



**Florida Network for Youth and Family Services
Compliance Monitoring Report for**



FAMILY RESOURCES – ST. PETERSBURG

**3821 5th Avenue North
St. Petersburg, FL 33713**

Compliance Monitoring Services Provided by



EXECUTIVE SUMMARY

Forefront LLC conducted a joint Quality Improvement (QI) and Florida Network of Youth and Family Services (FNYFS) monitoring visit for Family Resources St. Petersburg SafePlace2B for the FY 2020-2021 on March 3, 2021 at its program office located at 3821 5th Avenue North, St. Petersburg, 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. Family Resources St. Petersburg 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 Reviewers. Agency representatives from SafePlace2B present for the entrance interview were: Nicole Leslie, Vice President Residential and RHY Services; Andrew Coble, Vice President Community Services; Joseph Mabry, Residential Supervisor; and Elizabeth Polifrone, Community Service Supervisor. Additional agency personnel present at the entrance conference includes ICM and SNAP program staff whose names are documented on the Entrance Conference Attendance Log. The last onsite QI visit was conducted January 15-16, 2020.

In general, the Reviewer found that Family Resources St. Pete is in compliance with specific contract requirements. Family Resources St. Pete **received an overall compliance rating of 90.9% for achieving full compliance with 10 of the 11 indicators applicable indicators** of the CINS/FINS Monitoring Tool. There were no corrective actions resulting from the monitoring visit; however, one recommendation was made for an indicator rated as conditionally acceptable.

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

2020-2021 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL

Report Number: CM 03-03-2020-2021

Agency Name: Family Resources – St. Petersburg					Monitor Name: Marcia Tavares, Lead Reviewer		
Contract Type : CINS/FINS					Region/Office: 3821 5th Ave. North, St. Pete, FL 33713		
Service Description: Comprehensive Onsite Compliance Monitoring					Site Visit Date(s): March 3-4, 2021		
Explain Rating							
Major Programmatic Requirements	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable	Ratings Based Upon: I = Interview O = Observation D = Documentation PTV = Submitted Prior To Visit (List Who and What)	Notes Explain Unacceptable or Conditionally Acceptable: (Attach Supportive Documentation)
I. Administrative and Fiscal							
DJJ Quality Improvement Peer Reviewer							
a. Provider shall demonstrate that a minimum of two (2) staff members have been trained to be certified as DJJ QI Peer reviewers. Provider shall participate in a minimum of one (1) on-site quality assurance review of a similar type program in another judicial circuit during each 12-month period of the contract, if requested.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Interview/Documentation: The agency currently has a total of eight certified DJJ-QI Peer Reviewers, two of which are located at the St. Petersburg office: Joe Mabry and Elizabeth Polifrone. Peers have been scheduled and/or participated in peer reviews for the current FY.	
Additional Contracts							
a. Provider shall provide a listing of all current federal, state, or local government contracts, as well as other contracts entered into with for profit and not-for-profit organizations. Such listing shall identify the awarding entity and contract start & end dates. PTV	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Documentation: The agency provided a list of two contracts with DOH and JWB in addition to the FN for FY2020-2021. The list includes: the funder, service provided, and contract start and end dates. The program also maintains interagency agreements and Memorandums of Agreement (MOUs) with schools, mental health, and substance abuse providers. All of the agreements reviewed had current contract/agreement dates.	

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Limits of Coverage			<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
a. Provider shall provide and maintain during this contract, the following minimum kinds of insurance: Worker's Compensation and Employer's liability insurance as required by Chapter 440, F.S. with a minimum of \$100,000 per accident, \$100,000 per person and \$500,000 policy aggregate. Commercial General Liability with a limit of \$500,000 per occurrence, and \$1,000,000 policy aggregate. Automobile Liability Insurance shall be required and shall provide bodily injury and property damage liability covering the operation of all vehicles used in conjunction with performance of this contract, with a minimum limit for bodily injury of \$250,000 per person; with a minimum limit for bodily injury of \$500,000 per accident; with a minimum limit for property damage of \$100,000 per accident and with a minimum limit for medical payments or \$5,000-\$10,000 per person. Florida Network is listed as payee or co-payee. PTV			Documentation: General Liability through Alliance of Nonprofits for Ins. RRG, for limits of coverage \$1,000,000 each \$3,000,000 aggregate and medical expenses of \$20,000 for any one person, effective 6/1/2020 – 6/1/2021. Workers Compensation through Star Insurance Company with limits of \$2,000,000 each/aggregate, effective 6/1/2020 – 6/1/2021. Automobile insurance through Alliance of Nonprofits for Ins. RRG with combined single limits of \$1,000,000, effective 6/1/2020 – 6/1/2021. An umbrella policy through Allmerica Financial Benefits with limits of \$4,000,000 each/aggregate, effective 6/1/2020 – 6/1/2021. Directors and Officers Liability insurance through Alliance of Nonprofits for Ins. RRG with limits of \$1 million each/ \$2 million aggregate, effective 6/1/2020 – 6/1/2021.						

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							Florida Network is listed on the Worker's Compensation certificate as certificate holder.	
External/Outside Contract Compliance a. Provider has corrective action item(s) cited by an external funding source (Fiscal or Non-Fiscal). ON SITE			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	During the Entrance Conference, the provider indicated that there are no outstanding corrective action item(s) cited by any external funding source.
Fiscal Practice a. Agency must have employee and fiscal policy/procedures manuals that are in compliance with GAAP and provide sound internal controls. Agency maintains fiscal files that are audit ready. PTV			<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Documentation: Fiscal Policies and Procedures are contained in Section F- Financial Management of the Administrative Standard Operating Manual last reviewed July 2020. The procedures reviewed appear to be consistent with GAAP and provide for sound internal controls. Procedures are included for general ledger, payroll, petty cash, purchasing process, financial management, budget process, capital assets, 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			<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Documentation: General ledger for July 1, 2020 – December 2020. The agency maintains a detailed general ledger with a chart of accounts. The general ledger is structured to track all funding sources separately; FN is identified as 105 on the GL and cost centers are 034

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						(shelter), 039 (counseling), and 014 (SNAP).	
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			<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						Observation/Documentation: Reviewed petty cash Policy and Procedure included in the Fiscal Manual. Petty cash is maintained by the Residential Supervisor and is stored in a secured cash box. The fund is \$150 but a small amount usually \$25 is kept in the shelter for YCW's to access for emergency items for the youth. Petty cash is reconciled at least monthly by the custodian. All receipts are submitted to finance at the main office for reimbursement as needed. Reimbursement comes in the form of a check made out to the designee who will then cash it and place money in petty cash box.	
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			<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						Documentation: Reviewed Bank Statements and Bank Reconciliations for the period August - December 2020 for one account held with SunTrust. Three of the six bank reconciliation posting journals reviewed were dated within six weeks of the bank	Recommendation: 1) Ensure all bank reconciliations are completed within 6 weeks of receipt of the bank statements and are signed by the preparer and agency approval authority. The three months where bank reconciliations posting journals were beyond six weeks were: September – posted November 4th, October-posted

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							statements for the preceding month and two of the three has one signature of approval. The remaining 3 bank reconciliations were dated greater than 6 weeks of the respective bank statements and were not signed. Checks disbursed over \$750 are signed by two individuals with signing authority. Invoices are submitted on a monthly basis with supporting documentation. The agency maintains individual vendor files.	December 4th, and November 2020-posted January 5 th .	
e. Agency maintains inventory in accordance with a written policy and FNYFS contractual requirements. If over \$1,000 inventory has DJJ Property Inventory Number/Tag. In the event the provider has purchased computer equipment an Informational Resources Request (IRR) been submitted to DJJ. PTV/ON SITE			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	N/A - No DJJ inventory	
f. Agency submits payroll taxes and deposits (and retirement deposits as applicable), <u>Employee</u> IRS Form W-2 and <u>Independent Contractors</u> IRS Form 1099 forms prior to federal requirements. ON SITE			<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Documentation: Agency provided a printout of tax payment transactions made through the Electronic Federal Tax Payment System (EFTPS) for the 3 rd and 4 th quarters 2020. Payroll taxes are paid bi-weekly via the electronic payment through the IRS. These reports demonstrate submission of payroll taxes and deposits on time.	

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g. Budget to actual reports prepared and reviewed by appropriate management. Variance from the budget are investigated and explained. PTV/ON SITE			<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Documentation: Agency provided Budget to Actual statement for the FY2020 for the six months ending 12/31/2020. A review of these documents was conducted. Report shows program budget and actual for the current month, YTD, as well as a comparison from last FY. 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 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			<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Documentation: Financial audit conducted for year ending June 30, 2020 and 2019 was completed by Assurance Dimensions CPA and Associates in a report dated September 15, 2020. A separate Management Letter was issued solely for information and no Corrective Action Plan was not issued by the auditor. A copy of the audit was submitted to the FNYFS.
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			<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Documentation: Policies and procedures for Confidentiality/Release of Information, System Backup, System abuse, System Monitoring, and Disaster Recovery were reviewed. Policies are located in the Administrative Standard Operating

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documents are shredded and computer hard drives are wiped prior to discarding. ON SITE							Manual throughout various sections of the manual. A daily back-up is performed on all information saved on various servers throughout the agency. The Residential Supervisor reported no employee had a laptop.

CONCLUSION

Family Resources St. Petersburg has met the requirements for the CINS/FINS contract as a result of compliance with ten of the eleven applicable indicators of the Administrative and Fiscal Contract Monitoring Tool. Two of the thirteen indicators were not applicable because: 1) the provider does not have any outstanding corrective action item(s) cited by an external funding source, and 2) does not have any current inventory purchased with DJJ/FN Funds. Consequently, **the overall compliance rate for this contract monitoring visit is 90.9%**. There are no corrective actions cited but one (1) recommendation is made as a result of the monitoring visit.

RECOMMENDATION (S)

Recommendation:1)

Ensure all bank reconciliations are completed within 6 weeks of receipt of the bank statements and are signed by the preparer and agency approval authority.

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.

Recommendation (1) made is a suggestion regarding fiscal issues observed during the review. This item does not necessarily require a written response.



Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Family Resources – St. Petersburg
CINS/FINS Program

March 3-4, 2021

Compliance Monitoring Services Provided by





Quality Improvement Review

Family Resources St. Pete – March 3-4, 2021
Lead Reviewer: Marcia Tavares

CINS/FINS Rating Profile

Standard 1: Management Accountability

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

Percent of indicators rated Satisfactory: 85.71%

Percent of indicators rated Limited: 14.29%

Percent of indicators rated Failed: 0.00%

Standard 2: Intervention and Case Management

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

Percent of indicators rated Satisfactory: 90.00%

Percent of indicators rated Limited: 10.00%

Percent of indicators rated Failed: 0.00%

Standard 3: Shelter Care & Special Populations

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

Percent of indicators rated Satisfactory: 100.00%

Percent of indicators rated Limited: 0.00%

Percent of indicators rated Failed: 0.00%

Standard 4: Mental Health /Health Services

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

Percent of indicators rated Satisfactory: 80.00%

Percent of indicators rated Limited: 20.00%

Percent of indicators rated Failed: 0.00%

Overall Rating Summary

Percent of indicators rated Satisfactory: 89.66%

Percent of indicators rated Limited: 10.34%

Percent of indicators rated Failed: 0.00%



Quality Improvement Review

Family Resources St. Pete – March 3-4, 2021
Lead Reviewer: Marcia Tavares

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

Marvin Bliss - Department of Juvenile Justice

Julie Edison – Hillsborough County Children Services

Tammy Holcombe – Youth and Family Alternatives Inc.

Abram Jones – Bethel Community Foundation



Quality Improvement Review

Family Resources St. Pete – March 3-4, 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
- 1 # Case Managers
- 1 # Program Supervisors
- 0 # Food Service Personnel
- 1 # Healthcare Staff
- N/A # Maintenance Personnel
- 0 # Other (listed by title): _____

Documents Reviewed

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

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

- Visitation Logs
- Youth Handbook
- 5 # Health Records
- 5 # MH/SA Records
- 9 # Personnel /Volunteer Records
- 7 # Training Records
- 21 # Youth Records (Closed)
- 15 # Youth Records (Open)
- 0 # Other: _____

Surveys

6 # Youth

10 # 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

Family Resources St. Pete – March 3-4, 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

Family Resources, Inc. is a non-profit community-based corporation contracted with the Florida Network of Youth and Family Services (Florida Network) to operate Children in Need of Services/Families in Need of Services (CINS/FINS) residential and non-residential services to youth and families. The central office is in Pinellas Park, Florida and shelters are located in Clearwater, St. Petersburg, and Bradenton, Florida. This QI review was conducted for the St. Petersburg SafePlace 2B program located at 3821 5th Avenue North St. Petersburg. The shelter is licensed for 12 beds and offers 24-hour availability, youth supervision, food and clothing, life skills education, crisis counseling, individual and family counseling, recreation and leisure activities, and case management services. Educational services are provided by the local school districts in the counties served by the shelter. 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 specialized services to youth who meet the criteria for Staff Secure shelter, Domestic Minor Sex Trafficking, and youth referred by the Juvenile Justice Court System for domestic violence, probation respite, and Family/Youth Respite Aftercare Services (FYRAC). The agency is also contracted to provide Intensive Case Management (ICM) services and SNAP. During the QI visit the youth census was 9 CINS/FINS including 1 DV youth. Family Resources is currently accredited by the Council of Accreditation (COA) and was recently re-accredited through December 31, 2024.

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

To maintain a safe environment, the program implemented a visitor tool survey, face scan thermometers, HEPA filtration systems, and consistent sanitization of the facility. Even though the residential program had to limit its off-campus activities, it was still able to take youth to parks for nature walks and to the Morena Clay Center, which adheres to safe COVID protocol. One of the standout events that occurred was having Noah Ehlert end his cross-country bike ride from San Diego. This was the end of Noah's Discover Your Path Tour bringing a spotlight on youth shelters across the country. In conjunction with Noah's ride, Family Resources showcased its new Safe Connections/Street



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Outreach and a Family Counseling Building. This new building on its campus has provided a Resource Center and new office space for Street Outreach and Family Counseling. The move of these 2 programs from the shelter building has opened up more space for SafePlace2B, allowing full use of the multi-purpose room, which is now the Leadership Room “South Central”, as a reward for youth displaying leadership behavior. “South Central” is equipped with a One-on-One Basketball Game, 2 arcade games (Pacman and NBA Jam), and 2 Nintendo Switch video games. The space is also utilized for groups and treatment team.

The community counseling program had one staff leave in the past year but was able to hire new staff to fill the position in a timely manner. One of the program counselors was recently awarded a Ph.D. Outreach with local universities resulted in the recruitment of a MSW intern from Tulane University, completing her internship in the program. The program is currently accommodating telehealth and in-person counseling sessions. It offers group sessions based on “Success Workshop”, that focuses on anger management, impulse control, improved school performance, and many other topics. This group has been receiving positive feedback from youth, parents, and referral sources. The program is also working on implementing a teen girl group, focusing on healthy body image, self-esteem, and healthy relationships/communication.



Quality Improvement Review

Family Resources St. Pete – March 3-4, 2021
Lead Reviewer: Marcia Tavares

Narrative Summary

Family Resources Inc. is under the leadership of a management team that consists of a Chief Executive Officer, 2 Vice Presidents, a Senior Director of Quality Assurance, a Chief Grants Officer, a Chief Human Resources Officer, and a Chief Financial Officer. The residential component is overseen by the Vice President (VP) of residential and RHY Services and the non-residential component is overseen by the VP of community and clinical services. SafePlace 2B shelter is staffed by a residential supervisor, counseling and case management staff, Youth Development Specialists (YDS), a cook, part time nurse, and administrative assistant.

At the time of the QI visit, the program did not report any specific issues, problems, or current corrective actions with any funding sources. There were 2 vacancies reported for one residential counselor and one YDS position.

The overall findings for the QI review for Family Resources St Petersburg are summarized as follows:

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

Standard 2 has a total of ten indicators that relate to intervention and case management. Seven of the ten indicators were rated satisfactory with no exceptions (2.01, 2.02, 2.03, 2.04, 2.06, 2.07, and 2.08), two were rated satisfactory with exceptions (2.09 and 2.10), and one received a Limited rating (2.05).

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

Standard 4, Mental Health and Health Services, is comprised of five indicators. Four of the five indicators were rated satisfactory with no exceptions and indicator 4.03 received a Limited rating.

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

Standard 1:

Indicator 1.04 – Limited

One staff hired 1/13/2020 completed the DOJ training on 1/4/2021, after the December 31st deadline.



Two of three staff were deficient in completing all 12 mandatory trainings required during the first 120-days of hire; one was late in completing 9 of the 12 topics (including orientation training) and the second staff was late in completing 8 of the 12 topics, including Managing Aggressive Behavior (MAB) training which had not yet been completed as of the QI visit.

One first year staff did not complete LGBTQ annual required training prior to completion of the first year.

Two of the 3 in-service staff did not complete all mandatory annual training; one was missing MAB training and the other was missing SkillPro Sexual Harassment training, both topics are required every two years.

Standard 2 :

Indicator 2.05 – Limited

There is no way to determine if the group sessions held by the program during the review period met the criteria for group based on length of time. The SP2B group sign-in form used to document group sessions does not document duration of groups which is a required criterion. Therefore, the majority of group meetings held could not be classified as meeting the criteria for group sessions as required. There is also no collateral documentation maintained to support duration of groups held. It was also observed that six separate group sessions between December 2020 and February 2021 were missing group topic and/or facilitator.

Standard 4 :

Indicator 4.03 – Limited

Shift-to-shift counts were not conducted by staff regularly. One youth was missing the following counts: Shift to shift count not completed on 12/6/2020 for second shift, 12/11/2020 third shift, 12/12/2020 second shift, 12/19/2020 1, 2 and 3 shifts. Second staff verification of count missing on 12/6/2020 second and third shift, 12/10/2020 third shift, 12/11/2020 first shift, 12/12/2020 first shift, 12/13/2020 third shift, 12/14/2020 first shift, 12/15/2020 third shift, 12/18/2020 first shift, 12/20/2020 first shift, 12/21/2020 third shift, 12/22/2020 second and third shift, 12/23/2020 first shift.

Current practice did not support medication count discrepancies were cleared after each shift based on review of one applicable youth record selected during the review.



Family Resources ST Pete-March 3-4, 2021
 Lead Reviewer: Marcia Tavares

Quality Improvement Review

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 <i>For example: Interview/Surveys, Observation, and/or Type of Documentation</i>	Notes Explain any items that have any deficiencies, exceptions or are not applicable.
Standard One – Management Accountability							
1.01: Background Screening and compliance with DJJ OIG statewide procedures regarding BS of employees, contractors and volunteers							
Provider has a written policy and procedure that meets the requirement for Indicator 1.01						YES X NO (explain) The agency has the required policy and procedure # 1.01 in place that was approved July 2019 by the CEO.	
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 Berke pre-employment assessment (to determine suitability) for direct-care positions. Candidates must score medium or high in order to be considered for employment. The assessment was implemented prior to January 2020 and was administered to seven new staff hired and one intern. Twelve of the fourteen staff received scores of medium or high on the Berke assessment. One staff scored low on the assessment; management included an explanation in the personnel file documenting reason for hire decision.	
Background screening completed prior to hire/start date or exemption obtained prior to working with youth (if rated ineligible) for new hires, volunteers/interns, and contractors	X					A total of seven new staff were hired since the last onsite QI visit and one intern provided services. All eight background screenings were initiated prior to hire/start dates with eligibility documented on the Clearinghouse results. No exemptions were applicable.	



