Florida Network for Youth and Family Services
Compliance Monitoring Report for

Children's Home Society West Palm Beach Safe Harbor Shelter

3335 Forest Hills Blvd
West Palm Beach, FL 33406

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 Children's Home Society, Safe Harbor (CHS Safe Harbor) for the FY 2021-2022 at its program office located at 3335 Forest Hills Blvd., West Palm Beach, 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. CHS Safe Harbor is contracted with the Florida Network of Youth and Family Services (FNYFS) to provide direct services to Children/Families in Need of Services (CINS/FINS). The services to be provided are identified in Contract Section A - Descriptions and Specifications and Section B - Delivery and Performance and are funded with General Revenue Funds effective for July 2021 through June 30, 2022.

The review was conducted by Ashley Davies, Consultant for Forefront LLC, and Peer Reviewer(s). Agency representatives from CHS Safe Harbor present for the entrance interview were Lauren Fuentes, Director of Program Operations; Duane Gross, Program Manager; and Vincelyn Barbier, Community Counseling Supervisor. The last onsite QI visit was conducted on November 18 - 19, 2020.

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

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

2021-2022 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 10-13-2021

Agency Name: Children's Home Society, Safe Harbor	Monitor Name: Ashley Davies, Lead Reviewer
Contract Type: CINS/FINS	Region/Office: 3335 Forest Hills Blvd., West Palm Beach, FL
Service Description: Comprehensive Onsite Compliance Monitoring	Site Visit Date(s): October 13 – 14, 2021

Major Programmatic Requirements	Explain Rating: Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable	Ratings Based Upon: I = Interview; O = Observation; D = Documentation; PTV = Submitted Prior To Visit; (List Who and What)	Notes: Explain Unacceptable or Conditionally Acceptable: (Attach Supportive Documentation)
I. Administrative and Fiscal							
DJJ Quality Improvement Peer Reviewer a. Provider shall demonstrate that a minimum of two (2) staff members have been trained to be certified as DJJ QI Peer reviewers. Provider shall participate in a minimum of one (1) on-site quality assurance review of a similar type program in another judicial circuit during each 12-month period of the contract, if requested.	☐	☐	☒	☐	☐	Interview: The provider currently has five certified QI Peers: Kristi Walsh, Kelly Barnett, Solange Solis, Brittany Brown, and Duane Gross.	**No recommendation or Corrective Action.**
Additional Contracts a. Provider shall provide a listing of all current federal, state, or local government contracts, as well as other contracts entered into with for profit and not-for-profit organizations. Such listing shall identify the awarding entity and contract start & end dates. **PTV**	☐	☐	☒	☐	☐	Documentation: A list of three additional contracts for FY2021-2022 was provided for funding: HHS-Basic Center, Ballen Isles, and the Florida Network. The list includes name of funder; purpose of funding, amount funded, and date. The program also maintains interagency agreements and Memorandums of Agreement (MOUs) with schools, mental health, and substance abuse providers. All of the	**No recommendation or Corrective Action.**

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						agreements reviewed had current contract/agreement dates.	
Limits of Coverage a. Provider shall provide and maintain during this contract, the following minimum kinds of insurance: Worker's Compensation and Employer's liability insurance as required by Chapter 440, F.S. with a minimum of $100,000 per accident, $100,000 per person and $500,000 policy aggregate. Commercial General Liability with a limit of $500,000 per occurrence, and $1,000,000 policy aggregate. Automobile Liability Insurance shall be required and shall provide bodily injury and property damage liability covering the operation of all vehicles used in conjunction with performance of this contract, with a minimum limit for bodily injury of $250,000 per person; with a minimum limit for bodily injury of $500,000 per accident; with a minimum limit for property damage of $100,000 per accident and with a minimum limit for medical payments or $5,000-$10,000 per person. Florida Network is listed as payee or co-payee. **PTV**	☐	☐	☒	☐	☐	Documentation: General Liability through Alliance of Nonprofits for Insurance, for limits of coverage $1,000,000 each $3,000,000 aggregate and medical payments for $5000, effective 7/01/21-7/01/22. Auto Insurance through Alliance of Nonprofits for Insurance, with combined single limit coverage for $1,000,000, effective 7/01/21-7/1/22. Workers Compensation through United Wisconsin Insurance Co, with limits of $1,000,000 each incident and $1,000,000 policy limit, effective 7/01/21-7/01/22. Umbrella policy through Alliance of Nonprofits for Insurance, with limits of $5,000,000, each/aggregate, effective 7/01/21-7/1/22.	**No recommendation or Corrective Action.**

