Florida Network for Youth and Family Services
Compliance Monitoring Report for

CDS NW – Lake City
1884 Southwest Grandview Street
Lake City, FL 32055

December 15-16, 2021

Compliance Monitoring Services Provided by

EXECUTIVE SUMMARY

Forefront LLC conducted a joint Quality Improvement (QI) and Florida Network of Youth and Family Services (FNYFS) monitoring visit for the CDS Family & Behavioral Health Services, Inc. – Interface NW (CDS – Interface NW) for the FY 2021-2022 on December 15-16, 2022, at its program office located at 1884 SW Grandview Street, Lake 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. CDS Family & behavioral Health Services, Inc. – Interface NW 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.

Keith Carr, Consultant for Forefront LLC and Peer Reviewer(s) conducted the compliance monitoring review. Agency representatives from CDS Family & Behavioral Health Services, Inc. – Interface NW present for the entrance interview were Carlos Lopez, Residential Supervisor; Kathy Hardee, Registered Nurse; Stephanie Douglas, LMHC, Senior Family Action Counselor/Case Manager and Tracey Ousley, Chief Operating Officer. The last QI visit was conducted September 9-10, 2020.

In general, the Reviewer found that CDS Interface NW is in compliance with specific contract requirements. **CDS Interface NW received an overall compliance rating of 100% for achieving full compliance with 11 indicators** of the CINS/FINS Monitoring Tool. There were no corrective actions as a result of the monitoring visit.

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

2021-2022 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 12-15-16-22

Agency Name: CDS – Interface NW	**Monitor Name: Keith Carr, Lead Reviewer**
Contract Type: CINS/FINS	**Region/Office: 1884 SW Grandview Street, Lake City, FL**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): 12/15-16/2021**

Major Programmatic Requirements	Explain Rating: Unacceptable	Explain Rating: Conditionally Unacceptable	Explain Rating: Fully Met	Explain Rating: Exceeded	Explain Rating: Not Applicable	Ratings Based Upon: I = Interview; O = Observation; D = Documentation; PTV = Submitted Prior To Visit; (List Who and What)	Notes: Explain Unacceptable or Conditionally Acceptable: (Attach Supportive Documentation)
I. Administrative and Fiscal							
DJJ Quality Improvement Peer Reviewer a. Provider shall demonstrate that a minimum of two (2) staff members have been trained to be certified as DJJ QI Peer reviewers. Provider shall participate in a minimum of one (1) on-site quality assurance review of a similar type program in another judicial circuit during each 12-month period of the contract, if requested.	☐	☐	☒	☐	☐	**D:** CDS Agency has 7 certified peers that cover all 3 program site locations. Sabriena Williams, Regional Director and Carlos Lopez, Residential Supervisor are both based in the CDS-NW location.	No corrective action required
Additional Contracts a. Provider shall provide a listing of all current federal, state, or local government contracts, as well as other contracts entered into with for profit and not-for-profit organizations. Such listing shall identify the awarding entity and contract start & end dates. **PTV**	☐	☐	☒	☐	☐	**D:** The agency provided a list of 6 additional contracts for FY21-22. The current list includes six (6) additional contract engagements outside of contracts with the FNYFS. The Excel formatted list contains the Contractor; the contract #; the amendment #; the contact address; email address; service, start and end terms; date executed, any main changes; and the annual amount. Additional details on these contracts are available upon requests.	No corrective action required
Limits of Coverage	☐	☐	☒	☐	☐	**D:** General Liability through Berkshire Hathaway Specialty Insurance	No corrective action required

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	Explain Rating						
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**						Company. The General Liability limits include coverage for $1,000,000 each/$1,000,000; $3,000,000 General Aggregate; $1,000,000 personal injury; $1,000,000 damage to rented property; $3,000,000 Products-Comp/Op Agg; $1,000,000 Employee Benefits; Policy Effective 01/10/2021-01/10/2022. Auto Insurance is provided through Berkshire Hathaway Specialty Insurance Company, with combined single limits of $1,000,000 and PIP Basic $10,000; Each Occurrence $1,000,000; Aggregate $1,000,000 effective 01/20/2022-01/10/2022. Workers Compensation and Employers' Liability is provided by Bridgefield Employers Insurance Company $500,000 each accident, $500,000 per each employee; and $500,000 for policy limitations. Effective dates are 05/01/2021 – 05/01/2022. The FNYFS is confirmed and listed as certificate holder on the certificate.	

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External/Outside Contract Compliance a. Provider has corrective action item(s) cited by an external funding source (Fiscal or Non-Fiscal). **ON SITE**	☐	☐	☐	☐	☒	**I:** The agency did not report any corrective actions for external funding sources related to any of its existing contracts.	No corrective action required
Fiscal Practice a. Agency must have employee and fiscal policy/procedures manuals that are in compliance with GAAP and provide sound internal controls. Agency maintains fiscal files that are audit ready. **PTV**	☐	☐	☒	☐	☐	**D:** The agency provided fiscal policies for all related financial processes and associated procedures. The most recent update and revision is related to Fiscal policies and procedures October 2019.	No corrective action required
b. Agency maintains a general ledger and the corresponding source documents. General ledger must be set up to track the activity of the grant separately (standard account numbers / separate funds for each revenue source, etc.). **PTV**	☐	☐	☒	☐	☐	**D:** The agency provided a General Ledger Detail Report with Detail Postings for Journal, Source and Batch Period 01 July 1, 2020, Thru Period 03 Ending July 16, 2021. The ledger includes category columns that list Account Number/Description; Period; Date; Journal; Source; Batch Beginning Balance; Debit; Credit; Net Change; and Ending Balance. The Categories include Earned Income, Salaries, FICA, Reemployment Tax, Group Insurance, Worker's Compensation, and Retirement Plan.	No corrective action required
c. Petty cash ledger system is balanced, and all cash disbursements are compliant with financial policies and allowable under the contract. (Disbursements/invoices are approved & monitored by management.) –**ON SITE**	☐	☐	☒	☐	☐	**D:** CDS has a procedure for petty cash, policy P-1257. The form captures the amounts that are reported from all receipts that are	No corrective action required

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	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable		
						submitted to the main office for reimbursement as needed, dates, the signature of the petty cash custodian and signature for program supervisor. The Administrative Assistant, receives the reimbursement check who will then cash it and replace the money in the petty cash box which is kept securely in his office. The Administrative Assistant evidence of reconciliation for petty cash for the following dates: July 2021 through November 2021. All reconciliation records were balanced and verified to be at $150. The reconciliations are reviewed and signed by the program supervisor.	
d. Financial records and reports are current. Includes bank statements reconciled within 6 weeks of receipt. Vendor invoices past 6 months. Invoices are submitted on a monthly basis with supporting documentation. (Disbursements/invoices are approved & monitored by management). **ON SITE**	☐	☐	☒	☐	☐	**D:** The agency provided documentation of all Reconciliation Report Activity Document Date Ranges from July 2021through October 2021. All statements have documentation for deposits and adjustments and evidence of general ledger and bank statements reconciliation for the aforementioned period.	No corrective action required
e. Agency maintains inventory in accordance with a written policy and FNYFS contractual requirements. If over	☐	☐	☐	☐	☒	**D:** CDS agency maintains a list of items purchased with DJJ funds;	No corrective action required

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$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**						however, no material inventory items amounting to more than $1000 were purchased since the last onsite visit.	
f. Agency submits payroll taxes and deposits (and retirement deposits as applicable), Employee IRS Form W-2 and Independent Contractors IRS Form 1099 forms prior to federal requirements. **ON SITE**	☐	☐	☒	☐	☐	**D:** The agency provided bank records that reflect withdrawal IRS Payment transactions. The bank documents provided by the agency document withdrawals from July 2021 through October. There is evidence of payments starting January 2021 September 2021 and list all payments to the IRS as evidence of each payment.	No corrective action required
g. Budget to actual reports prepared and reviewed by appropriate management. Variance from the budget are investigated and explained. **PTV/ON SITE**	☐	☐	☒	☐	☐	**D:** The CDS agency provided the agency's Budget vs. Actual statement on all fiscal transactions. The report documents Revenues/Expenses; Actual; Budget; Percentage Used; and Variances for the June 2020 through July 2021. Variances in budget Profit and Loss Budget versus Actual statement are monitored on a routine basis by the Fiscal Officer and by the Executive Director.	No corrective action required
h. A Single Audit is performed as part of the annual audit if expenses are greater than $750,000. The agency must submit a Corrective Action Plan for findings cited in the	☐	☐	☒	☐	☐	**D:** The agency provided record of the annual audit completed by James Moore certified public accountants and	No corrective action required

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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**						consultants. The document provided list information on the annual audit Report on the Financial Statements audited June 30, 2020, and 2019. A management letter was issued with general findings. No fiscally deficient findings were documented in this report.	
i. Agency maintains confidentiality policy with written policies and procedures to ensure the security and privacy of all employee and client data. Personal information is not easily accessible. Agency maintains a backup system in case of accidental loss of financial information. Security procedures are in place to protect laptops. Obsolete documents are shredded, and computer hard drives are wiped prior to discarding. **ON SITE**	☐	☐	☒	☐	☐	**D:** Agency provided 7 confidentiality policies and written policies and procedures for security and privacy as follows: P-1046 Youth Case Record, P-1073 IT Confidentiality Standards, P-1066 Virus Protection, P-1065 Backup, P-1009 Record Elimination, P-1072 Security, and P-1167 Uses and Disclosures of Confidential and Protected Health Information. These documents were last updated in October 2019.	No corrective action required

CONCLUSION

CDS Family & Behavioral Health, Inc. Interface NW has met the requirements for the CINS/FINS contract as a result of full compliance with **11** applicable indicators of the Administrative and Fiscal Contract Monitoring Tool. Two of the thirteen indicators were not applicable because: 1) does not have any outstanding corrective action item(s) cited by an external funding source and 2) does not have any current inventory purchased with DJJ/FN Funds. Consequently, **the overall compliance rate for this contract monitoring visit is 100%.** There are no corrective actions cited 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 conducted in a manner which meets the standard as described in the report findings.

