Florida Network for Youth and Family Services
Compliance Monitoring Report for

PREVENTION CENTRAL

1100 W Sunrise Boulevard
Fort Lauderdale, FL 33311

Compliance Monitoring Services Provided by

EXECUTIVE SUMMARY

Forefront LLC conducted a joint Quality Improvement (QI) and Florida Network of Youth and Family Services (FNYFS) virtual monitoring visit for Prevention Central, located at 1100 W. Sunrise Boulevard, Fort Lauderdale, Florida, for the FY 2020-2021 contract on October 28, 2020. 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. Prevention Central, formerly Mount Bethel Human Services Corporation, is contracted with the Florida Network of Youth and Family Services (FNYFS) to provide direct community-based 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 PREVENTION CENTRAL present for the entrance interview were: Dr. Rosby Glover, Executive Director; Tierra Smith, Chief Administrative Officer; Terence Washington, Prevention Program Director; Marie Wells, SNAP Program Director; Jandra Alexander, SNAP Coordinator; and case managers Ronald Thimothee and Paolo Andujar. The last onsite QI visit was conducted December 18, 2019.

In general, the Reviewer found that Prevention Central satisfactorily meets the requirements of specific contract requirements. **Prevention Central received an overall compliance rating of 100% as a result of compliance with all eleven (11) applicable indicators** of the Administrative and Fiscal Contract Monitoring Tool. Two of the indicators were not applicable because the provider does not currently have inventory purchased through FNYFS funds and there are no current corrective action items cited by an external funding source. There are no corrective actions cited or recommendations made as a result of the contract monitoring visit.

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

2020-2021 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 10-28-2020-2021

Agency Name: Prevention Central	**Monitor Name: Marcia Tavares, Lead Reviewer**
Contract Type : CINS/FINS	**Region/Office: 1100 W Sunrise Blvd, Fort Lauderdale, FL 33311**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): October 28, 2020**

Major Programmatic Requirements	**Explain Rating**					**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)**
	Unacceptable	**Conditionally Unacceptable**	**Fully Met**	**Exceeded**	**Not Applicable**		
I. Administrative and Fiscal							
DJJ Quality Improvement Peer Reviewer a. Provider shall demonstrate that a minimum of two (2) staff members have been trained to be certified as DJJ QI Peer reviewers. Provider shall participate in a minimum of one (1) on-site quality assurance review of a similar type program in another judicial circuit during each 12-month period of the contract, if requested.	☐	☐	☒	☐	☐	I- The provider currently has two certified DJJ-QI Peer Reviewers: Rosby Glover and Terrance Washington. Terrance Washington participated in a QI Peer Review during the current FY.	
Additional Contracts a. Provider shall provide a listing of all current federal, state, or local government contracts, as well as other contracts entered into with for profit and not-for-profit organizations. Such listing shall identify the awarding entity and contract start & end dates. **PTV**	☐	☐	☒	☐	☐	D - The agency maintains a list of 3 additional contracts for FY 2020-2021. The list includes: Funder, amount funded, service provided, and contract term dates. The program also maintains interagency agreements and Memorandums of Agreement (MOUs) with schools, mental health, and substance abuse providers. All agreements reviewed during the QI visit had current contract/agreement dates.	

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Limits of Coverage a. Provider shall provide and maintain during this contract, the following minimum kinds of insurance: Worker's Compensation and Employer's liability insurance as required by Chapter 440, F.S. with a minimum of $100,000 per accident, $100,000 per person and $500,000 policy aggregate. Commercial General Liability with a limit of $500,000 per occurrence, and $1,000,000 policy aggregate. Automobile Liability Insurance shall be required and shall provide bodily injury and property damage liability covering the operation of all vehicles used in conjunction with performance of this contract, with a minimum limit for bodily injury of $250,000 per person; with a minimum limit for bodily injury of $500,000 per accident; with a minimum limit for property damage of $100,000 per accident and with a minimum limit for medical payments or $5,000-$10,000 per person. Florida Network is listed as payee or co-payee. **PTV**	☐	☐	☐	☒	☐	D – Prevention Central provided a certificate of liability insurance that included: Commercial Liability Insurance with Western World Insurance with a limit of $1,000,000 per occurrence (exceeds minimum), and $3,000,000 policy aggregate (exceeds minimum), effective through 7/26/2021. Automobile Liability Insurance through Western World Insurance Co. with a combined single limit of 1,000,000 (exceeds minimum) effective until 7/26/2021. Director and Officer/Employment Practice Data Security Insurance through United States Liability Insurance Co. with a limit of 1,000,000 effective through 7/26/2021. Workers Compensation Insurance through Associated Industries Insurance Company Inc. with a $100,000 limit per accident /per	

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						employee and $500,000 policy limit effective 10/26/2019-10/26/2020. The Florida Network is listed on the Certificate of Liability Insurance 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**	☐	☐	☐	☐	☒	I - During the Entrance Conference, the provider indicated that there are no outstanding corrective action item(s) cited by an external funding source.	
Fiscal Practice a. Agency must have employee and fiscal policy/procedures manuals that are in compliance with GAAP and provide sound internal controls. Agency maintains fiscal files that are audit ready. **PTV**	☐	☐	☒	☐	☐	D - The agency maintains accounting policies and procedures in place for: accounting principles and procedures, payroll procedures, cash receipts, cost allocations, reserves and designated funds, and budgeting. The procedures reviewed appear to be consistent with GAAP and provide for sound internal controls.	
b. Agency maintains a general ledger and the corresponding source documents. General ledger must be set up to track the activity of the grant separately (standard account numbers / separate funds for each revenue source, etc.). **PTV**	☐	☐	☒	☐	☐	D- The General Ledger for the CINS/FINS program for FY 2020-2021 as of September 30, 2020 was provided. The general ledger (GL) is structured to track all funding sources and there is a separate GL for the CINS/FINS program which uses a chart of accounts that includes the type of transaction, date, Invoice #,	

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						Payee, description, debit/credit amount, and balance. Specific expenditures related to the CINS/FINS program were reviewed on the GL and were found to be consistent with standard program expenditures.	
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**	☐	☐	☒	☐	☐	D - Prevention Central provided a Petty Cash policy and procedure which states a $50 request maximum amount and petty cash fund of $500. Petty cash is documented on a petty cash transaction list, petty cash reconciliation sheet, and related petty cash disbursement supporting documents (request forms and receipts). The HR/Data Specialist is the petty cash custodian.	
d. Financial records and reports are current. Includes bank statements reconciled within 6 weeks of receipt. Vendor invoices past 6 months. Invoices are submitted on a monthly basis with supporting documentation. (Disbursements/invoices are approved & monitored by management). **ON SITE**	☐	☐	☒	☐	☐	D- Prevention Central provided Bank of America bank statements and corresponding bank reconciliations for the past 6 months, April-September 2020. All reconciliation reports reviewed showed reconciliation date within 6 weeks of receipt of the bank statement (5 were completed within one week and one within 3 weeks). Provider prepared a Reconciliation	

