Florida Network for Youth and Family Services
Compliance Monitoring Report for

Anchorage Children's Home of Bay County
2121 Lisenby Avenue
Panama City, Florida 32405

Compliance Monitoring Services Provided by

FOREFRONT

EXECUTIVE SUMMARY

Forefront LLC conducted a joint Quality Improvement (QI) and Florida Network of Youth and Family Services (FNYFS) monitoring visit for the Anchorage Children's Home of Bay County for the FY 2021-2022 at its program office located at 2121 Lisenby Avenue, Panama City, 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. Anchorage Children's Home of Bay County 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 2021 through June 30, 2022.

The review was conducted by Ashley Davies, Consultant for Forefront LLC, and Peer Reviewer(s). Agency representatives from Anchorage Children's Home of Bay County present for the entrance interview were Joel Booth, Executive Director; Krissy Botzong, Quality Improvement and Training Director; and Cindy Hoskins, Clinical Supervisor. The last onsite QI visit was conducted August 12 – 13, 2020.

In general, the Reviewer found that Anchorage Children's Home of Bay County is in compliance with specific contract requirements. **Anchorage Children's Home of Bay County received an overall compliance rating of 100% for achieving full compliance with eleven indicators** of the CINS/FINS Monitoring Tool. There were no corrective actions as a result of the monitoring visit and no recommendation was made for an indicator rated as conditionally acceptable.

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

2021-2022 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 09-22-2021

Agency Name: Anchorage Children's Home of Bay County	**Monitor Name: Ashley Davies, Lead Reviewer**
Contract Type: CINS/FINS	**Region/Office: 2121 Lisenby Avenue, Panama City, FL**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): September 22 – 23, 2021**

Major Programmatic Requirements	Explain Rating: Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable	Ratings Based Upon: I = Interview; O = Observation; D = Documentation; PTV = Submitted Prior To Visit; (List Who and What)	Notes: Explain Unacceptable or Conditionally Acceptable: (Attach Supportive Documentation)
I. Administrative and Fiscal							
DJJ Quality Improvement Peer Reviewer a. Provider shall demonstrate that a minimum of two (2) staff members have been trained to be certified as DJJ QI Peer reviewers. Provider shall participate in a minimum of one (1) on-site quality assurance review of a similar type of program in another judicial circuit during each 12-month period of the contract, if requested.	☐	☐	☒	☐	☐	Interview: The program currently has eight staff members certified as QI Peer reviewers.	**No recommendation or Corrective Action.**
Additional Contracts a. Provider shall provide a listing of all current federal, state, or local government contracts, as well as other contracts entered into with for profit and not-for-profit organizations. Such listing shall identify the awarding entity and contract start & end dates. **PTV**	☐	☐	☒	☐	☐	Documentation: A list of additional contracts for FY 2021- 2022 was provided by the provider. The list includes contract, contract number, funder, amount, service provided, start period, and end period. The list contained thirteen current contracts. The program also maintains interagency agreements and Memorandums of Agreement (MOUs) with schools, substance abuse, mental health partners, and other treatment providers. All the agreements	**No recommendation or Corrective Action.**

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	Explain Rating						
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						reviewed had recent contract/agreement dates.	
Limits of Coverage a. Provider shall provide and maintain during this contract, the following minimum kinds of insurance: Worker's Compensation and Employer's liability insurance as required by Chapter 440, F.S. with a minimum of $100,000 per accident, $100,000 per person and $500,000 policy aggregate. Commercial General Liability with a limit of $500,000 per occurrence, and $1,000,000 policy aggregate. Automobile Liability Insurance shall be required and shall provide bodily injury and property damage liability covering the operation of all vehicles used in conjunction with performance of this contract, with a minimum limit for bodily injury of $250,000 per person; with a minimum limit for bodily injury of $500,000 per accident; with a minimum limit for property damage of $100,000 per accident and with a minimum limit for medical payments or $5,000-$10,000 per person. Florida Network is listed as payee or co-payee. **PTV**	☐	☐	☒	☐	☐	Documentation: General Liability through Alliance for Nonprofits for Insurance, for limits of coverage $1,000,000 each $3,000,000 aggregate, effective 7/20/21– 7/20/22. Automobile insurance through Alliance for Nonprofits for Insurance with a combined single limit of $1,000,000 each accident. Policy effective for 7/20/21– 7/20/22. Directors and Officers Liability insurance through ACE Fire Underwriters Ins Co., for a limit of liability of $2,000,000 aggregate. Policy effective for 3/02/2021 – 3/02/2022. Workers Compensation through Markel-American Ins Co., for a limit of coverage of $2,701,000 for building, $600,000 personal property, and $1,145,000 business income. Policy effective 7/2/21-7/2/22.	**No recommendation or Corrective Action.**

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						Property insurance through Lloyds, for a limit of coverage of $2,000,000 each accident. Policy effective 6/1/21-6/1/22. 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**	☐	☐	☐	☐	☒	**N/A –** During the Entrance Conference, the provider indicated that there are no outstanding corrective action item(s) cited by an external funding source.	**No recommendation or Corrective Action.**
Fiscal Practice a. Agency must have employee and fiscal policy/procedures manuals that are in compliance with GAAP and provide sound internal controls. Agency maintains fiscal files that are audit ready. **PTV**	☐	☐	☒	☐	☐	Documentation: Fiscal Policies and Procedures are contained in Section F-Financial Management of the Administrative Standard Operating Manual. 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. Policies were last reviewed 3/5/2021 by the Executive Director.	**No recommendation or Corrective Action.**

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b. Agency maintains a general ledger and the corresponding source documents. General ledger must be set up to track the activity of the grant separately (standard account numbers / separate funds for each revenue source, etc.). **PTV**	☐	☐	☒	☐	☐	Documentation: Detailed General Ledger for the last FY, 7/1/2020 – 6/30/2021. Agency maintains a detailed general ledger that is structured to track all funding sources as well as activities for the CINS/FINS program and non-residential program. The ledger tracks the debit, credit, and balance.	**No recommendation or Corrective Action.**
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**	☐	☐	☒	☐	☐	Interview and Documentation: No change in practice was reported for the agency since the last program review in August 2020. Review of petty cash Policy and Procedure was conducted. The Petty Cash fund does not exceed the established minimum. Petty cash is stored in a locked box in a secure area. All receipts are submitted for reimbursement as needed.	**No recommendation or Corrective Action.**
d. Financial records and reports are current. Includes bank statements reconciled within 6 weeks of receipt. Vendor invoices past 6 months. Invoices are submitted on a monthly basis with supporting documentation. (Disbursements/invoices are approved & monitored by management). **ON SITE**	☐	☐	☒	☐	☐	Documentation: Reviewed Bank Statements and Bank Reconciliations for one account held with Centennial Bank. Bank reconciliation summary was provided as of 6/30/2021. Financial Statements are reported on a monthly basis and were found to be current. Bank	**No recommendation or Corrective Action.**

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	Unacceptable	**Conditionally Unacceptable**	**Fully Met**	**Exceeded**	**Not Applicable**		
						reconciliations are conducted each month for the activities and bank statements for the preceding month. Reconciliations are signed by two individuals. The agency maintains individual vendor files.	
e. Agency maintains inventory in accordance with a written policy and FNYFS contractual requirements. If over $1,000 inventory has DJJ Property Inventory Number/Tag. In the event the provider has purchased computer equipment an Informational Resources Request (IRR) been submitted to DJJ. **PTV/ON SITE**	☐	☐	☐	☐	☒	N/A – The agency has not purchased any items with FNYFS monies since the last time on-site.	**No recommendation or Corrective Action.**
f. Agency submits payroll taxes and deposits (and retirement deposits as applicable), Employee IRS Form W-2 and Independent Contractors IRS Form 1099 forms prior to federal requirements. **ON SITE**	☐	☐	☒	☐	☐	Documentation: Provider submitted evidence of form 941 and form Schedule B (Form 941) filed electronically for the last four quarters.	**No recommendation or Corrective Action.**
g. Budget to actual reports prepared and reviewed by appropriate management. Variance from the budget is investigated and explained. **PTV/ON SITE**	☐	☐	☒	☐	☐	Documentation: Agency provided Budget to Actual report for last fiscal year, 7/1/20 – 6/30/21. The report shows current YTD actual, current YTD budget, and current YTD variance. The shelter, family counseling, and SNAP program are all tracked separately.	**No recommendation or Corrective Action.**

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h. A Single Audit is performed as part of the annual audit if expenses are greater than $500,000. The agency must submit a Corrective Action Plan for findings cited in the management letter and single audit. An annual financial audit was completed within 120 days after the previous fiscal year/calendar year and that a copy was provided to the Network unless and extension has been requested and approved in writing. Copy of Audit is submitted to the FNYFS by December 31st. **Obtain from FNYFS**	☐	☐	☒	☐	☐	Documentation: Financial audit conducted for year ending June 30, 2020 was completed by James Moore. A separate Management Letter dated March 18, 2021 did not require any corrective actions. A copy of the audit was submitted to the FNYFS.	**No recommendation or Corrective Action.**
i. Agency maintains confidentiality policy with written policies and procedures to ensure the security and privacy of all employee and client data. Personal information is not easily accessible. Agency maintains a backup system in case of accidental loss of financial information. Security procedures are in place to protect laptops. Obsolete documents are shredded and computer hard drives are wiped prior to discarding. **ON SITE**	☐	☐	☒	☐	☐	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 Manual throughout various sections of the manual. A daily back-up is performed on all information saved on various servers throughout the agency. Policies were last reviewed March 5, 2021 by the Executive Director.	**No recommendation or Corrective Action.**

CONCLUSION

Anchorage Children's Home of Bay County has met the requirements for the CINS/FINS contract as a result of full compliance with eleven applicable indicators of the Administrative and Fiscal Contract Monitoring Tool. Two of the thirteen indicators were not applicable because: 1) the provider does not have any outstanding corrective action item(s) cited by an external funding source, and 2) does not have any current inventory purchased with DJJ/FN Funds. Consequently, t**he overall compliance rate for this contract monitoring visit is 100%.** There are no corrective actions cited and no recommendation is made as a result of the contract monitoring visit. Overall, the provider is performing satisfactorily in meeting the fiscal and administrative terms of its contract. In addition, the majority of indicators reviewed were carried out in a manner which meets the standard as described in the report findings.

