. Provides case termination notes 11. Provides follow-up after 30 days of exit 12. Provides follow-up after 60 days of exit							
The program maintains written agreements with other community partners that include services provided and a comprehensive referral process	**X**					Provider has agreements with 2 Mental Health Services, 3 Substance Abuse Centers, 1 Truancy, 2 Safe Place Agencies, 4 CINS/FINS Groups, 1 Employment Services, 7 Educational Facilities, 3 Medical Treatment Facilities, 7 Support Agencies	
Provider has a written policy and procedure that meets the requirement for Indicator 2.05						**YES X NO (explain)** The agency has the required policy and procedure # 2.05 in place that was approved December 28, 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**					Counseling services that addressed the needs identified during the assessment process were established in all applicable records reviewed in accordance with the youth's case/service plan.	
Shelter Program							
Shelter programs provides individual and family counseling	**X**					Residential youth received individual and family counseling as evident by the counseling notes.	
Group counseling sessions held a minimum of five days per week		**X**				The program's group sign in sheets for a 6-month period (October 2020 to March 2021) were reviewed. It was evident from the documents presented the program was not conducting groups five days per week consistently.	**Limited Exception** Out of 6 months of group data reviewed, groups were conducted five times per week (counting every 7 days) for two of the four

							months only. Only eighteen of all house meetings held could be counted as groups since the remainder did not meet group criteria.
Group counseling sessions consist of: a. Length of at least 30 minutes b. Opportunity for youth engagement c. Clear and relevant topic (informational/developmental/ educational) d. Clear leader or facilitator		**X**				The clinical groups met the criteria with minimal errors but not all house meetings met the criteria for groups.	**Limited Exception** Many of the house meetings did not meet group criteria due to lasting less than 30 minutes and not having clear/relevant topic for the activity itself.
Community Counseling							
Community counseling programs provide therapeutic community-based services designed to provide the intervention necessary to stabilize the family. Services are provided in the youth's home, a community location, or the local provider's counseling office.	**X**					All five applicable community counseling files reviewed showed youth received counseling services as evident with attached case notes. Due to the pandemic counseling services were provided by the program via Zoom. These Zoom sessions with youth/families were documented in the case progress notes.	
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 reflected coordination between presenting problem(s), psychosocial assessment, case/service plans, case/service plan reviews, case management, and follow-up when applicable.	
Maintain individual case files on all youth and adhere to all laws regarding confidentiality	**X**					All ten youth records were maintained in individual case files with adherence to all laws regarding confidentiality.	
Case notes maintained for all counseling services provided and documents youth's progress	**X**					Case notes were maintained in all ten files indicating the youth's progress as well as case notes for all services provided.	
On-going internal process that ensures clinical reviews of case records and staff performance	**X**					All ten files reviewed received ongoing clinical reviews of case records and staff performance. Case reviews are conducted by the supervisor and the review form is maintained in each case file.	

Provider has a written policy and procedure that meets the requirement for Indicator 2.06						**YES X NO (explain)** The agency has the required policy and procedure # 2.06 in place that was approved December 28, 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**					Two case staffings were held during the review period. Both staffings were initiated by program staff and not the parent/guardian.	
The youth, family and case staffing committee are contacted within a minimum of five working days a. Notification to youth/family no less than 5 working days prior to staffing b. Notification to committee no less than 5 working days prior to staffing	**X**					The youth, family, and case staffing committee were contacted via email in a timely manner.	
Case Staffing Committee							
Must include: a. DJJ rep. or CINS/FINS provider b. Local school district representative	**X**					Case Staffing meetings held included a DJJ representative and/or CINS/FINS provider and a local school district 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**					A mental health representative was present at the staffing.	
The program has an established case staffing committee, and has regular communication with committee members	**X**					The program has an established case staffing committee and contact information to facilitate email communication regularly and as needed with the committee members.	
The program has an internal procedure for the case staffing process, including a schedule for committee meetings	**X**					The program's case staffing meetings occur monthly and additional meetings may be held, if requested, including emergency case staffing.	
As a result of the Case Staffing							