If required, the provider must submit a corrective action plan to address corrective actions cited in the corresponding section of this report. The provider's Corrective Action Plan should address the issues, corrective actions item cited, time frames and staff responsible. Responses to items cited for corrective actions are due to the Florida Network and the Florida Network Contract Manager within fourteen (14) working days of receipt of this report (See Florida Network Site for the Service Provider Corrective Action Form). The Florida Network Contract Manager will then review the response to the corrective action(s) to determine if the response 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 CDS Family & Behavioral Health Services Inc. - Interface N.W
CINS/FINS Program

December 15-16, 2021

Compliance Monitoring Services Provided by

CINS/FINS Rating Profile

Standard 1: Management Accountability

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

Percent of indicators rated Satisfactory: 85.71 %
Percent of indicators rated Limited: 14.29 %
Percent of indicators rated Failed: 0 %

Standard 2: Intervention and Case Management

2.01 Screening and Intake	**Satisfactory**
2.02 Needs Assessment	**Satisfactory**
2.03 Case/Service Plan	**Satisfactory**
2.04 Case Management & Service Delivery	**Satisfactory**
2.05 Counseling Services	**Limited**
2.06 Adjudication/Petition Process	**Satisfactory**
2.07 Youth Records	**Satisfactory**
2.08 Sexual Orientation, Gender Identity, Gender Expression	**Satisfactory**
2.09 Special Populations	**Satisfactory**
2.10 Stop Now and Plan (SNAP)	**Not Applicable**

Percent of indicators rated Satisfactory: 90 %
Percent of indicators rated Limited: 10 %
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	**Limited**
3.07 Video Surveillance System	**Satisfactory**

Percent of indicators rated Satisfactory: 85.71 %
Percent of indicators rated Limited: 14.29 %
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: 89.66 %

Percent of indicators rated Limited: 10.34 %

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 demonstrated.
Limited Compliance	Exceptions to the requirements of the indicator that result in the interruption of service delivery, and typically require oversight by management to address the issues systemically.
Failed Compliance	The absence of a component(s) essential to the requirements of the indicator that typically requires immediate follow-up and response to remediate the issue and ensure service delivery.
Not Applicable	Does not apply.

Reviewers

Members

Keith Carr - Lead Reviewer Consultant-Forefront LLC/Florida Network of Youth and Family Services
Gwen Nelson – Regional Monitor, Department of Juvenile Justice
Logan Farrelly - Youth Crisis Center
Jennessa Hart - Anchorage Children's Home
Cyndy Freshour - Lutheran Services Florida Currie House

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		Case Manager		Nurse – Full time
	Chief Financial Officer		Counselor Non-Licensed	X	Nurse – Part time
X	Chief Operating Officer		Advocate		# Case Managers
	Executive Director		Direct – Care Full time	2	# Program Supervisors
	Program Director		Direct – Part time		# Food Service Personnel
	Program Manager		Direct – Care On-Call		# Healthcare Staff
	Program Coordinator		Intern		# Maintenance Personnel
	Clinical Director		Volunteer		# Other (listed by title): ___
	Counselor Licensed		Human Resources		

Documents Reviewed

	Accreditation Reports		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		Key Control Log	4	# MH/SA Records
	Continuity of Operation Plan	X	Fire Drill Log	14	# Personnel /Volunteer Records
X	Contract Monitoring Reports	X	Medical and Mental Health Alerts	8	# Training Records
	Contract Scope of Services		Precautionary Observation Logs	8	# Youth Records (Closed)
	Egress Plans	X	Program Schedules	3	# Youth Records (Open)
X	Fire Inspection Report		List of Supplemental Contracts		# Other: ___
	Exposure Control Plan		Vehicle Inspection Reports		

Observations During Review

	Intake	X	Posting of Abuse Hotline	X	Staff Supervision of Youth
	Program Activities		Tool Inventory and Storage	X	Facility and Grounds
	Recreation		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		Census Board

Comments

Due to COVID-19, this review was conducted via **hybrid (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

CDS Family Behavioral Health Services Inc. Interface N.W. has experienced many situations throughout the pandemic. This has led to the following updates:

Counselors
- Residential counselor resigned/terminated in October 2020. A new residential counselor was hired in July 2021-November 2021. CDS is currently advertising for a full-time residential counselor.
- Currently advertising for a full-time case manager (Family Action).

Other Hires & Terminations
- Have lost 8 youth care workers since September 2020.
- Currently have on staff seven youth care workers (4 full-time, 3 part-time or PRN).
- Currently have on staff one senior youth care worker.
- Seeking a case manager.
- House manager recently hired in November 2021.

COVID
- Seven staff members were affected by COVID.
- There is a daily COVID protocol for staff and youth participants.
- Nurse provides COVID updates at each staff meeting.

School
- Youth participated in virtual on-site learning from April 2020-January 2021.
- The program received four new desktop computers, two laptops and two 8-inch tablets.

Furloughs
- Due to staff shortages, CDS NW started site furloughs to CDS Interface Central (sister site) August 19 through November 28.
- Started weekend furloughs on June 12, 2021.

Narrative Summary

CDS Family & Behavioral Health Services, Inc. has 3 locations (Interface Central, Interface East and Interface NW) that provides short-term, residential (Interface Shelter) and counseling services (Family Action) using a family focused approach to assist both youth and their families through the Children in Need/Families in Need (CINS/FINS) contract through the Florida Network. They have several other programs across all three locations from various funding streams and partnerships including: Independent Living, Prevention, Emergency Shelter, and Basic Center/Safe Place. The agency was established in 1970 and their mission statement is 'strengthening communities by building strong families'. Family Action provides short term counseling to youth, ages 6-17, and their families. Youth that may be experiencing

homelessness, truancy, or at risk of runaway behaviors between the ages of 10-17 meet the criteria of the residential program. Interface NW is located on 1884 S.W. Grandview Street in Lake City, Florida. They provide services to the following counties: Alachua, Bradford, Columbia, Dixie, Gilchrist, Hamilton, Lafayette, Levy, Putnam, Suwannee, and Union County. The residential facility operates 24 hours a day, 7 days a week.

The agency has placed a pause on providing Stop Now and Plan (SNAP) services. They are currently contracted for but have not served any of the special population youth since the last quality improvement review: staff secure, domestic minor sex trafficking, probation respite, intensive case management, family/youth respite aftercare services.

The overall findings for the QI review for CDS Interface NW are summarized as follows:

Standard 1: There was a total of 7 applicable indicators for Standard 1 - Management Accountability. Five of the seven indicators were rated satisfactory. Indicator 1.04 - Training was rated as a limited rating. Indicator 1.05 had an exception due to review of training needs needing to be addressed but no corrective action has taken place. All other indicators were rated as satisfactory with no exceptions.

Standard 2: There was a total of 9 applicable indicators for Standard 2 – Intervention and Case Management. Two out of nine indicators were rated as satisfactory with exceptions. The following indicators did have exceptions: Indicator 2.02 – Three of eight files reviewed indicated that a youth was at an elevated risk of suicide as the result of the needs assessment. Two of the three youth were not properly placed on elevated supervision or referred for an assessment of suicide risk after reporting history of cutting behavior and previous Baker Acts. Indicator 2.03 – Case/Service Plan received an exception for 2 files missing a parent/guardian signature and 1 file was not reviewed for progress within 30 days nor signed. Indicator 2.05 was rated as a limited rating. All other indicators were rated satisfactory with no exceptions.

Standard 3: There were a total of 7 indicators for Standard 3 - Shelter Care. Four out of seven indicators were rated satisfactory with no exceptions. Indicator 3.01 – Shelter Environment received an exception for not having blinds without cords in the shelter, damage to the exterior of the building still awaiting repair and emergency lights not working during the shelter tour. Indicator 3.05 – Behavior Management System received an exception for two new hires that did not show evidence of BMS training. Indicator 3.06 was rated as a limited rating.

Standard 4: There were a total of 5 applicable indicators reviewed for Standard 4 – Mental Health/Health Services. Indicator 4.02 received an exception due to one closed client file containing a lack of evidence for 30 minute or less intervals of observations and one assessment not indicating a review by a clinician. All other indicators were rated satisfactory with no exceptions.