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						The Florida Network of Youth and Family Services, Inc. is listed as certificate holder on the certificate of coverage.	
External/Outside Contract Compliance a. Provider has corrective action item(s) cited by an external funding source (Fiscal or Non-Fiscal). **ON SITE**	☐	☐	☐	☐	☒	**N/A –** During the Entrance Conference, the provider indicated that there are no outstanding corrective action item(s) cited by an external funding source.	**No recommendation or Corrective Action.**
Fiscal Practice a. Agency must have employee and fiscal policy/procedures manuals that are in compliance with GAAP and provide sound internal controls. Agency maintains fiscal files that are audit ready. **PTV**	☐	☐	☒	☐	☐	Documentation: Fiscal Policies and Procedures are contained in the agency's Accounting Procedures Manual with a recent revision date of 12/01/2017 and review date of 12/01/2019. The procedures reviewed appear to be consistent with GAAP and provide for limited internal controls. Procedures are included for accounts receivable, accounts payable, cash management, contributions, purchasing, travel, and Payroll. Fiscal files are located in the agency's corporate office in Winter Park, Florida.	**No recommendation or Corrective Action.**

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	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable		
b. Agency maintains a general ledger and the corresponding source documents. General ledger must be set up to track the activity of the grant separately (standard account numbers / separate funds for each revenue source, etc.). **PTV**	☐	☐	☒	☐	☐	Documentation: Detailed General Ledger (Standard) for periods July-August 2021 was reviewed. CHS maintains a detailed general ledger with corresponding source documents. The General Ledger (GL) is structured with account numbers and journal entries. The GL is set up to track the CINS/FINS Safe Harbor program separately.	**No recommendation or Corrective Action.**
c. Petty cash ledger system is balanced, and all cash disbursements are compliant with financial policies and allowable under the contract. (Disbursements/invoices are approved & monitored by management.) –**ON SITE**	☐	☐	☒	☐	☐	Interview and Documentation: Reviewed petty cash Policy and Procedure 2.03 which is included in the Fiscal Policies and Procedures manual. The fund which does not exceed $500 is utilized for purchases under $50 unless approval is granted by Management. Petty cash is stored in a safe in the Residential Coordinator's office. The fund is reconciled as needed and submitted to the Executive Administrative Assistant/Human Resources for refunding. Disbursements and invoices are approved by the residential program coordinator.	**No recommendation or Corrective Action.**

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Major Programmatic Requirements	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable	**Ratings Based Upon:** I = Interview O = Observation D = Documentation PTV = Submitted Prior To Visit (List Who and What)	**Notes** **Explain Unacceptable or Conditionally Acceptable:** **(Attach Supportive Documentation)**
d. Financial records and reports are current. Includes bank statements reconciled within 6 weeks of receipt. Vendor invoices past 6 months. Invoices are submitted on a monthly basis with supporting documentation. (Disbursements/invoices are approved & monitored by management). **ON SITE**	☐	☐	☒	☐	☐	Documentation: Reviewed Bank Statements and Bank Reconciliations for March – August 2021 for the program's accounts payable account and payroll accounts held with Fifth Third Bank. Bank reconciliations are conducted by the Accounting Analyst each month for the activities and bank statements for the preceding month. The bank statements were all found to be reconciled consistently within six weeks of receipt and were signed by the Analyst and Accounting Manager. Financial Statements are reported on a monthly basis and were found to be current. The agency maintains individual vendor files that are kept in secure file cabinets in the fiscal office at the corporate location.	**No recommendation or Corrective Action.**
e. Agency maintains inventory in accordance with a written policy and FNYFS contractual requirements. If over $1,000 inventory has DJJ Property Inventory Number/Tag. In the event the provider has purchased computer equipment an Informational Resources Request (IRR) been submitted to DJJ. **PTV/ON SITE**	☐	☐	☐	☐	☒	N/A – The agency has not purchased any items with FNYFS monies since the last time on-site.	**No recommendation or Corrective Action.**