Family Resources ST Pete-March 3-4, 2021
Lead Reviewer: Marcia Tavares

Quality Improvement Review

Five-year re-screening completed every 5 years from initial date of hire	X					The program had one eligible staff who met the criteria for 5-year re-screening. A review of the agency's clearinghouse staff list shows the staff has valid retained prints in the clearinghouse.	
Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?	X					The program had a signed and notarized Annual Affidavit of Compliance with Level 2 Screening Standards that was completed, notarized, and sent to the Background Screening Unit on January 6, 2021 prior to the January 31st deadline.	
Proof of E-Verify for all new employees obtained from the Department of Homeland Security	X					Proof of E-Verify work authorizations were maintained in all seven new hire files.	
1.02: Provision of an abuse free environment to ensure safety and abuse free environment for youth in care							
Provider has a written policy and procedure that meets the requirement for Indicator 1.02						<p>YES NO (explain) X</p> <p>The agency has the required policies and procedures # 1.02 and Grievance Process #3.08 that were last reviewed September 2019 and March 2021, respectively and approved by the Vice President.</p>	<p>Policy 3.08 indicated that "any staff may accept a written grievance from a client" which did not align with indicator 1.02 that states Program Director/Supervisor will have access to and manage grievances unless it is towards themselves. In addition, the 72 – hour timeline for resolution of grievances was not depicted in the policy regarding if there is a delay in resolution within 72 hours, there will be documentation explaining the cause for delay in resolution. The grievance policy was updated March 4, 2021 by the Vice President.</p>
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
Abuse Free Environment							
Agency has a code of conduct of policy and there is evidence that staff are aware of agency's code of conduct.	X					Code of Conduct is included in the Human Resources document that is signed by all employees at the program orientation. Code of Conduct is outlined in Policy 5.01, last reviewed January	



Family Resources ST Pete-March 3-4, 2021
Lead Reviewer: Marcia Tavares

Quality Improvement Review

						2019, and specifies that all employees shall maintain high standards of personal conduct in the capacity of their position and act in accordance with the highest standards of professional integrity and ethics while providing respect and courtesy to co-workers, clients, and the general public.	
Child Abuse Registry telephone number is visible to youth and posted common areas of the facility	X					Child Abuse hotline contact information is displayed in all the common areas. (Dining, Game Room, Classroom, etc.). Abuse hotline calls were reviewed. Documentation shows a total of 13 non-institutional calls made between September 2020 and February 2021. Seven training files were reviewed, and all staff received training on Child Abuse Recognition Reporting and Prevention training within the time frames specified for first year and in-service staff.	
Youth were informed of the Abuse and Contact Number (see youth survey results)	X					Each youth receives a handbook upon admission and a review of youth rights, grievance procedures, and how to contact the Florida Abuse Hotline is also noted. Six youth surveys were completed. All six youth indicated staff is respectful towards them and they feel safe in the program. The six youth also stated they were aware of the abuse hotline number and its location in the facility.	
Management takes immediate action to address any incidents of threats or abuse	X					There were no incidents that required management to take immediate action to address incidents of physical and/or psychological abuse, verbal intimidation, use of profanity, and/or excessive use of force.	
Grievance Process							
Agency has a formal grievance process	X					Youth are informed of the grievance process as evidenced by observation of Facility Client Orientation Checklist form. The checklist outlines review of Rights	



Family Resources ST Pete-March 3-4, 2021
Lead Reviewer: Marcia Tavares

Quality Improvement Review

						and Responsibility and grievance procedure. Youth are required to initial next to the line item and youth and staff signatures are required at the bottom of the form. The youth orientation handbook details the grievance process.	
Locked box accessible to only management and available to youth in a common area	X					One locked Grievance box is also located in a common area with blank forms and a posted grievance process sign.	
Direct care does not handle the complaint/grievance unless assistance is asked for by the youth. Program director/supervisor will have access to and manage grievances unless it is towards themselves.	X					The grievance forms instruct youth to submit grievance in a sealed envelope and marked confidential to the Residential Supervisor, Clinical Supervisor or Program Manager.	
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					Four grievances were reviewed by the supervisor and all were resolved within 72 hours. Two out of the four grievances had missing dates, 1 youth did not date the grievance and 1 youth did not date the resolution of the grievance although the Residential Supervisor did.	
1.03: Incident Reporting							
Provider has a written policy and procedure that meets the requirement for Indicator 1.03						YES X NO (explain) The provider has the required policies and procedures #1.03 Incident Reporting and sub-policy 1.03 A – CCC Incident Report. Both policies were last reviewed July 2019 and approved by Vice President, Andy Coble.	
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		X				Eleven reports including DJJ internal and CCC reports were submitted and reviewed of which 3 were CCC reports. Two of the three incident reports indicated that the CCC is being notified of incidents within the 2-hour window.	Exception One CCC report regarding a missed medication was not called in within 2 hours.



Family Resources ST Pete-March 3-4, 2021
Lead Reviewer: Marcia Tavares

Quality Improvement Review

within two hours of the program learning of the incident							
The program completes follow-up communication tasks/special instructions as required by the CCC	X					It was noted that there was follow up counseling and retraining to address the deficiency with staff for the missed medication CCC incident.	
Incidents are documented in the program logs and on incident reporting forms	X					All CCC reports reviewed were documented in the program logbook.	
All incident reports are reviewed and signed by program supervisors/directors	X					All incidents were reviewed and signed by program supervisors/directors.	
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 provider has the required policy and procedure #1.04 that was last reviewed July 2019 and approved by Vice President.
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. <i>(Staff hired before January 1st were required to complete no later than December 31, 2020)</i>		X				Two of three new staff files reviewed have documentation supporting completion of the training during the required timeframe.	Limited Exception One staff hired 1/13/2020 completed the DOJ training on 1/4/2021, after the December 31 st deadline.
All staff receives all mandatory training during the first 90 days of employment from date of hire.		X				Staff training was rated based on the previous 120-day training requirement applicable to all 3 staff hired prior to implementation of 90-day requirement effective January 1, 2021 Three first year staff files were reviewed. One of three staff met all 120-day new hire mandatory training requirements.	Limited Exception Two of three staff were deficient in completing all 12 mandatory trainings required during the first 120-days of hire; one was late in completing 9 of the 12 topics (including orientation training) and the second staff was late in completing 8 of the 12 topics, including Managing Aggressive Behavior (MAB) training which had



Family Resources ST Pete-March 3-4, 2021
Lead Reviewer: Marcia Tavares

Quality Improvement Review

							not yet been completed as of the QI visit.
All staff completes all mandatory Florida Network and SkillPro training during the first-year employment.		X				Two of three staff met all 1st year mandatory Florida Network and SkillPro training requirements.	Limited Exception One staff did not complete LGBTQ training prior to completion of the first year.
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					One applicable non-licensed clinical shelter staff file was reviewed for assessment of suicide risk training. There was evidence of the staff completing 5 suicide risk assessments with written confirmation of completion by the licensed professional.	
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					Verification of training by the licensed professional included date of confirmation, signature and license number.	
In-Service Direct Care Staff							



Family Resources ST Pete-March 3-4, 2021
Lead Reviewer: Marcia Tavares

Quality Improvement Review

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				The training files of 3 in-service staff were reviewed. All 3 exceeded the 40 training hours required annually. One of the 3 staff completed all required annual trainings.	Exception Two of the 3 in-service staff did not complete all mandatory annual training; one was missing MAB training and the other was missing SkillPro Sexual Harassment training, both topics are required every two years.
Required Training Documentation							
The program maintains an individual training file for each staff, which includes an annual employee training hours tracking form and related documentation, such as certificates, sign-in sheets, and agendas for each training attended.		X				The program has training files for each staff that contains training hours tracking forms, certificates, sign-in sheets and other training material.	
Provider has a written policy and procedure that meets the requirement for Indicator 1.05						YES X	NO (explain) The program has a written policy and procedures #1.05 that was last reviewed and approved July 2019 by CEO. In addition, the agency has a comprehensive PQI Plan dated 2019 to ensure programs adhere to the highest quality standards with quality and integrity and that agency resources are effectively utilized.
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
Case record review reports demonstrate reviews are conducted quarterly, at a minimum	X					A review of peer record reviews for FY 20-21 was conducted. The record reviews were conducted monthly for the family counseling program and within quarterly timeframes (August, September, and November 2020) for the shelter program. A total of 23 and 19 cases were reviewed during those periods, respectively. The program documents compliance for each record as well as deficiencies.	
The program conducts reviews of incidents, accidents, and grievances quarterly, at a minimum	X					Incident reports are reviewed and analyzed by the Risk Management Committee based on incident total by program; agency-wide incident totals by	



Family Resources ST Pete-March 3-4, 2021
 Lead Reviewer: Marcia Tavares

Quality Improvement Review

						type; and incident type by program. The report also aggregates data for grievances and workers compensation. The Risk Management Committee completed CQI/Risk Management Analysis for the 1st and 2 nd quarters of FY 2020-2021.	
The program conducts an annual review of customer satisfaction data	X					Survey results are tracked monthly for the shelter and non-residential clients separately and compiled into quarterly and an annual report. A copy of the CQI/Risk Management Analysis for the 1st and 2 nd quarters of FY 2020-2021 shows an increase in client satisfaction by the end of the 2 nd quarter with overall satisfaction score of 96%, up from 94% the previous quarter.	
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					Program outcome data is documented monthly by each program, incorporating the contract, Netmis, and program outcomes required by the Florida Network and DJJ QI. The quarterly outcome data reports demonstrate the provider is capturing and monitoring outcome indicators for both the residential and non-residential program. Quarterly Impact Management Committee meetings are held to review/discuss the quarterly reports.	
The program conducts a monthly review of NetMIS data reports.	X					Netmis data, QI activities, reports, and areas identified as needing improvements or changes needed from analysis. Netmis and JJIS data quality checks are conducted twice per month at staff meetings.	
The Florida Network conducts monthly reconciliation by comparing NetMIS data to JJIS data. Agency has evidence that they have reconciled any differences noted.	X					Data reconciliation is resolved by the Administrative Assistant who reports status to the program manager upon completion. A copy of the last data reconciliation addressed by the program was reviewed.	
The program has a process in place to review and improve accuracy of data entry & collection	X					Data entered into JJIS and NETMIS is reviewed and reconciled by an Administrative Assistant through quality checks and weekly emails.	