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						Detail for each month listing the statement period ending dates, dates reconciled, beginning balance, cleared balance, register balance, and ending balance. Beginning and ending balances of the bank statements match the beginning and cleared balances on the reconciliation reports. The printed copies did not show signatures of parties completing and/or approving the reconciliation.	
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**	☐	☐	☐	☐	☒	**Not Applicable** Per Program Director, Prevention Central has not purchased any FN inventory or item amounting to more than $1000 since the last QI visit.	
f. Agency submits payroll taxes and deposits (and retirement deposits as applicable), Employee IRS Form W-2 and Independent Contractors IRS Form 1099 forms prior to federal requirements. **ON SITE**	☐	☐	☒	☐	☐	Documentation: Agency provided a printout of Form 941 and Schedule B 941 (Report of Tax Liability) for the 1st and 2nd quarters of 2020. On the Schedule B 941, the 1st quarter shows 2 payments made and the 2nd quarter shows a total of 8 payments made. No balances were reported on the two quarterly 941s reviewed. Per the Executive	

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						Director, the agency had paid off the tax liability for last year's payroll taxes and is currently up-to-date on current payroll taxes. The agency currently has a payment arrangement of $1500 each month with the IRS for repayment of delinquent taxes (2012-2015). Since the last onsite visit, the agency has contracted with Paladin Group accounting firm for fiscal responsibilities and with Village Growth to provide fiscal oversight. The agency contracts with ADP for payroll services.	
g. Budget to actual reports prepared and reviewed by appropriate management. Variance from the budget are investigated and explained. **PTV/ON SITE**	☐	☐	☒	☐	☐	Documentation: Agency provided budget to actual year-to-date reports for FY 2020-2021. The report shows actual year-to-date expenditures, budgeted amounts, and variance. A review of these documents was conducted. Reports shows a net loss of approximately $49,000 y-t-d. Variances in budget are monitored on a regular basis and are discussed with the Board.	

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h. A Single Audit is performed as part of the annual audit if expenses are greater than $750,000. The agency must submit a Corrective Action Plan for findings cited in the management letter and single audit. An annual financial audit was completed within 120 days after the previous fiscal year/calendar year and that a copy was provided to the Network unless and extension has been requested and approved in writing. Copy of Audit is submitted to the FNYFS by December 31st. **Obtain from FNYFS**	☐	☐	☒	☐	☐	Documentation: Financial audit conducted for year ending June 30, 2019 was completed by BAS Partners LLC, Certified Public Accountant, on May 26,2020. A separate Management Letter requiring a Corrective Action Plan was not issued by the auditor. Per the ED, the auditor is currently processing its fiscal audit for 2020 and it's expected to be completed by year's end.	
i. Agency maintains confidentiality policy with written policies and procedures to ensure the security and privacy of all employee and client data. Personal information is not easily accessible. Agency maintains a backup system in case of accidental loss of financial information. Security procedures are in place to protect laptops. Obsolete documents are shredded and computer hard drives are wiped prior to discarding. **ON SITE**	☐	☐	☒	☐	☐	Documentation: Review of the agency's Record Retention and Confidentiality policies and procedures that address secure and confidential storage, retention timeframe, and access to records. The policy is applicable to youth, personnel, and financial records. Agency maintains quarterly back-up of files which is kept in a safe. Cloud storage is used for daily back up of files.	

CONCLUSION

Prevention Central has met the requirements for the CINS/FINS contract as a result of full compliance with 11 applicable indicators of the Administrative and Fiscal Contract Monitoring Tool. Two of the thirteen indicators were not applicable as follows: 1) the provider did not have any inventory purchased with FN/DJJ funds, and 2) the agency does not have any current corrective action items cited by an external funding source. Consequently, t**he overall compliance rate for this contract monitoring visit is 100%.** There are no corrective actions cited or recommendations made as a result of the contract monitoring visit. Overall, the provider is performing satisfactorily in meeting the fiscal and administrative terms of its contract. In addition, the majority of indicators reviewed were carried out in a manner which meets the standard as described in the report findings.

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

Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Prevention Central – Fort Lauderdale
CINS/FINS Program

October 28, 2020

Compliance Monitoring Services Provided by

FOREFRONT

CINS/FINS Rating Profile

Standard 1: Management Accountability

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

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

Standard 2: Intervention and Case Management

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

Percent of indicators rated Satisfactory: 90.00%
Percent of indicators rated Limited: 10.00%
Percent of indicators rated Failed: 0.00%

Overall Rating Summary
Percent of indicators rated Satisfactory: 93.75%
Percent of indicators rated Limited: 6.25%
Percent of indicators rated Failed: 0.00%

Rating Definitions

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

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

Reviewer

Members

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

Tevis Bush - Department of Juvenile Justice

Solange Solis – Children's Home Society

Quality Improvement Review

Prevention Central – October 28, 2020
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 2019).

Persons Interviewed

- ☐ Chief Executive Officer
- ☐ Chief Executive Officer
- ☒ Chief Financial Officer
- ☐ Program Coordinator
- ☐ Direct – Part time
- ☐ Volunteer
- ☐ Clinical Director
- ☐ Counselor Non-Licensed
- ☐ Advocate
- ☐ Nurse – Full time
- ☒ Executive Director
- ☒ Program Director
- ☐ Direct – Care Full time
- ☐ Direct – Care On-Call
- ☒ Intern
- ☐ Counselor Licensed
- ☒ Case Manager
- ☒ Human Resources
- ☐ Nurse – Part time
- ☐ Chief Operating Officer
- ☐ Program Manager
- **2** # Case Managers
- **0** # Program Supervisors
- **0** # Food Service Personnel
- **0** # Healthcare Staff
- **0** # Maintenance Personnel
- **N/A** # 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
- ☒ Supplemental Contracts
- ☐ Telephone Logs
- ☐ Vehicle Inspection Reports
- ☐ Visitation Logs
- ☒ Youth Handbook
- **0** # Health Records
- **0** # MH/SA Records
- **4** # Personnel /Volunteer Records
- **4** # Training Records
- **8** # Youth Records (Closed)
- **7** # Youth Records (Open)
- _ # Other:

Surveys

- **0** # Youth
- **3** # Direct Care Staff
- **0** # Other: _____

Observations During Review

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

Comments

Due to COVID-19, this QI review was completed remotely.

Overview

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

Prevention Central, formerly Mount Bethel Human Services Corporation (MBHSC) is a non-profit community-based corporation contracted with the Florida Network of Youth and Family Services (Florida Network) to provide non-residential services to youth and families through the Children In Need of Services/Families In Need of Services (CINS/FINS) program in Broward County. The program is located at 1100 W. Sunrise Boulevard, Fort Lauderdale, Florida. Funding through CINS/FINS allows the agency to serve both male and female youth up to seventeen years old that are locked out, runaway, ungovernable and/or truant, homeless, abused, neglected, or at-risk. The agency also provides services to special populations who meet the criteria for Family and Youth Respite Aftercare Services (FYRAC) and is also contracted to provide SNAP Clinical Group and SNAP in School programs.