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	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable		
f. Agency submits payroll taxes and deposits (and retirement deposits as applicable), Employee IRS Form W-2 and Independent Contractors IRS Form 1099 forms prior to federal requirements. **ON SITE**	☐	☐	☒	☐	☐	Documentation: Copies of payroll summaries and tax liability Form 941 and Schedule B (Form 941) for the 3rd and 4th quarters 2020 and 1st and 2nd quarters of 2021 demonstrate the agency submits payroll taxes to the appropriate authority as required. CHS is exempt from filing Form 940 (FUTA); instead, it files Forms 941 quarterly.	**No recommendation or Corrective Action.**
g. Budget to actual reports prepared and reviewed by appropriate management. Variance from the budget is investigated and explained. **PTV/ON SITE**	☐	☐	☒	☐	☐	Documentation: Agency's income statement report for the period July 1-August 2021 was reviewed. The reports demonstrate that the provider tracks budget variances for the CINS/FINS program separately on a monthly basis. Variance to date indicates a net surplus in the program. Variances in budget are monitored on a regular basis and approved by the Executive Director and management.	**No recommendation or Corrective Action.**
h. A Single Audit is performed as part of the annual audit if expenses are greater than $500,000. The agency must submit a Corrective Action Plan for findings cited in the management letter and single audit. An annual financial	☐	☐	☒	☐	☐	Documentation: Copy of financial audit conducted for year ending June 30, 2019 and 2020 by RSM US, LLP and	**No recommendation or Corrective Action.**

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	Explain Rating						
Major Programmatic Requirements	**Unacceptable**	**Conditionally Unacceptable**	**Fully Met**	**Exceeded**	**Not Applicable**	**Ratings Based Upon:** **I = Interview** **O = Observation** **D = Documentation** **PTV = Submitted Prior To Visit** **(List Who and What)**	**Notes** **Explain Unacceptable or Conditionally Acceptable:** **(Attach Supportive Documentation)**
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**						dated 10/30/2020. No Management Letter was required as there were no findings required to be reported in a separate management letter. A copy of the financial audit is on file with the Reviewer.	
i. Agency maintains confidentiality policy with written policies and procedures to ensure the security and privacy of all employee and client data. Personal information is not easily accessible. Agency maintains a backup system in case of accidental loss of financial information. Security procedures are in place to protect laptops. Obsolete documents are shredded, and computer hard drives are wiped prior to discarding. **ON SITE**	☐	☐	☒	☐	☐	Documentation: CHS maintains confidentiality policy with written policies and procedures to ensure the security and privacy of all employee and client data as follows: Policy and Procedure number: CHS 1017 (Confidentiality and Access to Client Information and Records); CHS 2001 (Records Management), CHS 5004 (Equipment and Property Assignment); and IT Disaster Recovery Plan.	**No recommendation or Corrective Action.**

CONCLUSION

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

SUMMARY OF RECOMMENDATIONS

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

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

Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Children's Home Society, West Palm Beach, FL
CINS/FINS Program

October 13 - 14, 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	**Satisfactory**
1.05 Analyzing and Reporting Information	**Satisfactory**
1.06 Client Transportation	**Satisfactory**
1.07 Outreach Services	**Satisfactory**

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

Standard 2: Intervention and Case Management

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

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

Standard 3: Shelter Care & Special Populations

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

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

Standard 4: Mental Health/Health Services

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

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

Overall Rating Summary

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

Rating Definitions

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

Satisfactory Compliance	No exceptions to the requirements of the indicator; limited, unintentional, and/or non-systemic exceptions that do not result in reduced or substandard service delivery; or exceptions with corrective action already applied and 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

Ashley Davies - Lead Reviewer Consultant-Forefront LLC/Florida Network of Youth and Family Services
Rondarrell George – Regional Monitor, Department of Juvenile Justice
Krizia Santana - Center for Family and Child Enrichment, Inc.
Scoundrel Oliver - Lutheran Services Florida
Tierra Smith - Prevention Central

Methodology

This review was conducted in accordance with FDJJ-1720 (Quality Assurance Policy and Procedures), and focused on the areas of (1) Management Accountability, (2) Intervention and Case Management, (3) Shelter Care/Health Services, and (4) Mental Health/Health Services, which are included in the Children/Families in Need of Services (CINS/FINS) Standards (Effective August 1, 2021).