The youth and family are provided a new or revised plan for services	X					The youth and family received a new plan of service documented on the service plan form.	
Written report is provided to the parent/guardian within 7 days of the case staffing meeting, outlining recommendations and reasons behind the recommendations	X					A report was given to the parent/guardian at the end of the case staffing meeting that outlined recommendations.	
If applicable, the program works with the circuit court for judicial intervention for the youth/family			X			None of the files required the program work with the circuit court for judicial intervention for the youth/family.	
Case Manager/Counselor completes a review summary prior to the court hearing			X			None of the files required the Case Manager/Counselor complete a review summary prior to court hearings.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.07						**YES X NO (explain)** The agency has the required policy and procedure # 2.07 in place that was approved December 28, 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					It was observed that all files (virtually uploaded) were marked confidential.	
All records are kept in a secure room or locked in a file cabinet that is marked "confidential"	X					All records were kept in a secure locked room in a locked file cabinet marked as confidential as observed during onsite tour.	
When in transport, all records are locked in an opaque container marked "confidential"	X					Staff provided photo evidence showing they have locked opaque containers marked "confidential" to use for the transportation of records.	
All records are maintained in a neat and orderly manner so that staff can quickly and easily access information	X					All files were observed to be clearly divided into sections which were consistent in their organization among residential and nonresidential files.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.08						**YES NO (explain) X** The agency has the required policy and procedure # 2.08 in place that was approved December 28, 2020 by the Regional Director.	Current policy 2.08 does not address the following requirements of Florida Network's policy 5.08: • Youth's preferred name and gender pronouns are used in the logbook and on all outward-facing documents and census boards

							• Youth preference is considered and documented for room assignment • Youth will be provided hygiene products, undergarments, and clothing that affirms their gender identity or gender expression.
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**			The program has not served any youth during the annual review period who met the criteria for the indicator.	
Youth in need of specialized support is referred to qualified resources (as applicable)			**X**			No eligible youth served	
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**			No eligible youth served	
Youth is provided hygiene products, undergarments and clothing that affirms their gender identity or gender expression			**X**			No eligible youth served	
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**			No eligible youth served	
Provider has a written policy and procedure that meets the requirement for Indicator 2.09						**YES NO (explain) X** The agency has the required policy and procedure # 2.09 in place that was approved December 28, 2020 by the Regional Director.	Policy 2.09 for Domestic Violence includes reference to the QI requirement, but agency's procedures do not include the following: 1) Data entry into NetMIS and JJIS within three (3) business days of intake and discharge,

							2) Documentation in file of transition to CINS/FINS or Probation Respite placement, if applicable, and 3) Case Plan reflects goals for aggression management, family coping skills, or other interventions designed to reduce propensity for violence in the home.
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Staff Secure							
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? **(If no, select rating "No eligible items for review")**	**YES**	**NO** **X**	**N/A**			The program has not served any Staff Secure youth since the last onsite QI visit and has no eligible items for review.	
Staff Secure policy and procedure outlines the following: a. In-depth orientation on admission b. Assessment and service planning c. Enhanced supervision and security with emphasis on control and appropriate level of physical intervention d. Parental involvement e. Collaborative aftercare			**X**				
Program only accept youth that meet legal requirements of F.S. 984 for being formally court ordered in to Staff Secure Services			**X**				
Staff Assigned: a. One staff secure bed and assigned staff supervision to one staff secure youth at any given time b. Program assign specific staff during each shift to monitor location/ movement of staff secure youth			**X**				

c. Agency clearly documents the specific staff person assigned to the staff secure youth in the logbook or any other means on each shift							
Agency provides a written report for any court proceedings regarding the youth's progress			**X**				
Domestic Minor Sex Trafficking (DMST)							
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? **(If no, select rating "No eligible items for review")**	**YES**	**NO X**	**N/A**			The program has not served any DMST youth since the last onsite QI visit and has no eligible items for review.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Agency has evidence that the FNYFS was contacted for approval prior to admission for all Domestic Minor Sex Trafficking (DMST) placements			**X**				
Services provided to these youth specifically designated services designed to serve DMST youth			**X**				
Did the placement of DMST youth require additional supervision for the safety of the youth or the program? If so, did the agency provide the appropriate level of supervision and safety measures?			**X**				
Length of Stay: a. Youth in program do not have length of stay in DMST placement that exceeds seven (7) days b. Agency has approval for stays and support beyond seven (7) days for DMST placements that are obtained			**X**				

on a case-by-case basis? (If applicable.)							
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**					Three closed applicable Domestic Violence (DV) Respite records were reviewed. All three records had pending DV charges, were screened by JAC, and did not meet criteria for secure detention.	
Data entry into NetMIS and JJIS within (3) business days of intake and discharge		**X**				Reviewed NetMIS data entry lag and JJIS prevention service record for 3 DV youth records reviewed.	**Exception** Two of three DV youth data entry had NetMIS exit lags exceeding 72 hours of discharge; one was by 1 day and the other by 20 days. Similarly, the same two youth records have JJIS data entry lag >72 hours. One of the youth had an incorrect discharge date in JJIS. LSF's record shows 12/30/20, JJIS was 12/31/20. The JJIS record was corrected during the QI visit.