Since the last onsite QI review on December 18, 2019, the agency changed its name from Mount Bethel Human Services Corporation to Prevention Central. This change was filed with the State of Florida on 2/19/2020.

Also, during the past year, the program experienced turnover in a few key positions such as the Chief Administrative Officer (November 2019), HR Specialist/Data Integrity Officer (January 2020), SNAP Coordinator (May 2020), and CINS/FINS Case Manager (July 2020). All the positions including the data entry position were replaced and the former Fiscal Manager is serving as the HR/Office Manager. The agency has contracted with Village Growth for fiscal responsibilities. The program is also currently utilizing the services of an intern since August 2020.

As a result of the Covid-19 pandemic, staff are working remotely. Parental consent for services is obtained electronically via text/email and intake is conducted virtually. Outreach efforts are also conducted remotely as program staff reaches out via email to school social workers and other agencies and participate in DJJ Circuit meetings through Zoom. The program has conducted food drives and obtained school supplies to continue to meet the needs of its youth and families.

Narrative Summary

Prevention Central is under the leadership of an Executive Director, a Chief Administrative Officer, a Director of Prevention Services, and Director of Outreach Services. The CINS/FINS program is staffed with two case managers, one bi-lingual Spanish-speaking and one multi-lingual. No current staff vacancies were reported at the time of the QI visit.

The overall findings for the QI review for Prevention Central are summarized as follows:

Standard 1 has a total of seven indicators regarding Management Accountability. One of the indicators, Indicator 1.06- Client Transportation, is not applicable for non-residential programs. All six remaining indicators in Standard 1 were rated satisfactory with no exceptions (1.01, 1.02, 1.03, 1.04, 1.05, and 1.07).

Standard 2 has a total of ten indicators that relate to intervention and case management. Eight of the ten indicators were rated satisfactory with no exceptions. Indicator 2.03 was rated satisfactory with exception and indicator 2.01 received a Limited rating

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

Standard 2:
Indicator 2.01 – Limited*.*
None of the ten files reviewed contained evidence that youth and parent/guardian received, in writing, available service options, rights & responsibilities of youth, parents and/or guardians. Additionally, none of the ten files contained evidence the program made available (or reviewed) youth and parents/guardians: possible actions occurring through involvement with CINS/FINS services and grievance procedures.

CINS/FINS QUALITY IMPROVEMENT TOOL

Quality Improvement Indicators	Rating: Explain – Satisfactory	Non-compliant	No Eligible Items For Review	No Practice	Not Applicable	Review Based Upon **Document Source:** *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
Standard One – Management Accountability							
1.01: Background Screening and compliance with DJJ OIG statewide procedures regarding BS of employees, contractors and volunteers							
Provider has a written policy and procedure that meets the requirement for Indicator 1.01						☒ YES ☐ NO (explain) Policy PC1.01 last reviewed 6/30/20 and effective 7/1/10 was approved by the CEO.	
a. 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.	☒	☐	☐	☐	☐	The agency uses Avatar pre-employment suitability assessment. The program has been using the tool since September 2018 and has established a pass rate of 70%. The Avatar was administered prior to the hiring of a new staff who received a score of 67%. No documentation was provided to support the hiring of staff with sub-score results.	
b. 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	☒	☐	☐	☐	☐	A total of three eligible background screening files were reviewed for two new staff hired since the last onsite QI review and one intern/volunteer. The background screenings and eligible results were obtained prior to hire/start date.	
c. Five-year re-screening completed every 5 years from initial date of hire	☒	☐	☐	☐	☐	There was one staff eligible for 5-year re-screening during the review period. The new employee was background screened and had evidence of a DJJ Clearinghouse valid retained prints through 11/23/2021.	
d. Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?	☒	☐	☐	☐	☐	Annual Affidavit of Compliance with Good Moral Character was submitted to the Department of Juvenile Justice Background	

Quality Improvement Indicators	Rating: Explain – Satisfactory	Non-compliant	No Eligible Items For Review	No Practice	Not Applicable	Review Based Upon **Document Source:** *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
						Screening Unit on January 14, 2020 with email confirmation of receipt by DJJ BSU.	
e. Proof of E-Verify for all new employees obtained from the Department of Homeland Security	☒	☐	☐	☐	☐	E-verify and proof of employment authorization is on file in the two employee's HR file.	
1.02: Provision of an abuse free environment to ensure safety and abuse free environment for youth in care							
Provider has a written policy and procedure that meets the requirement for Indicator 1.02						☒ YES ☐ NO (explain) Policy PC1.02, was reviewed and approved by the CEO on 6/30/2020. PC1.02 does not address the grievance process but the program has a separate un-numbered policy for grievance procedures.	
Abuse Free Environment							
a. Agency has a code of conduct of policy and there is evidence that staff are aware of agency's code of conduct.	☒	☐	☐	☐	☐	The program staff are provided an employee handbook which outlines the code of conduct procedure. Staff are required to sign the code of conduct verifying they have read and understand the policy.	
b. Child Abuse Registry telephone number is visible to youth and posted common areas of the facility	☒	☐	☐	☐	☐	Observations during virtual tour confirmed the program has the Florida Abuse Hotline and the Central Communications Center (CCC) telephone numbers posted throughout the facility.	
c. Youth were informed of the Abuse and Contact Number (see youth survey results)	☒	☐	☐	☐	☐	All 10 youth files reviewed had notes indicating information was communicated about the abuse hotline through the virtual meeting with youth and family during intake.	
d. Management takes immediate action to address any incidents of threats or abuse	☐	☐	☒	☐	☐	No incidents of abuse or threats by staff was identified and/or reported during the review period needing management action.	
Grievance Process							

Quality Improvement Indicators	Rating: Explain: Satisfactory	Non-compliant	No Eligible Items For Review	No Practice	Not Applicable	Review Based Upon **Document Source:** *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
a. Agency has a formal grievance process	☒	☐	☐	☐	☐	The grievance process is outlined in the program's grievance policy and youth handbook.	
b. Locked box accessible to only management and available to youth in a common area	☒	☐	☐	☐	☐	The program has a locked box designated for youth to submit a grievance if they feel their basic right have been denied or violated. Youth have access to the grievance forms, which are located next to the grievance box. If the grievance is not submitted in person, then the grievance is mailed to the Program Director. An interview with Prevention Program Director indicated the program had no grievances since the last review.	
c. Direct care does not handle the complaint/grievance unless assistance is asked for by the youth	☒	☐	☐	☐	☐	Per agency's policy, once the grievance is filled out, it is placed in the grievance box at the facility by youth or mailed to the Program Director.	
d. 72-hour resolution requirement by management	☐	☐	☒	☐	☐	An interview with Prevention Program Director indicated the program had no grievances since the last review. Grievances are to be resolved by the program supervisor within 72 hours of submission and maintained for one year which the program is aware and has designated a file folder in the event a grievance has been filed.	
e. Grievance maintained on file for a minimum of 1 year	☐	☐	☒	☐	☐	There were no grievances or staff complaints submitted since the last QI review.	
1.03: Incident Reporting							
Provider has a written policy and procedure that meets the requirement for Indicator 1.03						☒ YES ☐ NO (explain) Policy PC1.03 was reviewed and approved by the CEO on 6/30/2020.	
a. During the past 6 months, the program notified the Department's CCC (Central Communication Center) no later than two hours after any	☐	☐	☒	☐	☐	A review of the Central Communication Center (CCC) reports for the past twelve	