SUMMARY OF RECOMMENDATIONS

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

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

Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Anchorage Children's Home - Bay County
CINS/FINS Program

September 22 - 23, 2021

Compliance Monitoring Services Provided by

FOREFRONT

CINS/FINS Rating Profile

Standard 1: Management Accountability

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

Percent of indicators rated Satisfactory: 100 %
Percent of indicators rated Limited: 0 %
Percent of indicators rated Failed: 0 %

Standard 2: Intervention and Case Management

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

Percent of indicators rated Satisfactory: 100 %
Percent of indicators rated Limited: 0 %
Percent of indicators rated Failed: 0 %

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 %
Percent of indicators rated Limited: 0 %
Percent of indicators rated Failed: 0 %

Standard 4: Mental Health/Health Services

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

Percent of indicators rated Satisfactory: 100 %
Percent of indicators rated Limited: 0 %
Percent of indicators rated Failed: 0 %

Overall Rating Summary

Percent of indicators rated Satisfactory: 100 %
Percent of indicators rated Limited: 0 %
Percent of indicators rated Failed: 0 %

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
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.

Reviewers

Members

Ashley Davies - Lead Reviewer Consultant-Forefront LLC/Florida Network of Youth and Family Services
Patrick McKinstry – Regional Monitor, Department of Juvenile Justice
Tara Shock - Youth and Family Alternatives
Tiffany Martin - Florida Network
Howard Johnson - Lutheran Services

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, (3) Shelter Care/Health Services, and (4) Mental Health/Health Services, which are included in the Children/Families in Need of Services (CINS/FINS) Standards (Effective August 1, 2021).

Persons Interviewed

	Chief Executive Officer	X	Case Manager		Nurse – Full time
	Chief Financial Officer	X	Counselor Non-Licensed	X	Nurse – Part time
	Chief Operating Officer		Advocate	1	# Case Managers
X	Executive Director	X	Direct – Care Full time	2	# Program Supervisors
X	Program Director		Direct – Part time	0	# Food Service Personnel
	Program Manager		Direct – Care On-Call	1	# Healthcare Staff
	Program Coordinator		Intern	0	# Maintenance Personnel
X	Clinical Director		Volunteer	1	# Other: PQI/Training Director
X	Counselor Licensed	X	Human Resources		

Documents Reviewed

	Accreditation Reports	X	Table of Organization		Visitation Logs
X	Affidavit of Good Moral Character	X	Fire Prevention Plan	X	Youth Handbook
X	CCC Reports	X	Grievance Process/Records	5	# Health Records
X	Logbooks	X	Key Control Log	5	# MH/SA Records
X	Continuity of Operation Plan	X	Fire Drill Log	12	# Personnel /Volunteer Records
X	Contract Monitoring Reports	X	Medical and Mental Health Alerts	10	# Training Records
X	Contract Scope of Services	X	Precautionary Observation Logs	5	# Youth Records (Closed)
X	Egress Plans	X	Program Schedules	5	# Youth Records (Open)
X	Fire Inspection Report	X	List of Supplemental Contracts		# Other: ___
X	Exposure Control Plan	X	Vehicle Inspection Reports		

Observations During Review

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

Comments

Due to COVID-19, this review was conducted via hybrid method (virtually and on-site).

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

The program exceeded their bed days and ended the FY at 111.9% performance for this deliverable. This was quite the accomplishment as the facility has not been able to exceed 12 youth (opposed to their licensed capacity of 20 youth) served at any given time due to staffing. Hidle House has not met this deliverable since before Hurricane Michael in 2018.

Covid-19 continues to be a challenge as they navigate serving active/busy teens. They have significantly limited, and at times halted, onsite visitors. Offsite outings have been restricted to open, outdoor venues where the youth and staff are able to socially distance.

The interviewing and hiring process continues to be a challenge; however, the Shelter Manager and Assistant Shelter Manager have remained diligent in hiring quality candidates.

The shelter has seen an overall increase in LGBTQ youth, both community youth and foster care youth. This has encouraged conversation and growth surrounding their practices to ensure the highest quality of care for these youth.

A pole barn was installed to provide additional outdoor space to the residents. The program staff have coordinated several onsite events to help keep the youth entertained. Events include “glow parties,” color parties, and laser tag.

Hidle House has hosted numerous Social Work interns, including 2 within this fiscal year. The interns have provided additional support to the youth and staff.

Narrative Summary

Anchorage Children’s Home (ACH) operates the Hidle House Youth Shelter. The agency is a well-established, not-for-profit organization located in Panama City, Florida. The shelter and main community counseling offices are located at 2121 Lisenby Avenue in Panama City, Florida. The agency is led by Mr. Joel Booth, Executive Director. The Executive Director oversees a Program Administrator, who oversees all residential services, and a Clinical Supervisor, who oversees the residential counseling and community counseling programs.

The agency has a total of ten (seven full-time and three part-time) Youth Care Specialist (YCS), one Shelter Manager, one Assistant Shelter Manager, one Registered Nurse, three Residential Case Managers, five community counseling counselors, one Human Resource Director, one Administrative Assistant, one Business Office Manager, one Maintenance Coordinator, one Financial Director, one Fundraising Director, and one PQI/Training Director. At the time of the review there were no vacant positions.

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

The agency provides both residential and community counseling services to youth and their families in Bay, Gulf, Calhoun, Holmes, Jackson, and Washington counties. The Clinical Supervisor oversees the five community counseling counselors and three Residential Case Managers. The Clinical Supervisor has a master's degree in Counseling/Psychology and is also a Licensed Mental Health Counselor (LMHC). All the community counseling counselors and Residential Case Managers have a bachelor's degree, apart from one community counseling counselor who has a master's degree.

The agency also operates a Stop Now and Plan (SNAP) program at this site. The SNAP program is staffed with one SNAP Supervisor and three SNAP Facilitators.

The program has only provided Domestic Violence and Probation Respite services in the last year. The program has not had any examples of Staff Secure, Domestic Minor Sex Trafficking, or Family and Youth Respite Aftercare Services (FYRAC) youth in the last year. This site also does not provide Intensive Case Management Services.

The shelter runs three shifts and follows a daily schedule that allows time for school, homework, reading, meals, recreation, and sleeping. The schedule is posted in all common areas throughout the shelter.

The shelter is licensed by the Department of Children and Families for twenty beds. At the time of the review the shelter had four CINS/FINS youth.

All youth are screened for suicide at intake using the six approved questions on the CINS Intake Assessment Form. If youth receive a positive screening they are placed on sight and sound supervision until seen and assessed by a qualified mental health professional. All staff receive training on suicide prevention.

Health services are overseen by a part-time Registered Nurse (RN). The RN will distribute all medications when on-site and trained Youth Care Specialists will distribute medications when the RN is not on-site. The RN provides various trainings for staff, including Medication Administration.

All medications in the facility are stored in the Pyxis Med-Station 4000 Medication Cabinet. The RN completes a weekly inventory of all medications on-site. Youth Care Specialists complete shift-to-shift inventories of all controlled medications and maintain perpetual inventories of all other medications. Over-the-counter medications are inventoried at least weekly and when given.

The overall findings for the QI Review for Anchorage Children's Home are summarized as follows:

Standard 1: This standard has a total of seven indicators regarding management accountability. All seven indicators were rated satisfactory. There were exceptions noted in indicator 1.04 Training Requirements and 1.06 Client Transportation. The exceptions noted in 1.04 were due to one staff who completed a training late and three staff who did not complete a required training. The exception noted in 1.06 was due to a staff on the approved drivers list who had an expired/suspended driver's license. The exceptions in these two indicators did not result in limited ratings. All other indicators in this standard were rated satisfactory with no exceptions.

Standard 2: This standard has a total of ten indicators that relate to intervention and case management. All seven indicators were rated satisfactory. There were exceptions noted in indicators 2.01 Screening and Intake, 2.03 Case/Service Plan, 2.05 Counseling Services, and 2.06 Adjudication/Petition Process. The exception noted in 2.01 was due to the eligibility screening completed late in two community counseling files; one secret shopper screening not being completed at all and one shelter screening entered into NETMIS within 72 hours. The exception noted in 2.03 was due to one Case/Service Plan in a shelter file not having completion dates and the Case/Service Plan reviews being done late in the five community counseling files reviewed. The exception noted in 2.05 was due to groups not being constantly held five days a week in August 2021 and not documenting a time length. The exception noted in 2.06 was due to no new or revised plan of services or written report was provided to the family in one case staffing file reviewed. These exceptions did not result in limited ratings. All other indicators in this standard were rated satisfactory with no exceptions.

Standard 3: This standard has a total of seven indicators regarding shelter care. All seven indicators were rated satisfactory. There was an exception noted in 3.02 Program Orientation due to one youth not receiving a handbook within 24 hours of admission. This exception did not result in a limited rating. All other indicators in this standard were rated satisfactory with no exceptions.

Standard 4: This standard has a total of five indicators regarding mental health and health services. All five indicators were rated satisfactory. There was an exception noted in indicator 4.02 Suicide Prevention due to a missing suicide risk assessment. This exception did not result in a limited rating. All other indicators in this standard were rated satisfactory with no exceptions.