Family Resources ST Pete-March 3-4, 2021
Lead Reviewer: Marcia Tavares

Quality Improvement Review

There is documentation that findings are regularly reviewed by management and communicated to staff and stakeholders.	X					The Risk Management committee meets to review all data areas including safety trends, peer record review, data collection, audits, and committee updates. Corrective actions plans are implemented to address areas of concern which are also addressed at quarterly CINS team meetings.	
There is evidence that strengths and weaknesses are identified, improvements are implemented or modified, and staff are informed and involved throughout the process.	X					Senior leadership meets weekly to discuss and review policies and procedures, data presentations, and fiscal information. Monthly team/staff minutes were reviewed for the QI period and were 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 provider has the required policy and procedures #1.10 that was last reviewed July 2019 and approved by the Vice President.	
Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	X					The agency maintains a list of seventeen approved drivers. The list was submitted for review.	
Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	X					All drivers named on the approved drivers' list have current driver's licenses and are covered under the agency's insurance policy. The agency's auto insurance policy was also provided for review.	
Agency's Transportation policy prohibit transporting a client without maintaining at least one other passenger in the vehicle during the trip and include exceptions in the event that a 3 rd party is NOT present in the vehicle while transporting	X					The agency policy outlines the importance of avoiding single youth transports. It also specifies that in the event of a single transport, open lines are initiated and documented in the logbook and all single transports are approved by the Residential Supervisor. There is also a list of staff that have been given pre-authorization to provide single transports if a third party cannot be provided but the practice is still	



Family Resources ST Pete-March 3-4, 2021
Lead Reviewer: Marcia Tavares

Quality Improvement Review

						to receive prior authorization and all single transports must include open lines.	
In the event that a 3rd party cannot be obtained for transport, the agency's supervisor or managerial personnel consider the clients' history, evaluation, and recent behavior		X				A random selection of nine transports on the dates 9/9/20, 9/12/20, 10/2/20 (2), 11/16/20, 1/6/21, 2/8/21, 2/8/21, and 2/10/21 were reviewed and transportation logs were compared with logbook entries.	Exception Most of the single transports noted on the transportation log documented approvals after the time of transport and some noted approval the subsequent day. Two single youth transports occurring 10/2/20 and 11/16/20 were conducted by the Residential Supervisor; however, the open line log entry could not be verified for these dates as it appears the supervisor did not document the open line in the logbook.
The 3 rd party an approved volunteer, intern, agency staff, or other youth	X					Transportation logs for the review period showed third party was agency staff or other youth.	
There is documentation of use of vehicle that notes name or initials of driver, date and time, mileage, number of passengers, purpose of travel and location.		X				Transportation logs reviewed included initials of driver and youth; date and time of transport; mileage; number of passengers; and destination/purpose of trip.	Exception Many of the transport times noted on the transportation log do not document a.m. or p.m. or is illegible.
Provider has a written policy and procedure that meets the requirement for Indicator 1.07						YES X NO (explain) The provider has the required policy and procedures #1.11 that was last reviewed January 2021 and approved by the Vice President.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
The program has a lead staff member designated to participate in local DJJ board and council meetings with evidence that includes minutes of the event or other verification of staff participation	X					There are two lead staff designated to attend the DJJ Circuit meetings and other staff attend if one of the leads are unavailable. Chief Probation Officer, Melissa Fuller confirmed Family Resources' participation in a Virtual Roundtop meeting on 11/17/20. Family Resources was able to provide program updates and information. There is only one agency representative that attends	



Family Resources ST Pete-March 3-4, 2021
Lead Reviewer: Marcia Tavares

Quality Improvement Review

						these meetings. The meetings are conducted twice a year and the cancellation of the April 2020 Meeting was provided via email.	
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					There were 37 outreach activities scheduled from September through February 2021. These events were conducted by various staff.	
The program maintains written agreements with other community partners which include services provided and a comprehensive referral process.	X					The agency maintains interagency agreements that describe and specify services, scope, and nature of cooperation, collaboration, and responsibilities of all agencies involved in providing program services identified as needed for parent and or youth. The agency provided 10 active interagency agreements with community partners.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.01						YES X NO (explain) The agency has the required policy and procedure #2.01 that was last reviewed January 2021 and approved by a VP.	
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 residential files were reviewed, 2 open and 3 closed. All 5 youth records had the eligibility screening completed, immediately during the intake, using the NETMIS screening form.	
Community counseling: Eligibility screening is completed within 3 business days of referral by a trained staff using the NetMIS form	X					Five community counseling files were reviewed, 3 open and 2 closed. NetMIS eligibility screenings were completed within 3 business days of referral by staff in all 5 files.	
Youth and parents/guardians receive the following in writing: a. Available service options	X					All ten files included the consent for services form that provided information about available service options and rights and responsibilities; all were signed by the	



Family Resources ST Pete-March 3-4, 2021
Lead Reviewer: Marcia Tavares

Quality Improvement Review

b. Rights and responsibilities of youth and parents/guardians						parent and guardian acknowledging receipt of the information in writing.	
The following is also available to the youth and parents/guardians: a. Possible actions occurring through involvement with CINS/FINS services (case staffing committee, CINS petition, CINS adjudication) b. Grievance procedures	X					All ten files included the consent for services forms that provided information about the possible actions occurring through involvement with CINS/FINS services and grievance procedures.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.02						YES X NO (explain) The agency has the required policy and procedure #2.02 that was last reviewed July 2019 and approved by a VP.	
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 residential files were reviewed, 2 open and 3 closed. The needs assessment was initiated within 72 hours of admission in each file and dates supported that they were completed in the required timeframe	
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					Five community counseling files were reviewed, 3 open and 2 closed. All five needs assessments were completed within 2 to 3 face to face contacts after the initial intake.	
Needs Assessment is conducted by a bachelor's or master's level staff member	X					All ten files reviewed had the needs assessment completed by a bachelor's or master's level staff member.	
Needs Assessment includes a supervisor's review signature upon completion	X					All ten files reviewed had the needs assessment signed by the 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 of the ten files were identified with a suicide risk.	



Family Resources ST Pete-March 3-4, 2021
Lead Reviewer: Marcia Tavares

Quality Improvement Review

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					The assessments of suicide risk were conducted in all five applicable files by counselors under the direct supervision of a licensed mental health professional.
Provider has a written policy and procedure that meets the requirement for Indicator 2.03						YES X NO (explain) The agency has the required policy and procedure #2.03 that was last reviewed July 2019 and approved by a VP.
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					Case/service plans were observed to be developed on time in all ten files reviewed.
Case plan service Plan includes: 1. Individualized and prioritized need(s) and goal(s) identified by the Needs Assessment 2. Service type, frequency, location 3. Person(s) responsible 4. Target date(s) for completion and Actual completion date(s) 5. Signature of youth, parent/guardian, counselor, and supervisor 6. Date the plan was initiated	X					All ten files were found to have individualized and prioritized needs and goals, service type, frequency, location, target date(s) for completion and person(s) responsible. Five applicable closed files had actual completion dates for goals achieved. All ten files included signatures of the youth, parent/guardian, counselor, and supervisor. All ten files included the date the service plans were initiated.
Case/service plans are reviewed for progress/revised by counselor and parent (if available) every 30 days for the first three months and every 6 months after	X					All ten files reviewed demonstrated timely reviews for progress by the counselor during the required timeframes.
Provider has a written policy and procedure that meets the requirement for Indicator 2.04						YES X NO (explain) The program has the required policy #2.04 that was last reviewed July 2019 and approved by a Vice President.
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable	
Counselor/Case Manager is assigned	X					All ten files were assigned a counselor/case manager.



Family Resources ST Pete-March 3-4, 2021
Lead Reviewer: Marcia Tavares

Quality Improvement Review

<p>The Counselor/Case Manager completes the following as applicable:</p> <ol style="list-style-type: none"> 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					<p>All ten files reviewed established the need for referrals based on the needs assessments and the case managers coordinated the needed services.</p> <p>In all ten files reviewed, the counselors coordinated service plan implementation and established goals for the youth and families. Progress toward achieving goals were monitored and documented in all ten service plans reviewed.</p> <p>The counselors were actively involved in providing supportive service to youth and families through case management.</p> <p>Five of the ten files reviewed received residential services and the counselors monitored out-of-home placements for all five youth.</p> <p>None of the ten cases required court attendance.</p> <p>All five applicable closed cases included discharged notes and referrals for additional services.</p> <p>Thirty and sixty-day follow ups were completed timely in five applicable closed files reviewed.</p>	
<p>The program maintains written agreements with other community partners that include services provided and a comprehensive referral process</p>	X					<p>The program has 10 interagency agreements active for the provision of educational, runaway hotline, behavioral health, and delinquency diversion services.</p>	
<p>Provider has a written policy and procedure that meets the requirement for Indicator 2.05</p>						<p>YES X NO (explain) The program has the required policy #2.05 that was last reviewed July 2019 and approved by a Vice President.</p>	
<p>Rating Criteria</p>	<p>Satisfactory</p>	<p>Non-compliant</p>	<p>No Eligible Items for Review</p>	<p>No Practice</p>	<p>Not Applicable</p>		



Family Resources ST Pete-March 3-4, 2021
Lead Reviewer: Marcia Tavares

Quality Improvement Review

Youth and families receive counseling services, in accordance with the youth's case/service plan, to address needs identified during the assessment process	X					Counseling services that addressed the needs identified during the assessment process were established in all ten files reviewed in accordance with the youth's case/service plan	
Shelter Program							
Shelter programs provides individual and family counseling	X					Five residential files received individual and family counseling services. These counseling services are documented on the service plans and in the progress notes.	
Group counseling sessions held a minimum of five days per week		X				There was evidence youth participated in groups in the five residential files reviewed. The agency's group sign in sheets for a 6-month period (September 2020 to February 2021) were also reviewed. It was evident from the documents presented the program conducts sessions with youth on a frequent basis, at a minimum five times per week, and twice on some days. However, the majority of group forms do not indicate duration as the form used does not have a section to document time.	Limited Exception There is no way to determine if the group sessions held by the program during the review period met the criteria for group based on length of time as this is not documented on the majority of group sign in forms.
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				Group sign in sheets for the period September 2020 to February 2021 were reviewed. Staff occasionally wrote the duration of time on a few group sign-in sheets during the period and omitted group topic and/or facilitator on some of the sheets.	Limited Exception It was observed the program conducted group meetings frequently; however, the SP2B group sign-in form used to document group sessions does not document duration of groups which is a required criterion. There is also no collateral documentation maintained to support duration of groups held. It was also observed that six separate group sessions between December 2020 and February 2021 were missing group topic and/or facilitator.
Community Counseling							
Community counseling programs provide therapeutic community-based services designed to	X					All five applicable community counseling files reviewed showed youth received counseling services as evident with	