Quality Improvement Indicators	Rating: Explain – Satisfactory	Non-compliant	No Eligible Items For Review	No Practice	Not Applicable	Review Based Upon **Document Source:** *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
reportable incident occurred or within two hours of the program learning of the incident						months indicated there were no incidents reported.	
b. The program completes follow-up communication tasks/special instructions as required by the CCC	☐	☐	☒	☐	☐	No CCC incidents to review.	
c. Incidents are documented in the program logs and on incident reporting forms	☐	☐	☒	☐	☐	No CCC incidents to review.	
d. All incident reports are reviewed and signed by program supervisors/directors	☐	☐	☒	☐	☐	No CCC incidents to review.	
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 ☒ NO (explain) Policy PC1.04 was reviewed and approved by the CEO on 6/30/2020.	A review of the program policy does not reflect universal precautions as a training topic for the first year of employment.
First Year Direct Care Staff							
a. Direct care staff receives all mandatory training during the first 120 days of employment	☐	☐	☒	☐	☐	The program has two new employees since the last review. Both employees have begun the required training in order to receive the necessary and essential skills; however, both have not been employed longer than 120 days.	
b. Direct care staff completes all mandatory Florida Network and SkillPro training during the first year employment.	☐	☐	☒	☐	☐	New employees have not yet completed a full year of service.	
Non-licensed Mental Health Clinical Shelter Staff (within first year of employment)							
a. Non-licensed mental health clinical shelter staff Assessment of Suicide Risk Training	☐	☐	☐	☐	☒	N/A for Non-residential program	
b. 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	☐	☐	☐	☐	☒	N/A	

Quality Improvement Indicators	Rating: Explain: Satisfactory	Non-compliant	No Eligible Items For Review	No Practice	Not Applicable	Review Based Upon **Document Source:** *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
(includes date, signature and license number of the licensed mental health professional supervisor).							
In-service Direct Care Staff							
Direct care staff completes 24 hours of mandatory refresher Florida Network, SkillPro, and job-related training annually *(40 hours if the program has a DCF child caring license).*	☒	☐	☐	☐	☐	Two in-service training records were reviewed and verified each received the required training and an excess of twenty-four hours of in-service training.	
Required Training Documentation							
The program maintains an individual training file for each staff, which includes an annual employee training hours tracking form and related documentation, such as certificates, sign-in sheets, and agendas for each training attended.	☒	☐	☐	☐	☐	The program maintains individual training files for each employee, which include annual employee training hours tracking forms and related documentation, such as certificates, sign-in sheets, and agendas for trainings completed.	
1.05: Analyzing and Reporting Information **The program collects and reviews several sources of information to identify patterns and trends. Program should have sample reports of aggregated data and committee/workgroup minutes analyzing information.**							
Provider has a written policy and procedure that meets the requirement for Indicator 1.05						☐ YES ☒ NO (explain) Policy PC1.05 was reviewed and approved by the CEO on 6/30/2020.	Policy and procedures do not describe process in place to review and improve accuracy of data entry and collection.
Quarterly Reviews							
a. Case record review reports demonstrate reviews are conducted quarterly, at a minimum	☒	☐	☐	☐	☐	Monthly peer record reviews were verified as follows: April-May, 21 reviews; Jun-July,13 reviews; Aug-Sept, 9 reviews = 43 total.	
b. The program conducts reviews of incidents, accidents, and grievances quarterly, at a minimum	☒	☐	☐	☐	☐	Incidents, accidents, and grievance data is collected and reviewed monthly at staff meetings by the program staff. Verification of monthly meetings was evidenced by staff meeting agendas, minutes, and attendance.	
Annual Reviews							

Quality Improvement Review

Quality Improvement Indicators	Rating: Satisfactory	Explain: Non-compliant	Explain: No Eligible Items For Review	Explain: No Practice	Explain: Not Applicable	Review Based Upon – Document Source: *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes – **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
a. The program conducts an annual review of customer satisfaction data	☒	☐	☐	☐	☐	Satisfaction surveys were reviewed with staff at the June 29, 2020 meeting, discussing findings for 18 responses.	
b. The program conducts an annual review of outcome data	☒	☐	☐	☐	☐	The executive director receives monthly benchmark reports from the Florida Network which shows the program's performance in relation to program outcomes. The reports are emailed to the Prevention Program Director who reviews them monthly at staff meetings; staff meeting minutes reviewed supported this practice.	
Monthly Reviews							
The program conducts a monthly review of NetMIS data reports	☒	☐	☐	☐	☐	Netmis data reports are reviewed at monthly staff meetings held virtually and were included on the agenda and minutes for each meeting.	
Quality Improvement Process							
a. The program has a process in place to review and improve accuracy of data entry & collection	☒	☐	☐	☐	☐	Designated data staff is responsible for ensuring Netmis and JJIS data quality checks are conducted, and data entry is accurate.	
b. There is documentation that findings are regularly reviewed by management and communicated to staff and stakeholders.	☒	☐	☐	☐	☐	As evidenced by the program's monthly staff meetings minutes.	
c. There is evidence that strengths and weaknesses are identified, improvements are implemented or modified and staff are informed and involved throughout the process.	☒	☐	☐	☐	☐	Monthly staff meetings were found to document discussion of QI activities, reports, and areas identified as needing improvements resulting from analysis of data collected.	
1.06: Client Transportation **Policy is established to avoid situations that put youth or staff in danger of real or perceived harm, or allegations of inappropriate conduct by either staff or youth.**							
Provider has a written policy and procedure that meets the requirement for Indicator 1.06						☐ YES ☐ NO (explain) ☒ N/A	Indicator 1.06 is not applicable for non-residential service providers.
Approved agency drivers							

Quality Improvement Indicators	Rating: Satisfactory	Rating: Explain: Non-compliant	Rating: Explain: No Eligible Items For Review	Rating: Explain: No Practice	Rating: Explain: Not Applicable	Review Based Upon **Document Source:** *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
a. Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	☐	☐	☐	☐	☒	N/A	
b. Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	☐	☐	☐	☐	☒	N/A	
Third party present in the vehicle							
a. Agency's Transportation policy prohibit transporting a client without maintaining at least one other passenger in the vehicle during the trip and include exceptions in the event that a 3rd party is NOT present in the vehicle while transporting	☐	☐	☐	☐	☒	N/A	
b. 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	☐	☐	☐	☐	☒	N/A	
c. The 3rd party an approved volunteer, intern, agency staff, or other youth	☐	☐	☐	☐	☒	N/A	
Transportation documentation							
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	☐	☐	☐	☐	☒	N/A	
1.07: Outreach Services **The agency participates in local DJJ board and council meetings to increase public safety by reducing juvenile delinquency through effective prevention, intervention and treatment services and ensure CINS/FINS services are represented in a coordinated approach.**							
Provider has a written policy and procedure that meets the requirement for Indicator 1.07						☒ YES ☐ NO (explain) Policy PC1.07 was reviewed and approved by the CEO on 6/30/2020.	