Persons Interviewed

	Chief Executive Officer	X	Case Manager		Nurse – Full time
	Chief Financial Officer	X	Counselor Non-Licensed		Nurse – Part time
	Chief Operating Officer		Advocate	1	# Case Managers
	Executive Director	X	Direct – Care Full time	1	# Program Supervisors
X	Program Director		Direct – Part time		# Food Service Personnel
X	Program Manager		Direct – Care On-Call		# Healthcare Staff
	Program Coordinator		Intern		# Maintenance Personnel
	Clinical Director		Volunteer		# Other (listed by title): ___
X	Counselor Licensed	X	Human Resources		

Documents Reviewed

	Accreditation Reports	X	Table of Organization		Visitation Logs
X	Affidavit of Good Moral Character	X	Fire Prevention Plan	X	Youth Handbook
X	CCC Reports	X	Grievance Process/Records	5	# Health Records
X	Logbooks		Key Control Log	5	# MH/SA Records
X	Continuity of Operation Plan	X	Fire Drill Log	10	# Personnel /Volunteer Records
X	Contract Monitoring Reports	X	Medical and Mental Health Alerts	8	# Training Records
X	Contract Scope of Services	X	Precautionary Observation Logs	5	# Youth Records (Closed)
X	Egress Plans	X	Program Schedules	5	# Youth Records (Open)
X	Fire Inspection Report	X	List of Supplemental Contracts		# Other: ___
X	Exposure Control Plan	X	Vehicle Inspection Reports		

Observations During Review

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

Comments

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

Due to COVID-19 the program has continued to service the youth in the CINS/FINS program differently to ensure that they are keeping both the staff and clients safe. This has changed their daily census and capacity at the shelter to ensure they are practicing social distancing, but they have gradually increased over this last year. They have also met with many clients in a virtual format or in person depending on the needs of the clients through Community Counseling.

The program's turnover this year has reduced when it comes to front line staff and community counseling staff. The Supervisor of Community Counseling and Program Manager for the shelter have been consistent since the last audit. They have two Community Counselors in place and one position that is vacant. They have also seen stability in their Residential Counselor who has been with the agency since March 2021. They have also signed a contract with a local nursing agency to assist with the prior barriers of nurse turnover/vacancy at the shelter. The shelter staff has remained fairly stable and have no issues with ensuring all shifts are filled. Staff morale in the shelter is good and all staff work well together.

Narrative Summary

CHS Safe Harbor is under the leadership of a management team that consists of a Director of Program Operations (DPO), a Community Counseling Supervisor who oversees the community counseling component, a Residential Program Manager and a Data Management Supervisor.

The residential program is staffed by a Residential/Non-residential Counselor, two full-time Residential Shift Leaders, five fulltime and two part-time Youth Care Workers (YCW). The community counseling component of the program includes three full-time counseling positions. The program had four church member volunteers and no interns during the review period.

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

The agency provides both residential and community counseling services to youth and their families in West Palm Beach, Florida. The counseling component consists of a total of four counseling positions (three community counseling and one residential) and a Community Counseling Supervisor. All the counselors have a bachelor's degree.

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

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

The shelter is licensed by the Department of Children and Families for twelve beds. At the time of the

review the shelter had seven CINS/FINS youth.

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

The program recently hired a nursing agency to oversee healthcare services in the program. A Registered Nurse (RN) from the agency began coming to the program on October 11, 2021. The contract with the agency was executed in July 2021. However, due to Covid-19 related issues and delays in the background screening process services did not begin in the program until October 2021. After the last QI review the program hired a nurse who started and worked for one day and quit. That is when the program made the decision to go with a nursing agency.

All medications in the facility are stored in the Pyxis Med-Station Medication Cabinet. Youth Care Workers complete shift-to-shift inventories of all controlled medications and maintain perpetual inventories of all other medications. Over-the-counter medications are inventoried at least weekly and when given.

<u>The overall findings for the QI Review for CHS West Palm are summarized as follows:</u>
Standard 1: This standard has a total of seven indicators regarding management accountability. All seven indicators were rated satisfactory. There was an exception noted in indicator 1.01 Background Screening due to no explanation in writing as to why five staff were hired with a low Berke score. This exception did not result in a limited rating. All other indicators in this standard were rated satisfactory with no exceptions.