Youth in program do not have length of stay in DV Respite placement that exceeds 21 days. If more than 21 days, documentation exists in youth file of transition to CINS/FINS or Probation Respite placement, if applicable.	**X**					The length of stay exceeded 21 days in one of the three applicable youth records reviewed. The youth was transitioned to CINS/FINS prior to the 21st day with documentation in the file showing the youth was transitioned to CINS/FINS.	
Case plan in file reflects goals focusing aggression management, family coping skills, or other intervention design to reduce reoccurrence of violence in the home	**X**					The case plans in 2 applicable records reflected goals that were appropriate such as aggression management, coping skills, and communication. One of the three DV youth was on runaway status within 48 hours of intake, prior to staff developing the case plan.	
All other services provided to Domestic Violence Respite youth are consistent with all other general CINS/FINS program requirements	**X**					All other services provided to DV youth were found to be consistent with general CINS/FINS program service requirement in the 3 applicable records.	
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**	**N/A** **X**			LSF Southeast is not contracted to provide Probation Respite services.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
All probation respite referrals are submitted to the Florida Network.					**X**		
Probation Respite Referral come from DJJ Probation and are all youth referred on probation regardless of adjudication status					**X**		
Data entry into NetMIS and JJIS within (3) business days of intake and discharge					**X**		
Length of stay is no more than fourteen (14) to thirty (30) days? (Placement beyond thirty (30) days requires the					**X**		

approval of the JPO and/or CPO)							
All case management and counseling needs have been considered and addressed					X		
All other services provided to Probation Respite youth are consistent with all other general CINS/FINS program requirements					X		
Intensive Case Management (ICM)							
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? **(If no, select rating "No eligible items for review")**	**YES**	**NO**	**N/A** X			LSF Southeast is not contracted to provide Intensive Case Management services.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Youth receiving services was court ordered or referred by case staffing committee					X		
Services for youth and family include: a. Four (4) direct contacts per month b. Four (4) collateral contacts per month					X		
Assessments include: a. A Child Behavior Checklist (CBCL) is completed within 14 days of intake and at discharge (if applicable) b. An approved self-report assessment that was completed at intake c. An approved self-report assessment that was completed every 90 days following intake and at discharge (if applicable)					X		
Case plan demonstrates a strength-based, trauma-informed focus					X		

Agency has evidence that ICMS has a strength-based perspective in one or more of the following areas; engaging the family, advocating on their behalf, initiating change agent activities, helping to access supports in the community, teaching problem solving skills, modeling productive behaviors, and/or successful completion of youth and family developmental milestones					**X**		
Family and Youth Respite Aftercare Services (FYRAC)– Non-residential Only							
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? **(If no, select rating "No eligible items for review")**	**YES**	**NO**	**N/A** **X**			LSF Southeast is not contracted to provide FYRAC services.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Youth is referred by DJJ for a domestic violence arrest on a household member, and/or the youth is on probation regardless of adjudication status and at risk of violating					**X**		
Agency has evidence that all FYRAC referrals have documented approval from the Florida Network office					**X**		
Intake and initial assessment sessions meets the following criteria: a. Face-to-face gathering of family history and demographic information b. Includes development of the service plan and is documented through signature of the youth and his/her parent/guardian as well as orientation to the program					**X**		

Life Management Sessions meets the following criteria: a. Sessions are face-to-face, sixty (60) minutes in length and focus on strengthening the family unit b. Individual Sessions are with the youth and family and focus to engage, identify strengths and needs of each member that help to improve family functioning					X		
Group Sessions: a. Focus on the same issues as individual/family sessions with the overall goal of strengthening relationships and prevention domestic violence b. Shall be no more than eight (8) youth at one (1) time and shall be for a minimum of sixty (60) minutes per session					X		
Youth and family participate in services for thirteen (13) sessions or ninety (90) consecutive days of services, or there is evidence in the youth's file that an extension is granted by DJJ circuit Probation staff					X		
2.10: STOP NOW AND PLAN (SNAP)							
Provider has a written policy and procedure that meets the requirement for Indicator 2.10						**YES NO (explain) N/A X** LSF Southeast is not contracted to provide SNAP services.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
SNAP Clinical Groups							
Youth are screened to determine eligibility of services					X		
Needs assessment is completed at initial intake, or					X		