CINS/FINS QUALITY IMPROVEMENT TOOL

Quality Improvement Indicators:	Satisfactory (S)	Non-compliant (E)	No Eligible Items for Review (N)	No Practice (NP)	Not Applicable (N/A)	Review Based Upon	Notes
Standard One – Management Accountability							
1.01: Background Screening (BS) 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** **If NO, explain here:** The agency has a policy in place that addresses the requirements of this indicator titled ACH-ADM-HR-009 and 026. The policies were last reviewed on March 5, 2021 by the Executive Director.	
Agency utilizes an employee suitability prescreening assessment with a passing rate criterion prior to an offer of hire for direct care staff working with youth or the agency has provided an explanation for staff hired with a non-passing/low score.	X					A total of twelve new staff were hired since the last QI review. All twelve staff documented an employee suitability prescreening assessment was completed using the Berke Assessment. All prescreening assessments were completed prior to the employee's hire date and documented a passing score.	
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					There were a total of twelve employees and three interns hired since the last QI review. All twelve employees and three interns had a background screening prior to hire with an eligible rating.	
Agency has evidence for employees who have had a break in service and who are in good standing and reemployed with the same agency without an additional suitability assessment or background screening if the break is less than 90 days.			X			There were no applicable staff during this QI review.	
Five-year re-screening completed every 5 years from initial date of hire			X			There were no staff applicable for a five year re-screening during this review period.	

Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?	X					The agency submitted the Annual Affidavit of Compliance with Level 2 Screening Standards via email on December 22, 2020.	
Proof of E-Verify for all new employees obtained from the Department of Homeland Security	X					Documentation of approval of E-Verify work eligibility was provided for all twelve new staff hired.	
1.02: Provision of an abuse free environment to ensure safety and abuse free environment for youth in care							
Provider has a written policy and procedure that meets the requirement for Indicator 1.02						**YES** **If NO, explain here:** The agency has three policies in place to address the requirements of this indicator. Policies titled ACH-CS-SD-018 Abuse/Neglect Reporting, ACH-HH-BX-002 Discipline Policy, and ACH-HH-PM-017 Youth/Family Grievances were all last reviewed on March 5, 2021 by the Executive Director.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Abuse Free Environment							
Agency has a code of conduct of policy and there is evidence that staff are aware of agency's code of conduct.	X					All employees sign a form upon hire documenting receipt of the employee handbook, safety program, and compliance statement wherein the code of conduct is referenced. This form is kept in the employees' personnel file. A sample of five personnel files were reviewed of staff hired since the last QI review and all five files documented receipt of the code of conduct.	
Child Abuse Registry telephone number is visible to youth and posted common areas of the facility	X					During the on-site tour, the Child Abuse Registry telephone number was observed posted in the dayroom of the facility.	
Youth were informed of the Abuse and Contact Number (see youth survey results)	X					All 8 youth surveyed reported they were informed of the Abuse Hotline number.	
Management takes immediate action to address any incidents of threats or abuse			X			There were no incidents of threats or abuse reported during the review period requiring management action.	
Grievance Process							

Agency has a formal grievance process	X					Policy ACH-HH-PM-017 Youth/Family Grievances outlines the program's formal grievance process.	
Locked box accessible to only management and available to youth in a common area	X					During the on-site tour, the grievance box was observed in the dayroom of the facility. The box was locked and grievance forms were located next to the box.	
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					There was one grievance submitted during this last review period. The grievance was resolved by the Shelter 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					The one grievance submitted during this review period was resolved within 72 hours.	
1.03: Incident Reporting							
Provider has a written policy and procedure that meets the requirement for Indicator 1.03						**YES** **If NO, explain here:** Policy ACH-HH-PM-006 Unusual Incidents. Last reviewed March 5, 2021 by the Executive Director.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
During the past 6 months, the program notified the Department's CCC (Central Communication Center) no later than two hours after any reportable incident occurred or within two hours of the program learning of the incident	X					Fifteen incidents were reported to the CCC during the review period. All fifteen reported incidents were done within the two hour window as required.	
The program completes follow-up communication tasks/special instructions as required by the CCC	X					All reported CCC incidents that needed follow-up was completed.	
Incidents are documented in the program logs and on incident reporting forms	X					Evidence was given that required documentation regarding incidents is being recorded on the agency forms. Screenshots of entries in the log-book of incidents document incidents are being recorded.	

All incident reports are reviewed and signed by program supervisors/directors	X					All reviewed incident reports and CCC reports 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** **If NO, explain here:** Policy in place titled ACH-HH-PM-008 Professional Development. Last reviewed September 1, 2021 by the Executive Director.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
First Year Direct Care Staff							
All staff completed the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days from date of hire. *(Staff hired before January 1st were required to complete no later than December 31, 2020)*		X				There were 6 newly hired staff training files reviewed. 5 of the 6 staff completed the DOJ Civil Rights and Federal Funds training in the first 30 days of hire.	Exception: One staff completed the training approximately 3 months after hired and not within the required first 30 days.
All staff receives all mandatory training during the first 90 days of employment from date of hire.	X					There were 6 first year staff training files reviewed. All 6 staff had completed all mandatory training required during the first 90 days.	
Non-licensed Mental Health Clinical Shelter Staff (within first year of employment)							
Non-licensed mental health clinical shelter staff Assessment of Suicide Risk Training	X					There were 2 non-licensed mental health clinical staff applicable.	
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					Both non-licensed mental health staff files reviewed had all 5 supervised Suicide Assessments required within one year, documented 20 hours of Suicide Risk Assessment training, and were signed by the Clinical 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).*		X				There were 4 in-service staff training files reviewed and all 4 documented over 40 hours of training for the last completed training cycle. One of the 4 staff documented all required trainings were completed.	Exception: Three staff had not completed the DJJ Skill Pro Child Abuse Reporting training in the last year.
Required Training Documentation							
The program maintains an individual training file for each staff, which includes an annual employee training hours tracking form and related documentation, such as certificates, sign-in sheets, and agendas for each training attended.	X					In all training files there was a spreadsheet with all trainings, date completed, and hours. Also, training files included training certificates and training worksheets.	
Provider has a written policy and procedure that meets the requirement for Indicator 1.05						**YES** **If NO, explain here:** Policy in place titled ACH-ADM-PQI-004 Performance Quality Improvement. Last reviewed March 5, 2021 by the Executive Director.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Case record review reports demonstrate reviews are conducted quarterly, at a minimum	X					Quarters three and four case record review reports were provided. These reports are reviewed at the quarterly Performance and Quality Improvement meetings.	
The program conducts reviews of incidents, accidents, and grievances quarterly, at a minimum	X					Incidents, accidents, and grievances are reviewed monthly at the Senior Management Team meetings and quarterly at the Performance and Quality Improvement meetings. Meeting minutes for the last six months and the last two quarters were reviewed.	
The program conducts an annual review of customer satisfaction data	X					Satisfaction data is reviewed monthly at the Senior Management Team meetings and quarterly at the Performance and Quality Improvement meetings. Meeting minutes for the last six months and the last two quarters were reviewed.	

The program conducts an annual review of outcome data and (if applicable) there is evidence of annual reconciliation that occurs through communication from the Florida Network via email or phone call when corrections are needed and the information is corrected and submitted within the requested timeframes.	X					Outcome data is reviewed monthly at the Senior Management Team meetings and quarterly at the Performance and Quality Improvement meetings. Meeting minutes for the last six months and the last two quarters were reviewed. The last annual reconciliation was conducted with the Florida Network via email on May 5, 2021. All corrections were made and submitted in requested time frames.	
The program conducts a monthly review of NetMIS data reports. The program submits NetMIS invoices by the fourth business day of the following reporting month.	X					A monthly review of NetMIS data reports is conducted by the Office Business Manager. The Office Business Manager then submits the NetMIS invoice by the 4th business day of the following month. The last six months of invoices and emails were provided and reviewed.	
The Florida Network conducts monthly reconciliation by comparing NetMIS data to JJIS data. Agency has evidence that they have reconciled any differences noted.	X					The program provided the last six months of emails from the Florida Network to show monthly reconciliation of NetMIS and JJIS data.	
The program has a process in place to review and improve accuracy of data entry & collection	X					Data entry and collection is reviewed monthly at the Senior Management Team meetings to ensure accuracy. The last six months of meeting minutes were provided.	
There is documentation that findings are regularly reviewed by management and communicated to staff and stakeholders.	X					Findings are discussed at monthly Senior Management Team meetings and quarterly at the Performance and Quality Improvement Team meetings. Last six months and last two quarters of meetings were provided. The Executive Director meets with the Board of Directors monthly and the Performance and Quality Improvement report is reviewed during general Board meetings.	
There is evidence the program demonstrates that critical performance data reports are shared with the Board of Directors frequently. All final reports that include a Limited or Failed score is submitted electronically or by mail to the providers Executive Committee on the Board of Directors.	X					The Executive Director meets with the Board of Directors monthly and the Performance and Quality Improvement report is reviewed during general Board meetings. The program did not have any limited or failed scores on this QI report that would require it be submitted to the Board of Directors.	

There is evidence that strengths and weaknesses are identified, improvements are implemented or modified, and staff are informed and involved throughout the process.	X					Strengths and weaknesses are identified and improvements implemented when needed during the monthly Senior Management Team meetings and quarterly at the Performance and Quality Improvement Team meetings. Staff are informed and involved by attending monthly team meetings. Meeting minutes for the last six months and two quarters were provided.	
Provider has a written policy and procedure that meets the requirement for Indicator 1.06						**YES** **If NO, explain here:** Policy in place titled ACH-HH-PM-005 Transportation. Last reviewed March 5, 2021 by the Executive Director.	
Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	X					List of agency approved drivers was reviewed which documented 15 staff approved to transport youth.	

Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy		**X**				14 of the 15 staff approved to transport youth had a valid Florida driver's license. Proof of insurance was provided to show all drivers are covered under the company policy.	Exception: Upon review of staff driver's license from the approved drivers list it was discovered that one staff had an expired driver's license. It was also discovered that a random check of all staff driver's license was conducted on 08/12/2020 and documented this same staffs driver's license was suspended. The program missed this and the staff remained on the approved drivers list until the date of the QI review. This staff worked the overnight shift so it was reported this staff did not transport any youth. Transportation logs were reviewed from the date the staff was hired in March 2020 until present and it was noted the staff did not transport any youth or drive any agency vehicles since hired. The staff was removed from the approved drivers list.
Agency's Transportation policy prohibit transporting a client without maintaining at least one other passenger in the vehicle during the trip and include exceptions in the event that a 3rd party is NOT present in the vehicle while transporting	**X**					The program's policy titled Transportation prohibits transporting a youth without another passenger in the vehicle. There are provisions in place in case a 3rd party is not present in the vehicle.	

In the event that a 3rd party cannot be obtained for transport, the agency's supervisor or managerial personnel consider the clients' history, evaluation, and recent behavior	X					A review of vehicle logs for the last six months documented all single client transports had a supervisor's approval obtained prior to the transport taking place. The vehicle logs show single client transport and name of the supervisor that approved the transport.	
The 3rd party an approved volunteer, intern, agency staff, or other youth	X					The 3rd party present on transports reviewed for the last six months was either an agency staff member or another youth.	
There is documentation of use of vehicle that notes name or initials of driver, date and time, mileage, number of passengers, purpose of travel and location.	X					The vehicle logs document each transport, identifying the date and time of the transport, the driver, number of youth, destination, and mileage for the vehicle.	
Provider has a written policy and procedure that meets the requirement for Indicator 1.07						**YES** **If NO, explain here:** Policy in place titled ARC-ADM-PQI-003 Public/Community Involvement. Last reviewed March 5, 2021 by the Executive Director.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
The program has a lead staff member designated to participate in local DJJ board and council meetings with evidence that includes minutes of the event or other verification of staff participation	X					DJJ circuit 14 Council meeting agendas and minutes were provided that show verification of staff participation of meetings during last six months. Some meetings were virtual due to Covid-19.	
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					Review of outreach and prevention services show community involvement offering information and education on services provided. NetMIS outreach list which includes title of event, date of event, number of youth and adults in event, purpose of event, and what area the event took place in the community, was provided.	
The program maintains written agreements with other community partners which include services provided and a comprehensive referral process.	X					The program maintains written agreements with Life Management Center of Northwest Florida, Panama City Police Department, Jackson County School District, Gulf Coast Sexual Assault Program, Chemical Addictions Recovery Effort, Bay County Teen Court, and Bay County School District. All agreements reviewed were current.	

Provider has a written policy and procedure that meets the requirement for Indicator 2.01						**YES** **If NO, explain here:** Policy in place titled ACH-HH-AD-002 Intake/Orientation Process. Policy was last reviewed on March 5, 2021 by the Executive Director.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
Shelter youth: Eligibility screening is completed immediately for all shelter placement inquiries. If staff on duty cannot complete the screening, an on-call supervisor is contacted and eligibility is determined within 30 minutes from initial inquiry.		X				There were 5 shelter files reviewed (3 closed, 2 open). All 5 files documented the eligibility screening was completed immediately. Two secret shopper calls were made to the agency and both of those screenings were completed.	
Community counseling: Eligibility screening is completed within 3 business days of referral by a trained staff using the NetMIS form		X				There were 5 community counseling files reviewed (2 closed, 3 open). 3 of the 5 files had a screening completed within 3 business days of the referral.	Exception: Two of five files did not have a screening completed within 3 business days of the referral, one was completed 6 days after the referral and one was completed 9 days after the referral.
There is evidence all referrals for service is screened for eligibility and is logged in NetMIS within 72 hours of screening completion.		X				There were 5 community counseling files reviewed (2 closed, 3 open) and 5 shelter files reviewed (3 closed, 2 open). All 10 files documented the eligibility screening was entered into NetMIS the same day it was completed. Two secret shopper calls were made to the agency.	Exception: Two of the secret shopper call screenings were not entered into NETMIS within 72 hours.
Youth and parents/guardians receive the following in writing: a. Available service options	X					There were 5 community counseling files reviewed (2 closed, 3 open) and 5 shelter files reviewed (3 closed, 2 open). In all 10 files there was clear evidence that parents/guardians received available service options, and rights and responsibilities.	

b. Rights and responsibilities of youth and parents/guardians							
The following is also available to the youth and parents/guardians: a. Possible actions occurring through involvement with CINS/FINS services (case staffing committee, CINS petition, CINS adjudication) b. Grievance procedures	X					There were 5 community counseling files reviewed (2 closed, 3 open) and 5 shelter files reviewed (3 closed, 2 open). In all 10 files there was evidence youth and parents/guardians received grievance procedures and possible actions occurring through involvement with CINS/FINS services.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.02						**YES** **If NO, explain here:** Policy in place titled ACH-HH-AD-003 Intake Assessment. Policy last reviewed March 5, 2021 by the Executive Director.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
Completion of Needs Assessment							
Shelter Youth: Needs Assessment initiated within 72 hours of admission	X					There were 5 files reviewed (3 closed, 2 open). All had a Needs Assessment initiated within 72 hours of admission.	
Non-Residential youth: Needs Assessment is done within 2 to 3 face-to-face contacts after the initial intake **OR** updated, if most recent assessment is over 6 months old	X					There were 5 files reviewed (2 closed, 3 open) for the Needs Assessment. All were completed within 2-3 face to face contacts.	
Needs Assessment is conducted by a bachelor's or master's level staff member	X					All shelter and community counseling Needs Assessments were completed by bachelor's or master's level staff.	
Needs Assessment includes a supervisor's review signature upon completion	X					All shelter and community counseling Needs Assessments were reviewed and signed by a supervisor upon completion.	
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			There were 5 community counseling files reviewed (2 closed, 3 open) and 5 shelter files were reviewed (3 closed, 2 open). None of the youth were identified with an elevated risk of suicide as a result of the Needs Assessment.	

If yes, the youth was referred for an Assessment of Suicide Risk conducted by or under the direct supervision of a licensed mental health professional			X			There were 5 community counseling files reviewed (2 closed, 3 open) and 5 shelter files reviewed (3 closed, 2 open). None of the youth were identified with an elevated risk of suicide as a result of the Needs Assessment.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.03						**YES** **If NO, explain here:** Policy in place titled ACH-HH-CS-002 Case Planning and Reviewing. Policy last reviewed on March 5, 2021 by the Executive Director.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Case/Service plan is developed within 7 working days of Needs Assessment	X					There were 5 community counseling files reviewed (2 closed, 3 open) and 5 shelter files reviewed (3 closed, 2 open). In all files the Case/Service Plan was developed within 7 working days of the Needs Assessment.	
Case plan service Plan includes: 1. Individualized and prioritized need(s) and goal(s) identified by the Needs Assessment 2. Service type, frequency, location 3. Person(s) responsible 4. Target date(s) for completion and Actual completion date(s) 5. Signature of youth, parent/ guardian, counselor, and supervisor 6. Date the plan was initiated		X				There were 5 community counseling files reviewed (2 closed, 3 open) and 5 shelter files reviewed (3 closed and 2 open). In all 10 files the Case/Service Plan included: individualized and prioritized needs and goals identified by the Needs Assessment, service type, frequency, and location; target dates for completion, signature of youth, parent/guardian, counselor, and supervisor; and the date the plan was initiated. 4 of the 5 closed files reviewed documented actual completion dates.	Exception: One closed shelter file had no completion dates.
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				There were 5 community counseling files reviewed (2 closed, 3 open) and 5 shelter files reviewed (3 closed and 2 open). None of the shelter files were applicable for a 30 day review for progress of the Case/Service Plans due to the youth being in the program less than 30 days. All five community counseling files were applicable for a 30 day review.	Exception: In all community counseling files the Case/Service Plan was reviewed more than 30 days after the initial date of the plan. The reviews were between 3 and 11 days late.
						YES **If NO, explain here:**	

Provider has a written policy and procedure that meets the requirement for Indicator 2.04						Policy in place titled ACH-HH-CS-001 Case Management. Policy last reviewed on March 5, 2021 by the Executive Director.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
Counselor/Case Manager is assigned	X					There were 5 community counseling files reviewed (2 closed, 3 open) and 5 shelter files reviewed (3 closed, 2 open). In all files there was evidence of a counselor being assigned.	
The Counselor/Case Manager completes the following as applicable: 1. Establishes referral needs and coordinates referrals to services based upon the on-going assessment of the youth's/family's problems and needs 2. Coordinates service plan implementation 3. Monitors youth's/family's progress in services 4. Provides support for families 5. Monitors out-of-home placement (if necessary) 6. Makes referrals to the case staffing to address problems and needs of the youth/family 7. Accompanies youth and parent/guardian to court hearings and related appointments 8. Refers the youth/family for additional services when appropriate 9. Provides case monitoring and reviews court orders 10. Provides case termination notes 11. Provides follow-up after 30 days of exit 12. Provides follow-up after 60 days of exit	X					There were 5 community counseling files reviewed (2 closed, 3 open) and 5 shelter files reviewed (3 closed, 2 open). All 10 files establish referral needs and coordinated referrals to services based upon the ongoing assessment of the youth's/family's problems and needs, coordinated service plan implementation, monitored youth's/family's progress in service, and provided support to families. None of the files were applicable for monitoring out-of-home placement. None of the files were applicable for referring the youth and family to the case staffing committee. None of the files were applicable for accompanying youth/guardian to court hearings and related appointments. 4 files were applicable and referred the youth/family for additional services. 2 files were applicable and provided case monitoring and reviews. All 5 applicable files provided case termination documentation. There were 5 files applicable for providing follow-up after 30 days of exit and 4 files after 60 days of exit. All follow-ups were completed as required.	