Quality Improvement Indicators	Rating: Explain – Satisfactory	Non-compliant	No Eligible Items For Review	No Practice	Not Applicable	Review Based Upon **Document Source:** *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
a. 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	☒	☐	☐	☐	☐	Review of documentation and staff interviews confirmed the program consistently and actively participate monthly in local Department of Juvenile Justice Advisory Board and council meetings as well as other community meetings.	
b. 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.	☒	☐	☐	☐	☐	The agency has a designated position, Director of Outreach, to provide outreach services. The program has a strong community impact by offering community awareness, information and educational services to youth and families. The program meets the needs of the community by providing services to include food distribution, school supplies, individuals and groups discussions, distribute program materials at community events, school presentations, and participate in fund raising events.	
c. The program maintains written agreements with other community partners which include services provided and a comprehensive referral process.	☒	☐	☐	☐	☐	The program has memorandums of agreement with the Community Based Connections, and the O.K.A.Y. Institute, Inc. to enhance the services provided to youth and families.	
Standard Two – Intervention and Case Management							
2.01: Screening and Intake							
Provider has a written policy and procedure that meets the requirement for Indicator 2.01						☒ YES ☐ NO (explain) Policy PC2.01 was last reviewed 06/30/2020 and with an effective date of July 1, 2020 and approved by the CEO.	
Eligibility screening is completed within 7- calendar days of referral	☒	☐	☐	☐	☐	Ten non-residential files (4 open, 6 closed) were reviewed. All files reviewed were	

Quality Improvement Indicators	Rating: Explain: Satisfactory	Non-compliant	No Eligible Items For Review	No Practice	Not Applicable	Review Based Upon **Document Source:** *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
						eligibility screened within 7 calendar days of referral and actually completed upon intake.	
Youth and parents/guardians receive the following in writing: • Available service options • Rights and responsibilities of youth and parents/guardians	☐	☒	☐	☐	☐	Ten non-residential files (4 open, 6 closed) were reviewed. Due to the COVID-19 pandemic, there were no face-to-face meetings. The program obtained consent to complete intake by text message and/or email. All ten files contained a copy of the text and/or email from the parent or guardian giving the program consent to complete an intake by phone or via video. Per the program director, virtual/phone intakes incorporate a discussion of the intake packet including available service options as well as rights and responsibilities; however, there was no documentation/note in the file to indicate these specific items were reviewed with the parent/guardian or that the program offered copies of forms detailing available service options and rights & responsibilities.	**Limited Exception** 0 of 10 files contained evidence youth and parent/guardian received, in writing, available service options, rights & responsibilities of youth and parents/guardians.
The following is also available to the youth and parents/guardians: • Possible actions occurring through involvement with CINS/FINS services (case staffing committee, CINS petition, CINS adjudication) • Grievance procedures	☐	☒	☐	☐	☐	Ten non-residential files (4 open, 6 closed) were reviewed. There is no documentation or note the program and the parent/guardian reviewed possible actions that occur through CINS/FINS services and grievance procedures. There is no evidence the program made these items available or offered to provide copies of these items to the parent/ guardian.	**Limited Exception** 0 of 10 files contained evidence program made available (or reviewed) with youth and parents/guardians the possible actions occurring through involvement with CINS/FINS services and grievance procedures.
2.02: Needs Assessment							
Provider has a written policy and procedure that meets the requirement for Indicator 2.02						☒ YES ☐ NO (explain)	

Quality Improvement Indicators	Rating					Review Based Upon **Document Source:** *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
		Explain					
	Satisfactory	Non-compliant	No Eligible Items For Review	No Practice	Not Applicable		
						Policy PC2.02 was last reviewed 06/30/2020 with an effective date of July 1, 2020 and was approved by the CEO.	
Completion of Needs Assessment							
a. Shelter Youth: Needs Assessment initiated within 72 hours of admission	☐	☐	☐	☐	☒	**N/A**	
b. 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	☒	☐	☐	☐	☐	Ten applicable non-residential youth case files were reviewed. The Needs Assessment was completed within 2 to 3 face-to-face contacts in all 10 records.	
c. Needs Assessment is conducted by a Bachelor's or Master's level staff member	☒	☐	☐	☐	☐	All ten Needs Assessments were conducted by a Bachelor's or Master's level staff member.	
d. Needs Assessment includes a supervisor's review signature upon completion	☒	☐	☐	☐	☐	A supervisor's signature was present on all 10 Needs Assessments reviewed.	
Suicide Risk as a Result of the Needs Assessment							
a. Youth was identified with an elevated risk of suicide as a result of the Needs Assessment	☐	☐	☐	☐	☒	**N/A** because no elevated risk of suicide was identified.	
b. 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	☐	☐	☐	☐	☒	**N/A** because no elevated risk of suicide was identified.	
2.03 Case/Service Plan							
Provider has a written policy and procedure that meets the requirement for Indicator 2.03						☒ YES ☐ NO (explain) Policy PC2.03 was last reviewed 06/30/2020 with an effective date of July 1, 2020 and was approved by the CEO.	

Quality Improvement Indicators	Rating					Review Based Upon **Document Source:** *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
		Explain					
	Satisfactory	Non-compliant	No Eligible Items For Review	No Practice	Not Applicable		
Case/Service plan is developed within 7 working days of Needs Assessment	☒	☐	☐	☐	☐	Ten non-residential files (4 open, 6 closed) were reviewed. All ten files contained a case/ service plan that was developed within 7 working days of Needs Assessment.	
Case/Service Plan includes:							
• Individualized and prioritized need(s) and goal(s) identified by the Needs Assessment • Service type, frequency, location • Person(s) responsible • Target date(s) for completion and Actual completion date(s) • Signature of youth, parent/guardian, counselor, and supervisor • Date the plan was initiated	☐	☒	☐	☐	☐	All case/ service plan listed the date the plan was initiated and target dates for completion and/or actual completion dates. All case/service plans reviewed have individualized and prioritized needs and goals, identified by the needs assessment. The agency's service plan form does not have a designated place to document location of service, type of service, and frequency of service. As a result, this information was not consistently documented in the goals in the ten files. There were no service plan and/or service plan review signatures in the files for youth and parent/guardian because staff met virtually or via telephone due to COVID-19. The program's practice is to obtain consent for intake and other services, for the duration of time in the program, via text message that is authorized by the parent/guardian. A copy of the consent for virtual services is maintained in all 10 files reviewed. The files also contained evidence of services provided including service plan implementation and reviews. All ten files included notes on the service plan and service plan reviews that clearly describes how staff met with the youth/family, names of persons participating in the session, topics discussed, follow up on	**Exception** A total of 20 goals were reviewed across all ten files. Frequency of services was not found in 9 of the 20 goals reviewed and 2 of the 9 also did not include location of services.