within two face-to-face sessions							
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 the required policy and procedure # 3.01 in place that was approved December 28, 2020 by the Regional Director.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Facility Inspection		X				The Regional Director informed Lead Reviewer that the facility recently achieved its fundraising goal that will allow major renovations of the facility; consequently, some general maintenance and minor repairs were suspended temporarily such as painting and non-hazardous repairs needed to baseboard etc. During the walk through of the shelter it was observed furnishings were in good repair and the building was free of insect infestation. Bathrooms, bedrooms, and common areas were free of any contraband and hazardous objects. Showers were clean and functional and the lighting in the shelter was adequate to perform tasks. Bedroom walls are painted with bright colors and doors are chalk board painted to discourage graffiti in other areas of the facility. The grounds were well maintained. The city provides 5 large trash cans and 2 large recycle containers; all of the receptacles were covered with lids. All agency and staff vehicles were locked. Agency vehicles were equipped with safety equipment which included first aid kits, fire extinguisher, flashlight, glass breaker, and seat belt cutter. All staff appeared to be compliant with key control. The shelter had posted information for staff and youth that consisted of egress plans, shelter rules, grievance procedures, abuse hotline information and DJJ reporting procedures.	**Exceptions** • Door vents in rooms 4, 8, and 9 are loose and partly detached from door • Poster board in room 9 is not fully attached to wall • Bulk debris (file cabinet, bed frame, bench parts, building material) in backyard pose a hazard and needs to be removed • 2 broken window screens were observed on the exterior of bedrooms • Both agency vans were missing air bag deflator • MSDS sheet was missing for 6 chemicals in use by the program • Chemical inventory was not accurate because staff did not include count of items in a second storage container • A fire extinguisher kept in the medication room was last inspected January 2019 and had an expired tag

						The agency has a current DCF license displayed in the shelter. DCF license was effective 6/28/2020. Chemicals are approved and inventoried weekly; however, upon review, the inventory was not accurate. All chemicals were locked in 2 large storage bins on the rear patio of the shelter. The shelter has two heavy duty washers and two dryers which appeared to be operable during the tour. A lint cleaning log ensures staff conducts frequent cleaning of the dryer and surrounding areas. Each youth has own bed with a clean mattress covers, pillow and blank. A laundry schedule for linens was posted in the shelter. All youth have a safe lockable area for clothing in the bedroom and valuable personal belongings are locked away in a cabinet in the medication room.	
Fire and Safety Health Hazards	**X**					Annual fire inspection was completed by Oakland Park Fire Rescue on 2/2/2021 and all items cited were cleared during the reinspection on 3/1/2021. An annual review of the extinguishers, sprinklers, and alarm systems was conducted February 2021. All but one fire extinguisher was tagged and up to date. Reviewed fire drill logs demonstrate fire drills were conducted within one to two minutes as required and completed monthly. Mock emergency drills reviewed are completed quarterly on each shift. The program has a satisfactory food inspection completed on 10/23/2020 by the Department of Health (DOH). DOH did not complete a group care inspection in 2020 and was contacted during the QI visit; an inspection was scheduled for 4/16/21. All menus were posted and signed by licensed dietitian on 11/4/20. All food items appeared to be properly stored and labeled. Freezers and refrigerators are clean and	

						functional. Freezer temperature –4 degrees and refrigerator temperature 40 degrees.	
Youth Engagement							
a. Youth are engaged in meaningful, structured activities (e.g., education, recreation, counseling services, life and social skill training) seven days a week during awake hours. Idle time is minimal. b. At least one hour of physical activity is provided daily. c. Youth are provided the opportunity to participate in a variety of faith-based activities. Non-punitive structured activities are offered to youth who do not choose to participate in faith-based activities. d. Daily programming includes opportunities for youth to complete homework and access a variety of age appropriate, program approved books for reading. Youth are allowed quiet time to read. e. Daily programming schedule is publicly posted and accessible to both staff and youth.	**X**					Youth are engaged in meaningful, structured activities seven days a week during wake hours. Some of the activities include but not limited: educational, recreational, life, counseling, and social skill training. Idle time is minimal. Daily schedules reflect at least one hour of physical activity is provided daily and notated in the logbook. Youth are provided the opportunity weekly to participate in faith-based activities. Non-punitive structured activities such as reading, journaling, tutoring, education, recreational board game and counseling are offered to youth as an alternative to youth who do not choose to participate in faith-based activities. Daily programming includes opportunities for youth to complete homework and access books in the facility library that have been approved by the agency. Daily programming schedule is publicly posted in the two areas (living room and provided to the youth) and accessible to both staff and youth.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.02						**YES X NO (explain)** The agency has the required policy and procedure # 3.02 in place that was approved December 28, 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**					Youth admitted to the shelter complete a comprehensive orientation process and handbook provided within 24 hours.	