The program maintains written agreements with other community partners that include services provided and a comprehensive referral process	X					The program maintains written agreements with Life Management Center of Northwest Florida, Panama City Police Department, Jackson County School District, Gulf Coast Sexual Assault Program, Chemical Addictions Recovery Effort, Bay County Teen Court, and Bay County School District.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.05						**YES** **If NO, explain here:** Policy in place titled ACH-HH-CS-003 Counseling. Policy last reviewed on March 5, 2021 by the Executive Director.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Youth and families receive counseling services, in accordance with the youth's case/service plan, to address needs identified during the assessment process	X					There were 5 community counseling files reviewed (2 closed, 3 open) and 5 shelter files reviewed (3 closed, 2 open). Each file documented the youth and families received counseling services in accordance with their individual needs identified during their assessment process.	
Shelter Program							
Shelter programs provides individual and family counseling	X					There were 5 files reviewed (3 closed, 2 open). Each file documented that the program provided individual and family counseling.	

Group counseling sessions held a minimum of five days per week		X				August 2021 group logs were reviewed.	Exception: Groups were not consistently held 5 days per week. Week 1 documented 4 groups, week 2 documented 3 groups, week 3 documented 2 groups, and week 4 documented 4 groups. There were emails provided that list reasons group was not provided for the following dates: 8/4/21 youth experiencing a crisis (week 1), 8/12/21 extended supervised visit for 2 youth (week 2), and 8/18/21 time constraints (week 3).
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				August 2021 group logs were reviewed. All group logs had a clear topic listed, all groups, with the exception of 4, had a facilitator listed, and all groups provided an opportunity for youth engagement.	Exception: There was no facilitator listed on 4 groups. There was no time length listed for any groups.
Community Counseling							
Community counseling programs provide therapeutic community-based services designed to provide the intervention necessary to stabilize the family. Services are provided in the youth's home, a community location, the local provider's counseling office or virtually if written documentation is provided in the youth's file for reasons why it is in the best interest of the youth and family.	X					The community counseling program provides therapeutic community based services. There is no evidence in the 5 community counseling files reviewed that services are being provided virtually.	
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					There were 5 community counseling files reviewed (2 closed, 3 open) and 5 shelter files reviewed (3 closed, 2 open). In all files there was evidence case files have coordination between presenting problems, assessments, service plans, case management, and follow up.	
Maintain individual case files on all youth and adhere to all laws regarding confidentiality	X					There were 5 community counseling files reviewed (2 closed, 3 open) and 5 shelter files reviewed (3 closed, 2 open). In all files there was evidence of confidentiality laws being adhered to.	
Case notes maintained for all counseling services provided and documents youth's progress	X					There were 5 community counseling files reviewed (2 closed, 3 open) and 5 shelter files reviewed (3 closed, 2 open). In all files there is consistent completion of progress notes to document the youth's progress.	
On-going internal process that ensures clinical reviews of case records and staff performance	X					There were 5 community counseling files reviewed (2 closed, 3 open) and 5 shelter files reviewed (3 closed, 2 open). In all files there was evidence of an ongoing internal process that ensures clinical reviews of case records and staff performance. Clinical Supervisor provided documentation of clinical reviews conducted at team meetings with staff.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.06						**YES** **If NO, explain here:** Policy in place titled ACH-HH-CS-004 Case Staffing Committee. Policy last reviewed on March 5, 2021 by the Executive Director.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
Case Staffing Initiation and Notifications							
If parent/guardian initiates, staffing is held within 7 days					X	Parent/guardian did not initiate either case staffing.	
The youth, family and case staffing committee are contacted within a minimum of five working days a. Notification to youth/family no less than 5 working days prior to staffing b. Notification to committee no less than 5 working days prior to staffing	X					Notification was sent via email to the committee and youth/family no more than five days prior to the case staffing.	

Case Staffing Committee							
Must include: a. DJJ rep. or CINS/FINS provider b. Local school district representative	**X**					In the 2 case staffing files reviewed the CINS/FINS provider and local school district representative were present as members of the case staffing committee.	
Other members may include: a. State Attorney's Office b. Others requested by youth/ family c. Substance abuse representative d. Law enforcement representative e. DCF representative f. Mental health representative	**X**					There was a mental health representative present for both case staffing files reviewed.	
The program has an established case staffing committee, and has regular communication with committee members	**X**					Based on observation and interviews the program has a case staffing committee and there is regular communication. Although the program was able to explain who the members were and how they communicate, there was no written evidence of practice.	
The program has an internal procedure for the case staffing process, including a schedule for committee meetings	**X**					Based on observation and interviews, the program has an internal procedure for case staffing process. There was no evidence of a schedule; however, it is clear staffings are held when needed.	
As a result of the Case Staffing							
The youth and family are provided a new or revised plan for services		**X**				2 case staffing files were reviewed for this indicator. In one file, the family was provided a new or revised plan of services.	Exception: In the other file, no new or revised plan of services was provided to the family.
Written report is provided to the parent/guardian within 7 days of the case staffing meeting, outlining recommendations and reasons behind the recommendations		**X**				2 case staffing files were reviewed for this indicator. In one file, a written report was provided to the parent/guardian on the same day of the case staffing.	Exception: In the other file, no written report was provided to the family.
If applicable, the program works with the circuit court for judicial intervention for the youth/family	**X**					2 case staffing files were reviewed for this indicator. In both files, there was evidence of judicial intervention for the youth/family.	
Case Manager/Counselor completes a review summary prior to the court hearing	**X**					2 case staffing files were reviewed for this indicator. In both files, there was evidence of review summaries prior to the court hearing.	
						YES	

Provider has a written policy and procedure that meets the requirement for Indicator 2.07						**If NO, explain here:** Policy in place titled ACH-HH-DR-001 Case Files. Policy last reviewed on March 5, 2021 by the Executive Director.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
All records are clearly marked 'confidential'.	X					During the on-site tour of the facility files were observed to be marked "confidential".	
All records are kept in a secure room or locked in a file cabinet that is marked "confidential"	X					During the on-site tour of the facility files were observed to be stored in locked file cabinets marked "confidential".	
When in transport, all records are locked in an opaque container marked "confidential"	X					During the on-site tour of the facility a locked, opaque container marked "confidential" was observed to transport files.	
All records are maintained in a neat and orderly manner so that staff can quickly and easily access information	X					All ten files reviewed were observed to be organized and maintained in a neat and orderly manner so staff can easily access information.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.08						**YES** **If NO, explain here:** Policy in place titled ACH-HH-PM-020 Sexual Orientation, Gender Identity, and Gender Expression. Policy last reviewed on March 5, 2021 by the Executive Director.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
Use of youth's preferred name/ pronoun: a. Youth are addressed according to their preferred name and gender pronouns b. Youth's preferred name and gender pronouns are used in logbook and on all outward-facing documents and census boards	X					A review of the Florida Network's SOGIE Report as of September 8, 2021 revealed there were two youth who fell under the requirements of this indicator. There was one applicable open shelter file reviewed. Youth was addressed by preferred name/pronoun and preferred name/pronoun was used in logbook and outward facing documents. There was also one applicable community counseling file reviewed and this youth was addressed according to their preferred name and gender pronoun.	
Youth in need of specialized support is referred to qualified resources (as applicable)			X			Neither youth was in need of specialized support.	

Youth preference is considered and documented for room assignment and youth is not roomed in isolation due to sexual orientation, gender identity, or gender expression	X					For the one shelter youth, the youth's preference for room assignment was honored by the program and the youth was not roomed in isolation.	
Youth is provided hygiene products, undergarments and clothing that affirms their gender identity or gender expression	X					For the one shelter youth, the youth was provided hygiene products and clothing that affirmed their gender identity.	
The agency has signage and brochures/publication placed in common areas indicating that all youth are welcome regardless of sexual orientation, gender identity, and gender expression	X					During the on-site tour of the facility, there was signage observed on a bulletin board in the dayroom, intake area, and counseling offices.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.09						**YES** **If NO, explain here:** Policy in place titled ACH-HH-CS-06 DV Respite, Probation Respite, and Domestic Minor Sex Trafficking Services. Policy last reviewed on March 5, 2021 by the Executive Director. Program also has policy titled ACH-HH-CS-005 titled Staff Secure Shelter Program. Policy last reviewed on March 5, 2021 by the Executive Director. Program also has policy in place titled ACH-AFC-DO-003 Family/Youth Respite Aftercare Services (FYRAC). Policy last reviewed on March 5, 2021 by the Executive Director.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Staff Secure							
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? **(If no, select rating "No eligible items for review")**	NO					The provider has not served any youth meeting the criteria for staff secure since the last QI review.	
Staff Secure policy and procedure outlines the following: a. In-depth orientation on admission						Reviewed policy ACH-HH-CS-005 titled Staff Secure Shelter Program.	

b. Assessment and service planning c. Enhanced supervision and security with emphasis on control and appropriate level of physical intervention d. Parental involvement e. Collaborative aftercare	X						
Program only accept youth that meet legal requirements of F.S. 984 for being formally court ordered in to Staff Secure Services			X			No applicable youth files to review.	
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			No applicable youth files to review.	
Agency provides a written report for any court proceedings regarding the youth's progress			X			No applicable youth files to review.	
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")**	**NO**					The provider has not served any youth meeting the criteria for DMST since the last QI review.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		