<u>Summary of Deficiencies resulting in Limited:</u>

Standard 1:
Indicator 1.04: Training – This indicator is rated as limited due to two new hires not completing several required training within their first 30 days and 90 days of employment. Both new hires missed seven trainings and one of the two did not take an additional twelve trainings.

Standard 2:
Indicator 2.05: Counseling Services – This indicator is rated as limited due to the agency only completing 31

group counseling sessions (out of a possible 120 sessions) within a total of six months of service. When sessions were conducted, most documentation did not include a clear facilitator or start and end time. It is unclear if groups were 30 minutes.

Standard 3:
Indicator 3.06: Staffing and Youth Supervision – This indicator is rated as limited due to several shifts having only one staff member present supervising youth as well as several hours of undocumented bed checks.

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 Document Source	Notes Explain any items that have any deficiencies, exceptions or are not applicable.
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: Policies P-1025 (Background Check, Reference Check, Fingerprinting for Personnel, Volunteers or Interns) and P-1292 (Pre-employment Suitability Assessment) including corresponding procedures were revised and signed by the COO on January 20, 2021. The policies and procedures meet the requirements for Indicator 1.01.	**Add any exceptions below:**
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					The program had twelve new hires. The program utilized the suitability prescreening assessment tool prior to an offer of employment. All of the new hires had passing scores.	
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					Background screenings were completed for all twelve new hires.	
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			Policy and procedures are in place.	

Five-year re-screening completed every 5 years from initial date of hire	X					The program have two staff members requiring re-screening. The two staff members were rescreened based on the program's policy and procedures.	
Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?	X					The program submitted (by fax) the Annual Affidavit of Compliance Level-2 to the Department of Juvenile Justice on January 7, 2021.	
Proof of E-Verify for all new employees obtained from the Department of Homeland Security	X					The program provided proof of E-Verify for the twelve new hires. None of the new hires had a negative report.	
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: Policies P-1044 (Florida Abuse Reporting), P-1105 (Compliant/Grievance Process for Participants or Companions with Disabilities), P-1032 (Behavioral Expectations for Staff), P-1128 (Rule Violations) and P-1212 (Standards of Conduct) including corresponding procedures were revised and signed by the COO on January 20, 2021. These policies and procedures direct in the requirements for Indicator 1.02.	**Add any exceptions below:**
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
Abuse Free Environment							
Agency has a code of conduct of policy and there is evidence that staff are aware of agency's code of conduct.	X					The program has a code of conduct which all staff members are required to review and sign knowledge of such.	
Child Abuse Registry telephone number is visible to youth and posted common areas of the facility	X					The Abuse Registry telephone number is posted throughout the facility. Youth surveys indicated knowledge of contacting the Abuse Registry.	
Youth were informed of the Abuse and Contact Number (see youth survey results)	X					Youth surveys reviewed indicated knowledge of the process to contact Child Abuse Registry.	
Management takes immediate action to address any incidents of threats or abuse			X			The program did not report any incidents of threats or physical abuse during the review period.	
Grievance Process							

Agency has a formal grievance process	X					The program has a formal grievance process. The program reported one grievance during the review period. The grievance process followed the program's policy and procedures. The incident was reviewed by the management and forwarded to the COO. The form was completed by the youth, supervisor and reviewed by the COO. A review of youth, residential (9) and non-residential (2) surveys indicated the following: all of the youth said they felt safe in the program and they have never been denied an abuse call when requested. The youth had knowledge of the grievance process and none of the youth said they could not file a grievance.	
Locked box accessible to only management and available to youth in a common area	X					The program has a locked box for the youth to place grievance forms.	
Direct care does not handle the complaint/grievance unless assistance is asked for by the youth. Program director/supervisor will have access to and manage grievances unless it is towards themselves.	X					The program's policy and procedures indicate direct care staff do not handle grievances. Staff surveys indicate management process grievances.	
72-hour resolution requirement by management. If this does NOT occur within the 72 hour period, there is sufficient documentation explaining the cause for the delay in resolution.	X					The program policy and procedures states a resolution within 72 of the youth filing. The one incident for the review period was completed 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: Policies P-1045 (Incident Reporting Procedure) and P-1051 (Unusual Event Report - Internal) including corresponding procedures were revised and signed by the COO on January 20, 2021. The policies and procedures meet the requirements for Indicator 1.03.	**Add any exceptions below:**
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		

			for Review				
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					The program has a policy and procedures to address CCC calls to the Department. The program had a total of ten CCC reportable incidents--two medication errors and eight COVID related. The ten calls were called into the CCC within two hours of knowledge of the incidents.	
The program completes follow-up communication tasks/special instructions as required by the CCC			X			None required.	
Incidents are documented in the program logs and on incident reporting forms	X					The CCC incidents reviewed were documented in the program's log book.	
All incident reports are reviewed and signed by program supervisors/directors	X					All incident reports were reviewed as per the policy and procedures. All of the incidents were reviewed and signed by management.	
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						**NO** If NO, explain here: Agency's policy does not include the following required trainings - Florida Network Youth Suicide Prevention, Motivational Interviewing, PAT, Non-licensed clinical staff suicide assessment. It also does not include the language pertaining to employee break of employment. Policy P-1030 (Training Policy) including corresponding procedures was revised and signed by the COO on January 20, 2021.	**Add any exceptions below:**
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				Two training files of staff hired within the last year were reviewed. One of the new hires did complete the required USDOJ Civil Rights & Federal Funds training within their first 30 days from the date of hire.	Limited Exception: One of the 2 new hires did not complete the DOJ Civil Rights & Federal Funding training within their first 30 days of hire.

All staff receives all mandatory training during the first 90 days of employment from date of hire.		X				Two training files of staff hired within the last year were reviewed. There was evidence provided that indicated the staff did complete some of the mandatory training within their first 90 days of hire.	Limited Exception: Both files indicated the following missing trainings: Managing Aggressive Behavior, FL Network Youth Suicide Prevention, Behavior Management, Universal Precautions with COVID related element, and SkillPro Child Abuse: Recognition, Reporting and Prevention. Training missing in one of the two files includes CINS FINS Core, Signs & Symptoms of Mental Health and Substance Abuse, CPR, First Aid, SkillPro Human Trafficking, Serving LGBTQ Youth and the following SkillPro trainings: Information Security Awareness, Equal Employment Opportunity, PREA, Sexual Harassment, Trauma Informed Care, Medication Distribution.
Non-licensed Mental Health Clinical Shelter Staff (within first year of employment)							
Non-licensed mental health clinical shelter staff Assessment of Suicide Risk Training			X			The eligible items for review during the review period.	
Documentation of non-licensed mental health clinical staff person's training in Assessment of Suicide Risk form or written confirmation by a licensed mental health professional of training (includes date, signature and license number of the licensed mental health professional supervisor).			X			The eligible items for review during the review period.	
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				Six training files of direct care staff were reviewed. There was evidence provided that indicated the staff did complete some of the mandatory annual and refresher training.	Limited Exception: Of the six files reviewed, two were missing the Florida Network Youth Suicide Prevention Training, one was missing the Fire Safety Training, three were missing the SkillPro PREA and Sexual Harassment Training. Four were missing the SkillPro Human Trafficking 101 and six were missing the Child Abuse: Recognition, Reporting and Prevention training.
Required Training Documentation							
The program maintains an individual training file for each staff, which includes an annual employee training hours tracking form and related documentation, such as certificates, sign-in sheets, and agendas for each training attended.	X					Eight training files of direct care staff were reviewed. Included in all eight files were the tracking of training hours and related documentation.	
Provider has a written policy and procedure that meets the requirement for Indicator 1.05						**NO**	**Add any exceptions below:**
						If NO, explain here: The policy does not include the most recent Florida Network change to the Analyzing and Reporting Information Indicator: once NetMIS data report accuracy is ensured, NetMIS must be locked and the invoice should be created and submitted to the Florida Network (invoice@floridanetwork.org) by the forth (4th) business day of the following reporting month.	
						Policies P-1180 (Quality Improvement Program), P-1049 (Risk Management Planning) and Data Integrity including corresponding procedures were revised and signed by the COO on January 20, 2021.	

Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
Case record review reports demonstrate reviews are conducted quarterly, at a minimum	X					Reviewed monthly, quarterly, and annual reports and data. Case record reviews are conducted at minimum, quarterly.	
The program conducts reviews of incidents, accidents, and grievances quarterly, at a minimum	X					Reviewed monthly, quarterly, and annual reports and data. The program conducts reviews of incidents, accidents, and grievances quarterly, at minimum.	
The program conducts an annual review of customer satisfaction data	X					The program does maintain documentation of an annual review of customer satisfaction data. This is evidenced by their annual report.	
The program conducts an annual review of outcome data and (if applicable) there is evidence of annual reconciliation that occurs through communication from the Florida Network via email or phone call when corrections are needed and the information is corrected and submitted within the requested timeframes.	X					The program's annual review of outcome data and minutes from meetings were reviewed. The program does conduct an annual review of outcome data.	
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					The program does conduct a monthly review of NetMIS data reports. Reviewed were the NetMIS reports with minutes to meetings containing discussion.	
The Florida Network conducts monthly reconciliation by comparing NetMIS data to JJIS data. Agency has evidence that they have reconciled any differences noted.	X					As evidenced by the program's meeting minutes, the agency maintains documentation that they have reconciled any differences noted.	
The program has a process in place to review and improve accuracy of data entry & collection	X					The program does have a process in place to review and improve accuracy of data entry and collection.	