Family Resources ST Pete-March 3-4, 2021
Lead Reviewer: Marcia Tavares

Quality Improvement Review

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.						attached case notes. Due to the pandemic counseling services were provided by the program conducted via Zoom. These Zoom sessions with youth/families were documented in the case progress notes.	
Counseling Services							
Reflect all case files for coordination between presenting problem(s), psychosocial assessment, case/service plan, case/service plan reviews, case management, and follow-up	X					All ten files reviewed reflected coordination between presenting problem(s), psychosocial assessment, case/service plans, case/service plan reviews, case management, and follow-up when applicable.	
Maintain individual case files on all youth and adhere to all laws regarding confidentiality	X					All ten youth records were maintained in individual case files with adherence to all laws regarding confidentiality.	
Case notes maintained for all counseling services provided and documents youth's progress	X					Case notes were maintained in all ten files indicating the youth's progress as well as case notes for all services provided.	
On-going internal process that ensures clinical reviews of case records and staff performance	X					All ten files reviewed received ongoing clinical reviews of case records and staff performance. Case reviews are conducted by the supervisor and the review form is maintained in each case file.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.06						YES X NO (explain) The program has the required policy #2.06 that was last reviewed July 2019 and approved by a Vice President.	
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			One applicable case staffing record was initiated by program staff and not the parent/guardian.	
The youth, family and case staffing committee are contacted within a minimum of five working days a. Notification to youth/family no less than 5 working days prior to staffing	X					One applicable closed file was reviewed. The youth, family, and case staffing committee were contacted via letter and email, respectively, in a timely manner.	



Family Resources ST Pete-March 3-4, 2021
Lead Reviewer: Marcia Tavares

Quality Improvement Review

b. Notification to committee no less than 5 working days prior to staffing							
Case Staffing Committee							
Must include: a. DJJ rep. or CINS/FINS provider b. Local school district representative	X					Case Staffing meetings held for youth included a DJJ representative/CINS/FINS provider and a local school district representative.	
Other members may include: a. State Attorney's Office b. Others requested by youth/family c. Substance abuse representative d. Law enforcement representative e. DCF representative f. Mental health representative	X					No additional representation was applicable for the case staffing.	
The program has an established case staffing committee, and has regular communication with committee members	X					The program has an established case staffing committee and contact information to facilitate email communication regularly and as needed with the committee members.	
The program has an internal procedure for the case staffing process, including a schedule for committee meetings	X					One closed file was reviewed with a procedure for the case staffing process that included a schedule for committee meeting.	
As a result of the Case Staffing							
The youth and family are provided a new or revised plan for services	X					The youth and family received a new plan of service documented on the service plan form.	
Written report is provided to the parent/guardian within 7 days of the case staffing meeting, outlining recommendations and reasons behind the recommendations	X					A report was given to the parent/guardian at the end of the case staffing meeting that outlined recommendations.	
If applicable, the program works with the circuit court for judicial intervention for the youth/family			X			None of the files required that the program work with the circuit court for judicial intervention for the youth/family.	
Case Manager/Counselor completes a review summary prior to the court hearing			X			None of the files required that the Case Manager/Counselor completes a review summary prior to court hearings.	



Family Resources ST Pete-March 3-4, 2021
Lead Reviewer: Marcia Tavares

Quality Improvement Review

Provider has a written policy and procedure that meets the requirement for Indicator 2.07						YES X	NO (explain) The program has the required policy #2.07 that was last reviewed July 2019 and approved by a Vice President.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable			
All records are clearly marked 'confidential'.	X						It was observed that all files (virtually uploaded) were marked confidential on papers within the file.	
All records are kept in a secure room or locked in a file cabinet that is marked "confidential"	X						All records were kept in a secure locked room and all files were kept locked in a cabinet marked as confidential as observed during virtual tour.	
When in transport, all records are locked in an opaque container marked "confidential"	X						Staff provided photo evidence showing they have locked opaque containers marked "confidential" to use for the transportation of records.	
All records are maintained in a neat and orderly manner so that staff can quickly and easily access information	X						All files were observed to be clearly divided into sections which were consistent in their organization among residential and nonresidential files.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.08						YES X	NO (explain) The program has the required policy #5.08 that was last reviewed July 2019 and approved by a Vice President.	Add any exceptions here:
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable			
Use of youth's preferred name/ pronoun: a. Youth are addressed according to their preferred name and gender pronouns b. Youth's preferred name and gender pronouns are used in logbook and on all outward-facing documents and census boards			X				The program has not served any youth during the annual review period who met the criteria for the indicator.	
Youth in need of specialized support is referred to qualified resources (as applicable)			X				No eligible youth served	
Youth preference is considered and documented for room assignment and youth is not			X				No eligible youth served	



Family Resources ST Pete-March 3-4, 2021
Lead Reviewer: Marcia Tavares

Quality Improvement Review

roomed in isolation due to sexual orientation, gender identity, or gender expression							
Youth is provided hygiene products, undergarments and clothing that affirms their gender identity or gender expression			X			No eligible youth served	
The agency has signage and brochures/publication placed in common areas indicating that all youth are welcome regardless of sexual orientation, gender identity, and gender expression	X					During a tour of the facility, "safe place" rainbow signs were posted throughout the facility in all common areas signifying that youth are welcome and should feel safe regardless of sexual orientation, gender identity, and gender expression. Publication including the Zine is accessible to youth/family. It was previously noted during review of the training files that one of the three new staff had not completed LGBTQ training required in the first year.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.09						YES The program has the required policy #3.07 that was last reviewed July 2019 and approved by a Vice President.	NO (explain) X P&P 3.07 has not been updated since July 2019 to reflect changes effective Jan 2021 to QI indicator 2.09 regarding NetMIS/JJIS data entry timeframes within 3 business days of intake and discharge as well as the reduction of direct and collateral contacts from 6 to 4 direct and 4 collateral contacts per month and completion of CBCL at discharge.
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			X				



Family Resources ST Pete-March 3-4, 2021
 Lead Reviewer: Marcia Tavares

Quality Improvement Review

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							
Program only accept youth that meet legal requirements of F.S. 984 for being formally court ordered in to Staff Secure Services			X				
Staff Assigned: a. One staff secure bed and assigned staff supervision to one staff secure youth at any given time b. Program assign specific staff during each shift to monitor location/ movement of staff secure youth c. Agency clearly documents the specific staff person assigned to the staff secure youth in the logbook or any other means on each shift			X				
Agency provides a written report for any court proceedings regarding the youth's progress			X				
Domestic Minor Sex Trafficking (DMST)							
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	YES	NO X	N/A			The program has not served any 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			X				



Family Resources ST Pete-March 3-4, 2021
 Lead Reviewer: Marcia Tavares

Quality Improvement Review

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



Family Resources ST Pete-March 3-4, 2021
Lead Reviewer: Marcia Tavares

Quality Improvement Review

rating “No eligible items for review”)						
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable	
Youth admitted to DV Respite placement have a pending DV charge and have evidence of being screened by JAC/Detention, but do not meet criteria for secure detention	X					Four applicable (3 closed, 1 open) Domestic Violence (DV) Respite files were reviewed. All four files 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 4 DV youth records reviewed. No NetMIS data entry lag exceeding 3 days were observed for any of the 4 DV respite records reviewed. No JJIS exit data lags were observed on the prevention service records for the 3 youth records.
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 applicable record out of the four youth records reviewed. The youth was transitioned to CINS/FINS prior to the 21 st day with documentation in the file showing the youth was transitioned to CINS/FINS.
Case plan in file reflects goals focusing aggression management, family coping skills, or other intervention design to reduce reoccurrence of violence in the home	X					The case plans in 2 applicable records reflected goals that were appropriate such as aggression management, coping skills, and communication. Two of the four DV youth were discharged the following day after intake, prior to staff developing the case plans.
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 2 applicable files.
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	YES	NO X	N/A			The program has not served any Probation Respite youth since the last onsite QI visit and has no eligible items for review.



Family Resources ST Pete-March 3-4, 2021
Lead Reviewer: Marcia Tavares

Quality Improvement Review

rating “No eligible items for review”)						
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable	
All probation respite referrals are submitted to the Florida Network.			X			
Probation Respite Referral come from DJJ Probation and are all youth referred on probation regardless of adjudication status			X			
Data entry into NetMIS and JJIS within (3) business days of intake and discharge			X			
Length of stay is no more than fourteen (14) to thirty (30) days? (Placement beyond thirty (30) days requires the approval of the JPO and/or CPO)			X			
All case management and counseling needs have been considered and addressed			X			
All other services provided to Probation Respite youth are consistent with all other general CINS/FINS program requirements			X			
Intensive Case Management (ICM)						
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating “No eligible items for review”)	YES X	NO	N/A			
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable	
Youth receiving services was court ordered or referred by case staffing committee	X					Three open Intensive Case Management (ICM) files were reviewed. Three youth served met the criteria for ICM services; all three youth were court ordered.