Agency has evidence that the FNYFS was contacted for approval prior to admission for all Domestic Minor Sex Trafficking (DMST) placements.			X			No applicable youth files to review.	
There is evidence the youth was entered into NetMIS as a Special Populations youth at admission and a Human Trafficking Screening Tool (HTST) was completed.			X			No applicable youth files to review.	
Services provided to these youth specifically designated services designed to serve DMST youth			X			No applicable youth files to review.	
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			No applicable youth files to review.	
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			No applicable youth files to review.	
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			No applicable youth files to review.	
All other services provided to DMST youth are consistent with all other general CINS/FINS program requirements			X			No applicable youth files to review.	
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**						
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Youth admitted to DV Respite placement have a pending DV charge and have evidence of being screened by JAC/Detention, but do not meet criteria for secure detention	**X**					There were two files reviewed, both closed. Both files had a face sheet indicating a pending DV charge and both were screened by the JAC and did not meet criteria for secure detention.	
Data entry into NetMIS and JJIS within (3) business days of intake and discharge	**X**					Both files had evidence of data entry within three business days of intake and within three business days of discharge.	
Youth in program do not have length of stay in DV Respite placement that exceeds 21 days. If more than 21 days, documentation exists in youth file of transition to CINS/FINS or Probation Respite placement, if applicable.	**X**					One youth did not exceed 21 days in the program. The other youth was in the program for 23 days, the youth was not transferred to CINS/FINS or Probation Respite but there was documentation in the file that the youth's stay was extended due to being eligible for other services.	
Case plan in file reflects goals focusing aggression management, family coping skills, or other intervention design to reduce reoccurrence of violence in the home	**X**					Both files had Service Plans that focused on anger management and family coping skills.	
All other services provided to Domestic Violence Respite youth are consistent with all other general CINS/FINS program requirements	**X**					Both youth received all other general CINS/FINS required services.	
Probation Respite							
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? **(If no, select rating "No eligible items for review")**	**YES**						
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**					There was one closed Probation Respite youth file reviewed. Approval by the Florida Network was obtained for the youth and located in the file.	
Probation Respite Referral come from DJJ Probation and are all youth referred on probation regardless of adjudication status	**X**					Referral came from probation officer and a DJJ face sheet was present in the file showing probation status of the youth.	
Data entry into NetMIS and JJIS within (3) business days of intake and discharge	**X**					There was evidence of data entry within three business days of intake and discharge in the file.	
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**					The youth was in the program between 14 to 30 days and did not stay in the program beyond 30 days.	
All case management and counseling needs have been considered and addressed	**X**					All case management and counseling needs identified were addressed.	
All other services provided to Probation Respite youth are consistent with all other general CINS/FINS program requirements	**X**					The youth received all other general CINS/FINS required services.	
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")**	**N/A**					This program does not provide Intensive Case Management Services.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Youth receiving services was court ordered					**X**	This program does not provide Intensive Case Management Services.	

Services for youth and family include: a. Two (2) direct contacts per month b. Two (2) collateral contacts per week c. Direct and collateral contacts not obtained must have documentation to support attempts made to obtain them. All reasonable attempts (at minimum of three) must be made to reach all contacts (direct and collateral) and documented in the case file and NetMIS.					X	This program does not provide Intensive Case Management Services.	
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	This program does not provide Intensive Case Management Services.	
Case plan demonstrates a strength-based, trauma-informed focus					X	This program does not provide Intensive Case Management Services.	
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	This program does not provide Intensive Case Management Services.	
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")**	**NO**					The provider has not served any youth meeting the criteria for FYRAC since the last QI review.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Youth is referred by DJJ for a domestic violence arrest on a household member, and/or the youth is on probation regardless of adjudication status and at risk of violating			**X**			No applicable youth files to review.	
Agency has evidence that all FYRAC referrals have documented approval from the Florida Network office			**X**			No applicable youth files to review.	
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**			No applicable youth files to review.	
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**			No applicable youth files to review.	
Group Sessions:						No applicable youth files to review.	

a. Focus on the same issues as individual/family sessions with the overall goal of strengthening relationships and prevention domestic violence b. Shall be no more than eight (8) youth at one (1) time and shall be for a minimum of sixty (60) minutes per session			X				
Youth and family participate in services for thirteen (13) sessions or ninety (90) consecutive days of services, or there is evidence in the youth's file that an extension is granted by DJJ circuit Probation staff			X			No applicable youth files to review.	
2.10: STOP NOW AND PLAN (SNAP)							
Provider has a written policy and procedure that meets the requirement for Indicator 2.10						**YES** **If NO, explain here:** Policies in place titled ACH-CS-SNAP-001-006: Intake Requirements, Discharge Requirements, Fidelity Adherence Monitoring, SNAP Group Delivery, SNAP in Schools, and Suicide Prevention and Intervention. All policies were last reviewed on September 1, 2021 by the Executive Director.	
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					There were 4 open and 4 closed files reviewed. All 8 files had NetMIS Screening form and SNAP Brief Intake Screening form.	
Needs assessment is completed at initial intake, or within two face-to-face sessions	X					Needs Assessment was initiated at intake in all eight files.	
SNAP Assessments						A pre CBCL was completed in 7 of the 8 files. In one	

a. Child Behavior Checklist (CBCL) is completed by the caregiver (pre & post) b. Teacher Report Form (TRF) completed by the teacher (pre & post) c. Tool for Parenting Self Efficacy (TOPSE) completed by the caregiver (pre & post) d. Prevention Assessment Tool (PAT) (pre & post) There must be at least three (3) documented attempts in the youths' file to obtain all pre-assessment (listed above) information.	**X**					file the CBCL was sent to the parent to complete on 8/11/2021, the parent was contacted on 8/13/2021 and 9/20/2021 to attempt to obtain the CBCL. The program is going to make another attempt to obtain the CBCL from the parent. All 4 closed files had a post CBCL. 3 files documented a pre TRF was completed and returned by the teacher. The remaining 5 files documented the TRF was sent to the teacher to be completed, however, those 5 were not returned completed. There were follow-up emails in each file documenting attempts made to have the teachers fill out the TRF's and return them. None of the 4 closed files had a post TRF completed due to services ending during the summer months when school was not in session. A pre TOPSE was completed in 7 of the 8 files. In one file the TOPSE was sent to the parent to complete on 8/11/2021, the parent was contacted on 8/13/2021 and 9/20/2021 to attempt to obtain the TOPSE. The program is going to make another attempt to obtain the TOPSE from the parent. All 4 closed files had a post TOPSE. All 8 files had a pre PAT Assessment completed at intake. The 4 closed files had post PAT Assessment completed at discharge.	
SNAP discharge report summary	**X**					All 4 closed files had a SNAP discharge report summary.	
SNAP Boys/SNAP Girls **Parent** Group Evaluation Form	**X**					All 4 closed files had a Parent Group Evaluation Form.	
SNAP Boys/SNAP Girls **Child** Group Evaluation Form	**X**					All 4 closed files had a Child Group Evaluation Form.	
SNAP for Schools & Communities							
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		

All cycles conducted outside of the school setting is reviewed by the Florida Network prior to the facilitation of services.			X			All cycles reviewed were conducted in a school.	
Each classroom or community setting group session has the following: a. a minimum of 45 minutes in length b. children ages 6-11 years of age with a minimum of five (5) children present c. one trained SNAP facilitator as well as a teacher or community facilitator in each session.	X					Each session reviewed was 45 minutes long; children were between the ages of 6-11; there were more than 5 children present for each session; there was a SNAP facilitator and teacher present for each session.	
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					All 13 weekly attendance sheets were present with youth names, and teacher and facilitator signatures.	
"Class Goal" sheet	X					"Class Shoot for Your Goal" sheet was completed.	
Measure of Classroom Environment (MoCE) (Pre and Post) is used to identify baseline and treatment outcomes of reported classroom dynamics.	X					A pre and post MoCE was completed.	
Pre and Post Evaluations	X					Pre and post evaluations were present for all youth and the teacher.	
One SNAP® Fidelity Adherence Checklist completed per classroom in a 13 – week SNAP in Schools group and uploaded to Dropbox	X					There was one Fidelity Adherence Checklist completed.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.01						**YES** **If NO, explain here:** There are several policies where this indicator is covered. All were signed by the Executive Director on March 5, 2021.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		

Facility Inspection	**X**					An on-site tour of the facility revealed the furnishings were in good repair. The program was free of insect infestation. Bathrooms and shower areas were clean and functional. There was no graffiti observed. Lighting is adequate for the most past. There are some rooms where the lighting is dim. Exterior areas are free of debris and the grounds are free of hazards. Doors are secure, with in and out access limited to staff, and key control is in compliance. Egress plans, client rules, grievance forms, Abuse Hotline information, DJJ Incident Reporting Number are posted. Agency vehicles are locked and are equipped with first aid kits, fire extinguishers, glass breakers, seat belt cutter, and air bag deflators. It was noted first aid kits in vehicles should be consistent and contain the same items. Interior areas do not contain contraband and are free from hazardous unauthorized metal/foreign objects. Chemicals are listed, approved, inventoried, and stored securely and MSDS are maintained on each item. The washers/dryers are operational and maintained. The current DCF license is displayed that is valid November 10, 2020 until November 9, 2021. Each youth has their own bed with clean linens.	Exception: During initial inspection of the lint traps on the dryers, one was full and needed cleaning. This was cleaned out immediately at the time of the tour.
Fire and Safety Health Hazards	**X**					The annual fire inspection, completed on August 17, 2021, shows the facility in compliance with fire safety codes. The annual fire alarm and fire sprinkler system inspections were done on September 13, 2021 with satisfactory findings. The annual overhead hood inspection was completed on July 15, 2021 with satisfactory findings. At least one fire drill was observed to be completed in two minutes or less monthly. Mock drills were observed to be completed quarterly. Residential Group Care and Food Service inspections were completed October 6, 2020 with satisfactory ratings, and menus are posted.	

