Florida Network for Youth and Family Services
Compliance Monitoring Report for

<u>Safe Children Coalition</u>
1106 South Briggs Avenue, Sarasota, FL 34237

Compliance Monitoring Services Provided by

EXECUTIVE SUMMARY

Forefront LLC conducted a joint Quality Improvement (QI) with Florida Network of Youth and Family Services (FNYFS) monitoring visit for the Safe Children Coalition (SCC) for the FY 2020-2021 at its program office located at 1106 South Briggs Avenue, Sarasota, 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. Safe Children Coalition 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 SCC present for the entrance interview were: Brena Slater, President/CEO; Jennifer Powers, Director of Contracts; Stacy Walker, CFO; Stacey Schaeffer, Senior Director of Prevention and Diversion Services; Jill Steiner, Senior Director of Out of Home Care; Charles Harris, Director of Residential Programs; and Jennifer Warwick, Clinical Supervisor. The last onsite QI visit was conducted March 5, 2020.

In general, the Reviewer found that Safe Children Coalition is in compliance with specific contract requirements. Safe Children Coalition **received an overall compliance rating of 100% for achieving full compliance with all twelve indicators** of the CINS/FINS Monitoring Tool. There were no corrective actions as a result of the monitoring visit or recommendations made for any conditionally acceptable item.

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

2020-2021 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 5-19-2020-2021

Agency Name: Safe Children Coalition	**Monitor Name: Marcia Tavares, Lead Reviewer**
Contract Type : CINS/FINS	**Region/Office: 1106 South Briggs Ave., Sarasota FL**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): May 19-20, 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.	☐	☐	☒	☐	☐	**I:** The agency has four certified peer reviewers: Kenneth Kochenderfer, Charles Harris, Sarah Mann, and Amanda Colafrancesco that are certified to participate in on-site quality visits for the agency. Two of the certified peers participated in QI reviews for this QI period.	
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**	☐	☐	☒	☐	☐	D: SCC provided a listing of four additional funding sources identifying the awarding entity, service provided, award amount, and contract start & end dates. The additional funders include: SCC/DCF, Sarasota County Government CHS 20 and CHS 21, and DHHS-Basic Center. The program also maintains interagency agreements and Memorandums of Agreement (MOUs) with schools,	

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						mental health, and substance abuse providers. All of the agreements reviewed had current contract or agreement dates.	
Limits of Coverage a. Provider shall provide and maintain during this contract, the following minimum kinds of insurance: Worker's Compensation and Employer's liability insurance as required by Chapter 440, F.S. with a minimum of $100,000 per accident, $100,000 per person and $500,000 policy aggregate. Commercial General Liability with a limit of $500,000 per occurrence, and $1,000,000 policy aggregate. Automobile Liability Insurance shall be required and shall provide bodily injury and property damage liability covering the operation of all vehicles used in conjunction with performance of this contract, with a minimum limit for bodily injury of $250,000 per person; with a minimum limit for bodily injury of $500,000 per accident; with a minimum limit for property damage of $100,000 per accident and with a minimum limit for medical payments or $5,000-$10,000 per person. Florida Network is listed as payee or co-payee. **PTV**	☐	☐	☐	☒	☐	**D:** The agency maintains the following coverages through the Alliance of NonProfits Insurance Company: • General liability coverage for limits of $1,000,000 each and $3,000,000 aggregate including medical expenses • for $20,000 for any one person, effective 7/1/2020-7/1/2021. • Automobile liability coverage effective 7/1/2020-7/1/2021 with combined single limit per accident of $1,000,000, with medical payments of $5,000. • Umbrella liability coverage effective 7/1/2020-7/1/2021 with $6,000,000 for each occurrence or aggregate.	

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						• Professional liability coverage effective 7/1/2020-7/1/2021 with $1,000,000 limits per occurrence and $3,000,000 aggregate. Workers Compensation is provided through Zenith Insurance Company, effective 1/1/21-1/1/22, with a policy limit of $500,000 each accident, each employee, or aggregate policy limit. Florida Network is listed as the Certificate Holder on all policies.	
External/Outside Contract Compliance a. Provider has corrective action item(s) cited by an external funding source (Fiscal or Non-Fiscal). **ON SITE**	☐	☐	☐	☐	☒	**I-** Per the VP, SCC does not have any corrective action items cited by an external funding source.	
Fiscal Practice a. Agency must have employee and fiscal policy/procedures manuals that are in compliance with GAAP and provide sound internal controls. Agency maintains fiscal files that are audit ready. **PTV**	☐	☐	☒	☐	☐	**D,I**- Fiscal Policies and Procedures are maintained and approved by the President of SCC. The procedures are revised as needed and appear to be consistent with GAAP and provide for sound internal controls. Procedures are included for vendor invoices, check writing, purchasing, credit cards,	

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	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable		
						travel, employee reimbursement, billing, cash management, petty cash, bank accounts, and other relevant financial processes.	
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**	☐	☐	☒	☐	☐	D: The agency's general ledger was provided for the current FY for 7/1/2020 – 4/30/2021. The general ledger provides details to demonstrate that all activity is tracked and funds are managed separately for FNYFS contract.	
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**	☐	☐	☒	☐	☐	**I,O:** The agency has a policy, CM -130 Petty Cash Funds, and maintains a petty cash system that is secured in a locked box and managed by the Director of Residential Services. The finances are disbursed, and reconciliations are verified by the designee in the finance department before reimbursement is made. Total amount was $451.80 Total cash on hand was $ 378.19. Total is receipts were $73.61. Agency utilizes an agency reconciliation form to capture	

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						beginning cash balance, ending cash balance and to list all receipts.	
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**	☐	☐	☒	☐	☐	D,O: Financial statements are prepared monthly, comparing month and year to date actual results to budget. Bank Statements and Bank Reconciliations for the period October 2020 - April 2021 were reviewed for the Operating account held with BB&T Bank and State Contract Payments account held with Northern Trust for wire transfers from the FN. Funds are moved from the latter to the operating account where daily transactions take place for the CINS/FINS program are paid from. Bank Statements are reconciled on a monthly basis, for the activities and bank statements, on the last day each month. The agency maintains individual vendor files related to program expenditures at the corporate office.	
e. Agency maintains inventory in accordance with a written policy and FNYFS contractual requirements. If over	☐	☐	☒	☐	☐	D,I- Agency maintains a written property and equipment inventory	

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	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable		
$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**						showing last purchase September 2018. No new equipment was purchased with FN funds since the last onsite visit.	
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**	☐	☐	☒	☐	☐	D- The agency provided Form 941 documentation for the 4th quarter 2020 and 1st quarter 2021. Submission of the Quarterly Federal Tax Returns provided evidence of the agency's payroll taxes paid. The reports do not indicate any balances due by the agency.	
g. Budget to actual reports prepared and reviewed by appropriate management. Variance from the budget are investigated and explained. **PTV/ON SITE**	☐	☐	☒	☐	☐	D,I- Agency provided a Budget to Actual report for the current FY 7/1/20-4/30/21. A review of these documents was conducted. The report shows Current Year Actual with YTD Budgeted Original, and YTD Budget Variance with a net deficit. Variances in budget are monitored on a regular basis and approved by management.	
h. A Single Audit is performed as part of the annual audit if expenses are greater than $750,000. The agency must	☐	☐	☒	☐	☐	D- Financial audit was conducted for the prior year ending June 30, 2020	

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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**						and was completed by Kerkering, Barberio & Company in a report dated December 28, 2020 (completed late due to the the COVID-19 pandemic). A separate Management Letter requiring a Corrective Action Plan was not issued by the auditor.	
i. Agency maintains confidentiality policy with written policies and procedures to ensure the security and privacy of all employee and client data. Personal information is not easily accessible. Agency maintains a backup system in case of accidental loss of financial information. Security procedures are in place to protect laptops. Obsolete documents are shredded and computer hard drives are wiped prior to discarding. **ON SITE**	☐	☐	☒	☐	☐	D, I- Agency has written policies and procedures for file and data security (IT-220), Records Retention (FM-265), and client confidentiality. Agency maintains a back-up system in case of accidental loss. The policies were approved by the agency's President	

CONCLUSION

Safe Children Coalition has met the requirements for the CINS/FINS contract as a result of full compliance with twelve 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, **the overall compliance rate for this contract monitoring visit is 100%.** There are no corrective actions cited or recommendations 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 Safe Children Coalition
CINS/FINS Program