Orientation includes the following: a. Youth is given a list of contraband items b. Disciplinary action is explained c. Dress code explained d. Review of access to medical and mental health services e. Procedures for visitation, mail and telephone f. Grievance procedure g. Disaster preparedness instructions h. Physical layout of the facility i. Sleeping room assignment and introductions j. Suicide prevention- alerting staff of feelings or awareness of others having suicidal thoughts						A review of four residential files (two open and two closed) indicated that all four clients received a comprehensive orientation during the intake process which was documented on the Client Orientation Checklist as well as resident & parent orientation handbook, and were initialed/signed by staff, guardian, and youth. All four files reviewed had acknowledgement from the youth of receiving a comprehensive orientation handbook, contraband rules, disciplinary action, dress code expectations, access to medical and mental health services, daily activity schedule, grievance procedures, emergency/disaster preparedness, physical layout of the facility and room assignment.	
Documentation of each component of orientation, including orientation topics and dates of presentation, as well as signatures of the youth and staff involved is maintained in the individual youth record	**X**					All four files reviewed included a Client Orientation Checklist with specific areas of orientation documented on the list and initialed by the youth.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.03						**YES X NO (explain)** The agency has the required policy and procedure # 3.03 in place that was approved December 28, 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		**X**				Four residential files were reviewed (two closed and two open files). The client room assignment section of the Intake Form was completed in all four files and	**Exception** Initial observations of youth during intake was not documented on the

b. Initial collateral contacts, c. Initial interactions with and observations or the youth d. Separation of younger youth from older youth, e. Separation of violent youth from non-violent youth f. Identification of youth susceptible to victimization g. Presence of medical, mental or physical disabilities h. Suicide risk i. Sexual aggression and predatory behavior j. Sexual orientation gender identity/ expression k. Acute health symptoms requiring quarantine or isolation						documented all required information except for initial interactions and observations of the youth.	CINS/FINS Intake form for two of the four youth.
An alert is immediately entered into the program's alert system when a youth is admitted with special needs and risks such as risk of suicide, mental health, substance abuse, physical health or security risk factors	**X**					Admission Forms for the four residential files were reviewed. Alerts for the youth were documented on the cover sheet for each youth file.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.04						**YES X NO (explain)** The agency has the required policy and procedure # 3.04 in place that was approved December 28, 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**					The program utilizes the electronic logbook. Entries that impacted the safety and security of the youth or program were observed to be 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	**X**					Logbook entries were reviewed for randomly selected weeks as follows: 10/10/20 - 10/19/20, 11/1/20 - 11/11/20, 12/19/20 - 12/31/20 and 2/1/21 - 2/20/21. 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 providing pertinent information • Name and signature of person making the entry						brief statement, and included the name and signature of the person making the entry.	
Recording errors are struck through with a single line. The staff person must initial and date the correction. The use of whiteout and erasures is prohibited.	**X**					Errors were observed to be struck through with a single line, initialed and dated.	
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**					Shelter Manager or designee reviewed the logbook weekly and notated dates reviewed with any recommendations.	
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**					Overall, most staff reviewed the logbook for at least the previous two shifts and included the dates they reviewed; however, notation of the dates being reviewed was not consistently documented by all staff.	
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**					Supervisor reviewed the logbook at beginning of their shift for at least the previous two shifts and included the dates they 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 the required policy and procedure # 3.05 in place that was approved December 28, 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,	**X**					The agency has a detailed written description of the Behavioral Management System that is intended to gain compliance with program rules	

and it is explained during program orientation						but impact the youth to make positive choices. The Behavioral Management System is outlined in the Parent & Resident Orientation Handbook and in the intake paperwork.	
Behavior Management Strategies MUST include: a. Supervisors are trained BMS is designed to teach youth new behaviors and help youth understand the natural consequences for their actions b. Behavioral interventions are applied immediately, with certainty, and reflect the severity of the behavior c. BMS uses a wide variety of awards/incentives to encourage participation and completion of the program d. Appropriate consequences and sanctions are used by the program and consequences for behavior are logical and designed to promote skill-building for the youth e. Counseling, verbal intervention and de-escalation techniques are used prior to physical intervention (Only techniques approved by the Florida Network and DJJ are used if physical intervention is required) f. Only staff discipline youth. Group discipline is not imposed g. Room restriction is not used as part of the system or for youth who are	**X**					The shelter is a hands-off facility and staff is trained in (MAB) behavioral intervention to utilize the least amount of force necessary to address the situation and basic rights of youth are not violated. The program has a variety of rewards (recreational outings, extra privileges on a daily and weekly basis), appropriate consequences and behavioral management system which is based on a token economy of points. The (BMS) phases is used to teach youth new behaviors and help youth to understand the positive accountability for their actions. During the interview with the shelter manager, (BMS) procedure that is in place was described. In the review of four files, it was confirmed that staff does explain the (BMS) during program orientation. In addition, staff document the behavioral notes daily. All consequences appear fair in respect to the behavior management plan. The system does not allow for group discipline or room restriction and does not deny the youth of basic rights.	