Quality Improvement Indicators	Rating: Satisfactory	Explain: Non-compliant	Explain: No Eligible Items For Review	Explain: No Practice	Explain: Not Applicable	Review Based Upon **Document Source:** *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
						referrals, and progress of youth. The parent's consent obtained during intake is noted each time a meeting is held with youth/family. It was observed staff wrote "N/A COVID 19" on youth and parent/guardian signature lines in lieu of stating the service plan and reviews were conducted via Zoom or over the phone. Proof of parental participation was documented in the corresponding case notes.	
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	☒	☐	☐	☐	☐	All case/service plans are reviewed for progress/ revised by counselor and parent, (when available) every 30 days for the first three months and every 6 months after. Case notes on service plan do confirm review of services or attempts to review with youth & parent/guardian.	
2.04: Case Management and Service Delivery							
Provider has a written policy and procedure that meets the requirement for Indicator 2.04						☒ YES ☐ NO (explain) Policy PC2.04 was last reviewed 06/30/2020 with an effective date of July 1, 2020 and was approved by the CEO.	
Counselor/Case Manager is assigned	☒	☐	☐	☐	☐	Ten non-residential files (4 open, 6 closed) were reviewed and identified an assigned counselor/ case manager for each youth.	
The Counselor/Case Manager completes the following as applicable: • Establishes referral needs and coordinates referrals to services based upon the on-going assessment of the youth's/family's problems and needs	☒	☐	☐	☐	☐	All files demonstrated the program provides support for families, monitors youth and family's progress and coordinates service plan implementation. In addition, the services demonstrate once needs are identified, appropriate referrals to services are	

Quality Improvement Indicators	Rating: Explain – Satisfactory	Non-compliant	No Eligible Items For Review	No Practice	Not Applicable	Review Based Upon **Document Source:** *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
• Coordinates service plan implementation • Monitors youth's/family's progress in services • Provides support for families • Monitors out-of-home placement (if necessary) • Makes referrals to the case staffing to address problems and needs of the youth/family • Accompanies youth and parent/guardian to court hearings and related appointments • Refers the youth/family for additional services when appropriate • Provides case monitoring and reviews court orders • Provides case termination notes • Provides follow-up after 30 days of exit • Provides follow-up after 60 days of exit						coordinated. These needs are based on the ongoing assessment of youth and family's problems/needs. The families are referred for additional services, if appropriate. None of the files reviewed identified a need for out of home placement or case staffing. All six closed files completed case termination on the existing service plan, not a separate termination note or discharge summary. The six closed files contained a 30-day follow-up after exit. Four applicable files out of the six closed files provided a 60-day follow-up and two did not provide a 60-day follow-up because it has not been 60 days since exit.	
2.05: Counseling Services							
Provider has a written policy and procedure that meets the requirement for Indicator 2.05						☒ YES ☐ NO (explain) Policy PC2.05 was last reviewed 06/30/2020 with an effective date of July 1, 2020 and was approved by the CEO.	
Youth and families receive counseling services, in accordance with the youth's case/service plan, to address needs identified during the assessment process	☒	☐	☐	☐	☐	Ten non-residential files (4 open, 6 closed) were reviewed. All files contained the appropriate documents: needs assessment, case/service plan, case/service plan reviews, progress notes. All files demonstrated a process for reviewing case records, proof that client and family are receiving services and/or referrals based on needs assessment.	
Shelter Program							

Quality Improvement Indicators	Rating: Explain: Satisfactory	Non-compliant	No Eligible Items For Review	No Practice	Not Applicable	Review Based Upon **Document Source:** *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
Shelter programs provides individual and family counseling	☐	☐	☐	☐	☒	**N/A** - Not a shelter program.	
Group counseling sessions held a minimum of five days per week	☐	☐	☐	☐	☒	**N/A** - Not a shelter program.	
Group counseling sessions consist of: • Length of at least 30 minutes • Opportunity for youth engagement • Clear and relevant topic (informational/developmental/educational) • Clear leader or facilitator	☐	☐	☐	☐	☒	**N/A** - Not a shelter program.	
Non-residential Program							
Non-residential programs provide therapeutic community-based services designed to provide the intervention necessary to stabilize the family. Services are provided in the youth's home, a community location, or the local provider's counseling office.	☒	☐	☐	☐	☐	The program provides therapeutic community-based services designed to provide the intervention necessary to stabilize the family. Services are provided in the home, a community location, or the local provider's counseling office.	
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	☒	☐	☐	☐	☐	Coordination of services was observed in all 10 files reviewed.	
Maintain individual case files on all youth and adhere to all laws regarding confidentiality	☒	☐	☐	☐	☐	Individual case files are maintained for all 10 youth files reviewed and comply with all laws regarding confidentiality.	
Case notes maintained for all counseling services provided and documents youth's progress	☒	☐	☐	☐	☐	Case notes were observed in all 10 files reviewed and progress is noted on the service plan reviews.	
On-going internal process that ensures clinical reviews of case records and staff performance	☒	☐	☐	☐	☐	The program has an ongoing internal monthly file review process and the supervisor reviews files monthly.	
2.06: Adjudication/Petition Process							

Quality Improvement Review

Quality Improvement Indicators	Rating					Review Based Upon **Document Source:** *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
	Satisfactory	Non-compliant	No Eligible Items For Review	No Practice	Not Applicable		
Provider has a written policy and procedure that meets the requirement for Indicator 2.06						☒ YES ☐ NO (explain) Policy PC2.06 was last reviewed 06/30/2020 with an effective date of July 1, 2020 and was approved by the CEO.	
Case Staffing Initiation and Notifications							
If parent/guardian initiates, staffing is held within 7 days	☒	☐	☐	☐	☐	Interview with program manager confirmed program had one case staffing meeting since the last review. The program manager also explained the CINS/FINS counselor was the person who initiated the case staffing.	
The youth, family and case staffing committee are contacted within a minimum of five working days • Notification to youth/family no less than 5 working days prior to staffing • Notification to committee no less than 5 working days prior to staffing	☒	☐	☐	☐	☐	The notification letter was sent to the family and committee on 01/14/2020 and case staffing was held 02/11/2020.	
Case Staffing Committee							
Must include: a. DJJ rep. or CINS/FINS provider b. Local school district representative	☒	☐	☐	☐	☐	Staffing attendees included the youth and family, school representative, and DJJ representative.	
Other members may include: • State Attorney's Office • Others requested by youth/family • Substance abuse representative • Law enforcement representative • DCF representative • Mental health representative	☒	☐	☐	☐	☐	Additional attendees included a mental health agency representative and a substance abuse agency representative.	
The program has an established case staffing committee, and has regular communication with committee members	☒	☐	☐	☐	☐	The program conducts joint case staffing with Lutheran Services Florida Southeast. Standing committee members include a school representative and DJJ representative.	