Youth Engagement							
a. Youth are engaged in meaningful, structured activities (e.g., education, recreation, counseling services, life and social skill training) seven days a week during awake hours. Idle time is minimal. b. At least one hour of physical activity is provided daily. c. Youth are provided the opportunity to participate in a variety of faith-based activities. Non-punitive structured activities are offered to youth who do not choose to participate in faith-based activities. d. Daily programming includes opportunities for youth to complete homework and access a variety of age appropriate, program approved books for reading. Youth are allowed quiet time to read. e. Daily programming schedule is publicly posted and accessible to both staff and youth.	X					After reviewing the daily schedule it was observed that youth are engaged in meaningful, structured activities seven days a week during awake hours and idle time is minimal. Youth are provided at least one hour of physical activity daily. Upon request youth may participate in faith-based activities. Youth are provided opportunities for homework and have access to a variety of books. Daily schedule is posted and accessible.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.02						**YES** **If NO, explain here:** Policy titled ACH-HH-AD-002 Intake/Orientation Process. Last reviewed by the Executive Director on March 5, 2021.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Youth received a comprehensive orientation and handbook provided within 24 hours		X				An orientation was provided within 24-hours in all 5 shelter files reviewed. A handbook was provided to 4 out of the 5 youth within 24 hours.	Exception: One youth did not receive the handbook within 24 hours.
Orientation includes the following: a. Youth is given a list of contraband items						Orientation was observed to include a list of contraband items, disciplinary action is explained, dress code is explained, review of access to medical and mental health services, procedures for visitation,	

b. Disciplinary action is explained c. Dress code explained d. Review of access to medical and mental health services e. Procedures for visitation, mail and telephone f. Grievance procedure g. Disaster preparedness instructions h. Physical layout of the facility i. Sleeping room assignment and introductions j. Suicide prevention- alerting staff of feelings or awareness of others having suicidal thoughts	X					mail and telephone, grievance procedure, disaster preparedness instructions, physical layout of the facility, sleeping room assignment, introductions, and suicide prevention in all 5 shelter files reviewed.	
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					Observation of all 5 shelter files showed documentation of orientation, including topics, dates of presentation, as well as signatures of the youth and staff involved.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.03						**YES** **If NO, explain here:** Policy titled ACH-HH-PM-009 Room Assignment. Last reviewed by the Executive Director on March 5, 2021.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
A process is in place that includes an initial classification of the youths, to include:							
a. Review of available information about the youth's history, status and exposure to trauma b. Initial collateral contacts, c. Initial interactions with and observations or the youth						Review of available information about the youth's history, status and exposure to trauma, initial collateral contacts, initial observation of interaction with youth, risk factors, sexual orientation, and health symptoms were documented in all 5 shelter files reviewed.	

d. Separation of younger youth from older youth, e. Separation of violent youth from non-violent youth f. Identification of youth susceptible to victimization g. Presence of medical, mental or physical disabilities h. Suicide risk i. Sexual aggression and predatory behavior j. Sexual orientation gender identity/ expression k. Acute health symptoms requiring quarantine or isolation	X						
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 for youth with risk factors were observed in all 5 shelter files reviewed with a color-dot system (green/yellow/red).	
Provider has a written policy and procedure that meets the requirement for Indicator 3.04						**YES** **If NO, explain here:** Policy titled ADH-HH-DR-002 Log Book Documentation. Last reviewed by the Executive Director on March 5, 2021.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Log book entries that could impact the security and safety of the youth and/or program are highlighted	X					The program uses the Note Active electronic log. Reviewed a sample of logbook entries over the last 5 months, 5/15/2021 - 9/18/2021. Important entries were observed to be highlighted.	
All entries are brief, legibly written in ink and include: • Date and time of the incident, event or activity • Names of youth and staff involved • Brief statement providing pertinent information	X					All entries are brief, typed electronically, date/time stamped, and signed by person making the entry.	

• Name and signature of person making the entry							
Recording errors are struck through with a single line. The staff person must initial and date the correction. The use of whiteout and erasures is prohibited.	X					No error or redaction entries were observed.	
The program director or designee reviews the facility logbook(s) every week and makes a note chronologically in the logbook indicating the dates reviewed and if any correction, recommendations and follow-up are required and sign/date the entry	X					The program manager or designee was observed to review the program logbook and provided recommendations. All reviews included a date and time stamped electronically.	
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					The program staff were observed to review, at minimum, 2 previous shifts.	
At the beginning of their shift, oncoming supervisor and shelter counselor reviews the logbook of all shifts since their last log entry and makes a signed and dated entry and into log book indicating the dates reviewed.	X					The program supervisor and case managers were observed to review the logbook. Logbook reviews were electronically stamped with the date and time.	
Logbook entries include: a. Supervision and resident counts b. Visitation and home visits	X					Observed logbook entries included supervision and resident counts, and visitation and home visits.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.05						**YES** **If NO, explain here:** Policy titled ACH-HH-BX-001 Behavioral Intervention. Last reviewed by the Executive Director on March 5, 2021.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		

The program has a detailed written description of the BMS, and it is explained during program orientation	**X**					The program is currently utilizing a level-based Behavior Management System that is reviewed in the orientation handbook provided to youth at intake. The program also utilizes an increase in allowance with each level advancement.	
Behavior Management Strategies MUST include: a. Supervisors are trained BMS is designed to teach youth new behaviors and help youth understand the natural consequences for their actions b. Behavioral interventions are applied immediately, with certainty, and reflect the severity of the behavior c. BMS uses a wide variety of awards/incentives to encourage participation and completion of the program d. Appropriate consequences and sanctions are used by the program and consequences for behavior are logical and designed to promote skill-building for the youth e. Counseling, verbal intervention and de-escalation techniques are used prior to physical intervention (Only techniques approved by the Florida Network and DJJ are used if physical intervention is required) f. Only staff discipline youth. Group discipline is not imposed g. Room restriction is not used as part of the system or for youth who are physically and/or emotionally out of control	**X**					After reviewing the Behavior Management System it was observed that staff are provided training; behavior interventions are applied immediately and reflect the severity of the behavior; uses a variety of awards through a level-system and allowance; appropriate consequences and counseling and de-escalation techniques are to be used prior to physical intervention, with an emphasis on trauma informed care. Room restriction is not used as part of their system or for youth who are physically and/or emotionally out of control. Youth are not denied basic rights such as meals, clothing, sleep, services, exercise, or correspondence.	

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**					Documentation of staff being trained in the theory and practice of the Behavior Management System was observed in staff training files.	
There is a protocol for providing feedback and evaluation of staff regarding their use of BMS rewards and consequences	**X**					Use of the Behavior Management System rewards and consequences is documented in the program's Behavior Intervention policy.	
Supervisors are trained to monitor the use of rewards and consequences by their staff	**X**					Documentation of monitoring the Behavior Management System was observed in staff training files.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.06						**YES** **If NO, explain here:** Policy in place titled ACH-HH-PM-010 Staffing Requirements and Scheduling. Last reviewed on March 5, 2021 by the Executive Director.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
The program maintains minimum staffing ratios as required by Florida Administrative Code and contract. • 1 staff to 6 youth during awake hours and community activities • 1 staff to 12 youth during the sleep period	**X**					Reviewed monthly staff schedules from January – August 2021. Reviewed five random nights of video surveillance: August 29 12am – 1am, September 3 2am – 3am, September 7 4am – 5am, September 11 1am -2am, and September 16 3am - 4am. Program maintains staffing ratios as required by Florida Administrative Code and contract. Program maintains 1 staff to 6 youth during awake hours and 1 staff to twelve 12 youth during the sleep period.	
All shifts must always provide a minimum of two staff present	**X**					All shifts consistently maintain a minimum of 2 staff present.	

Program staff included in staff-to-youth ratio includes only staff that are background screened and properly trained youth care workers, supervision staff, and treatment staff	X					All staff included in ratio were trained and screened.	
The staff schedule is provided to staff or posted in a place visible to staff	X					Monthly schedules are readily available and visible to staff.	
There is a holdover or overtime rotation roster which includes the telephone numbers of staff who may be accessed when additional coverage is needed	X					Holdover roster includes staff contact information which 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					Reviewed five random nights of video surveillance: August 29 12am – 1am, September 3 2am – 3am, September 7 4am – 5am, September 11 1am -2am, and September 16 3am - 4am. Reviewed corresponding bed checks in log book for the above dates and times. Staff consistently observe youth every 10 minutes while in their sleeping rooms.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.07						**YES** **If NO, explain here:** Policy in place titled ACH-HH-DO-18 Video Surveillance System. Policy last reviewed on March 5, 2021 by the Executive Director.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Surveillance System							
The agency, at a minimum, shall demonstrate: a. A written notice that is conspicuously posted on the premises for the purpose of security b. System can capture and retain video photographic images which must be stored for a minimum of 30 days						A written notice is posted. System can capture and retain video for a minimum of 30 days. System can record date, time, and location, and maintain resolution that enables facial recognition. System has back-up capabilities. Cameras are posted in interior and exterior general locations. Cameras are never placed in bathrooms or sleeping quarters. All cameras were observed to be visible.	

c. System can record date, time, and location; maintain resolution that enables facial recognition d. Back-up capabilities consist of cameras' ability to operate during a power outage e. Have cameras placed in interior and exterior general locations of the shelter where youth and staff congregate and where visitors enter and exit. Cameras are never placed in bathrooms or sleeping quarters. f. All cameras are visible	**X**						
A list of designated personnel who can access the video surveillance system is maintained (includes off-site capability per personnel)?	**X**					The program has a list of designated personnel who can access the video surveillance system.	
Supervisory review of video is conducted a minimum of once every 14 days and timeframes reviewed are noted in the logbook. The reviews assess the activities of the facility and include a review of random sample of overnight shifts	**X**					Video Surveillance Review log was reviewed from 1/31/2021 - 8/30/2021. Supervisory review of video is conducted by the Shelter Manager at a minimum of every 14 days and assesses the activities of the facility including random samples of overnight shifts.	
Grant the requesting of video recordings to yield a result within 24-72 hours from program quality improvement visits and when an investigation is pursued after an allegation of an incident	**X**					The program has procedures in place in policy titled Video Surveillance System to handle requests of video recordings within 24 – 72 hours.	
Camera service order/requests will be made within 24 hours of discovery of camera malfunctioning or being inoperable. All efforts made to obtain repairs are documented and maintained	**X**					The program has procedures in place in policy titled Video Surveillance System to ensure service orders are made within 24 hours of discovery and includes documentation requirements.	
						YES	
						If NO, explain here:	

Provider has a written policy and procedure that meets the requirement for Indicator 4.01						Policy titled ACH-HH-HC-008 Medical Care for Routine, Acute, and Chronic Medical Conditions. Policy last reviewed on March 5, 2021 by the Executive Director.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Preliminary Healthcare Screening							
Screening includes : a. Current medications b. Existing (acute and chronic) medical conditions c. Allergies d. Recent injuries or illnesses e. Presence of pain or other physical distress f. Observation for evidence of illness, injury, physical distress, difficulty moving, etc. g. Observation for presence of scars, tattoos, or other skin markings h. Acute health symptoms requiring quarantine or isolation	X					Reviewed five shelter youth files. Each of the youth files contained a health screening form completed on date of youth's admission. Each health screening form contained all required elements.	
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			Reviewed five shelter youth files. Youth are screened for chronic conditions and documentation provided. Policy would dictate practices for referral/follow-up; none of the cases resulted in the need for medical referral/follow-up in large due to youth not requiring such services for duration of time at shelter.	
When needed, the parent is involved with the coordination and scheduling of follow-up medical appointments			X			Reviewed shelter policy which addresses practices required for referral/follow-up. None of the five youth presented with chronic conditions requiring a referral to ensure medical care.	
All medical referrals are documented on a daily log.			X			Reviewed shelter policy which addresses practices required for referral/follow-up. None of the five youth presented with chronic conditions required a referral to ensure medical care.	