h. physically and/or emotionally out of control. Youth should never be denied basic rights such as meals, clothing, sleep, services, exercise, or correspondence privileges							
Program's Use of the BMS							
All staff are trained in the theory and practice of administering BMS rewards and consequences	**X**					Training files for four staff (three on-going and one 1st year) were reviewed; all four documented the staff are trained on the program's BMS annually.	
There is a protocol for providing feedback and evaluation of staff regarding their use of BMS rewards and consequences	**X**					Shelter manager was interviewed and indicated program manager/supervisor reviews youth behavioral sheets and provides feedback to staff on the usage of positive and negative consequences.	
Supervisors are trained to monitor the use of rewards and consequences by their staff	**X**					Supervisors are trained to monitor the use of awards and consequences by staff.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.06						**YES X NO (explain)** The agency has the required policy and procedure # 3.06 in place that was approved December 29, 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**					Reviewed eight random samples of video surveillance for the following dates and times: 3/19/21 (12am – 5am), 3/20/21 (1sm – 6am), 3/26/21 (12am – 5:30am), 3/30/21 (12:30am – 5 am), 4/2/21 (1:30am – 5am), 4/9/21 (12:30am – 6am), 4/11/21 (2:30am – 6am) and 4/12/21 (12am – 5am). A review of the above video surveillance samples, staff schedules, and logbook entries documented the required staffing ratios were met for the awake hours and sleeping hours.	
All shifts must always provide a minimum of two staff present	**X**					Reviewing the team schedule 12/1/20 - 4/10/21 and random logbook entries documented two staff were present on all three shifts.	
Program staff included in staff-to-youth ratio includes only staff that are background screened and properly trained	**X**					A review staff personnel files, training files, staff schedules, and logbook entries documented the required staffing ratios were met. Only staff that are background screened and properly trained are included on the staff schedules and shifts.	

youth care workers, supervision staff, and treatment staff							
The staff schedule is provided to staff or posted in a place visible to staff	**X**					Shelter manager indicated staff schedule is posted in the office area for staff to review. A copy of the schedule was observed during the onsite tour.	
There is a holdover or overtime rotation roster which includes the telephone numbers of staff who may be accessed when additional coverage is needed	**X**					The program maintains a holdover and overtime roster with staff names and numbers.	
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**					The random video surveillance samples reviewed above documented that staff observed the youth at least every 15 minutes during the overnight sleeping hours. All 15-minute bed checks were conducted in real time in the electronic logbook and verified. The shelter has 9 bedrooms located down a single hallway. Six of the bedrooms have 2 beds and two bedrooms contain 3 beds. There is one bedroom close to the staff monitoring station that has a single bed for youth with suicide risk or other alert needing enhanced supervision.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.07						**YES X NO (explain)** The agency has the required policy and procedure # 3.07 in place that was approved December 29, 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;	**X**					Reviewer observed cameras and written notice in front entrance and common area during virtual tour. Video surveillance system was reviewed via Microsoft Teams with program shelter manager. System can capture and retain video images for up to 30 days. A review of random samples of overnight video surveillance revealed the system records date, time, 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 sleeping quarters or restrooms.	

maintain resolution that enables facial recognition d. Back-up capabilities consist of cameras' ability to operate during a power outage e. Have cameras placed in interior and exterior general locations of the shelter where youth and staff congregate and where visitors enter and exit. Cameras are never placed in bathrooms or sleeping quarters. f. All cameras are visible							
A list of designated personnel who can access the video surveillance system is maintained (includes off-site capability per personnel)?	**X**					A list of is maintained for designated staff who have access to video surveillance system.	
Supervisory review of video is conducted a minimum of once every 14 days and timeframes reviewed are noted in the logbook. The reviews assess the activities of the facility and include a review of random sample of overnight shifts	**X**					The shelter manager conducts a review of overnight bed checks a minimum of once every fourteen days. Timeframes reviewed are noted in document titled "supervisor log review of video surveillance".	
Grant the requesting of video recordings to yield a result within 24-72 hours from program quality improvement visits and when an investigation is pursued after an allegation of an incident	**X**					Per agency's policy titled 3.07, the program will grant request of video recordings within 72 hours if requested after an allegation or for investigative purpose.	
Camera service order/requests will be made within 24 hours of discovery of camera malfunctioning or being inoperable. All efforts made to obtain repairs are documented and maintained	**X**					The shelter manager will call in a service request immediately upon notice of malfunction. There was an issue with the system during this QI review and it was immediately addressed.	