Quality Improvement Indicators	Rating – Explain: Satisfactory	Non-compliant	No Eligible Items For Review	No Practice	Not Applicable	Review Based Upon – Document Source: *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes – **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
The program has an internal procedure for the case staffing process, including a schedule for committee meetings	☒	☐	☐	☐	☐	Case staffing is scheduled once per month.	
As a result of the Case Staffing							
The youth and family are provided a new or revised plan for services	☒	☐	☐	☐	☐	A revised service plan was completed and provided to the family immediately following the staffing.	
Written report is provided to the parent/guardian within 7 days of the case staffing meeting, outlining recommendations and reasons behind the recommendations	☒	☐	☐	☐	☐	Committee recommendations were provided to the family in writing immediately following the staffing.	
If applicable, the program works with the circuit court for judicial intervention for the youth/family	☐	☐	☐	☐	☒	**N/A** because case did not escalate to circuit court for judicial intervention.	
Case Manager/Counselor completes a review summary prior to the court hearing	☐	☐	☐	☐	☒	**N/A** because case did not escalate to a court hearing.	
2.07: Youth Records							
Provider has a written policy and procedure that meets the requirement for Indicator 2.07						☒ YES ☐ NO (explain) Policy PC2.07 was last reviewed 06/30/2020 with an effective date of July 1, 2020 and was approved by the CEO.	
All records are marked "confidential	☒	☐	☐	☐	☐	A total of 10 files were reviewed (4 open, 6 closed). All open files are kept in a 3-ring binder and had three red confidential stickers placed on the binder (front, back and spine). All 6 closed files were marked "confidential" by a red confidential sticker. All files had client name and identifying information on the file. All closed files are kept in a manila folder and marked "closed" in marker. Closed files are not bound or clipped when placed in the manila folder.	

Quality Improvement Indicators	Rating					Review Based Upon **Document Source:** *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
		Explain					
	Satisfactory	Non-compliant	No Eligible Items For Review	No Practice	Not Applicable		
All records are kept in a secure room or locked in a file cabinet that is marked "confidential"	☒	☐	☐	☐	☐	During the video tour it was observed that all files are kept in a secure filing cabinet marked "confidential" and accessed only by program staff. The filing cabinet that stores the closed files are located in the program manager's office space.	
When in transport, all records are locked in an opaque container marked "confidential"	☒	☐	☐	☐	☐	Each staff member has their own opaque, locked container (and labeled confidential) to transport client records.	
All records are maintained in a neat and orderly manner so that staff can quickly and easily access information	☒	☐	☐	☐	☐	All reviewed files were found to be organized consistently in a neat and orderly manner with section dividers and cover pages.	
2.08: Sexual Orientation, Gender Identity, Gender Expression							
Provider has a written policy and procedure that meets the requirement for Indicator 2.08						☒ YES ☐ NO (explain) Policy PC2.08 was last reviewed 06/30/2020 with an effective date of July 1, 2020 and was approved by the CEO.	
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	☐	☐	☒	☐	☐	Since the last QI visit the program has not served any youth who meets the criteria for this indicator. However, policies and procedures are established to meet the requirements.	
Youth in need of specialized support is referred to qualified resources (as applicable)	☐	☐	☒	☐	☐	No eligible youth served	
Youth preference is considered and documented for room assignment and youth is not roomed in isolation due to sexual orientation, gender identity, or gender expression	☐	☐	☒	☐	☐	No eligible youth served	

Quality Improvement Indicators	Rating: Explain – Satisfactory	Non-compliant	No Eligible Items For Review	No Practice	Not Applicable	Review Based Upon **Document Source:** *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
Youth is provided hygiene products, undergarments and clothing that affirms their gender identity or gender expression	☐	☐	☒	☐	☐	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	☒	☐	☐	☐	☐	During video tour, signage was observed to be posted throughout the facility in common areas. Published materials providing information and education for SOGIE youth is accessible adjacent to the reception area.	
2.09: Special Populations							
Provider has a written policy and procedure that meets the requirement for Indicator 2.09 for EACH special population served i.e. Staff Secure, DMST,DV, PR, ICM and FYRAC.						☒ YES ☐ NO (explain) Policy PC4.121 was last reviewed 06/30/2020 with an effective date of July 1, 2020 and was approved by the CEO.	
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			☒N/A			
Staff Secure policy and procedure outlines the following: • In-depth orientation on admission • Assessment and service planning • Enhanced supervision and security with emphasis on control and appropriate level of physical intervention • Parental involvement • Collaborative aftercare	☐	☐	☐	☐	☒	N/A	
Program only accept youth that meet legal requirements of F.S. 984 for being formally court ordered in to Staff Secure Services	☐	☐	☐	☐	☒	N/A	
Staff Assigned:	☐	☐	☐	☐	☒	N/A	

Quality Improvement Indicators	Rating: Explain – Satisfactory	Non-compliant	No Eligible Items For Review	No Practice	Not Applicable	Review Based Upon **Document Source:** *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
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							
Agency provides a written report for any court proceedings regarding the youth's progress	☐	☐	☐	☐	☒	N/A	
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			☒N/A			
Agency has evidence that the FNYFS was contacted for approval prior to admission for all Domestic Minor Sex Trafficking (DMST) placements	☐	☐	☐	☐	☒	N/A	
Services provided to these youth specifically designated services designed to serve DMST youth	☐	☐	☐	☐	☒	N/A	
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?	☐	☐	☐	☐	☒	N/A	
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.)	☐	☐	☐	☐	☒	N/A	

Quality Improvement Indicators	Rating: Explain — Satisfactory	Non-compliant	No Eligible Items For Review	No Practice	Not Applicable	Review Based Upon — Document Source: *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes — **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
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	☐	☐	☐	☐	☒	N/A	
All other services provided to DMST youth are consistent with all other general CINS/FINS program requirements	☐	☐	☐	☐	☒	N/A	
Domestic Violence							
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? **(If no, select rating "No eligible items for review")**	☐Yes ☐ No			☒N/A			
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	☐	☐	☐	☐	☒	N/A	
Data entry into NetMIS and JJIS within 24 hours of admission and 72 hours of release	☐	☐	☐	☐	☒	N/A	
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.	☐	☐	☐	☐	☒	N/A	
Case plan in file reflects goals focusing aggression management, family coping skills, or other intervention design to reduce reoccurrence of violence in the home	☐	☐	☐	☐	☒	N/A	
All other services provided to Domestic Violence Respite youth are consistent with all other general CINS/FINS program requirements	☐	☐	☐	☐	☒	N/A	
Probation Respite							
Does the agency have any cases in the last 6 months or since the last onsite QI review was	☐Yes ☐ No			☒N/A			