Family Resources ST Pete-March 3-4, 2021
Lead Reviewer: Marcia Tavares

Quality Improvement Review

Services for youth and family include: a. Four (4) direct contacts per month b. Four (4) collateral contacts per month	X					All three youth records demonstrated the youth and family had four direct contacts and four collateral contact each month during a 6-month period.
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					The Child Behavior Checklist (CBCL) was completed within 14 days of intake in all three cases. An approved self-report assessment was completed at intake in the 3 files with evidence of continued completion of self-report assessments, since the intake dates in February and March 2020, every 90 days.
Case plan demonstrates a strength-based, trauma-informed focus	X					The case plans address the issues of truancy; case management services demonstrated effort of the staff to engage the family and access supports when needed.
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					Direct and collateral contacts made on behalf of the youth and family demonstrate continued effort on the part of the staff to engage the families, advocate for services, assist families in gaining access to needed services, and teach problem solving skills.
Family and Youth Respite Aftercare Services (FYRAC)– Non-residential Only						
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating “No eligible items for review”)	YES	NO X		N/A		The program has not served any FYRAC youth since the last onsite QI visit and has no eligible items for review



Family Resources ST Pete-March 3-4, 2021
 Lead Reviewer: Marcia Tavares

Quality Improvement Review

Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
Youth is referred by DJJ for a domestic violence arrest on a household member, and/or the youth is on probation regardless of adjudication status and at risk of violating			X				
Agency has evidence that all FYRAC referrals have documented approval from the Florida Network office			X				
Intake and initial assessment sessions meets the following criteria: a. Face-to-face gathering of family history and demographic information b. Includes development of the service plan and is documented through signature of the youth and his/her parent/guardian as well as orientation to the program			X				
Life Management Sessions meets the following criteria: a. Sessions are face-to-face, sixty (60) minutes in length and focus on strengthening the family unit b. Individual Sessions are with the youth and family and focus to engage, identify strengths and needs of each member that help to improve family functioning			X				
Group Sessions: a. Focus on the same issues as individual/family sessions with the overall goal of strengthening relationships and prevention domestic violence			X				



Family Resources ST Pete-March 3-4, 2021
Lead Reviewer: Marcia Tavares

Quality Improvement Review

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							
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 X The program has the required policies and procedures 4.25 SNAP Intake Requirements, 4.16 SNAP Group Delivery, 4.19 SNAP in Schools, 4.17 SNAP Fidelity Adherence Monitoring and 4.18 SNAP Discharge Requirements all last reviewed July 2019 and approved by a Vice President.	NO (explain)
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
SNAP Clinical Groups							
Youth are screened to determine eligibility of services	X					Four youth records, three open and one closed, were reviewed to verify the files contained required documentation. All four youth were screened, using both the NETMIS screening form and the SNAP Brief Intake screening form to determine eligibility and identify presenting problems. All four youth have a consent form signed by the parent/guardian on the day of intake, prior to receiving services.	
Needs assessment is completed at initial intake, or within two face-to-face sessions	X					All four youth had a Needs Assessment initiated at intake.	
SNAP Assessments a. Child Behavior Checklist (CBCL) is completed by the caregiver (pre & post)		X				The four youth had a Pre- Child Behavior Checklist completed at intake and placed in the youth's file. None of the pre-TRFs or one applicable post-TRF was completed but there was	Exception Pre- PAT assessments were not completed at intake for 2 of the 4 records at intake as required. The SNAP supervisor indicated delays



Family Resources ST Pete-March 3-4, 2021
 Lead Reviewer: Marcia Tavares

Quality Improvement Review

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)						documentation in each file of emails sent to the teacher to complete the TRFs. A TOPSE assessment was completed and placed in the files for all four youth at intake and at discharge for one applicable closed record. Pre-PAT assessments were completed for 2 of the four youth at intake and one applicable youth at discharge.	were due to technology and pandemic challenges.
SNAP discharge report summary	X					A SNAP Discharge Summary Report was completed and retained in the file for one applicable youth.	
SNAP Boys/SNAP Girls Parent Group Evaluation Form	X					A SNAP Girls Parent Group Evaluation Form was completed and maintained in the youth's file.	
SNAP Boys/SNAP Girls Child Group Evaluation Form	X					A SNAP Girls Child Group Evaluation Form was completed and maintained in the youth's file.	
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					Documentation was reviewed for the only SNAP in SCHOOLS class held during the review period (due to the Pandemic) that has one session remaining to be completed. To date the class has completed twelve weeks. Documentation of weekly attendance sheets is maintained for all twelve sessions. All attendance sheets include youth names and signatures of the teacher and SNAP facilitator.	
"Class Goal" sheet	X					A Class Goal sheet was completed for the class but not dated.	
Measure of Classroom Environment (MoCE) (Pre and Post) is used to identify baseline and treatment outcomes of reported classroom dynamics.	X					A completed Pre-MoCE evaluation was completed for the class but not the post-MoCE pending completion of the 13 th session.	



Family Resources ST Pete-March 3-4, 2021
 Lead Reviewer: Marcia Tavares

Quality Improvement Review

Pre and Post Evaluations	X					A pre-teacher evaluation was completed but no applicable post evaluation, pending completion of the last session.	
One SNAP® Fidelity Adherence Checklist completed per classroom in a 13 – week SNAP in Schools group and uploaded to Dropbox	X					One Fidelity Adherence Checklist was completed for the classroom during the SNAP cycle period.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.01						<p>YES The program has eleven policies and procedures for this indicator: 1.06 Comprehensive Safety and Emergency Disaster/Preparedness last reviewed July 2019; 1.07 Flammable, Toxic and Poisonous Control reviewed July 2019; 1.09A Key Control last reviewed July 2019; 1.09B Personal Belongings (Staff) last reviewed June 2019; 3.01 Shelter Environment last reviewed July 2019; 3.09 Special Diets last reviewed July 2019; 3.10 Youth Hygiene last reviewed July 2019; 3.11 Visitation, Correspondence, Telephone Calls, last reviewed July 2019; 3.12 Parental Notification last reviewed July 2019; 5.09 Search last reviewed July 2019; and 5.10 Client Contact last reviewed July 2019. All policies were reviewed and approved by a VP.</p> <p>NO (explain) X Policy and procedure 1.06 - Comprehensive Safety and Emergency Disaster/ Preparedness does not indicate the length of time required for fire drill evacuation.</p>	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		



Family Resources ST Pete-March 3-4, 2021
 Lead Reviewer: Marcia Tavares

Quality Improvement Review

<p>Facility Inspection</p>		<p>X</p>				<p>An onsite and virtual tour of the facility was conducted. The facility appeared to be secure, and the building and grounds were well-maintained. A metal object was observed as a potential hazard in the ground adjacent to the work shed. The shelter appeared clean and presentable. Similarly, the bedrooms were observed to be clean, organized, and free of graffiti and insect infestation. A detailed map/egress plan is posted throughout the facility, and in the boy's bedroom but not the girls. The bathrooms were clean, free of graffiti and appeared to be in working order. The dumpster is not located on the grounds because it is maintained by the county and is on the other side of the fence. It was observed closed during the tour with no surrounding debris. Laundry area was organized, free of lint and appliances appeared to be in working condition. Youth have a place to lock up personal belongings if requested. Vehicles were locked and equipped with all major safety equipment. Key control appeared to be enforced and in compliance. Chemicals used had MSDS sheets maintained for each and were kept in the utility closet and inventoried daily. Food was properly stored and labeled. The refrigerator and freezer were at the appropriate temperatures.</p> <p>The Agency has an up-to-date DCF license issued effective December 16, 2020 for one year and is displayed in the building.</p> <p>All fire and mock emergency drills were completed according to the standard requirement; however, 2 out of 3 February fire drills did not have a supervisor</p>	<p>Exception Metal object in ground near the work shed poses a potential hazard and should be removed</p> <p>Egress plan was missing from girl's bedroom area.</p> <p>Three fire drills were conducted in February 2021. Two of the drills did not have a supervisor's signature (February 16 and 24, 2021) and 1 did not have the length of time (February 16, 2021) for the drill.</p>
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Family Resources ST Pete-March 3-4, 2021
 Lead Reviewer: Marcia Tavares

Quality Improvement Review

						<p>signature and 1 did not have the evacuation time for the drill.</p> <p>The agency met standard requirements regarding agency vehicles. The agency has one vehicle that maintains all required safety equipment. The fire extinguisher and flashlight are in the vehicle and the fire aid kit, glass breaker, seat belt cutter, air bag deflator, are kept locked away in a safe and taken when the vehicle is in use.</p> <p>Client rules and hotline information is posted throughout the facility.</p>	
Fire and Safety Health Hazards	X					<p>A satisfactory annual fire inspection was last completed on October 21, 2020. The following is a list of satisfactory inspections reviewed: Fire Extinguishers 2/9/2021, Kitchen Hood 2/18/2021, Fire Safety Equipment 10/21/2020, Sprinklers 10/20/2020, Fire Alarm 10/20/2020.</p>	
Youth Engagement							
<p>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.</p> <p>b. At least one hour of physical activity is provided daily.</p> <p>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</p>		X				<p>Youth are engaged in meaningful, structured activities during the week. Church is offered to those that wish to attend, however, during COIVD it has been via Zoom. The daily schedule is posted in the facility. Daily programming schedule is publicly posted and accessible to both staff and youth. Youth are engaged in meaningful, structured activities seven days a week during awake hours. Youth are provided opportunity for at least one hour of physical activity per day. Youth are given the choice participate in faith-based activities. Daily programming does include the opportunity</p>	<p>Exception None of the 4 youth files reviewed showed evidence, 7 days a week, of activities or physical activity documented on the service logs, group logs or the counseling life skills group summary sheets. There were 5 weeks of the logbook reviewed and it did not provide documentation of activities being consistent 7 days a week.</p>



Family Resources ST Pete-March 3-4, 2021
Lead Reviewer: Marcia Tavares

Quality Improvement Review

<p>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.</p>						<p>for youth to complete homework and access age appropriate, approved books for reading, and quiet time to read.</p>	
<p>Provider has a written policy and procedure that meets the requirement for Indicator 3.02</p>						<p>YES X NO (explain) The program has the required policy #3.02 that was last reviewed July 2019 and approved by a Vice President.</p>	
<p>Rating Criteria</p>	<p>Satisfactory</p>	<p>Non-compliant</p>	<p>No Eligible Items for Review</p>	<p>No Practice</p>	<p>Not Applicable</p>		
<p>Youth received a comprehensive orientation and handbook provided within 24 hours</p>	<p>X</p>					<p>Four youth records were reviewed, one open and three closed. All youth were provided with a comprehensive orientation and provided with a handbook at the time of intake.</p>	
<p>Orientation includes the following: a. Youth is given a list of contraband items b. Disciplinary action is explained c. Dress code explained d. Review of access to medical and mental health services e. Procedures for visitation, mail and telephone f. Grievance procedure g. Disaster preparedness instructions h. Physical layout of the facility i. Sleeping room assignment and introductions</p>	<p>X</p>					<p>During the initial intake, orientation includes the program expectations and a description of the Behavior Management Plan. It outlines the dress code and includes a list of items considered to be contraband. Client rights and responsibilities are explained as well as the grievance procedures. Orientation also reviews access to medical and mental health services, procedures for visitation, mail, and visitation. Youth are made aware of the disaster preparedness instructions. Youth are made aware of their room assignments at the time of intake. Staff reviews suicide awareness and prevention protocols with youth during orientation.</p>	