There is documentation that findings are regularly reviewed by management and communicated to staff and stakeholders.	X					There is documentation that findings are regularly reviewed by management and communicated to staff and stakeholders.	
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					There is evidence the program demonstrates that critical performance data reports are shared with the Board of Directors. In an interview with the Chief Operating Officer (COO), the COO explained the method of communicating with the Board of Directors to keep them informed of Quality Assurance Issues.	
There is evidence that strengths and weaknesses are identified, improvements are implemented or modified, and staff are informed and involved throughout the process.		X				While strengths and weaknesses are identified there is no evidence that corrective measures were implemented and checked on for compliance.	Exception: Minutes reviewed indicate that training needs to be addressed. However, corrective actions on training has not been implemented. Improvements were not noted from the previous review.
Provider has a written policy and procedure that meets the requirement for Indicator 1.06						**YES** If NO, explain here: Policy P-1013 (Vehicles Use and Safety Inspection) including corresponding procedures was revised and signed by the COO on January 20, 2021. The policy and procedures meet the requirements for Indicator 1.06.	**Add any exceptions below:**
Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	X					All of the staff currently listed as drivers for program are approved by the COO.	
Approved agency drivers are documented as having a valid Florida driver’s license and are covered under company insurance policy	X					All staff currently listed as drivers for program have active driver's licenses.	

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					A review of the vehicle logs indicated the program is following their policy and procedures for transporting youth.	
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					The program policy and procedures require the management to consider staff's driving history before assigned to transport youth. It also requires the program supervisor to be aware of the transport as well as consideration of youth's history, evaluation and recent behavior prior to depart.	
The 3rd party an approved volunteer, intern, agency staff, or other youth	X					The 3rd party staff are approved drivers.	
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					A review of the vehicle logs indicates the program is following their policy and procedures for transporting youth. The transportation forms includes staff initials, date/time of transport, mileage, number of passengers, and purpose and location of trip.	
Provider has a written policy and procedure that meets the requirement for Indicator 1.07						**YES** If NO, explain here: Policy P-1050 (Outreach Plan for Targeting Youth for Program Services) and P-1053 (Roles and Responsibilities - Prevention Outreach) including corresponding procedures were revised and signed by the COO on January 20, 2021. The policy and procedures meet the requirements for Indicator 1.07.	**Add any exceptions below:**
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
The program has a lead staff member designated to participate in local DJJ board and council meetings with evidence that includes minutes of the event or other verification of staff participation	X					The program's COO or designee are assigned to participate in board and council meetings. The program provided documentation of attending board and council meetings with agendas and list of persons attending.	
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					Outreach services are provided to the community by assigned staff. Agendas and minutes reviewed indicated program involvement in the community.	

The program maintains written agreements with other community partners which include services provided and a comprehensive referral process.	X					The program has sixteen active cooperative agreements with other community partners.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.01						**YES** If NO, explain here: Policy P-1112 (Screening Process) including corresponding procedures was revised and signed by the COO on January 20, 2021. The policy and procedures meet the requirements for Indicator 2.01.	**Add any exceptions below:**
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				Four out of four (2 open, 2 closed) shelter files reviewed met all the requirements of screening being completed immediately for all shelter placement inquiries. There is documentation of the residential supervisor reviewing all of the screenings within the required timeframe. Two secret shopper calls were made to the agency. One caller was provided a response within 30 minutes and the screening was completed.	Exception: One secret shopeer call was not provided a response and screening was not completed.
Community counseling: Eligibility screening is completed within 3 business days of referral by a trained staff using the NetMIS form	X					Four out of four (2 open, 2 closed) files reviewed met all the requirements of screening being completed within the required time frame on the NetMIS form.	
There is evidence all referrals for service is screened for eligibility and is logged in NetMIS within 72 hours of screening completion.		X				Eight out of eight files reviewed met all the requirements and showed evidence that all was logged in NetMIS within 72 hours of screening completion. One of the secret shopper calls was screened for eligibility and logged into NetMIS within the required 72 hours.	Exception: One secret shopper call was not logged into NetMIS.
Youth and parents/guardians receive the following in writing: a. Available service options	X					Eight out of eight files reviewed (2 open shelter, 2 closed shelter, 2 open community, 2 closed community) showed that the youth and guardians received service options and rights and responsibilities in writing.	

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					Eight out of eight files reviewed (2 open shelter, 2 closed shelter, 2 open community, 2 closed community) showed that the youth and guardians received information in writing about CINS/FINS services and grievance procedures of the program.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.02						**YES** If NO, explain here: Policy P-1019 (Needs Assessment) including corresponding procedures was revised and signed by the COO on January 20, 2021. The policy and procedures meet the requirements for Indicator 2.02.	**Add any exceptions below:**
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					Four of four shelter files reviewed (two open, two closed) met requirement for needs assessment being initiated within 72 hours. All needs assessments reviewed were completed within 24 hours of admission. One of the shelter files reviewed utilized an assessment from the stay a month prior. There was no documentation to explain. However, upon discussing with Residential Supervisor, youth was discharged for Thanksgiving and returned.	
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					Four of four non-residential files reviewed (two open, two closed) met requirement for needs assessment being completed within 2 or 3 face to face contacts. All needs assessments were completed at intake appointments.	
Needs Assessment is conducted by a bachelor's or master's level staff member	X					Eight out of eight files reviewed (2 open shelter, 2 closed shelter, 2 open community, 2 closed community) had needs assessments that were completed by Bachelor's level staff members.	

Needs Assessment includes a supervisor's review signature upon completion	X					Eight out of eight files reviewed (2 open shelter, 2 closed shelter, 2 open community, 2 closed community) had needs assessments that 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					Five of eight files reviewed indicated no further elevation of suicide risk was needed after 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				Five of eight files reviewed indicated no further elevation of suicide risk was needed after the Needs Assessment. One of the three youth identified received proper suicide risk assessment following the needs assessment.	Exception: Three of eight files reviewed indicated that a youth was at an elevated risk of suicide as the result of the needs assessment. Two of the three youth were not properly placed on elevated supervision or referred for an assessment of suicide risk after reporting history of cutting behavior and previous Baker Acts.
Provider has a written policy and procedure that meets the requirement for Indicator 2.03						**YES** If NO, explain here: Policy P-1162 (Individual Plan-DJJ QA) including corresponding procedures was revised and signed by the COO on January 20, 2021. The policy and procedures meet the requirements for Indicator 2.03.	**Add any exceptions below:**
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					Four of four residential files reviewed showed that service plans were developed within 24 hours of intake. Four of four community counseling files showed that service plans were developed at intake.	
Case plan service Plan includes: 1. Individualized and prioritized need(s) and goal(s) identified by the Needs Assessment						All eight files reviewed had service plans that were individualized, included type, frequency, and location, person responsible, and target dates. Six of eight files had signatures of youth, parent/guardian, counselor, and supervisor as required.	Exception: One (non-residential) of eight total files reviewed had an initial service plan that was not signed by

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				and supervisor as required.	that was not signed by youth or guardian. There was a progress note to indicate that service plan was discussed with family at intake but signature was failed to be obtained. One (residential file) of eight total files reviewed did not have a wet signature of guardian but signature line notes plan was discussed via phone.
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				Seven of eight files reviewed had a service plan reviewed every 30 days.	Exception: One of four residential files was not reviewed within 30 days. In this particular file, the signature review lines were all dated, but nothing was signed.
Provider has a written policy and procedure that meets the requirement for Indicator 2.04						**YES** If NO, explain here: Policy P-1162 (Individual Plan-DJJ QA) including corresponding procedures was revised and signed by the COO on January 20, 2021. The policy and procedures meet the requirements for Indicator 2.04.	**Add any exceptions below:**
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
Counselor/Case Manager is assigned	X					All eight files clearly had an assigned case manager/counselor.	
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						The counselor/case manager completed all the requirements in all eight of eight files reviewed.	