May 19-20, 2021

Compliance Monitoring Services Provided by

Quality Improvement Review

Safe Children Coalition – May 19-20, 2021
Lead Reviewer: Marcia Tavares

CINS/FINS Rating Profile

Standard 1: Management Accountability

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

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

Standard 2: Intervention and Case Management

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

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

Standard 3: Shelter Care & Special Populations

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

Percent of indicators rated Satisfactory: 71.43%
Percent of indicators rated Limited: 28.57%
Percent of indicators rated Failed: 0.00%

Standard 4: Mental Health /Health Services

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

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

Overall Rating Summary

Percent of indicators rated Satisfactory: 92.86%
Percent of indicators rated Limited: 7.14%
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

Stephanie Shay - Department of Juvenile Justice

Deborah Bianchi – Hillsborough County Children Services

Alex Culbreth – CDS Interface East

Tamika Gloston – Youth Crisis Center

Quality Improvement Review

Safe Children Coalition – May 19-20, 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
2 # Program Supervisors
0 # Food Service Personnel
0 # Healthcare Staff
N/A # Maintenance Personnel
0 # Other (listed by title): _____

Documents Reviewed

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

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

☐ Visitation Logs
☒ Youth Handbook
5 # Health Records
5 # MH/SA Records
12 # Personnel /Volunteer Records
7 # Training Records
19 # Youth Records (Closed)
10 # Youth Records (Open)
0 # Other: _____

Surveys

6 # Youth

7 # 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

Safe Children Coalition – May 19-20, 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

Safe Children's Coalition (SCC) Inc. is a non-profit community-based care provider that focuses on education, prevention, diversion, and child welfare services and serves Sarasota, Manatee, and Desoto counties in Florida. The corporate headquarters office is located at 1500 Independence Blvd., Suite #210, Sarasota, Florida. Program offices include the shelter which is located at 1106 S. Briggs Ave., Sarasota, and the Youth Prevention Services (YPS) community counseling program located at 5284 Paylor Lane, Lakewood Ranch, Florida. Funding through CINS/FINS allows the agency to serve both male and female youth up to seventeen years old that are locked out, runaway, ungovernable and/or truant, homeless, abuse, neglected, or at-risk. The agency also provides services to special populations who meet the criteria for Staff Secure shelter, Domestic Minor Sex Trafficking (DMST), and youth referred by the Juvenile Justice Court System for domestic violence, probation respite. SCC is not contracted to provide Family and Youth Respite Aftercare services (FYRAC), Intensive Case Management services and is not a SNAP provider. The youth census during the QI visit was 13 youth. SCC is currently accredited by COA through June 30, 2021.

The global pandemic has had a tremendous impact on all programs that serve children, youth and families. Despite the challenges presented, the agency focused on ensuring safety for their staff and participants by implementing Coronavirus Protocols. All staff members were part of required trainings on how to implement coronavirus protocols including the safe use of services while working remotely, following the most current and stringent requirements. Documentation of temperature, possible covid symptoms and staff entering the buildings were registered and extra cleaning measures were put into place.

In August 2020, school openings were delayed, which caused a significant reduction in referrals. The Clinical Supervisor and counseling staff conducted extensive outreach efforts to engage new referral sources, such as hospitals and churches.

Since the last QI visit, YPS office moved to the Northgate office then to the Lakewood Ranch office in April 2021. All files and equipment moved to the new office and stored

following HIPAA, SCC, DJJ, and FL Network protocols. Staff were allowed to work from this office and their home offices as needed due to coronavirus.

Several staff changes occurred during the past year including the turnover of 3 YPS staff, a Program Coordinator, and the promotion of Charles Harris to the position of Shelter Director and Aaron Bellamy to the position of Youth and Family Advocate Manager. The shelter program initiated several outreach efforts with community partners including the introduction of the Day Program.

Narrative Summary

The Regional Coordinator oversees both programs. The residential counseling program consists of one master's level counselor. The non-residential counseling program is housed on-site. The non-residential program consists of two, bachelor's level, counselor/case managers.

SCC under the leadership of a CEO, a Senior Director of Prevention and Diversion Services, a Senior Director of Out of Home Care, a Clinical Supervisor, and a Director of Residential Programs. The residential program staffing consists of a Residential Manager, a Youth and Family Advocate Manager, and a Residential Counselor. Youth care staff includes 8 fulltime Behavior Coaches (2 vacant positions) and 14 PRN Behavior Coaches (4 vacant). The community counseling program is housed off-site and consists of two bachelor's level and 4 master's level counselor/case managers, one of which was a vacant position.

The program has not reported any major challenges critical incidents, administrative review, or current external investigation outside the scope of the pandemic.

The overall findings for the QI review for Safe Children Coalition are summarized as follows:

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

Standard 2 has a total of ten indicators that relate to intervention and case management. One of the indicators, SNAP, is not applicable as SCC is not a SNAP provider. Eight of the nine applicable indicators were rated satisfactory with no exceptions (2.02-2.09) and one was rated satisfactory with exceptions (2.01).

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), one was rated satisfactory with exceptions (3.07), and two indicators 3.01 and 3.06 received a Limited rating.

Standard 4, Mental Health and Health Services is comprised of five indicators. Four of the indicators were rated satisfactory with no exceptions (4.01, and 4.03 - 4.05) and one indicator was rated satisfactory with exceptions (4.02).

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

Standard 3:
Indicator 3.01 – Limited
• There was no MSDS sheet for Microban and there was no MSDS for the brand of bleach that was present in the chemical closet.

• Chemicals are kept in different locations and there is concern about proper inventory of chemicals using a single inventory.

• Wood planks covering water irrigation system are loose and need to be secured. Flooring in boy's bathroom has chipped tile at entry/exit to shower. Flooring in girl's bathroom has mats that are at entry and exit that are not secured. Residents could slip and fall if floor is wet. The residential director stated that they are leasing the building and that it is up to the landlord to repair the issues.

• There were cords in the dayroom from the video games and the television set that could pose a hazard.

• Picnic tables and flooring on back deck have rough wood surfaces that could cause splinters.

• Wood covering for the water tank was not nailed down.

• The on-site reviewer also noted that there were several blinds that were either missing or damaged.

• Upon inspection of the vehicles, it was noted that the "new" van needed an oil change and the on-site reviewer noted that the log sheets needed the year notated on the pages. It was noted that the fire extinguishers in the vans did not have a signature from the inspector. It was also noted that the grey van has a rear hatch that does not lock and there was no evidence that a work order for repair has been issued. Staff stated that the Kia had a recall for the latch issue and that it has not been fixed due to the van needing to be used in the mornings for transport and that the fix will require approximately 6 weeks in the shop. Additionally, it was found that a couple flashlights were not working.

• The menus provided do not have an updated signature by the licensed dietician and it was reported by staff that the dietician did not physically come on site to sign the menus due to COVID 19 restrictions but that she stated that the menus would still be valid as a balanced and healthy meal plan.

On 12/15/ 20 the fire drill evacuation was conducted in 2 ½ minutes, exceeding the 2-minute limit.

Indicator 3.06 – Limited

On 5/7/21 staff was observed logging a bed check on two separate occasions, 5:08 am and 5:15 am, but did not get up to physically check on the youth. The same staff missed two consecutive checks on 5/7/21. There was a potential check at either 4:01am or 4:04 am but this could not be verified through surveillance and there was not another check until 4:36 am. There was potentially another missed check at 4:46 am but this could not be verified due to a glitch in the surveillance.

The same staff logged another bed check on 5/13/21 at 4:22 am but did not visually complete the bed check. Staff was informed to report knowledge of the finding to CCC and the report was accepted.

Checks were not able to be verified on 5/12/21 or 5/15/21 due to inadequate room lighting. An alternate day 4/29/21 was chosen. Staff conducted a bed check exceeding the 15-minute interval, conducting a bed check at 12:04 am and a subsequent check at 12:20 am. There was another instance where one staff conducted a bed check and exceeded the 15-minute time interval when the check was completed at 1:37 am and the previous was completed at 1:20 am.