Provider has a written policy and procedure that meets the requirement for Indicator 4.01						**YES X NO (explain)** The agency has the required policy and procedure # 4.01 in place that was approved October 29, 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**					Upon arrival of each youth, the program completes the CINS/FINS Intake Assessment form which includes specific physical health screening and a visual inspection of the youth. A review of two open and two closed youth records reflected screening forms were completed as required, in each record reviewed. Health care screening included current medications, existing medical conditions, allergies, recent injuries or illness, presence of pain or physical distress, observation or illness, injury, physical distress, difficulty moving, scars, tattoos, or other skin markings and acute health symptoms requiring quarantine and or isolation.	
Referral and Follow-up							
Youth with chronic medical conditions have a referral to ensure medical care (e.g. diabetes, pregnancy, seizure disorder, cardiac disorders, asthma, tuberculosis, hemophilia, head injuries, etc.)			**X**			None of the records reviewed indicated youth had a chronic medical condition needing immediate referral.	
When needed, the parent is involved with the coordination and scheduling of follow-up medical appointments			**X**			No eligible medical referrals applicable to the sample records reviewed.	
All medical referrals are documented on a daily log.			**X**			No eligible medical referrals applicable to the sample records reviewed.	
The program has a thorough referral process and a mechanism for necessary follow-up medical care as required and/or needed	**X**					The program does have a policy in place for referral of youth and notification of parent/guardian.	

Provider has a written policy and procedure that meets the requirement for Indicator 4.02						**YES X NO (explain)** The agency has the required policy and procedure # 4.02 in place that was approved October 29, 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					A review of two open and two closed youth records found that in each case the program completed an initial suicide risk assessment during the eligibility screening process. The review of the youth records also indicated all suicide screenings and assessments are completed in the required time frame, and the results were reviewed and signed by the Clinical Director and documented in each applicable youth record.	
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 has not been changed since approved by the Florida Network of Youth and Family Services.	
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					The review of the four youth records confirmed each youth was placed on sight and sound supervision due to an indication of suicide risk based on screening results.	
Staff person assigned to monitor youth documented youth's behavior at 30 minute or less intervals	X					Suicide Risk Screening and Precautionary Observation forms were completed in each of the reviewed records. The record's documentation revealed any youth placed on one-to-one or constant supervision is monitored at ten-minute intervals.	
Supervision level was not changed/reduced until a licensed professional or a non-licensed mental health professional under the supervision of a licensed professional completed a further assessment OR Baker Act by local law enforcement	X					Each youth supervision level is maintained until the Clinical Director completed a further assessment.	

Provider has a written policy and procedure that meets the requirement for Indicator 4.03						**YES X NO (explain)** The agency has the required policy and procedure # 4.03 in place that was approved October 29, 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**					Oral medications, controlled medications, and narcotics are stored separately from injectables epi-pens and topical medications in the required Pyxis Med-Station. The program was recently upgraded to the new Pyxis ES Med Station one week prior to the onsite visit. The Pyxis machine is located in a locked room and is not accessible to youth. There is a working refrigeration unit stored in the medication room for medication requiring refrigeration; however, no medication requiring refrigeration was present during the review.	
Medication Distribution							
a. Agency maintains a minimum of 2 Super Users for the Med-Station b. Only designated staff delineated in User Permissions have access to secured medications, with limited access to controlled substances (narcotics) c. A Medication Distribution Log shall be used for	**X**					The program submitted a list that includes the names of six super users trained for the use of the Pyxis Med-station and twelve trained staff authorized to distribute medication. Three youth medication records were reviewed and two of the three were prescribed controlled medications. A medication distribution log was used to document medication delivery to the three youth by licensed and non-licensed trained	**Limited Exception** Five of the six new non-licensed staff did not receive EpiPen training