Family Resources ST Pete-March 3-4, 2021
Lead Reviewer: Marcia Tavares

Quality Improvement Review

j. Suicide prevention-alerting staff of feelings or awareness of others having suicidal thoughts							
Documentation of each component of orientation, including orientation topics and dates of presentation, as well as signatures of the youth and staff involved is maintained in the individual youth record	X						All four files contained the required information regarding youth orientation. Documentation of all 4 youth having received a youth handbook was in the files. All the files contained documentation of youth and staff signatures.
Provider has a written policy and procedure that meets the requirement for Indicator 3.03						YES X NO (explain) The program has the required policy #3.03 that was last reviewed July 2019 and approved by a Vice President.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
A process is in place that includes an initial classification of the youths, to include:							
a. Review of available information about the youth's history, status and exposure to trauma b. Initial collateral contacts, c. Initial interactions with and observations of the youth d. Separation of younger youth from older youth, e. Separation of violent youth from non-violent youth f. Identification of youth susceptible to victimization g. Presence of medical, mental or physical disabilities h. Suicide risk i. Sexual aggression and predatory behavior j. Sexual orientation gender identity/ expression	X						There were 4 files, 3 closed and 1 open reviewed. Each file contained documentation of the required information being addressed before the youth room assignment with the exception of one youth file not indicating that sexual aggression was discussed.



Family Resources ST Pete-March 3-4, 2021
Lead Reviewer: Marcia Tavares

Quality Improvement Review

k. Acute health symptoms requiring quarantine or isolation							
An alert is immediately entered into the program's alert system when a youth is admitted with special needs and risks such as risk of suicide, mental health, substance abuse, physical health or security risk factors	X						Alerts were clearly documented in all four records at intake and the alerts are documented in the logbook as well.
Provider has a written policy and procedure that meets the requirement for Indicator 3.04						YES X	NO (explain) The program has the required policy #3.04 that was last reviewed July 2019 and approved by a Vice President.
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					Five weeks of the logbook entries were reviewed: September 1-7, 2020; November 15-21, 2020; December 21-28, 2020; January 1-7, 2021; February 8-15, 2021. Pertinent information in the logbook was highlighted; however, it was observed to be inconsistent. For example, some new intakes were highlighted and some were not. Several single youth transports were not highlighted for the beginning and ending times and, on 1/6/21, a single youth transport was not highlighted and did not show when the single youth transport ended.
All entries are brief, legibly written in ink and include: • Date and time of the incident, event or activity • Names of youth and staff involved • Brief statement providing pertinent information • Name and signature of person making the entry	X						Entries appeared to be written in ink and legible with a signature at the end of each entry. Dates and times of incidents/events/activities were listed with names of staff and youth involved. All pertinent information was provided.
Recording errors are struck through with a single line. The	X						The five weeks of logbook entries reviewed showed errors are marked with a



Family Resources ST Pete-March 3-4, 2021
Lead Reviewer: Marcia Tavares

Quality Improvement Review

staff person must initial and date the correction. The use of whiteout and erasures is prohibited.						single line through and are initialed. No whiteout or erasures was noticed.	
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 five weeks of logbook entries reviewed showed that the Residential Supervisor reviews a minimum of 1 time weekly and makes recommendations as needed consistently.	
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					Staff are documenting that they are reviewing the previous two shifts consistently.	
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					Both the residential supervisor and counselor reviewed and documented the dates of review in the logbook as required.	
Logbook entries include: a. Supervision and resident counts b. Visitation and home visits		X				The five weeks of logbook entries reviewed showed resident counts were entered daily at a minimum of 1 time. There was very little documentation of resident movement throughout the day. COVID has halted visitation and home visits.	Exception 5 weeks of the logbooks were reviewed and there was very minimal documentation of youth movement throughout the facility during awake time.
Provider has a written policy and procedure that meets the requirement for Indicator 3.05						YES X NO (explain) The program has the required policy #3.05 that was last reviewed July 2019 and approved by a Vice President.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
The program has a detailed written description of the BMS,	X					There were 4 residential files reviewed, 3 closed and 1 open. All files contained the required information regarding BMS	



Quality Improvement Review

<p>and it is explained during program orientation</p>						<p>during the youth orientation. Documentation of all 4 youth having received a youth handbook which also discusses the BMS was in the files. All the files contained documentation of youth and staff signatures.</p>	
<p>Behavior Management Strategies MUST include:</p> <ul style="list-style-type: none"> a. Supervisors are trained BMS is designed to teach youth new behaviors and help youth understand the natural consequences for their actions b. Behavioral interventions are applied immediately, with certainty, and reflect the severity of the behavior c. BMS uses a wide variety of awards/incentives to encourage participation and completion of the program d. Appropriate consequences and sanctions are used by the program and consequences for behavior are logical and designed to promote skill-building for the youth e. Counseling, verbal intervention and de-escalation techniques are used prior to physical intervention (Only techniques approved by the Florida Network and DJJ are used if physical intervention is required) f. Only staff discipline youth. Group discipline is not imposed g. Room restriction is not used as part of the system or for 	<p>X</p>					<p>The program uses a level system. The levels consist of Orientation, Citizenship, and Leadership. If a youth displays negative behaviors and gains a major violation, they are put on Ownership to reflect. The residents are provided opportunities for residents to earn points as rewards. The agency has signs posted throughout the facility for the youth and staff to see.</p> <p>Documentation was found in the residents files indicating the requirements are being met for this indicator.</p>	



Family Resources ST Pete-March 3-4, 2021
 Lead Reviewer: Marcia Tavares

Quality Improvement Review

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					2 staff files were reviewed and there was documentation of BMS training.	
There is a protocol for providing feedback and evaluation of staff regarding their use of BMS rewards and consequences	X					The Residential Supervisor holds monthly employee meetings and discusses the BMS.	
Supervisors are trained to monitor the use of rewards and consequences by their staff	X					Supervisors are trained to monitor the use of awards and consequences by staff.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.06						YES X NO (explain) The program has the required policy #3.06 that was last reviewed July 2019 and approved by a Vice President.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
The program maintains minimum staffing ratios as required by Florida Administrative Code and contract. • 1 staff to 6 youth during awake hours and community activities • 1 staff to 12 youth during the sleep period	X					Staff schedules were reviewed for the past 6 months which show 2 staff always scheduled on each shift with overlapping shifts. The program can have a maximum of 12 youth so this would meet the staffing ratio requirement.	
All shifts must always provide a minimum of two staff present	X					Staff schedules were reviewed for the past 6 months which shows 2 staff at all times with overlapping shifts.	



Family Resources ST Pete-March 3-4, 2021
Lead Reviewer: Marcia Tavares

Quality Improvement Review

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					Staff files were reviewed and had documentation of required trainings. There was also documentation of background screenings as indicated in Standard 1.	
The staff schedule is provided to staff or posted in a place visible to staff	X					The staff schedule is emailed to staff as well as posted at the staff station.	
There is a holdover or overtime rotation roster which includes the telephone numbers of staff who may be accessed when additional coverage is needed	X					The staff roster is posted at the staff station and the residential supervisor maintains a list of all staff with contact information who may be accessed when additional coverage is needed.	
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					Staff observe youth every 15 minutes while in their sleeping room and document in the bed check log. Reviews of bed checks and resident activities was conducted for the following randomly selected dates: February 10, 14, 20, 26, and March 1, 2021. All bed checks were completed and documented in real time. It was noted that the camera system to real time is off about 9 minutes, however still showed consistent 15-minute checks. The bedroom layout consists of 4 rooms with 3 beds in each room.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.07						YES X	NO (explain) The program has the required policy #4.13 that was last reviewed July 2019 and approved by a Vice President.
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	X					There is a written notice that is posted and visible as soon as you walk into the facility. It is also posted in other areas of the facility for youth and staff to see. The system can store video for a minimum of 30 days. The system records the date and time and is clear. The system will	



Family Resources ST Pete-March 3-4, 2021
Lead Reviewer: Marcia Tavares

Quality Improvement Review

<p>b. System can capture and retain video photographic images which must be stored for a minimum of 30 days</p> <p>c. System can record date, time, and location; maintain resolution that enables facial recognition</p> <p>d. Back-up capabilities consist of cameras' ability to operate during a power outage</p> <p>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.</p> <p>f. All cameras are visible</p>						<p>continue to operate during an outage as the facility has a generator. The cameras are located throughout the shelter inside and out and they are visible.</p>	
<p>A list of designated personnel who can access the video surveillance system is maintained (includes off-site capability per personnel)?</p>	X					<p>The residential supervisor of the program, residential supervisors from other Family Resource locations, Vice President, and CEO have access to the system.</p>	
<p>Supervisory review of video is conducted a minimum of once every 14 days and timeframes reviewed are noted in the logbook.</p> <p>The reviews assess the activities of the facility and include a review of random sample of overnight shifts</p>	X					<p>Supervisory review of video is conducted a minimum of 14 days and is documented in the logbook and the camera logbook.</p>	
<p>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</p>	X					<p>The residential supervisor responds to third-party requests within 24-72 hours.</p>	



Family Resources ST Pete-March 3-4, 2021
Lead Reviewer: Marcia Tavares

Quality Improvement Review

Camera service order/requests will be made within 24 hours of discovery of camera malfunctioning or being inoperable. All efforts made to obtain repairs are documented and maintained	X					The residential supervisor will call in a service request immediately upon notice of malfunction. There was an issue with the system during this QI review and it was immediately addressed.		
Provider has a written policy and procedure that meets the requirement for Indicator 4.01						YES X	NO (explain) The program has the required policy #4.01 that was last reviewed July 2019 and approved by a Vice President.	
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					Five youth records were reviewed, one open residential and four closed residential. All five youth were applicable for having a Healthcare Screening completed upon admission. All five youth had a healthcare screening completed the day of admission to the shelter. Screenings included: current medications, existing acute and chronic medical conditions, allergies, recent injuries or illnesses, pain or other physical distress, observations of illness, injury, pain or physical distress, observations for scars, tattoos or other skin markings, and acute health symptoms requiring quarantine or isolation.		
Referral and Follow-up								
Youth with chronic medical conditions have a referral to ensure medical care (e.g. diabetes, pregnancy, seizure disorder, cardiac disorders, asthma, tuberculosis, hemophilia, head injuries, etc.)			X			None of the five youth records reviewed had a chronic medical condition.		
When needed, the parent is involved with the coordination and scheduling of follow-up medical appointments			X			No eligible medical referrals applicable to the sample records reviewed.		