The bed check entries do not contain counts despite the logbook entry stating, “the following counts were noted:”

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 procedures 1.01 that was approved by the Chief Executive Officer (CEO) on 1/28/2021.	
Agency utilizes an employee suitability prescreening assessment with a passing rate criterion prior to an offer of hire for direct care staff working with youth or the agency has provided an explanation to for staff hired with a non-passing/low score.	X					The agency uses the Safe Children Coalition Candidate Evaluation Form pre-assessment tool with a passing score of 80% or higher. All six new hire staff documented a pre-employment suitability assessment was completed prior to hire using the tool and each staff exceeded the passing score of 80%.	
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					Six new staff were hired since the last on-site Quality Improvement review. All six staff were background screened with eligible ratings received prior to the staff members' hire date. The program did not utilize any applicable volunteers or interns during the review period.	
Five-year re-screening completed every 5 years from initial date of hire	X					There were six eligible five-year re-screenings during this review period. Clearinghouse background screening documentation demonstrated current/active retained prints for all six staff.	

Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?	X					The agency submitted an Affidavit of Annual Compliance with Level 2 Screening Standards to the Department of Juvenile Justice Background Screening Unit via fax on December 30, 2020, prior to the January 31, 2021 deadline.	
Proof of E-Verify for all new employees obtained from the Department of Homeland Security	X					HR requests the authorization verification from E-Verify and documents the case number provided, date of authorization, and signature of HR staff completing verification on the lower section of the I-9 form rather than printing the E-Verify authorization and maintaining printed copy in the employee record.	
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 procedures 1.02 that was approved by the Chief Executive Officer (CEO) on 1/28/2021.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
Agency has a code of conduct of policy and there is evidence that staff are aware of agency's code of conduct.	X					The agency has a written code of conduct that is a part of the agency's personnel policy and procedures and is signed and dated by each employee during hire.	
Child Abuse Registry telephone number is visible to youth and posted common areas of the facility	X					A tour of the facility was completed. During the tour Florida Abuse Hotline and S.O.G.I.E signage was observed posted in unobtrusive areas of the facility.	
Youth were informed of the Abuse and Contact Number (see youth survey results)	X					The Abuse Hotline and DJJ CCC contact number is included in the Resident Handbook that is given and reviewed with youth during intake. Six youth surveys were completed. All 6 youth indicated staff is respectful towards them and they feel safe in the program. All six youth stated they were aware of the abuse hotline number and knowing the location of the hotline number in the facility.	
Management takes immediate action to address any incidents of threats or abuse			X			No incident of threats or abuse by staff requiring management action was reported during the review period.	

Grievance Process							
Agency has a formal grievance process	X					The agency's grievance process was reviewed and is compliance with FL Network standards.	
Locked box accessible to only management and available to youth in a common area	X					During the facility tour, the grievance lockbox was observed being in an area accessible to youth. The residential supervisor has possession of the keys to the grievance boxes.	
Direct care does not handle the complaint/grievance unless assistance is asked for by the youth. Program director/supervisor will have access to and manage grievances unless it is towards themselves.	X					Per the agency policy, which is compliant with the Florida Network standards, directors and/or supervisors manage all grievances unless the grievance is toward themselves, and direct care staff do not handle grievances.	
72-hour resolution requirement by management. If this does NOT occur within the 72 hour period, there is sufficient documentation explaining the cause for the delay in resolution.	X					One applicable grievance was reviewed. Resolution was handled within 72 hours of submission of the grievance.	
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 procedures 1.03 that was approved by the Chief Executive Officer (CEO) on 1/28/2021.	
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					During the review period, 12 incident reports were reported to CCC. Per the documentation, all reports were reported within the required 2-hour timeframe.	
The program completes follow-up communication tasks/special instructions as required by the CCC	X					Follow up communication with the CCC was completed as needed.	

Incidents are documented in the program logs and on incident reporting forms	X					All twelve incident reports were documented on the agency incident reporting form and documented in the Note Active tablet.	
All incident reports are reviewed and signed by program supervisors/directors		X				Per the Residential Director, at one time the incident reports were 2 pages but was reduced to a 1-page document. The 2nd page documented a signature line for supervisor, CCC report number and names of other people notified of the incident. All incidents are reviewed by the program director but were not signed because of the elimination of the 2nd page.	**Exception** None of the incident reports reviewed included a signature from a supervisor or manager indicating the reports were reviewed.
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 procedures 1.04 that was approved by the Chief Executive Officer (CEO) on 1/28/2021.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
First Year Direct Care Staff							
All staff completed the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days from date of hire. *(Staff hired before January 1st were required to complete no later than December 31, 2020)*	X					Four new hire training records were reviewed for three staff hired prior to January 1, 2021, and one staff hired in January 2021. All four staff completed the Civil rights training within the required timeframe.	
All staff receives all mandatory training during the first 90 days of employment from date of hire.		X				One of the three staff hired in 2020 did not complete all required training within the first 120 days of hire. The staff hired in January 2021 completed mandatory trainings required during the first 90 days.	**Exception** One of three eligible staff did not complete a required training (Signs and Symptoms of Mental Health and Substance Abuse) during the first 120-day timeframe.

All staff completes all mandatory Florida Network and SkillPro training during the first-year employment.		X				Four new hire training records were reviewed. One out of 4 staff did not complete LGBTQ training required within the 1st year of employment.	**Exception** One of four new hire staff did not complete LGBTQ training, consequently not completing all annual required training.
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 has not hired any new non-licensed mental health clinical staff during the review period.	
Documentation of non-licensed mental health clinical staff person's training in Assessment of Suicide Risk form or written confirmation by a licensed mental health professional of training (includes date, signature and license number of the licensed 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				Three in-service staff training records were reviewed. One of the 3 records did not have all annual required training.	**Exception** One of three in-service staff did not complete the annual required Child Abuse Recognition, Reporting and Prevention training.
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				A total of 7 Training files were reviewed. 7 out of 7 tracking form were present but 5 of the 7 tracking forms were missing the total training hours. Sign-in sheets and certificates were present. One staff has digital proof of completing CPR/1st Aid; however a copy of the certificate was not in the training record.	**Exception** Five of the seven training tracking forms were missing the cumulative training hours on the tracking form. CPR/First Aid Certificate was missing in one of the training records.
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 procedures 1.05 that was approved by the	

						Chief Executive Officer (CEO) on 1/28/2021.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
Case record review reports demonstrate reviews are conducted quarterly, at a minimum	X					Record reviews were conducted October 2020 (1st Qtr.) and January 2021 (2nd Qtr.). A total of 10 residential records and 40 community counseling records were reviewed during the period.	
The program conducts reviews of incidents, accidents, and grievances quarterly, at a minimum	X					Monthly data is collected for incidents, accidents, and grievances. These trends are reviewed and were documented on staff meeting agendas and minutes. Staff meetings were held July-October 2020 and January-March 2021.	
The program conducts an annual review of customer satisfaction data	X					The program collected and reviewed customer satisfaction survey that was documented on the Community Success Factors report for FY2020-2021, Q1 and Q2.	
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 program conducts monthly outcomes and performance reviews reported on the Community Success Factors report. Monthly reports were reviewed for the months of October 2020-March 2021. Quarterly PQI minutes also document incidents, satisfaction surveys, performance/outcomes, and case file reviews.	
The program conducts a monthly review of NetMIS data reports.	X					NetMIS reports are shared and reviewed with management and staff monthly as documented in meeting minutes and agendas reviewed.	
The Florida Network conducts monthly reconciliation by comparing NetMIS data to JJIS data. Agency has evidence that they have reconciled any differences noted.	X					The shelter director provided a copy of the most recent data reconciliation email sent to the Florida Network in March 2021 as evidence differences between NetMIS and JJIS were reconciled.	