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						
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 community partners such as the Children's Consortium, Human Trafficking Task Force, DJJ.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.05						**NO** If NO, explain here: Policy does not include language pertaining to virtual services - "if services are provided virtually, written documentation if provided in the youth's file for reasons why it is in the best interest of the youth and family. Policy P-1163 (Case Management, Counseling, and Service Delivery) including corresponding procedures was revised and signed by the COO on January 20, 2021.	**Add any exceptions below:**
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					Eight of eight files reviewed showed evidence that all youth and families were receiving counseling services in accordance to the youth's case plan to address needs identified during the needs assessment.	
Shelter Program							

Shelter programs provides individual and family counseling	X					Four of four shelter files reviewed showed youth were receiving individual and/or family counseling.	
Group counseling sessions held a minimum of five days per week		X				Of the group logs and documentation reviewed, groups were not completed five days per week.	Limited Exception: Only 31 groups of 120 group sessions were documented as completed since the first week in July 2021.
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				Of the group logs and documentation reviewed, it was shown that youth were given the opportunity to participate and a clear and relevant topic is provided. Residential supervisor reviewed all group documentation.	Limited Exception: Most documentation did not include a clear facilitator or start and end time. It is unclear if groups were 30 minutes.
Community Counseling							
Community counseling programs provide therapeutic community-based services designed to provide the intervention necessary to stabilize the family. Services are provided in the youth's home, a community location, 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					Four of four community counseling files reviewed showed services are provided to stabilize the family in the home, community, counseling office, or virtually with written documentation.	
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					Eight of eight files reviewed showed reflection and coordination between presenting problems, needs assessment, case plan, reviews, case management, and follow up.	
Maintain individual case files on all youth and adhere to all laws regarding confidentiality	X					Eight of eight files reviewed had their own individual files and adhered to confidentiality.	
Case notes maintained for all counseling services provided and documents youth's progress	X					Eight of eight files reviewed demonstrated that case notes were maintained for all youth.	

On-going internal process that ensures clinical reviews of case records and staff performance	X					Documentation was provided that indicated there was an on-going internal process for clinical reviews of case records and staff performance.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.06						**YES** If NO, explain here: Policy P-1160 (Case Staffing Committee: Plan of Services) including corresponding procedures was revised and signed by the COO on January 20, 2021. The policy and procedures meet the requirements for Indicator 2.06.	**Add any exceptions below:**
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			There were no youth that met this criteria to review during the review period.	
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			There were no youth that met this criteria to review during the review period.	
Case Staffing Committee							
Must include: a. DJJ rep. or CINS/FINS provider b. Local school district representative			X			There were no youth that met this criteria to review during the review period.	
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 were no youth that met this criteria to review during the review period.	
The program has an established case staffing committee, and has regular communication with committee members			X			There were no youth that met this criteria to review during the review period.	

The program has an internal procedure for the case staffing process, including a schedule for committee meetings	X					The program has an internal procedure for the case staffing process. There were no youth that met this criteria to review a schedule for committee meetings.	
As a result of the Case Staffing							
The youth and family are provided a new or revised plan for services			X			There were no youth that met this criteria to review during the review period.	
Written report is provided to the parent/guardian within 7 days of the case staffing meeting, outlining recommendations and reasons behind the recommendations			X			There were no youth that met this criteria to review during the review period.	
If applicable, the program works with the circuit court for judicial intervention for the youth/family			X			There were no youth that met this criteria to review during the review period.	
Case Manager/Counselor completes a review summary prior to the court hearing			X			There were no youth that met this criteria to review during the review period.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.07						**YES** If NO, explain here: Policy P-1046 (Youth Case Record) including corresponding procedures was revised and signed by the COO on January 20, 2021. The policy and procedures meet the requirements for Indicator 2.07.	**Add any exceptions below:**
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
All records are clearly marked 'confidential'.	X					All records are properly stamped and labeled confidential.	
All records are kept in a secure room or locked in a file cabinet that is marked "confidential"	X					Records are kept in a locked file room that is marked confidential. Inside the file room are four drawer filing cabinets marked confidential.	
When in transport, all records are locked in an opaque container marked "confidential"	X					Staff utilize locking rolling carts to transport all records that are marked confidential.	
All records are maintained in a neat and orderly manner so that staff can quickly and easily access information	X					All records are maintained in a neat and orderly manner.	
						YES If NO, explain here:	

Provider has a written policy and procedure that meets the requirement for Indicator 2.08						Policy P-1284 (Sexual Orientation Gender Identity Gender Expression) included all policy and procedures regarding this indicator. This policy was reviewed and signed by the COO on January 20, 2021. The policy and procedures do meet the requirement for Indicator 2.08.	**Add any exceptions below:**
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			An interview was conducted with the Residential Supervisor. The agency reported that the agency did not have any available samples of youth that meet the SOGIE profile.	
Youth in need of specialized support is referred to qualified resources (as applicable)			X			The agency reported that the agency did not have any available samples of youth that meet the SOGIE profile.	
Youth preference is considered and documented for room assignment and youth is not roomed in isolation due to sexual orientation, gender identity, or gender expression			X			The agency reported that the agency did not have any available samples of youth that meet the SOGIE profile.	
Youth is provided hygiene products, undergarments and clothing that affirms their gender identity or gender expression			X			The agency reported that the agency did not have any available samples of youth that meet the SOGIE profile.	
The agency has signage and brochures/publication placed in common areas indicating that all youth are welcome regardless of sexual orientation, gender identity, and gender expression	X					The 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.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.09						**YES** If NO, explain here: Policy P-1267 (Staff Secure Shelter Services) including corresponding procedures was revised and signed by the COO on January 20, 2021. The policy and procedures meet the requirements for Indicator 2.09.	**Add any exceptions below:**

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				
Staff Secure policy and procedure outlines the following: a. In-depth orientation on admission b. Assessment and service planning c. Enhanced supervision and security with emphasis on control and appropriate level of physical intervention d. Parental involvement e. Collaborative aftercare	X					The program's staff secure policy and procedures do outline the required measures.	
Program only accept youth that meet legal requirements of F.S. 984 for being formally court ordered in to Staff Secure Services			X			There were no youth that met this criteria to review during the review period.	
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			There were no youth that met this criteria to review during the review period.	
Agency provides a written report for any court proceedings regarding the youth's progress			X			There were no youth that met this criteria to review during the review period.	
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**				
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			There were no youth that met this criteria to review during the review period.	
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			There were no youth that met this criteria to review during the review period.	
Services provided to these youth specifically designated services designed to serve DMST youth			X			There were no youth that met this criteria to review during the review period.	
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			There were no youth that met this criteria to review during the review period.	
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			There were no youth that met this criteria to review during the review period.	

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			There were no youth that met this criteria to review during the review period.	
All other services provided to DMST youth are consistent with all other general CINS/FINS program requirements			X			There were no youth that met this criteria to review during the review period.	
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					One file reviewed for DV respite placement contained all required documentation.	
Data entry into NetMIS and JJIS within (3) business days of intake and discharge	X					There was evidence of data entry into NetMIS and JJIS within (3) business days of intake and discharge.	
Youth in program do not have length of stay in DV Respite placement that exceeds 21 days. If more than 21 days, documentation exists in youth file of transition to CINS/FINS or Probation Respite placement, if applicable.	X					Client was in shelter 22 days and on the last day had an exit date on day 21 from DVR and intake completed for CINS/FINS.	
Case plan in file reflects goals focusing aggression management, family coping skills, or other intervention design to reduce reoccurrence of violence in the home	X					The case plan included appropriate goals for the DV client.	

All other services provided to Domestic Violence Respite youth are consistent with all other general CINS/FINS program requirements	X					Services provided were in line with CINS/FINS 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")**			NO				
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 were no youth that met this criteria to review during the review period.	
Probation Respite Referral come from DJJ Probation and are all youth referred on probation regardless of adjudication status			X			There were no youth that met this criteria to review during the review period.	
Data entry into NetMIS and JJIS within (3) business days of intake and discharge			X			There were no youth that met this criteria to review during the review period.	
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			There were no youth that met this criteria to review during the review period.	
All case management and counseling needs have been considered and addressed			X			There were no youth that met this criteria to review during the review period.	
All other services provided to Probation Respite youth are consistent with all other general CINS/FINS program requirements			X			There were no youth that met this criteria to review during the review period.	
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")**			NO				
Rating Criteria	Satisfactory	Non-compliant	No Eligible	No Practice	Not Applicable		

Rating Criteria	Satisfactory	Non-compliant	Items for Review	No Practice	Not Applicable		
Youth receiving services was court ordered			X			There were no youth that met this criteria to review during the review period.	
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			There were no youth that met this criteria to review during the review period.	
Assessments include: a. A Child Behavior Checklist (CBCL) is completed within 14 days of intake and at discharge (if applicable) b. An approved self-report assessment that was completed at intake c. An approved self-report assessment that was completed every 90 days following intake and at discharge (if applicable)			X			There were no youth that met this criteria to review during the review period.	
Case plan demonstrates a strength-based, trauma-informed focus			X			There were no youth that met this criteria to review during the review period.	
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			There were no youth that met this criteria to review during the review period.	
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				
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			There were no youth that met this criteria to review during the review period.	
Agency has evidence that all FYRAC referrals have documented approval from the Florida Network office			X			There were no youth that met this criteria to review during the review period.	
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			There were no youth that met this criteria to review during the review period.	
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			There were no youth that met this criteria to review during the review period.	
Group Sessions: a. Focus on the same issues as individual/family sessions with the overall goal of strengthening relationships and prevention domestic violence			X			There were no youth that met this criteria to review during the review period.	

b. Shall be no more than eight (8) youth at one (1) time and shall be for a minimum of sixty (60) minutes per session							
Youth and family participate in services for thirteen (13) sessions or ninety (90) consecutive days of services, or there is evidence in the youth's file that an extension is granted by DJJ circuit Probation staff			X			There were no youth that met this criteria to review during the review period.	