Quality Improvement Indicators	Rating – Explain: Satisfactory	Non-compliant	No Eligible Items For Review	No Practice	Not Applicable	Review Based Upon – Document Source: *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes – **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
conducted? **(If no, select rating "No eligible items for review")**							
Probation Respite Referral come from DJJ Probation and are all youth referred on probation regardless of adjudication status	☐	☐	☐	☐	☒	N/A	
Data entry into NetMIS and JJIS within 24 hours of admission and 72 hours of release	☐	☐	☐	☐	☒	N/A	
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)	☐	☐	☐	☐	☒	N/A	
All case management and counseling needs have been considered and addressed	☐	☐	☐	☐	☒	N/A	
All other services provided to Probation Respite youth are consistent with all other general CINS/FINS program requirements	☐	☐	☐	☐	☒	N/A	
Intensive Case Management (ICM)							
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	☐Yes ☐ No			☒N/A			
Youth receiving services was court ordered or referred by case staffing committee	☐	☐	☐	☐	☒	N/A	
Services for youth and family include: a. Six (6) direct contacts per month b. Six (6) collateral contacts per month	☐	☐	☐	☐	☒	N/A	
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	☐	☐	☐	☐	☒	N/A	

Quality Improvement Indicators	Rating: Satisfactory	Rating: Explain: Non-compliant	Rating: Explain: No Eligible Items For Review	Rating: Explain: No Practice	Rating: Explain: Not Applicable	Review Based Upon **Document Source:** *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
c. An approved self-report assessment that was completed every 90 days following intake and at discharge (if applicable)							
Case plan demonstrates a strength-based, trauma-informed focus	☐	☐	☐	☐	☒	N/A	
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	☐	☐	☐	☐	☒	N/A	
Family and Youth Respite Aftercare Services (FYRAC)– Non-residential Only							
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	☒Yes ☐ No			☐N/A		A total of 3 youth records were reviewed (1 open and 2 closed).	
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	☒	☐	☐	☐	☐	DV charge is documented on the DJJ Face Sheet for each of the 3 youth	
Agency has evidence that all FYRAC referrals have documented approval from the Florida Network office	☒	☐	☐	☐	☐	Florida Network approval for each youth was present in the files.	
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	☒	☐	☐	☐	☐	The initial intake assessment was via Zoom due to the pandemic. Staff completed the intake assessment, needs assessment, and service plan during the intake session. A note on the signature lines stated "Covid-19" indicating signatures could not be obtained.	

Quality Improvement Indicators	Rating – Explain: Satisfactory	Non-compliant	No Eligible Items For Review	No Practice	Not Applicable	Review Based Upon **Document Source:** *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
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	☒	☐	☐	☐	☐	Documentation of Life Management sessions and topics is maintained in each youth record. The sessions are at least 60 minutes long and include topics to improve family functioning.	
Group Sessions: a. Focus on the same issues as individual/family sessions with the overall goal of strengthening relationships and prevention domestic violence b. Shall be no more than eight (8) youth at one (1) time and shall be for a minimum of sixty (60) minutes per session	☐	☐	☐	☐	☒	Program conducts Life Management sessions in lieu of group sessions.	
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	☒	☐	☐	☐	☐	One of the two closed records documented 11 of 13 sessions completed but it was noted in the file 2 were missed due to family phone complications. The other youth completed all 13 sessions and the open case is on track for completing the 13th and final session.	
2.10: STOP NOW AND PLAN (SNAP)							
Provider has a written policy and procedure that meets the requirement for Indicator 2.10						☒ YES ☐ NO (explain) Policy PC4.15 was last reviewed 06/30/2020 with an effective date of July 1, 2020 and was approved by the CEO.	
SNAP Clinical Groups							
Youth are screened to determine eligibility of services	☒	☐	☐	☐	☐	Two closed and 2 open SNAP clinical group youth files were reviewed. All 4 files documented the youth were screened to determine eligibility using the NETMIS screening form and the SNAP Brief Intake	

Quality Improvement Indicators	Rating: Explain – Satisfactory	Non-compliant	No Eligible Items For Review	No Practice	Not Applicable	Review Based Upon – Document Source: *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes – **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
						screening form. There was a signed consent form in each file signed by the parent/guardian prior to receiving services.	
Needs assessment is completed at initial intake, or within two face-to-face sessions	☒	☐	☐	☐	☐	A needs assessment was completed at intake in all 4 files.	
SNAP Assessments a. Child Behavior Checklist (CBCL) is completed by the caregiver (pre & post)	☒	☐	☐	☐	☐	All 4 files had completed pre-CBCLs completed at intake and 2 applicable closed files contained post-CBCLs completed at discharge.	
b. Teacher Report Form (TRF) completed by the teacher (pre & post)	☐	☐	☐	☐	☒	Due to the pandemic and schools being closed, the program was not able to obtain TRF for any of the youth. This was clearly noted in each youth file.	
c. TOPSE (pre & post)	☒	☐	☐	☐	☐	All 4 files had completed pre-TOPSE completed at intake and 2 applicable closed files contained post-TOPSE completed at discharge.	
d. Prevention Assessment Tool (PAT) (pre & post)	☒	☐	☐	☐	☐	All 4 files had completed pre-PAT completed at intake and 2 applicable closed files contained post-PAT completed at discharge.	
SNAP® discharge report summary	☒	☐	☐	☐	☐	SNAP discharge summary was present in the 2 closed files.	
SNAP® Boys/SNAP® Girls Child Group Evaluation Form	☒	☐	☐	☐	☐	Observed in all 4 youth records	
SNAP® Boys/SNAP® Girls Parent Group Evaluation Form	☒	☐	☐	☐	☐	Documentation – youth records	
SNAP in Schools							
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)	☒	☐	☐	☐	☐	3 SNAP in school groups were started 3/16/2020 but only met for 4 sessions due to the pandemic and closing of schools.	

Quality Improvement Review

Quality Improvement Indicators	Rating					Review Based Upon **Document Source:** *E.g. Interview/Surveys, Observation, and/or Type of Documentation*	Notes **Explain any items that have any deficiencies, exceptions or are not applicable.** For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below
		Explain					
	Satisfactory	Non-compliant	No Eligible Items For Review	No Practice	Not Applicable		
"Class Shoot for Your Goal" sheet	☒	☐	☐	☐	☐	Class "Shoot for Your Goal" sheet was completed for each class.	
Pre and Post Evaluations	☒	☐	☐	☐	☐	All students and teachers completed the Pre-evaluations but sessions could not be completed due to the pandemic.	
One SNAP® Fidelity Adherence Checklist completed per classroom in a 13 – week SNAP in Schools group and uploaded to Dropbox	☒	☐	☐	☐	☐	Completed for each class.	