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						staff. Medication distribution is conducted by the nurse when on duty. In all four records the medication delivery process was consistent with the FNYFS medication management and distribution policy. The agency does not accept youth currently prescribed injectable medications, except for epi-pens. None of the youth were prescribed injectables. One of the six new staff received the required training on how to use an epi-pen.	
Medication Inventory							
a. For controlled substances, a perpetual inventory with running balances is maintained as well as a shift-to shift count verified by a witness and documented b. Over-the-counter medications that are accessed regularly are inventoried weekly by maintaining a perpetual inventory c. Syringes and sharps (needles, scissors, etc.) are secured, and counted and documented weekly		**X**				Shift-to-shift count was reviewed for the two applicable controlled medication youth records. Shift-to-shift counts verified by a witness was not consistently documented. Over-the-counter medications are brought in by the youth's guardian and are kept in the Pyxis machine. Evidence of a perpetual and weekly inventory of OTC medication was not observed. All sharps, including knives and first aid scissors, are secured and inventoried weekly.	**Limited Exception** Perpetual inventory and shift-to-shift counts of controlled medication were not consistently done on all three shifts as required in the two applicable randomly selected records reviewed. The nurse and staff were logging OTC medication distribution to youth but did not maintain a perpetual or weekly inventory of OTC medication.
There are monthly reviews of medication management practice via Knowledge Portal or Pyxis Med-Station Reports.		**X**				Monthly reviews of medication management practices was not demonstrated by the program.	**Limited Exception** No evidence of monthly review of knowledge portal reports run by the agency was observed for the review period.

Medication discrepancies are cleared after each shift.		**X**				Medication discrepancies being cleared after each shift was not consistently cleared at the end of the shift by staff.	**Limited Exception** A total of 38 medication discrepancies occurred between 11/1/2020 and 3/31/2021. Twenty-seven (27) of the 38 discrepancies were not cleared at the end of the shift where it was discovered as required.
Provider has a written policy and procedure that meets the requirement for Indicator 4.04						**YES X NO (explain)** The agency has the required policy and procedure # 4.04 in place that was approved October 29, 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**					A review of six youth records (1 open, 5 closed) found each youth was appropriately screened and placed on the program's alert system where applicable. There was no youth applicable to food allergies at the time of the review.	
Alert system includes precautions concerning prescribed medications, medical/mental health conditions	**X**					The program maintains a medical and mental health alert system to communicate essential medical conditions and other health related issues between staff in the program. The system includes precautions concerning medications and/or medical/mental health conditions.	
Staff are provided sufficient training, information and instructions to recognize/respond to the need for emergency care for medical/mental health problems	**X**					All the program's direct care staff training records reviewed received training in first aid, cardiopulmonary resuscitation, and emergency procedures prior to direct contact with youth in the shelter and is retrained as needed.	
A medical and mental health alert system is in place that ensures information concerning a youth's medical condition, allergies, common side effects of prescribed medications, foods and medications that are contraindicated, or other pertinent mental health treatment information, is communicated to all staff	**X**					The program maintained in the intake office a color-code alert board that was observed, and it is utilized to document alerts. The alert board is inaccessible to youth and includes any applicable medical condition, physical activity, restrictions, allergies, common side effects of medication, food allergies, and other treatment information. There was no youth applicable to food allergies at the time of the review. A review of four youth records found each youth was appropriately screened and placed on the program's alert system when applicable.	

Provider has a written policy and procedure that meets the requirement for Indicator 4.05						**YES X NO (explain)** The agency has the required policy and procedure # 4.05 in place that was approved October 29, 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**					The review of the past six months of reports called into the Department's Central Communications center (CCC) indicated the program has six incident reports regarding emergency care. In five of the six cases youth were transported by EMS or the program staff to Broward General Hospital in Fort Lauderdale, Florida, and in one case the program called youth's mother and she took the youth to the hospital. Documentation reviewed found the program has an episodic/emergency care log, that is maintained for emergency offsite care provided.	
All staff are trained on emergency medical procedures	**X**					All 7 training records reviewed show the staff received training in first aid, cardiopulmonary resuscitation, and emergency procedures. Interview with the program's manager indicated the program has one automated external defibrillator (AED) that is checked monthly and is in the supervisor's office.	
The program has a Knife-for-life and wire cutters accessible to staff in a secure location(s)	**X**					Knife for life is in a locked break box mounted on wall in the staff monitoring area of the youth lounge. The box also includes plyers, scissors, and a wire cutter.	
First aid kit/supplies are fully equipped and inventoried	**X**					Observations confirmed the program maintains two first aid kids within the shelter building, one located in the common area and the other located within the dining area. Additionally, the program maintains first-aid kits within each of the two transportation vans. The kits are inventoried weekly.	