2.10: STOP NOW AND PLAN (SNAP)

Provider has a written policy and procedure that meets the requirement for Indicator 2.10	**N/A** If NO, explain here: Program does not provide SNAP services. Indicate policy number, authorized signee, date(s) of last review/revision/approval:	**Add any exceptions below:**

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	As per Florida Network's Quality Improvement & Compliance Manager, the program is not currently contracted to provide SNAP services.	
Needs assessment is completed at initial intake, or within two face-to-face sessions					X	As per Florida Network's Quality Improvement & Compliance Manager, the program is not currently contracted to provide SNAP services.	
SNAP Assessments a. Child Behavior Checklist (CBCL) is completed by the caregiver (pre & post) b. Teacher Report Form (TRF) completed by the teacher (pre & post) c. Tool for Parenting Self Efficacy (TOPSE) completed by the caregiver (pre & post) d. Prevention Assessment Tool (PAT) (pre & post)					X	As per Florida Network's Quality Improvement & Compliance Manager, the program is not currently contracted to provide SNAP services.	

There must be at least three (3) documented attempts in the youths' file to obtain all pre-assessment (listed above) information.							
SNAP discharge report summary					X	As per Florida Network's Quality Improvement & Compliance Manager, the program is not currently contracted to provide SNAP services.	
SNAP Boys/SNAP Girls **Parent** Group Evaluation Form					X	As per Florida Network's Quality Improvement & Compliance Manager, the program is not currently contracted to provide SNAP services.	
SNAP Boys/SNAP Girls **Child** Group Evaluation Form					X	As per Florida Network's Quality Improvement & Compliance Manager, the program is not currently contracted to provide SNAP services.	
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	As per Florida Network's Quality Improvement & Compliance Manager, the program is not currently contracted to provide SNAP services.	
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	As per Florida Network's Quality Improvement & Compliance Manager, the program is not currently contracted to provide SNAP services.	
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	As per Florida Network's Quality Improvement & Compliance Manager, the program is not currently contracted to provide SNAP services.	
"Class Goal" sheet					X	As per Florida Network's Quality Improvement & Compliance Manager, the program is not currently contracted to provide SNAP services.	

Measure of Classroom Environment (MoCE) (Pre and Post) is used to identify baseline and treatment outcomes of reported classroom dynamics.					X	As per Florida Network's Quality Improvement & Compliance Manager, the program is not currently contracted to provide SNAP services.	
Pre and Post Evaluations					X	As per Florida Network's Quality Improvement & Compliance Manager, the program is not currently contracted to provide SNAP services.	
One SNAP® Fidelity Adherence Checklist completed per classroom in a 13 – week SNAP in Schools group and uploaded to Dropbox					X	As per Florida Network's Quality Improvement & Compliance Manager, the program is not currently contracted to provide SNAP services.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.01						**YES** If NO, explain here: Policies P-1293 (Shelter Environment), P-1122 (Leisure & Education Activities) and P-1137 (Faith-Based Activities) including corresponding procedures were revised and signed by the COO on January 20, 2021. The policies and procedures do meet the requirement for Indicator 3.01.	**Add any exceptions below:**
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		

Facility Inspection		X				Furnishings are in good repair. The program is free of insect infestation. Bathrooms and shower areas are clean and functional. It is free of foul odors, leaks, dust, and mildew and in good working order. Lighting is adequate for tasks performed. Dumpster and garbage can(s) are covered. All doors (including agency and staff vehicle doors) are secure. Agency vehicles are equipped with major safety equipment including first aid kit, fire extinguisher, flashlight, glass breaker, seat belt cutter, air bag deflator. In and out access is limited to staff members and key control is in compliance. Pertinent postings are listed in the day room. License located in the foyer of the shelter; effective date 4/1/21. The MSDS is located in the laundry room, a locked area. Laundry area was clean of debris/fire hazards. Staff note they clean lint collectors after each use. The program utilizes a lockable closet which the youth can store personal items. Only staff have access to this area.	Exceptions: The sleeping areas currently have blinds with strings. The program has submitted a purchase order to order cordless blinds for these areas. There is damage to the exterior (water damage to roof) since 10/28/21 that is still pending repair.
Additional Facility Inspection Narrative (if applicable)	None.						

Fire and Safety Health Hazards		X				Date of fire inspection(s) reviewed: 2/11/21 Fire Suppression inspections completed 4/27/21; alarms tested and inspected 6/29/21. Fire suppression inspections were completed with no deficiencies noted. Group Care Inspection (including Food Service Inspection) completed 2/17/21 with no deficiencies noted. The agency exceeds the fire drill requirement with documentation of one fire drill per shift per month. Dates of fire drills include: June 3, 4, 8; July 6, 12, 13; August 2, 3, 5; September 1, 2, 6; October 5, 11, 12; November 1, 2, 4. The agency exceeds the mock emergency drill requirement with documentation of 1 emergency drill, per shift, per month. Dates of the emergency drills include: June 6, 11, 22; July 7, 11, 23, August 6, 10, 23; September 6, 12, 21; October 11, 17, 27; November 8, 10, 22. Residential Group Care Inspection Report, dated 2/17/21, was a satisfactory report. Food Service Inspection included in Group Care Inspection dated 2/17/21. Menus signed and dated by licensed dietician 1/23/21.	Exception: Emergency lighting fixtures are currently not working. A purchase order was submitted to have these repaired.
Additional Fire and Safety Health Hazards Narrative (if applicable)	Nothing additional to note.						
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.						A review of program schedule was observed to include all items required for this indicator. Youth are offered daily time for meditation, physical activities, or other quiet activities. Religious observance noted on Sundays with an alternative outdoor activity.	

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						
Provider has a written policy and procedure that meets the requirement for Indicator 3.02						**YES** If NO, explain here: Policy P-1114 (Admission/Intake & Participant Orientation) including corresponding procedures was revised and signed by the COO on January 20, 2021. The policy and procedures do meet the requirement for Indicator 3.02.	**Add any exceptions below:**
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					Two open and two closed files were reviewed for this indicator. All four files contained documentation that program orientation, including a handbook, was provided the same day of intake.	
Orientation includes the following: a. Youth is given a list of contraband items b. Disciplinary action is explained c. Dress code explained d. Review of access to medical and mental health services e. Procedures for visitation, mail and telephone f. Grievance procedure	X					Two open and two closed files were reviewed for this indicator. All four files contained documentation verifying orientation included the required topics.	

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							
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					Two open and two closed files were reviewed. All four files contained the youth and staff signature, dated, as well as other required components.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.03						**YES** If NO, explain here: Policies P-1116 (Residential Admission: Sleeping Arrangements) and P-1119 (Medical & Mental Health Alert Process) including corresponding procedures were revised and signed by the COO on January 20, 2021. The policies and procedures do meet the requirement for Indicator 3.03.	**Add any exceptions below:**
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 d. Separation of younger youth from older youth, e. Separation of violent youth from non-violent youth f. Identification of youth susceptible to victimization	X					Two open and two closed files were reviewed for this indicator. Each file contained documentation including all pertinent information to be taken into consideration for room assignment. The room assignment process was thorough and consistent in all files.	

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							
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					An interview with the Residential Supervisor indicated there is an alert board in the staff office where alerts are entered. There is an additional alert board located in the kitchen where food allergies are indicated. Of the four files reviewed, two youth had mental health/medication alerts. The files were clearly documented that these alerts were present.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.04						**YES** If NO, explain here: Policy P-1149 (Program Logbook) including corresponding procedures was revised and signed by the COO on January 20, 2021. The policy and procedures do meet the requirement for Indicator 3.04.	**Add any exceptions below:**
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					A selection of logbook entries from June-November were reviewed to satisfy this indicator. Entries impacting the security/safety of the youth and/or program were highlighted as appropriate.	
All entries are brief, legibly written in ink and include: • Date and time of the incident, event or activity • Names of youth and staff involved • Brief statement providing pertinent information • Name and signature of person making the entry	X					A selection of logbook entries from June-November were reviewed to satisfy this indicator. All entries reviewed were neat, legible and included the following elements: date and time of entry, names of youth and staff involved, brief statement providing pertinent information, 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					Review of the program logbook indicate that any errors are struck through with a single line, initialed and dated. There is no evidence of whiteout or erasures in the log.	
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					Review of the program log indicates the Residential Supervisor is signing off on each page of the logbook consistently.	
All staff review the logbook of the previous two shifts and makes an entry signed and dated into the logbook indicating the dates reviewed	X					Review of the program log indicate staff are consistently documenting review of previous two shifts as they are coming on shift for the day.	
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					Review of the program log indicate Shift Leads sign off on each page of the logbook's entries for the day. It is noted that corrections and pertinent information are recorded in the log by Shift Leads.	
Logbook entries include: a. Supervision and resident counts b. Visitation and home visits	X					Review of the program log indicate that supervision and resident counts are documented both formally and informally. The coming and going of program staff, youth, visitors, tutors, etc. onsite and offsite are consistently documented.	
						YES If NO, explain here:	

Provider has a written policy and procedure that meets the requirement for Indicator 3.05						Policies P-1123 (Behavior Management System), P-1126 (Participant/Staff Interactions and Interventions), P-1125 (FACE System), P-1128 (Rule Violations), P-1032 (Behavioral Expectations for Staff) and P-1222 (Seclusion and Restraint & Aggression Control) including corresponding procedures were revised and signed by the COO on January 20, 2021. The policies and procedures do meet the requirement for Indicator 3.05.	**Add any exceptions below:**
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					All pertinent policies were reviewed. The program has thorough policies addressing the Behavior Management Strategy employed, the FACE system, expected staff behaviors, and approved/prohibited staff interventions. The BMS program rules and expectations are explained to each youth at intake. Of four files reviewed, all four contained documentation the youth received an explanation of the BMS during program orientation.	
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	X					A review of policies pertinent to this indicator were reviewed. An interview with the Residential Supervisor to discuss implementation and oversight of the BMS was conducted as well. Findings indicate the program utilizes the FACE system with the residents. The system is introduced in three stages to ensure orientation, understanding, and achievement of the system. A variety of privileges are used to encourage youth to master coping skills and adhere to program expectations. Consequences are applied in a systematic and logical way, encouraging relationship, dialogue, and a focus on coping skills. The program policy is clear on which behavioral interventions are not utilized with working with the clients. Rights and responsibilities are reviewed with youth care workers on a routine basis to ensure understanding.	