The program has a thorough referral process and a mechanism for necessary follow-up medical care as required and/or needed	X					There are procedures in place to involve the parent in any follow-up medical care or referrals needed.	
Provider has a written policy and procedure that meets the requirement for Indicator 4.02						**YES** **NO (explain below)** **If NO, explain here:** Policy titled ACH-HH-SS-006 Suicide Prevention and Intervention. Last reviewed on March 5, 2021 by the Executive Director.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Suicide Risk Screening and Approval							
Suicide risk screening occurred during the initial intake and screening process. Suicide screening results reviewed and signed by the supervisor and documented in the youth's case file.	X					Reviewed five shelter youth files. All five files contained a suicide risk screening completed during the screening and initial intake screening process that was signed by a supervisor.	
The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	X					Reviewed the program's Suicide Risk Assessment tool.	
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				Reviewed five shelter youth files, four were applicable for this indicator. Three out of the four youth were appropriately placed on supervision based upon suicide risk assessment.	Exception: One youth file out of the four, was missing the suicide risk assessment. The youth was on supervision; however, the suicide risk assessment was never completed.
Staff person assigned to monitor youth documented youth's behavior at 30 minute or less intervals	X					Reviewed five shelter youth files, four were applicable for this indicator. Each of the four youth were monitored while on supervision; documented at a minimum every thirty minutes.	

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				Reviewed five shelter youth files, four were applicable for this indicator. Three out of the four youth were maintained on supervision until a licensed mental health professional or a non-licensed mental health professional completed the necessary assessment.	Exception: One youth file out of the four was missing the suicide risk assessment. The youth was on suicide precautions and being observed; however, a suicide risk assessment was never completed. The youth remained on suicide precautions until discharged from the shelter.
Provider has a written policy and procedure that meets the requirement for Indicator 4.03						**YES** **If NO, explain here:** Policy titled ACH-HH-HC-006 Medication Management. Last reviewed on March 5, 2021 by the Executive Director.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Medication Storage							
a. All medications are stored in a Pyxis Med-Station 4000 Medication Cabinet that is inaccessible to youth (when unaccompanied by authorized staff) b. Pyxis machine is stored in accordance with guidelines in FS 499.0121 and policy section in Medication Management c. Oral medications are stored separately from injectable epi-pen and topical medications d. Medications requiring refrigeration are stored in a secure refrigerator that is used only for this purpose, at temperature range 2-8 degrees C or 36-46 degrees F. (If the refrigerator is not secure, the room is secure and inaccessible to youth.)	X					An on-site tour of the Pyxis Med-Station and medical room was completed with the Registered Nurse (RN). The Pyxis Med-Station is located in the medical room, is inaccessible to youth, and stored in accordance with required guidelines. All medications are stored in the Pyxis Med-Station 4000 medication cabinet. Oral medications are stored separately from topical medications located in the locked medical cabinet. There is a secure refrigerator in the medical room used only for medical purposes and maintained at 36 degrees F. All narcotic and controlled medications are stored in the Pyxis Med-Station 4000 medication cabinet. The Pyxis Med-Station was appropriately labeled for staff to be able to access medications in case of a malfunction.	

e. Narcotics and controlled medications are stored in the Med Station f. Pyxis keys with the following labels are accessible to staff in the event they need to access medications if there is a Pyxis malfunction: a TOP COVER b BACK PANEL- LEFT TALL CABINET LOCK- LEFT, c BACK PANEL- RIGHT TALL CABINET LOCK- RIGHT							
Medication Distribution							
a. Agency maintains a minimum of 2 Super Users for the Med-Station b. Only designated staff delineated in User Permissions have access to secured medications, with limited access to controlled substances (narcotics) c. A Medication Distribution Log shall be used for distribution of medication by non-licensed and licensed staff d. Agency verifies medication using one of four methods listed in the FNYFS Operations Manual e. When nurse is on duty, medication processes are conducted by the nurse f. The delivery process of medications is consistent with the FNYFS Medication Management and Distribution Policy g. Agency does not accept youth currently prescribed injectable medications, except for epi-pens h. Non-licensed staff have received training in the use of epi-pens provided by a registered nurse	**X**					The program provided a list of 19 staff delineated to have access to secured medication with two of those staff being designated as Super Users. Training documents support all applicable staff were trained by the program's RN in medication distribution. The RN distributes all medications when on-site and trained staff distribute medication when the RN is not on-site. A review of four youth files supported they took medication while in the program. All four files contained a Medication Distribution Log completed as required. Staff verify medication either by the RN or by calling the pharmacy. All staff have training in the use of epi-pens.	
Medication Inventory							

a. For controlled substances, a perpetual inventory with running balances is maintained as well as a shift-to shift count verified by a witness and documented b. Over-the-counter medications that are accessed regularly are inventoried weekly by maintaining a perpetual inventory c. Syringes and sharps (needles, scissors, etc.) are secured, and counted and documented weekly	X					Medication Distribution Logs reviewed documented controlled substances were inventoried perpetually and shift-to-shift. Over-the-counter (OTC) medication inventories were reviewed and documented OTC's are inventoried perpetually and weekly by the RN. Weekly inventories of sharps were reviewed and found to be accurate. There were no syringes on-site.	
There are monthly reviews of medication management practice via Knowledge Portal or Pyxis Med-Station Reports.	X					An interview with the RN and an on-site tour confirmed the RN completes weekly and monthly reviews of medication management via the Knowledge Portal.	
Medication discrepancies are cleared after each shift.	X					An interview with the RN, an on-site tour, and discrepancy reports confirmed discrepancies are cleared after each shift. There were no open discrepancies at the time of the review.	
Provider has a written policy and procedure that meets the requirement for Indicator 4.04						**YES** **If NO, explain here:** Policy titled ACH-HH-HC-007 Medical/Mental Health Issues Alert. Last reviewed on March 5, 2021 by the Executive Director.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Youth with a medical, mental health, or food allergy was appropriately placed on the program's alert system	X					Reviewed five youth shelter files. Each of the youth was appropriately placed within the program's alert system. All had color-coded dot on the front of file indicating appropriate alert.	
Alert system includes precautions concerning prescribed medications, medical/mental health conditions	X					Reviewed five youth shelter files. Each of the youth had required precautions concerning any prescribed medication(s), medical, and/or mental health conditions. Precautions were noted on Medication Distribution Logs and side effect sheets.	
Staff are provided sufficient training, information and instructions to recognize/respond to the need for emergency care for medical/mental health problems	X					A review of ten staff training files was conducted. Each staff had training on emergency medical procedures.	

A medical and mental health alert system is in place that ensures information concerning a youth's medical condition, allergies, common side effects of prescribed medications, foods and medications that are contraindicated, or other pertinent mental health treatment information, is communicated to all staff	X					Reviewed five youth shelter files. Each youth had required medical and/or mental health alert in place. Review of policy and ancillary documentation outlines shelter's practice for identifying and establishing a youth's medical/mental health concerns. The shelter utilizes a color system which clearly denotes what alert a youth is on.	
Provider has a written policy and procedure that meets the requirement for Indicator 4.05						**YES** **If NO, explain here:** Policy titled ACH-HH-EM-008 Emergency Medical Care. Last reviewed on March 5, 2021 by the Executive Director.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Off-site Emergency Services							
a. If off-site emergency medical or dental care was provided, an incident report was submitted for the medical or dental care b. Upon youth return, there is a verification receipt of medical clearance via discharge instructions with follow-up is present in file c. Youth's parent/guardian was notified d. A daily log is maintained for emergency care provided	X					Reviewed five youth files with no noted medical or dental off-site emergencies required. Pulled three separate central communication center (CCC) reports, which provided off-site emergency medical, incidents. Each of the three incidents had required documentation supporting youth were provided medical care. There was documentation addressing medical discharge instruction. In each of the three incidents, youth parent/guardian were notified. The program maintains an Episodic Log for Emergency Medical Care to document any emergency care provided.	
All staff are trained on emergency medical procedures	X					A review of ten staff training files was conducted. Each staff had training on emergency medical procedures.	
The program has a Knife-for-life and wire cutters accessible to staff in a secure location(s)	X					Conducted an interview with on-site nurse (RN) who was able to confirm practices/processes. Nurse confirmed the program has at a minimum one Knife-for-life contained within the building (main office), locked and only accessible to staff. The knife-for-life and wire cutters were observed during the on-site tour of the facility.	

First aid kit/supplies are fully equipped and inventoried	X					Conducted an interview with on-site nurse (RN) who was able to confirm practices/processes. Nurse confirmed the program has at a minimum ten first aid kits located in the building and for each vehicle. Contents were recently updated as of January 2021 and are inventoried weekly by the RN. First aid kits were observed and reviewed during the on-site tour of the facility.	