The program has a process in place to review and improve accuracy of data entry & collection	X					The shelter director is responsible for data reconciliation. Upon receipt of the reconciliation log from the Florida Network, the data is compared in NETMIS, JJIS, and entries in the youths physical file to correct whatever discrepancies are present. An email is sent to the FN to confirm completion of the reconciliation.	
There is documentation that findings are regularly reviewed by management and communicated to staff and stakeholders.	X					Quarterly PQI minutes document data reviewed by management and action plans identified to address areas of concern.	
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 procedures 1.06 that was approved by the Chief Executive Officer (CEO) on 1/28/2021.	
Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	X					The agency provided a list of 23 approved agency drivers that are agency staff.	
Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	X					Per the agency's policy and procedures, staff who provide transportation to youth while at the shelter must pass a driver's license background check prior to employment and have a valid Florida driver's license that is in good standing with the state of Florida. The agency maintains auto insurance policy to provide coverage for agency drivers.	
Agency's Transportation policy prohibit transporting a client without maintaining at least one other passenger in the vehicle	X					The agency policy was reviewed. The policy addressed one on one staff to client transport and the exception that can be made if a 3d party is not available. The	

during the trip and include exceptions in the event that a 3rd party is NOT present in the vehicle while transporting						Note Active tablet provide documentation of authorization given by a supervisor/manager for single client transports. The transportation logs provide the vehicle being used, staff names/initials, destination, mileage, date and time of transport.	
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**					Per the agency transportation policy, Managers/Supervisors review the client's behavior history prior to approving single client transport. All single transports reviewed during the review period were approved by the supervisor.	
The 3rd party an approved volunteer, intern, agency staff, or other youth	**X**					Per the agency transportation policy, an approved 3rd party can be a volunteer, intern, 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 transportation logs support names/initials of all staff and youth in the vehicles, date and time of transport, mileage, and destination of the vehicle.	
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 procedures 1.07 that was approved by the Chief Executive Officer (CEO) on 1/28/2021.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
The program has a lead staff member designated to participate in local DJJ board and council meetings with evidence that includes minutes of the event or other verification of staff participation	**X**					Two DJJ Circuit Board meetings were scheduled during the past 6 months but were all cancelled due to the pandemic and the committee not being able to meet in person. Email correspondence was provided to support cancellation of meetings.	
Outreach and prevention services are provided by designated staff and include increasing community awareness, offering informational and educational CINS/FINS services to youth and families.	**X**					The agency provided documentation of various outreach activities conducted during the last six months. The outreach activities were conducted at local schools, church, and virtual or on-site community events. Outreach activities are entered in NetMIS on a monthly basis.	

The program maintains written agreements with other community partners which include services provided and a comprehensive referral process.	X					A total of 16 MOUs were reviewed with providers of services as follows: runaway hotline, sex trafficking, Alanon, YMCA, planned parenthood, Juvenile Justice, AIDS, education, teen court, behavioral health, rape crisis, MAAD, and nutrition. At least 14 MOUs were initiated prior to 2020 and have not been updated from Sarasota YMCA to the agency's current name.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.01						**YES NO X (explain)** The agency has the required policy and procedures 2.01 that was approved by the Chief Executive Officer (CEO) on 1/28/2021.	Agency policy and procedure on screening for community counseling states contacting family within 7 working days of receiving referral; however, the QI indicator requires screenings to be completed within 3 business days of receipt of the referral for community counseling referrals.
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					Five (5) residential files (3 closed, 2 open) were reviewed. All five of the residential files met the requirements of having the eligibility screening completed timely for all shelter placement inquiries.	
Community counseling: Eligibility screening is completed within 3 business days of referral by a trained staff using the NetMIS form		X				Five (5) non-residential files (3 closed, 2 closed) were reviewed. Four of the five files were screened within 3 business days of receiving the referral.	**Exception** The screening was not completed in one of the 5 community counseling records reviewed. The screening was completed on 1/8/2021 which is beyond the 3 days from referral date 12/15/2020. There was no documentation indicating any attempts to contact family during the three business days.
Youth and parents/guardians receive the following in writing: a. Available service options	X					All ten files reviewed contained completed screening and intake forms and provided documentation that both youth and parent/guardian received client rights and	

b. Rights and responsibilities of youth and parents/guardians						responsibilities, available services, and grievance procedures.	
The following is also available to the youth and parents/guardians: a. Possible actions occurring through involvement with CINS/FINS services (case staffing committee, CINS petition, CINS adjudication) b. Grievance procedures	X					The parents are provided an informed consent form, packet, and CINS/FINS brochure at intake that includes information about case staffing and grievance procedures.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.02						**YES X NO (explain)** The agency has the required policy and procedures 2.02 that was approved by the Chief Executive Officer (CEO) on 1/28/2021.	
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					Five (5) residential files (3 closed, 2 open) were reviewed. All five of the residential files met the requirements of having the eligibility screening completed timely for all shelter placement inquiries.	
Non-Residential youth: Needs Assessment is done within 2 to 3 face-to-face contacts after the initial intake **OR** updated, if most recent assessment is over 6 months old	X					All five community counseling needs assessments were completed within two to three face to face contacts.	
Needs Assessment is conducted by a bachelor's or master's level staff member	X					All assessments reviewed were conducted at the Bachelor or Masters level staff member.	
Needs Assessment includes a supervisor's review signature upon completion	X					All ten Needs Assessments in the ten files were signed by a supervisor.	
Suicide Risk as a Result of the Needs Assessment							
Youth was identified with an elevated risk of suicide as a result of the Needs Assessment	X					Five (5) of the ten (10) files reviewed indicated an elevated suicide risk on the needs assessments.	

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					Appropriate procedures were followed in accordance with agency policy and procedures. The assessment tool was completed and reviewed by a licensed clinical supervisor/staff within 24 hours of completion.	
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 procedures 2.03 that was approved by the Chief Executive Officer (CEO) on 1/28/2021.	
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 10 youth records reviewed contained a comprehensive individualized service/case plan.	
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					Each case plan reviewed contained at a minimum, date of initiation of plan, needs and goals, type, frequency, and location of services provided, responsible individuals, realistic target and completion dates, and required signatures.	
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					Case/Service Plan reviews were reviewed by the counselor/therapist and the parent/guardian (if available) at a minimum of every thirty (30) days for the first three months, and every six (6) months thereafter for progress in achieving goals and objectives.	
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 procedures 2.04 that was approved by the Chief Executive Officer (CEO) on 1/28/2021.	

Safe Children Coalition – May 19-20, 2021
Lead Reviewer: Marcia Tavares

Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
Counselor/Case Manager is assigned	X					All ten reviewed files had a counselor or case manager assigned.	
The Counselor/Case Manager completes the following as applicable: 1. Establishes referral needs and coordinates referrals to services based upon the on-going assessment of the youth's/family's problems and needs 2. Coordinates service plan implementation 3. Monitors youth's/family's progress in services 4. Provides support for families 5. Monitors out-of-home placement (if necessary) 6. Makes referrals to the case staffing to address problems and needs of the youth/family 7. Accompanies youth and parent/guardian to court hearings and related appointments 8. Refers the youth/family for additional services when appropriate 9. Provides case monitoring and reviews court orders 10. Provides case termination notes 11. Provides follow-up after 30 days of exit 12. Provides follow-up after 60 days of exit	X					All youth files established referral needs to service based upon the ongoing assessment of youth family, needs for service based on the need's assessment. Support was provided to the families. The families are referred out for additional services as needed and copies of referrals were maintained in the files. Discharge plans were completed on clients with closed files. None of the ten files reviewed were applicable for a case staffing.	
The program maintains written agreements with other community partners that include services provided and a comprehensive referral process	X					A total of 16 MOUs were reviewed with providers of services as follows: runaway hotline, sex trafficking, Alanon, YMCA, planned parenthood, Juvenile Justice, AIDS, education, teen court, behavioral health, rape crisis, MAAD, and nutrition.	