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 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				Six program staff training records were reviewed. Three longer-term staff had training related to managing youth behaviors such as MAB, or training with the Residential Supervisor on FACE. Residential Supervisor reports using group sessions and pass-downs as informal means to discuss and train program staff on the FACE system.	Exception: Six program staff training records were reviewed. Two new hires did not show evidence of BMS training.
There is a protocol for providing feedback and evaluation of staff regarding their use of BMS rewards and consequences	X					An interview was conducted with the Residential Supervisor. It was determined both informal and formal feedback/evaluation is provided to staff. Formal evaluation includes annual evaluation which includes discussing implementation of the BMS and goals in this area. Informal methods include conversation during shift pass-down and staff communication notes.	
Supervisors are trained to monitor the use of rewards and consequences by their staff	X					Residential Supervisor has a firm understanding of the purpose of the BMS and works with staff and youth to successfully employ it. Informal and formal monitoring of the system is utilized, including annual evaluations, staff communication notes, and bringing youth and staff together during groups to talk about the BMS.	

Provider has a written policy and procedure that meets the requirement for Indicator 3.06						**YES** If NO, explain here: Policies P-1121 (Supervision and Staffing Ratio/Scheduling) and P-1133 (Bed Time Supervision and Bed Checks) including corresponding procedures were revised and signed by the COO on January 20, 2021. The policies and procedures do meet the requirement for Indicator 3.06.	**Add any exceptions below:**
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					Program logbook indicates staff on duty to youth served ratio is in compliance.	

All shifts must always provide a minimum of two staff present		X				A review of program's staff schedule from July-November 2021 and a sample of logbook documentation from July-November 2021 was conducted.	Limited Exception: This reviewer noted potential discrepancies between the number of staff scheduled and those who signed on shift in the program logbook for dates 7/19 (appears to be a 2 hour gap when staff is onsite alone); 7/20 (appears to be a 3 hour gap when staff is onsite alone); 9/6 (8a-4p, 4p-12a); 10/13 (4p-12a). Per Residential Supervisor call-outs on 9/6 (two shifts), 10/13, and 10/14 resulted in no replacement staff, supervisor provided supervision via remote viewing, which is not an approved Network method of supervision. Review of surveillance shows that on 12/9 from 10pm-1145pm only one male staff was on duty resulting in a gap of 2 hours for bed checks for the female residents.
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 background screenings were completed appropriately for staff being utilized in staff-to-youth ratio.	Limited Exception: The training records reviewed for the two new hires during this review indicate they did not have appropriate trainings in place.
The staff schedule is provided to staff or posted in a place visible to staff	X					An interview with Residential Supervisor indicated staff schedule is posted in the staff office as well as text to each staff member.	

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					A finding from an interview with Residential Supervisor is the on-call manager's information is posted on the staff schedule. Shift Leads assist in filling coverage and open shifts are noted on schedule.	
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				Logbook documentation for overnight checks was reviewed for 19 shifts (those requiring 15 minute bed checks per Network policy). The written logbook indicates staff were completing bed checks at 30 minute intervals; however, reports provided from the scanning device show bed checks were in fact completed at 15 minute intervals. Camera surveillance was reviewed for the following timeframes: 11/17 12a-2a, 11/19 2a-4a, 12/7 4a-6a (ended review at 5:30a due to wake-up call), and 12/9 11:30p-1:30a. The physical layout of sleeping arrangements include one male sleeping room and one female sleeping room.	Limited Exception: It was observed that on the 12/9 shift no bed checks had been completed for the female room beginning at the start of review time 11:30p-12:06a. Upon further review, it was confirmed that the female staff had departed for the day at 10pm and another didn't arrive until 11:45pm. There is a timespan from 10pm-12:06am where bed checks were not completed for the female bedroom.
Provider has a written policy and procedure that meets the requirement for Indicator 3.07						**YES** If NO, explain here: Policy P-1280 (Video Surveillance System) including corresponding procedures was revised and signed by the COO on January 20, 2021. The policy and procedures do meet the requirement for the Indicator.	**Add any exceptions below:**
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
Surveillance System							
The agency, at a minimum, shall demonstrate: a. A written notice that is conspicuously posted on the premises for the purpose of security							

b. System can capture and retain video photographic images which must be stored for a minimum of 30 days c. System can record date, time, and location; 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					Virtual tour of the program allowed observance that a written notice is conspicuously posted on the premises; all cameras are visible; cameras capture areas youth and staff congregate, including outdoor spaces; cameras are not placed in bedrooms. Residential Supervisor confirms cameras can retain surveillance for a minimum of three (3) months per the agency's IT department. The agency utilizes a generator which is automatically employed during a power outage.	
A list of designated personnel who can access the video surveillance system is maintained (includes off-site capability per personnel)?	X					Per Residential Supervisor review of camera surveillance is limited to himself, Regional Director, and the IT department. The Residential Supervisor and Regional Director have off-site capabilities.	
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					Camera review documentation was reviewed. Weekly review is documented beginning 4/26/21 through 12/6/21. Timeframes reviewed and any exceptions to this practice are clearly noted. In addition, reviewer observes logbook documentation in which Residential Supervisor noted camera review was completed and includes findings.	
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					Agency policy includes procedure/expectations for third party review of video recordings.	

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					Agency policy was reviewed. Agency provided documentation of such an event which included a thorough and timely response.	
Provider has a written policy and procedure that meets the requirement for Indicator 4.01						**YES** If NO, explain here: Policy P-1117 (Preliminary Physical Health Screening) included all policy and procedures regarding this indicator. This policy was reviewed and signed by the COO on January 20, 2021. The policy and procedures do meet the requirement for Indicator 4.01.	**Add any exceptions below:**
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						A total of five client files were reviewed to determine the member agency's adherence to the requirements of this health screening indicator. Of the client files reviewed, two were open client cases and three were closed client cases. All five client files had evidence of a preliminary health screening document. This document was completed in all five examples. All client files demonstrated evidence that the agency had completed screenings that specifically asked questions of the client about their current status for past or existing medications, existing acute and chronic medical conditions, any allergies, any recent injuries or illnesses, any presence of pain or other	

h. Acute health symptoms requiring quarantine or isolation	X					physical distress, or presence of difficulty and moving and observations for any physical markings and any other health symptoms that require a quarantine or isolation. The agency has a Registered Nurse on duty for a minimum of 20 hours per week. The reviewer for this indicator interviewed the nurse about her general duties and requirements associated with preliminary health screenings. The Registered Nurse conducts a review of all client files related to admissions to determine if all screenings were completed accurately and covered all of the screening requirements. The Registered Nurse also follows up with each client via an in-person interview to determine their status and to confirm findings documented in the preliminary health screening form.	
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					Of the five files reviewed, none of the youth had existing chronic medical conditions that required a referral to ensure proper medical care is given to the client.	
When needed, the parent is involved with the coordination and scheduling of follow-up medical appointments	X					None of the current samples of client files required parents to coordinate with the program with necessary appointments or scheduling any follow up medical services during the clients' shelter stay.	
All medical referrals are documented on a daily log.	X					All medical referrals when applicable are required to be documented on a daily log. The agency utilizes an emergency episodic log for all offsite emergency or medical services for both clients and/or staff. At the time of this review, in the last six months the clients did not have any examples that required offsite medical services to be provided.	
The program has a thorough referral process and a mechanism for necessary follow-up medical care as required and/or needed	X					The program has an existing system to conduct referrals for outside services when needed. A process is in place to ensure that the program has local entities it has partnerships with to ensure that any necessary follow up medical care is available as needed during the entire term that the client is receiving services.	
						NO	