Family Resources ST Pete-March 3-4, 2021
Lead Reviewer: Marcia Tavares

Quality Improvement Review

All medical referrals are documented on a daily log.			X			No eligible medical referrals applicable to the sample records reviewed.	
The program has a thorough referral process and a mechanism for necessary follow-up medical care as required and/or needed	X					The program does have a policy in place for referring youth, as well as a log sheet to document referrals in the youth's file.	
Provider has a written policy and procedure that meets the requirement for Indicator 4.02						YES X The program has the required policy #4.02 that was last reviewed July 2019 and approved by a Vice President.	NO (explain)
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					Five youth records were reviewed, one open and four closed residential. All five youth were applicable for having a suicide risk screening completed during intake. All five youth had a screening completed at the time of admission to the shelter. All five screening results were reviewed and signed by the supervisor and documentation of the review was found in all five youth records reviewed.	
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 last 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					Four of the five youth were placed on sight and sound supervision due to an indication of suicide risk based on screening results. The unlicensed mental health professional found a recent Baker Act on a youth five days after the initial screening where the youth or parent failed to provide the information, the youth was placed on sight and sound supervision until assessment could be completed.	
Staff person assigned to monitor youth documented youth's behavior at 30 minute or less intervals	X					Observation logs for all five youth included documentation staff person assigned to monitor youth's behavior at 30-minute intervals until the youth were removed from sight-and-sound supervision.	



Family Resources ST Pete-March 3-4, 2021
Lead Reviewer: Marcia Tavares

Quality Improvement Review

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					All four youth had a suicide assessment completed by a licensed professional or unlicensed mental health professional the day of admission to the shelter and were promptly stepped down from sight and sound supervision by the licensed mental health professional following the review of the suicide assessment.	
Provider has a written policy and procedure that meets the requirement for Indicator 4.03						YES X NO (explain) The program has the required policy #4.03 that was last reviewed July 2019 and approved by a Vice President.	
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)	X					Oral medications, controlled medications, and narcotics are stored separately from injectables epi-pens and topical medications in the required Pyxis Med-Station 4000 medication cabinet. The Pyxis machine is located in a locked room and is not accessible to youth. There is a refrigeration unit stored in the medical clinic for medication requiring refrigeration.	
b. Pyxis machine is stored in accordance with guidelines in FS 499.0121 and policy section in Medication Management							
c. Oral medications are stored separately from injectable epi-pen and topical medications							
d. Medications requiring refrigeration are stored in a secure refrigerator that is used only for this purpose, at temperature range 2-8 degrees C or 36-46 degrees F. (If the refrigerator is not secure, the room is secure and inaccessible to youth.)							
e. Narcotics and controlled medications are stored in the Med-Station							
Medication Distribution							



Quality Improvement Review

<p>a. Agency maintains a minimum of 2 Super Users for the Med-Station</p> <p>b. Only designated staff delineated in User Permissions have access to secured medications, with limited access to controlled substances (narcotics)</p> <p>c. A Medication Distribution Log shall be used for distribution of medication by non-licensed and licensed staff</p> <p>d. Agency verifies medication using one of four methods listed in the FNYFS Operations Manual</p> <p>e. When nurse is on duty, medication processes are conducted by the nurse</p> <p>f. The delivery process of medications is consistent with the FNYFS Medication Management and Distribution Policy</p> <p>g. Agency does not accept youth currently prescribed injectable medications, except for epi-pens</p> <p>h. Non-licensed staff have received training in the use of epi-pens provided by a registered nurse</p>	<p>X</p>					<p>The program submitted a list that includes the names of four super users trained for the use of the Pyxis Med-station 4000 and fourteen additional designated staff authorized to distribute medication.</p> <p>Four of the five youth records reviewed were applicable for being prescribed medications, three of the four youth were prescribed controlled medications. A medication distribution log was used to document medication delivery to the four youth by licensed and non-licensed staff. Medication distribution is conducted by the nurse when on duty.</p> <p>In all four records the medication delivery process was consistent with the FNYFS medication management and distribution policy.</p> <p>The agency does not accept youth currently prescribed injectable medications, except for epi-pens.</p> <p>No youth were prescribed injectables as required and staff received the required training on how to use an epi-pen.</p>	
<p>Medication Inventory</p>							
<p>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</p> <p>b. Over-the-counter medications that are accessed regularly are inventoried weekly by</p>		<p>X</p>				<p>Three of the four applicable youth on controlled medications required a shift-to-shift count verified by a witness and is documented. Two of the three youth records had completed documentation of shift-to-shift counts being conducted and verified by two staff.</p> <p>Over-the-counter medications are brought in by the youth's guardian and are inventoried weekly.</p>	<p>Limited Exception One youth was missing the following counts: Shift to shift count not completed on 12/6/2020 for second shift, 12/11/2020 third shift, 12/12/2020 second shift, 12/19/2020 1, 2 and 3 shifts. Second staff verification of count missing on 12/6/2020 second and third shift, 12/10/2020 third shift, 12/11/2020 first shift, 12/12/2020</p>



Family Resources ST Pete-March 3-4, 2021
Lead Reviewer: Marcia Tavares

Quality Improvement Review

maintaining a perpetual inventory c. Syringes and sharps (needles, scissors, etc.) are secured, and counted and documented weekly						All sharps, including razors and scissors, are secured and inventoried daily.	first shift, 12/13/2020 third shift, 12/14/2020 first shift, 12/15/2020 third shift, 12/18/2020 first shift, 12/20/2020 first shift, 12/21/2020 third shift, 12/22/2020 second and third shift, 12/23/2020 first shift.
There are monthly reviews of medication management practice via Knowledge Portal or Pyxis Med-Station Reports.	X					Monthly reviews of medication management practices are done by the nurse and/or residential supervisor.	
Medication discrepancies are cleared after each shift.		X				Three youth on controlled medications required a shift-to-shift count. Medication discrepancies being cleared could not be determined for one applicable youth, however, the other two youth records with controlled medication had no discrepancies noted.	Limited Exception Medication count discrepancies were not cleared after each shift for one youth.
Provider has a written policy and procedure that meets the requirement for Indicator 4.04						YES X NO (explain) The program has the required policy #4.04 that was last reviewed July 2019 and approved by a Vice President.	
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					Five youth records were reviewed, one open and four closed residential. All five youth required an alert for medical or mental health conditions, or a food allergy and the alerts were completed per policy.	
Alert system includes precautions concerning prescribed medications, medical/mental health conditions	X					The alert system included precautions concerning prescribed medications on four of the four applicable youth taking medications. The alert system included precautions for youth with mental health conditions or being placed on sight and sound supervision for all five youth.	
Staff are provided sufficient training, information and instructions to recognize/respond to the need for emergency care for medical/mental health problems	X					Staff are trained in CPR/First Aid to recognize/respond to the need for emergency care for medica/health problems. CPR/First Aid training was verified in all 6 training records reviewed.	
A medical and mental health alert system is in place that ensures information concerning a youth's medical condition, allergies,	X					The program utilizes a color-coded alert system. Each alert is assigned a color. Red is for constant sight and sound, green is for mental health, blue is for substance	



Family Resources ST Pete-March 3-4, 2021
Lead Reviewer: Marcia Tavares

Quality Improvement Review

common side effects of prescribed medications, foods and medications that are contraindicated, or other pertinent mental health treatment information, is communicated to all staff						abuse, purple is for sharps restriction, black is for medical issues, orange is for medications, and pink is for allergies and special diets. An assessment is completed on each youth and a color-coded sticker is placed on the side of the youth's file and on the programs alert board to inform staff of the alerts for each youth. The alerts are also logged in the logbook and it is documented that each staff reviews the logbook when they come on staff.	
Provider has a written policy and procedure that meets the requirement for Indicator 4.05						YES X NO (explain) The program has the required policy #4.05 that was last reviewed July 2019 and approved by a Vice President.	
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	X					Two applicable youth records were reviewed for off-site emergency medical or dental care. Both youth records indicated there was an internal reports submitted for the incident and a Central Communications Center (CCC) report completed as required.	
b. Upon youth return, there is a verification receipt of medical clearance via discharge instructions with follow-up is present in file						Both records indicated the parent was notified. Both youths' incidents were uploaded into the daily log.	
c. Youth's parent/guardian was notified						A daily Episodic Logbook is kept for all incidents. The daily log includes the date, name of youth, a brief description of the incident, what treatment was rendered, any notifications, and staff initials.	
d. A daily log is maintained for emergency care provided							
All staff are trained on emergency medical procedures	X					Staff were trained in 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 a knife-for-life and wire cutters located in the staff office.	
First aid kit/supplies are fully equipped and inventoried	X					The first aid kit is fully equipped and located in a locked cabinet behind the YDS desk. A weekly inventory of the first aid kit was verified for August 2020-January 2021.	



Family Resources ST Pete-March 3-4, 2021
Lead Reviewer: Marcia Tavares

Quality Improvement Review