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 procedures 2.05 that was approved by the Chief Executive Officer (CEO) on 1/28/2021.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
Youth and families receive counseling services, in accordance with the youth's case/service plan, to address needs identified during the assessment process	X					All of the files reflected coordination of services for the youth/family through completion of the need's assessment and service plan. Case notes are maintained for all client files.	
Shelter Program							
Shelter programs provides individual and family counseling	X					Documentation supported youth and families received individual and family counseling as needed in accordance with the Case Plan.	
Group counseling sessions held a minimum of five days per week	X					Groups were held on a consistent basis a minimum five times per week during the review period.	
Group counseling sessions consist of: a. Length of at least 30 minutes b. Opportunity for youth engagement c. Clear and relevant topic (informational/developmental/ educational) d. Clear leader or facilitator	X					The groups had specific relevant topics to help address some of the needs of the youth. The topics were relevant and groups last at least 30 minutes.	
Community Counseling							
Community counseling programs provide therapeutic community-based services designed to provide the intervention necessary to stabilize the family. Services are provided in the youth's home, a community location, or the local provider's counseling office.	X					There were five community counseling records reviewed. All five records reviewed provided services in locations convenient to the family. The services were therapeutic to meet the individual needs of the family.	
Counseling Services							
Reflect all case files for coordination between presenting	X					All 10 files reviewed provided counseling services. There was a coordination of	

problem(s), psychosocial assessment, case/service plan, case/service plan reviews, case management, and follow-up						services based on individual needs of the family.	
Maintain individual case files on all youth and adhere to all laws regarding confidentiality	X					The program maintained individual case files marked confidential in locked areas labeled confidential and secure.	
Case notes maintained for all counseling services provided and documents youth's progress	X					Chronological notes were thorough and clearly documented in all reviewed files.	
On-going internal process that ensures clinical reviews of case records and staff performance	X					Documentation in the files supported an ongoing process of internal reviews by the clinical supervisor of case records and staff performance.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.06						**YES X NO (explain)** The agency has the required policy and procedures 2.06 that was approved by the Chief Executive Officer (CEO) on 1/28/2021.	
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					During the QI review, three (3) case staffing files were reviewed. Each of the 3 files documented a written request from a committee member.	
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 agency is responsible for notifying the appropriate case staffing participants. The child, family, and staffing committee are contacted within five (5) working days of meeting commencement notifying dates and times. Families are contacted the day before the meeting as a reminder to the family. All contacts with the child/family are to be documented on the Chronological contact form and copies maintained of all.	
Case Staffing Committee							
Must include: a. DJJ rep. or CINS/FINS provider b. Local school district representative	X					Committee members include a DJJ representative and local school district representative	
Other members may include: a. State Attorney's Office	X					Additionally, the committee exceeded the minimum staffing compilation of members	

b. Others requested by youth/ family c. Substance abuse representative d. Law enforcement representative e. DCF representative f. Mental health representative						and a list of those participants is maintained in the Staffing binder	
The program has an established case staffing committee, and has regular communication with committee members	X					The committee may be convened on an individual basis or maintained through a standing case staffing committee protocol. The composition of the case staffing committee is based on the needs of the youth/family.	
The program has an internal procedure for the case staffing process, including a schedule for committee meetings	X					Should a parent of active CINS/FINS youth request a case staffing in writing, the committee shall convene within seven (7) working days of the request. (Excluding weekends and holidays)	
As a result of the Case Staffing							
The youth and family are provided a new or revised plan for services	X					Recommendations from committee participants are located in the youth files as well as in binders labeled CINS Case Staffings/Court	
Written report is provided to the parent/guardian within 7 days of the case staffing meeting, outlining recommendations and reasons behind the recommendations	X					Written reports are provided to the youth/family immediately following the case staffing.	
If applicable, the program works with the circuit court for judicial intervention for the youth/family			X			None of the records reviewed were applicable for court intervention.	
Case Manager/Counselor completes a review summary prior to the court hearing			X			Not applicable to any of the records reviewed.	
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 procedures 2.07 that was approved by the Chief Executive Officer (CEO) on 1/28/2021.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		

All records are clearly marked 'confidential'.	X					All ten records reviewed were observed to be marked confidential.	
All records are kept in a secure room or locked in a file cabinet that is marked "confidential"	X					During the tour of the facility, a locked area for case files was observed and also secured container for transporting files. The file cabinets and files were marked confidential.	
When in transport, all records are locked in an opaque container marked "confidential"	X					The locked container used for transporting files is marked confidential.	
All records are maintained in a neat and orderly manner so that staff can quickly and easily access information	X					All files appear to be organized and maintained in a consistent manner with file sections and cover pages listing content of each section.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.08						**YES X NO (explain)** The agency has the required policy and procedures 2.08 that was approved by the Chief Executive Officer (CEO) on 1/28/2021.	
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					Two eligible youth were served during the review period. The youth were addressed by their preferred name and pronoun and preferred name and pronoun was used in the logbook, on the census board, and on all outward facing documents.	
Youth in need of specialized support is referred to qualified resources (as applicable)	X					The program has access to specialized services if needed but none of the youth required additional services.	
Youth preference is considered and documented for room assignment and youth is not roomed in isolation due to sexual orientation, gender identity, or gender expression	X					The two youth were able to choose sleeping arrangement and was assigned to their desired living arrangement as noted on the intake form.	
Youth is provided hygiene products, undergarments and clothing that affirms their gender identity or gender expression	X					Youth were able to dress in clothing and were not denied use of desired hygiene products that affirm their gender identity.	

The agency has signage and brochures/publication placed in common areas indicating that all youth are welcome regardless of sexual orientation, gender identity, and gender expression	X					The facility has signage located throughout the shelter including in the hallways, lobby, and common areas indicating the program is a safe space for all youth regardless of actual or perceived sexual orientation, gender identity, and gender expression.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.09						**YES X NO (explain)** The agency has the required policy and procedures 2.09 that was approved by the Chief Executive Officer (CEO) on 1/28/2021.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
Staff Secure							
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? **(If no, select rating "No eligible items for review")**	**YES**	**NO** **X**	**N/A**			The 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			X				

one staff secure youth at any given time b. Program assign specific staff during each shift to monitor location/ movement of staff secure youth c. Agency clearly documents the specific staff person assigned to the staff secure youth in the logbook or any other means on each shift							
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			X				

placement that exceeds seven (7) days b. Agency has approval for stays and support beyond seven (7) days for DMST placements that are obtained on a case-by-case basis? (If applicable.)							
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. Data for each youth was entered into NetMIS and JJIS within three (3) business days of intake and discharge.	

Youth in program do not have length of stay in DV Respite placement that exceeds 21 days. If more than 21 days, documentation exists in youth file of transition to CINS/FINS or Probation Respite placement, if applicable.	X					The 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 all three youth records reflected goals that were appropriate such as aggression management, coping skills, and communication.	
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 three 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** **X**	**N/A**			The program has not served any Probation Respite eligible youth since the last onsite QI visit and has no eligible items for review.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
All probation respite referrals are submitted to the Florida Network.			X				
Probation Respite Referral come from DJJ Probation and are all youth referred on probation regardless of adjudication status			X				
Data entry into NetMIS and JJIS within (3) business days of intake and discharge			X				
Length of stay is no more than fourteen (14) to thirty (30) days? (Placement beyond thirty (30)			X				

days requires the 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**			Safe Children Coalition 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**		Safe Children Coalition does not participate in the Family/Youth Respite Aftercare Services (FYRAC) in its Community Counseling Program (YPS).	
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					X		

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							
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**	Safe Children Coalition is not contracted to provide SNAP services.
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	**X**		

Safe Children Coalition – May 19-20, 2021
Lead Reviewer: Marcia Tavares

SNAP Clinical Groups							
Youth are screened to determine eligibility of services					X		
Needs assessment is completed at initial intake, or within two face-to-face sessions					X		
SNAP Assessments a. Child Behavior Checklist (CBCL) is completed by the caregiver (pre & post) b. Teacher Report Form (TRF) completed by the teacher (pre & post) c. Tool for Parenting Self Efficacy (TOPSE) completed by the caregiver (pre & post) d. Prevention Assessment Tool (PAT) (pre & post)					X		
SNAP discharge report summary					X		
SNAP Boys/SNAP Girls **Parent** Group Evaluation Form					X		
SNAP Boys/SNAP Girls **Child** Group Evaluation Form					X		
SNAP in Schools							
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
Weekly attendance sheet with youth names and/or identifying number completed with signatures of teacher and facilitator(s) (For a total of 13 attendance sheets)					X		
"Class Goal" sheet					X		
Measure of Classroom Environment (MoCE) (Pre and Post) is used to identify					X		