Provider has a written policy and procedure that meets the requirement for Indicator 4.02						If NO, explain here: Agency's policy does not make note of new Florida Network indicator update - non-licensed clinical staff to have at minimum 5 one-to-one assessments of suicide risk or crisis assessments (20 hours of documented training) and waiver involved. Policy P-1144 (Mental Health, Substance Abuse and Suicide Risk Screening-Residential) addresses most of the requirements of Indicator 4.02. This policy was reviewed and signed by the COO on January 20, 2021.	**Add any exceptions below:**
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Suicide Risk Screening and Approval							
Suicide risk screening occurred during the initial intake and screening process. Suicide screening results reviewed and signed by the supervisor and documented in the youth's case file.	X					A total of four client files were reviewed to determine the member agency's adherence to the requirements of this Suicide Risk Screening indicator. Of the client files reviewed, all four were closed client cases. All four client files had evidence of a suicide risk document.	
The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	X					The program reported that the current suicide risk screening process has been submitted, reviewed and approved by the Florida Network of Youth and Family Services. The current suicide risk screening and assessment process used by the agency has not changed.	
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					A review of all four client files indicate that in each case the youth are placed on the appropriate supervision level. In one of the four client cases reviewed, the youth did not initially screen as at risk for suicide which would necessitate that they be placed on sight and sound supervision. However, a review of the client progress notes and observation checks conducted by direct care staff indicate that the youth was placed on sight and sound supervision that included observation checks every 30 minutes.	
Staff person assigned to monitor youth documented youth's behavior at 30 minute or less intervals		X				The agency procedure for documenting the status of the youth every 30 minutes while on elevated supervision is in place. Three out of the four client files reviewed had evidence that the agency completed checks documenting the client's status every 30 minutes or less.	Exception: Required evidence that includes evidence of a copy of the observations was not located for one client (closed file). A review of client file documentation was conducted. No 15-30 minute client observation checks on this client's status were found in the client file.
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				The agency has a procedure that requires that all youth be screened to determine their current status for risk for suicide during the intake process. A total of 3 of the 4 client files in the sample assessed by the reviewer indicated that there is evidence that the supervision level was not changed until it was reviewed by a Clinician.	Exception: One assessment out of the four completed on youth does not indicate that it was reviewed by a Clinician. However, there is documented evidence that the assessment document was reviewed by the Residential Supervisor and Regional Director.
						YES	
						If NO, explain here:	

Provider has a written policy and procedure that meets the requirement for Indicator 4.03						Policy P-1120 (Medication Provision, Storage, Access, Inventory and Disposal) included all policy and procedures regarding this indicator. This policy was reviewed and signed by the COO on January 20, 2021. The policy and procedures do meet the requirement for Indicator 4.03.	Add any exceptions below:
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
Medication Storage							
a. All medications are stored in a Pyxis Med-Station 4000 Medication Cabinet that is inaccessible to youth (when unaccompanied by authorized staff) b. Pyxis machine is stored in accordance with guidelines in FS 499.0121 and policy section in Medication Management c. Oral medications are stored separately from injectable epi-pen and topical medications d. Medications requiring refrigeration are stored in a secure refrigerator that is used only for this purpose, at temperature range 2-8 degrees C or 36-46 degrees F. (If the refrigerator is not secure, the room is secure and inaccessible to youth.) e. Narcotics and controlled medications are stored in the Med Station 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	X					A review of the agency's medication practices found that all medications (prescribed - controlled and non-controlled) are stored in a Pyxis medication cabinet that is located in a locked room adjacent to the day room. The medication cabinet has limited access to all parties and requires that they have a key to unlock the door. At the time of this review, an interview with the residential supervisor reported that only five staff members are permitted to assist in the delivery of medication to clients. The only additional staff member that can provide medication is the Registered Nurse. A review of the agency's storage practices indicate that all oral medication is stored separately from any injectable or topical medications. The agency also has storage standards for medications that require refrigeration. Medications that require refrigeration are stored in a small refrigerator that is utilized only for the purpose of storing medication. The refrigerator has limited access and requires a key to access all medications. The refrigerator also is equipped with a thermometer to ensure that the medication is stored at the recommended temperature level. All narcotics and/or controlled medications are stored in the Pyxis medication cabinet. The keys to the Pyxis medication cart are located in the residential supervisor's office. This office is secured by a key lock.	

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					At the time of this program review, the agency utilizes a total of five super users to assist in delivery and medications plus one registered nurse. The agency also uses a medication distribution log to document by hand each session where youth is provided medication whether it is a controlled, non-controlled or prescription type of medication. The agency utilizes a multi step medication verification process that has four steps that are consistent with the Florida Network operations manual. The nurse is the primary person that distributes medication in both the morning and evening across all seven days of the week. When the nurse is off duty or on vacation one of the five super users distribute the medication when she is not working. The process that the agency uses to distribute medication is consistent with Florida Network policy includes multiple steps covering verification of the medication and distributions steps. The agency does not use or provide services for youth that require insulin. However the agency does assist in this youth that require injectable medication such as EpiPen's. All youth received a training from the Registered Nurse in medication distribution and Epi-Pen assistance.	
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	X					The agency has standard procedures for securing/maintaining inventories both controlled and non-controlled medications and sharps. An interview was conducted with the agency's Registered Nurse. The Registered Nurse reported that the agency's process for documenting daily counting of all controlled medications are conducted on each shift 3 times per day. Each count conducted with non-licensed staff has a witness and both parties sign the shift count record. All non-controlled medications are	

c. Syringes and sharps (needles, scissors, etc.) are secured, and counted and documented weekly						counted daily and when distributed. All over-the-counter medications are counted weekly and when distributed. All sharps including needles, scissors, razors and clippers are counted weekly and when distributed.	
There are monthly reviews of medication management practice via Knowledge Portal or Pyxis Med-Station Reports.	X					The agency does utilize the knowledge portal and record all medication distribution sessions on a daily basis. The Registered Nurse produces samples of reports that are printed on a monthly basis to track and monitor all medication sessions on a 30 day basis.	
Medication discrepancies are cleared after each shift.	X					Medication discrepancies are cleared after each shift. Each day the registered nurse also checks for any discrepancies to ensure that they are cleared as required by the agency's policy and procedures.	
Provider has a written policy and procedure that meets the requirement for Indicator 4.04						**YES** If NO, explain here: Policy P-1119 (Medical and Mental Health Alert Process) included all policy and procedures regarding this indicator. This policy was reviewed and signed by the COO on January 20, 2021. The policy and procedures do meet the requirement for Indicator 4.04.	**Add any exceptions below:**
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Youth with a medical, mental health, or food allergy was appropriately placed on the program's alert system	X					A total of five (5) client files were reviewed to determine the agency's adherence to meet the requirements of this indicator. Of these client files, two were open client files and three were closed client files. All client files indicated a fully complete health admission screening form. All five client files have evidence of a completed health admission screening form that have completed medical health, allergy and mental health sections.	

Alert system includes precautions concerning prescribed medications, medical/mental health conditions	X					The agency's general alert system screens for all medications including controlled and non-controlled. The alert system identifies all youth on prescribed medications and those youth with identified medical or mental health risks. One of the open client files has documented seasonal allergy alerts. The other open client file was properly screened, but did not have any documented medical or mental health alerts in this file. The one open client file is marked as being on alert on the general alert board.	
Staff are provided sufficient training, information and instructions to recognize/respond to the need for emergency care for medical/mental health problems	X					All staff are trained on how to be aware of and to respond to the medical and mental health needs of youth as documented in each youth's health admission screening form. All staff are trained and are informed of formal instructions to recognize/respond to the need for emergency care for medical/mental health problems on a case by case basis.	
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					All information related to the medical and mental health status of each client was documented in the files according to the agency's policy and procedures. The agency has a client base file alert and a general alert board system that informs all staff at all times of the medical and mental health status of each client respectively.	
Provider has a written policy and procedure that meets the requirement for Indicator 4.05						**YES** If NO, explain here: Policy P-1166 (Episodic Emergency Care) included all policy and procedures regarding this indicator. This policy was reviewed and signed by the COO on January 20, 2021. The policy and procedures do meet the requirement for Indicator 4.05.	**Add any exceptions below:**
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
An							
a. If off-site emergency medical or dental care was provided, an incident report was submitted for the medical or dental care						The agency has a detailed off-site medical emergency response process. An interview conducted with the agency's Residential Supervisor indicated that the agency did not have any reported	

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					incidents that required off-site medical or dental emergency care. The current process also requires that the agency meet all required follow-up care following a discharge. The Supervisor also reported that the agency must contact the youth's parent and/or guardian at the time of gained knowledge of the incident. The agency also requires that the agency maintain a daily log that captures all medical and/or dental emergency care events.	
All staff are trained on emergency medical procedures	X					A review of the agency's training practices including topics on emergency care courses was reviewed. A review of both new and in-service staff member training files indicated that the agency provides a broad range of emergency care, universal precautions, first aid and CPR Training.	
The program has a Knife-for-life and wire cutters accessible to staff in a secure location(s)	X					An onsite tour of the agency's youth shelter was conducted. The agency has a knife-for-life, wire cutter and other emergency equipment such as first aid kits in secure limited access locations.	
First aid kit/supplies are fully equipped and inventoried	X					An onsite tour of the youth shelter found that the agency has a first aid kit inside the shelter located in the same room as the medication cabinet and in the agency transportation van.	