baseline and treatment outcomes of reported classroom dynamics.							
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** **NO X (explain)** The agency has a policy and procedures 3.01 that was approved by the Chief Executive Officer (CEO) on 1/28/2021.	Policy 3.01 does not address fire or emergency drills, chemicals, key control, or that the trash cans should be covered. These issues were also noted on the last review.
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Facility Inspection		X				A tour of the facility was conducted in order to review the shelter environment. During the tour it was evidenced throughout that all furnishings were in good repair, there was no evidence of insect infestation, and the grounds were all landscaped and well-maintained. It was mentioned that there are new kitchen chairs being ordered. There was no evidence of graffiti on the walls, doors, or windows and the lighting throughout the facility appeared to be adequate for the required tasks performed in the specific locations. The interior areas did not appear to contain contraband and were free from hazardous unauthorized metal/foreign objects. It was found by on-site reviewer that there were some potential safety hazards. During the inspection of the outside of the facility it was evident that the exterior areas were free of debris, the grounds were free of hazards, and the garbage cans were covered. It was noted that the facility no	**Limited Exceptions:** • There was no MSDS sheet for Microban and there was no MSDS for the brand of bleach that was present in the chemical closet. When alternative products are purchased the MSDS needs to be updated in real-time. ***UPDATE:*** The MSDS were updated in real time and shown to the on-site reviewer. The books were reorganized with current sheets and legacy sheets divided by a tab. • Chemicals are kept in different locations and there is concern about proper inventory of chemicals using a single inventory. Agency needs to create chemical inventory at each location where chemicals are stored. • Wood planks covering water irrigation system are loose & need to be secured. Flooring in boy's

						longer has a dumpster due to program relocations. During the walk through and vehicle inspections it was evident that all doors and vehicles were locked and secure except one. All agency vehicles were equipped with first aid kits, a fire extinguisher, flashlight, glass breaker, seat belt cutter, and air bag deflater. It was evident that the fire extinguishers were up to date with inspections. It was also noted that access is limited to staff members and key control is in compliance with policy and procedure. It was discussed that there was a chip in the boy's bathroom floor. Despite this issue, the bathroom and shower areas appeared to be clean and functional. During the walk through it was evident that a detailed map and egress plans of the facility, general client rules, grievance forms, abuse hotline information, DJJ incident reporting number and other related notices were clearly posted. These items were posted in the main entrance/lobby and also in the girl's and boy's day and bedrooms. In the laundry room, the washers and dryers appeared to be clean and functional and on the dryers the lint traps were clean. Upon inspection of the bedrooms, it was evident that each youth has their own individual bed with clean covered mattress, pillow, linens, and blanket. It was also witnessed that each youth has a safe, lockable place to keep their personal belongings. The agency has a current DCF Child Care License displayed in the facility in the lobby	bathroom has chipped tile at entry/exit to shower. Flooring in girl's bathroom has mats that are at entry and exit that are not secured. Residents could slip and fall if floor is wet. The residential director stated that they are leasing the building and that it is up to the landlord to repair the issues. ***UPDATE***: Staff provided emails between maintenance director and contractors displaying efforts to obtain the repairs. • The on-site reviewer noted that there were cords in the dayroom from the video games and the television set that could pose a hazard. ***UPDATE***: While the on-site reviewer was present staff moved the cords so that no one could trip and tucked them behind the entertainment center. • Picnic tables and flooring on back deck have rough wood surfaces that could cause splinters. • Wood covering for the water tank was not nailed down. • The on-site reviewer also noted that there were several blinds that were either missing or damaged. ***UPDATE***: Email correspondence was provided during QI visit indicating maintenance will be in the following day to address the issues with the blinds, secure wood covering for water tank, and sand down rough wood surface on deck. • Upon inspection of the vehicles, it was noted that the "new" van needed an oil change and the on-site reviewer noted that the log sheets needed the year notated

						that is effective June 2020 through May 31, 2021. All but 2 chemicals were listed and approved for use.	on the pages. It was noted that the fire extinguishers in the vans did not have a signature from the inspector. It was also noted that the grey van has a rear hatch that does not lock and there was no evidence that a work order for repair has been issued. Staff stated that the Kia had a recall for the latch issue and that it has not been fixed due to the van needing to be used in the mornings for transport and that the fix will require approximately 6 weeks in the shop. Additionally, it was found that a couple flashlights were not working. ***UPDATE:*** While on-site, the on-site reviewer witnessed the staff replace the expired wound wash with new ones that were already on campus and replaced flashlights with operational ones from on campus as well. • The menus provided do not have an updated signature by the licensed dietician and it was reported by staff that the dietician did not physically come on site to sign the menus due to COVID 19 restrictions but that she stated that the menus would still be valid as a balanced and healthy meal plan.
Fire and Safety Health Hazards		**X**				An annual facility fire inspection was conducted on 2/11/21 by Sarasota County Fire Department and the facility was in compliance with local fire marshal and fire safety code within the jurisdiction. All annual fire safety equipment inspections are valid and up-to-date (extinguishers, sprinklers, alarm system, and kitchen	**Limited Exception:** On 12/15/ 20 the fire drill evacuation was conducted in 2 ½ minutes, exceeding the 2-minute limit.

						overhead hood). Cintas Fire inspected the extinguishers, lights, and signs on 1/6/21 and no deficiencies were noted and Piper Fire Protection conducted the annual alarm inspection on 1/29/21 and no deficiencies were found. The facility has a current Satisfactory Food Service inspection report from the Department of Health dated 3/5/21. The food menus are posted and signed by Licensed Dietician with a date of 1/21/20. All cold food is properly stored, marked, and labeled and dry storage/pantry area is clean and food is properly stored. The refrigerators and freezers are clean and well maintained and all small and medium sized appliances are operable and clean for use as needed. Upon inspection of the temperature logs, all appliances were in the normal range for the majority of the readings. The large freezer stayed almost consistently below 0 with only 2 instances above and the small stayed below 0 with only two instances of above and the case was the same for the refrigerator where it stayed at or below 40 degrees. The agency completed all but one fire drill per month within 2 minutes or less for the logs that were reviewed covering 12/15/20 to 5/1/21. The agency completes 1 mock emergency drill per shift per quarter as evidenced by review of logs from 11/20 to 5/21. The agency has a current Satisfactory Residential Group Care Inspection report dated 2/9/21 that expires 9/30/21 from the Health Department, despite it noting several minor issues.	
Youth Engagement							

a. Youth are engaged in meaningful, structured activities (e.g., education, recreation, counseling services, life and social skill training) seven days a week during awake hours. Idle time is minimal. b. At least one hour of physical activity is provided daily. c. Youth are provided the opportunity to participate in a variety of faith-based activities. Non-punitive structured activities are offered to youth who do not choose to participate in faith-based activities. d. Daily programming includes opportunities for youth to complete homework and access a variety of age appropriate, program approved books for reading. Youth are allowed quiet time to read. e. Daily programming schedule is publicly posted and accessible to both staff and youth.	X					The youth are engaged in meaningful, structured activities seven days a week during awake hours and idle time is minimal as evidenced by the daily schedule of activities provided and posted around the facility. Youth in the program are provided at least one hour of physical activity daily and they are also provided the opportunity to participate in a variety of faith-based activities and provided alternatives for those that chose not to participate in these activities. Youth are also provided opportunities to complete homework and have access to a variety of age appropriate, program approved books for reading and are allowed quiet time to do so. The schedule is publicly posted and accessible to youth and staff and could be found in the common areas.	
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 procedures 3.02 that was approved by the Chief Executive Officer (CEO) on 1/28/2021.	
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:	X					Four residential records were reviewed, two open and two closed. In all 4 records the youth received a comprehensive orientation and handbook was provided within 24	

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						hours of admission. Documentation in each file verified that the orientation encompassed all required information including explanation of disciplinary action, dress code, access to medical and mental health services, visitation, mail, and telephone procedures, grievance procedure, emergency disaster procedures, contraband rules, layout of the facility, room assignment, suicide prevention/precaution procedures/alerts, daily activity, and the abuse hotline information.	
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					Documentation of each component of orientation, including orientation topics and dates of presentation, as well as signatures of youth and staff involved is maintained in the youth record.	
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 procedures 3.03 that was approved by the Chief Executive Officer (CEO) on 1/28/2021.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
A process is in place that includes an initial classification of the youths, to include:							
a. Review of available information about the youth's history, status and exposure to trauma	X					Four residential records were reviewed, two open and two closed. Upon review of the 4 files, All four records included documentation required by the indicator to conduct an initial classification of the youth.	

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						It was also noted that acute health symptoms requiring quarantine or isolation (including COVID19) were also considered in the determination for room assignment.	
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					It was noted that 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 when determining room assignment.	
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 procedures 3.04 that was approved by the Chief Executive Officer (CEO) on 1/28/2021.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
Log book entries that could impact the security and safety of the youth and/or program are highlighted	X					Logbooks were reviewed covering periods 11/1/2020 to 11/7/2020 and 3/8/21 to 3/14/21. Entries that could impact the security and safety of the youth and/or program are highlighted.	
All entries are brief, legibly written in ink and include: • Date and time of the incident, event or activity	X					The logbooks for the agency are electronic and entries are typed. The entries include date and time of incident, event, or activity, names of youth and staff involved, a brief	

• Names of youth and staff involved • Brief statement providing pertinent information • Name and signature of person making the entry						statement providing pertinent information, and 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**					There were no noted errors in the logbooks reviewed but agency policy does state that recording errors must be struck through with a single line and the staff person must initial and date the correction. Policy also states that the use of whiteout and erasure is prohibited, however, this does not affect the agency due to the use of electronic logs.	
The program director or designee reviews the facility logbook(s) every week and makes a note chronologically in the logbook indicating the dates reviewed and if any correction, recommendations and follow-up are required and sign/date the entry	**X**					The program director 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-ups required, and sign/dates the entry.	
All staff review the logbook of the previous two shifts and makes an entry signed and dated into the logbook indicating the dates reviewed	**X**					It was noted that all staff review the logbook for the previous 2 shifts and make signed and dated entries in the logbook indicating the dates reviewed.	
At the beginning of their shift, oncoming supervisor and shelter counselor reviews the logbook of all shifts since their last log entry and makes a signed and dated entry and into log book indicating the dates reviewed.	**X**					At the beginning of their shift, the oncoming supervisor and the shelter counselor review the logbook of all shifts since their last log entry and make a signed and dated entry into the logbook indicating the dates reviewed.	
Logbook entries include: a. Supervision and resident counts b. Visitation and home visits	**X**					Upon review of the logbook entries, it was noted that the entries include supervision and resident counts and documentation of 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 procedures 3.05 that was approved by the Chief Executive Officer (CEO) on 1/28/2021.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
The program has a detailed written description of the BMS, and it is explained during program orientation	X					The program has a detailed, written description of the behavioral management system that is reviewed with youth upon intake and is in the Youth Shelter Resident Handbook.	
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	X					Supervisors in the agency are trained in the behavioral management system and the system is designed to teach youth new behaviors and help them understand the natural consequences to their actions. All 4 youth files reviewed contained signed point sheets. The program has a variety of rewards, 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. Only staff discipline youth and group discipline is not employed. Room restriction is not used as part of the system or for youth who are physically and/or emotionally out of control. Youth are never denied basic rights such as meals, clothing, sleep, services, exercise, or correspondence privileges.	

are used if physical intervention is required) f. Only staff discipline youth. Group discipline is not imposed g. Room restriction is not used as part of the system or for youth who are physically and/or emotionally out of control h. Youth should never be denied basic rights such as meals, clothing, sleep, services, exercise, or correspondence privileges							
Program's Use of the BMS							
All staff are trained in the theory and practice of administering BMS rewards and consequences	X					All four new staff training records show staff are trained in the theory and practice of administering the behavioral management system rewards and consequences.	
There is a protocol for providing feedback and evaluation of staff regarding their use of BMS rewards and consequences	X					Residential director was interviewed and indicated staff is provided feedback on the usage of positive and negative consequences during staff meetings.	
Supervisors are trained to monitor the use of rewards and consequences by their staff	X					Supervisors are trained to monitor the use of rewards and consequences by their 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 procedures 3.06 that was approved by the Chief Executive Officer (CEO) on 1/28/2021.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
The program maintains minimum staffing ratios as required by Florida Administrative Code and contract.	X					A review of staff schedules and logbook entries documented the required staffing ratios were met for the awake hours and sleeping hours.	

• 1 staff to 6 youth during awake hours and community activities • 1 staff to 12 youth during the sleep period							
All shifts must always provide a minimum of two staff present	**X**					All shifts consistently maintain a minimum of 2 staff present.	
Program staff included in staff-to-youth ratio includes only staff that are background screened and properly trained youth care workers, supervision staff, and treatment staff	**X**					Only staff that are background screened and properly trained are included on the staff schedules and shifts.	
The staff schedule is provided to staff or posted in a place visible to staff	**X**					The program staff schedule is posted in the staff office and was observed during the tour of the facility. The schedule is visible to all staff.	
There is a holdover or overtime rotation roster which includes the telephone numbers of staff who may be accessed when additional coverage is needed	**X**					There is a holdover or overtime rotation roster which includes only staff that are background screened and properly trained youth care workers, supervision staff, and treatment staff.	
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**				Physical layout of sleeping arrangements: The facility has a girl's dorm, boy's dorm, and single girl's and boy's rooms. Three randomly selected overnight shifts were selected within the last 30 days to observe bed checks via video surveillance recordings as follows: 4/29/21, 5/7/21, and 5/13/21. In two of the three dates selected, staff was observed falsely documenting bed checks in the logbook and not physically conducting a visual bed check of youth in sleeping room(s).	**Limited Exception** On 5/7/21 staff was observed logging a bed check on two separate occasions, 5:08 am and 5:15 am, but did not get up to physically check on the youth. The same staff missed two consecutive checks on 5/7/21. There was a potential check at either 4:01am or 4:04 am but this could not be verified through surveillance and there was not another check until 4:36 am. There was potentially another missed check at 4:46 am but this could not be verified due to a glitch in the surveillance. The same staff logged another bed check on 5/13/21 at 4:22 am but did not visually complete the bed check.

							Staff was informed to report knowledge of the finding to CCC and the report was accepted. Checks were not able to be verified on 5/12/21 or 5/15/21 due to inadequate room lighting. An alternate day 4/29/21 was chosen. Staff conducted a bed check exceeding the 15-minute interval, conducting a bed check at 12:04 am and a subsequent check at 12:20 am. There was another instance where one staff conducted a bed check and exceeded the 15-minute time interval when the check was completed at 1:37 am and the previous was completed at 1:20 am. The bed check entries do not contain counts despite the logbook entry stating, "the following counts were noted:"
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 procedures 3.07 that was approved by the Chief Executive Officer (CEO) on 1/28/2021.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
Surveillance System							
The agency, at a minimum, shall demonstrate: a. A written notice that is conspicuously posted on the premises for the purpose of security b. System can capture and retain video photographic images which must be stored for a minimum of 30 days		X				The agency posts a video surveillance notice on the front door as well as provides a sheet for signature of informed consent. Cameras are in the interior and exterior of the facility. There are 16 cameras total inside and outside the facility, eight outside and 8 inside. The indoor cameras are located in the day room, medication pass area, front hallway, conference room, kitchen, lobby, common rooms, and laundry room. The outside cameras are located in	**Exception** Upon review of the cameras, there was very poor resolution and the cameras would skip times and bed checks were not clearly seen. Staff stated that the camera system is motion activated and does not record when there is no movement in the rooms. This was not the case with some of the observed bed checks. The worker was seen sitting

c. System can record date, time, and location; maintain resolution that enables facial recognition d. Back-up capabilities consist of cameras' ability to operate during a power outage e. Have cameras placed in interior and exterior general locations of the shelter where youth and staff congregate and where visitors enter and exit. Cameras are never placed in bathrooms or sleeping quarters. f. All cameras are visible						the backyard, the front porch, deck, driveway, shed, on kitchen door, and 2 in courtyard. All cameras are visible and none are placed in the bathrooms or sleeping areas. The camera system can capture and retain video photographic images and are stored a minimum of 30 days. Staff stated that footage can be stored for three months. The system can record date, time, location, and at times has resolution that enables facial recognition.	and then there was a glitch and there was movement but the worker could not be witnessed completing the bed check. The worker can be seen entering one room but then the video will jump to staff exiting another room where the rooms are not connected, thus presenting gaps in the video stream. Two video surveillance dates selected, 5/12/21 and 5/15/21, could not be reviewed due to inadequate room lighting resulting in poor video quality.
A list of designated personnel who can access the video surveillance system is maintained (includes off-site capability per personnel)?	X					The shelter director stated that only management staff have access to the video surveillance system and the shelter director has off-site access.	
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					As verified by review of documents, supervisory review of video is conducted a minimum of once every 14 days and timeframes reviewed are noted in the logbook. The documents provided covered reviews from multiple dates in 2021.	
Grant the requesting of video recordings to yield a result within 24-72 hours from program quality improvement visits and when an investigation is pursued after an allegation of an incident	X					The agency complies with granting the request 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.	
Camera service order/requests will be made within 24 hours of discovery of camera malfunctioning or being inoperable. All efforts made to	X					The agency complies with the camera service order/requests made within 24 hours of discovery of camera malfunctioning or being inoperable. All	

obtain repairs are documented and maintained						efforts made to obtain repairs are documented and maintained.	
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 procedures 4.01 that was approved by the Chief Executive Officer (CEO) on 1/28/2021.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
Preliminary Healthcare Screening							
Screening includes : a. Current medications b. Existing (acute and chronic) medical conditions c. Allergies d. Recent injuries or illnesses e. Presence of pain or other physical distress f. Observation for evidence of illness, injury, physical distress, difficulty moving, etc. g. Observation for presence of scars, tattoos, or other skin markings h. Acute health symptoms requiring quarantine or isolation	X					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 three 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. At the time of admission four of the five youth were on medications, two with allergies, and two with recent injuries or illnesses.	
Referral and Follow-up							
Youth with chronic medical conditions have a referral to ensure medical care (e.g. diabetes, pregnancy, seizure disorder, cardiac disorders, asthma, tuberculosis, hemophilia, head injuries, etc.)			X			None of the five youth were admitted with chronic conditions requiring further medical evaluation.	
When needed, the parent is involved with the coordination and			X			No eligible medical referrals applicable to the sample records reviewed.	

scheduling of follow-up medical appointments							
All medical referrals are documented on a daily log.			X			No eligible medical referrals applicable to the sample records reviewed for this indicator.	
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 procedures 4.02 that was approved by the Chief Executive Officer (CEO) on 1/28/2021.	
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					Three closed files and two open files were reviewed. All five youth were screened for suicide risk during the initial intake and screening process and the results were reviewed and signed by the supervisor and documented in each youth's file.	
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					Each of the five youth were placed on constant sight and sound, the appropriate level of supervision based on the results of the suicide risk assessment.	
Staff person assigned to monitor youth documented youth's behavior at 30 minute or less intervals	X					Each of the five youth were either assessed by a licensed mental health professional or a non-license under the direct supervision of the licensed professional within twenty-four from the suicide risk screening results. Each youth's assessment of suicide screening was completed the same day as the screening date. The staff assigned to monitor each youth, documented the youth's behavior in thirty-minute intervals	

						and includes the time of day, behavioral observations, any warning signs observed, and the observer's initials.	
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				Four of five youth's level of supervision level was not changed/reduced until further assessment was conducted by a licensed mental health clinical staff or a non-license under the direct supervision of the licensed professional prior to being reduced.	**Exception** One of five youth's level of supervision level was not signed by the licensed mental health clinical staff prior to being reduced.
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 procedures 4.03 that was approved by the Chief Executive Officer (CEO) on 1/28/2021.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
Medication Storage							
a. All medications are stored in a Pyxis Med-Station 4000 Medication Cabinet that is inaccessible to youth (when unaccompanied by authorized staff) b. Pyxis machine is stored in accordance with guidelines in FS 499.0121 and policy section in Medication Management c. Oral medications are stored separately from injectable epi-pen and topical medications d. Medications requiring refrigeration are stored in a secure refrigerator that is used only for this purpose, at temperature range 2-8 degrees C or 36-46 degrees F. (If the refrigerator is not secure, the room is secure and inaccessible to youth.)	X					The program maintains the youth prescription medications, as well as currently used over-the-counter medications, all separated in the Pyxis Medication Station in single locked containers which are only able to be opened by an authorized user for a specific medication to distribute or inventory. All oral medications are stored separately from injectable epi-pen and topical medications. Temperature logs for the refrigerator showed it is maintained at the required temperature range. The area where the Med-station and refrigerator are located was observed to be secure in a locked room and inaccessible to youth unless accompanied by staff.	

e. Narcotics and controlled medications are stored in the Med-Station							
Medication Distribution							
a. Agency maintains a minimum of 2 Super Users for the Med-Station b. Only designated staff delineated in User Permissions have access to secured medications, with limited access to controlled substances (narcotics) c. A Medication Distribution Log shall be used for distribution of medication by non-licensed and licensed staff d. Agency verifies medication using one of four methods listed in the FNYFS Operations Manual e. When nurse is on duty, medication processes are conducted by the nurse f. The delivery process of medications is consistent with the FNYFS Medication Management and Distribution Policy g. Agency does not accept youth currently prescribed injectable medications, except for epi-pens h. Non-licensed staff have received training in the use of epi-pens provided by a registered nurse	X					The agency maintains a minimum of 2 Super Users, and currently has 4 active Super Users. Staff permitted access to medications are identified in writing, and each staff on the list received training on distributing medication, including use of an Epi-Pen. At the time of the QI visit, the program contracted with a part time registered nurse who worked twice per day, in the morning and evening. Medication processes are conducted by the nurse when on duty. Three closed files and one open file was reviewed. None of the youth reviewed had any injectable medications prescribed and does not accept youth currently prescribed injectable medications, except for epi-pens. In each of the four files reviewed, the medications were verified at the time of admission. All four youth had medications and a medication distribution log for each medication they received. Three of the four youth were on controlled medication and each had a perpetual inventory with running balances maintained. In all four files, the medication delivery process was consistent with the program's medication management and distribution policy.	
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	X					Narcotics and controlled medications are stored in the med-station, shift-to-shift counts are verified by a witness and documented for controlled substances, and a perpetual inventory with running balances are maintained for controlled substances.	

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						The agency maintains a perpetual and a weekly inventory for over-the-counter medication, sharps and syringes.	
There are monthly reviews of medication management practice via Knowledge Portal or Pyxis Med-Station Reports.	X					The residential director conducts monthly reviews of medication management practice via Knowledge Portal or Pyxis Med-Station Reports.	
Medication discrepancies are cleared after each shift.	X					Discrepancies in medication counts and medications errors were cleared by the end of the shift and training was documented for staff when errors or discrepancies occurred.	
Provider has a written policy and procedure that meets the requirement for Indicator 4.04						**YES X NO (explain)** The agency has the required policy and procedures 4.04 that was approved by the Chief Executive Officer (CEO) on 1/28/2021.	
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					Three closed files and two open files were reviewed. All five youth had either a medical or mental health alert and/or a food allergy alert and were appropriately placed on the program's alert system.	
Alert system includes precautions concerning prescribed medications, medical/mental health conditions	X					The alert system observed include medications each youth were prescribed, precautions concerning prescribed medications to include side effects, food allergies, if applicable, and 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					Training record for 4 new staff hired supported staff were trained in CPR/First Aid, mental health/substance abuse, and universal precaution to recognize/respond to the need for emergency care for medical/mental health problems.	

A medical and mental health alert system is in place that ensures information concerning a youth's medical condition, allergies, common side effects of prescribed medications, foods and medications that are contraindicated, or other pertinent mental health treatment information, is communicated to all staff	X					Five youth records reviewed demonstrate a medical and mental health alert system is in place for identify youth alerts and communicating with staff. The program uses a color coded/dots alert system to inform staff of the youth's specific alert. There is a client board in the staff office which indicates all youth currently residing in the program and the corresponding dot/ check mark next to their names. The board is updated as needed to alert staff of each youth's specific alerts/ needs. Documentation in the youth record includes concerns, allergies, side effects, and other pertinent information.	
Provider has a written policy and procedure that meets the requirement for Indicator 4.05						**YES X NO (explain)** The agency has the required policy and procedures 4.05 that was approved by the Chief Executive Officer (CEO) on 1/28/2021.	
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					Four closed files were reviewed and each of the four youth was taken off-site for either emergency and/or episodic care. All off-site emergency and/or episodic care was documented in the off-site emergency/episodic care log. Upon each youth's return, verification receipt of medical clearance via discharge instructions with follow-up care were placed in each file, the parent/guardian was notified, and a daily log was maintained.	
All staff are trained on emergency medical procedures	X					All 7 staff records reviewed revealed staff are trained on emergency medical procedures.	
The program has a Knife-for-life and wire cutters accessible to staff in a secure location(s)	X					The program has one knife for life and wire cutters that is located in the staff office which is adjacent to the day room and dorms.	

First aid kit/supplies are fully equipped and inventoried	X					The program has six first aid kits; one in the staff office, one in the kitchen, one in each of the three vans, and one in the staff bathroom closet which is part of the hurricane evacuation supplies.	