Standard 2: This standard has a total of ten indicators that relate to intervention and case management. Nine of the ten indicators were rated satisfactory. Indicator 2.10 Stop Now and Plan was rated not applicable as the program does not provide SNAP services. There were exceptions noted in indicators 2.01 Screening and Intake and 2.09 Special Populations. The exception noted in 2.01 was due to two of the secret shopper screenings not being entered into NetMIS within 72 hours. The exception noted in 2.09 was due to all DV and probation respite youth being transferred to a CINS bed after three days in the program. These exceptions did not result in limited ratings. All other indicators in this standard were rated satisfactory with no exceptions.

Standard 3: This standard has a total of seven indicators regarding shelter care. All seven indicators were rated satisfactory. There was an exception noted in 3.04 Logbooks due to the residential counselors not indicating the dates/shifts reviewed in the logbook. This exception did not result in a limited rating. All other indicators in this standard were rated satisfactory with no exceptions.

Standard 4: This standard has a total of five indicators regarding mental health and health services. All five indicators were rated satisfactory with no exceptions.

CINS/FINS QUALITY IMPROVEMENT TOOL

Quality Improvement Indicators:	Satisfactory (S)	Non-compliant (E)	No Eligible Items for Review (N)	No Practice (NP)	Not Applicable (N/A)	Review Based Upon	Notes
Standard One – Management Accountability							
1.01: Background Screening (BS) and compliance with DJJ OIG statewide procedures regarding BS of employees, contractors and volunteers							
Provider has a written policy and procedure that meets the requirement for Indicator 1.01						**YES** If NO, explain here: The agency has a policy in place titled CHS/7101 Background Screening of Employees/Volunteers, Annual Affidavit of Compliance with Good Moral Character, & Annual Abuse Registry Clearance that addresses the requirements of this indicator. The policy was last reviewed on October 4, 2021 by the Director of Program Operations.	

Agency utilizes an employee suitability prescreening assessment with a passing rate criterion prior to an offer of hire for direct care staff working with youth or the agency has provided an explanation for staff hired with a non-passing/low score.		X				A total of nine new staff were hired since the last QI review. All nine staff documented an employee suitability prescreening assessment was completed using the Berke Assessment. All prescreening assessments were completed prior to the employee's hire date. Four of the nine staff documented a passing score. The remaining five staff documented a score of "low" on the assessment.	Exception: There was no documentation in writing provided to explain why the five staff with the low score were hired. However, the Residential Program Manager explained the management team discusses all potential candidates for hire, especially the ones with low scores on the Berke Assessment. They make a decision based on the candidate's job related experience, as well as the strengths that are represented on the Berke Assessment to determine if they should move forward with that particular candidate. During the Interview process, they rely on asking a majority of the questions where the candidate scored low on the Berke to determine if their response to them is more favorable than it might have been on the Berke in the same area of questioning.
Background screening completed prior to hire/start date or exemption obtained prior to working with youth (if rated ineligible) for new hires, volunteers/interns, and contractors	X					There were a total of nine employees hired since the last QI review. All nine employees had a background screening prior to hire with an eligible rating.	

Agency has evidence for employees who have had a break in service and who are in good standing and reemployed with the same agency without an additional suitability assessment or background screening if the break is less than 90 days.			X			There were no applicable staff during this QI review.	
Five-year re-screening completed every 5 years from initial date of hire	X					There was one staff applicable for a re-screening during this review period. The re-screening was completed prior to the staff's retained fingerprints expiration date.	
Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?	X					The agency submitted the Annual Affidavit of Compliance with Level 2 Screening Standards via email on November 6, 2020.	
Proof of E-Verify for all new employees obtained from the Department of Homeland Security	X					Documentation of approval of E-Verify work eligibility was provided for all nine new staff hired.	
1.02: Provision of an abuse free environment to ensure safety and abuse free environment for youth in care							
Provider has a written policy and procedure that meets the requirement for Indicator 1.02						**YES** If NO, explain here: The agency has a policy in place titled CHS/7102 Providing an Abuse Free Environment that addresses the requirements of this indicator. The policy was last reviewed on September 28, 2021 by the Director of Program Operations.	
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 that all staff are required to adhere to, that is located in personnel policies. All staff receive a copy of this policy at hire and sign an acknowledgement form.	
Child Abuse Registry telephone number is visible to youth and posted common areas of the facility	X					Multiple pictures were provided displaying the Child Abuse Registry telephone number visible throughout the facility.	

Youth were informed of the Abuse and Contact Number (see youth survey results)	X					All 10 files reviewed, 5 shelter and 5 community counseling, included safety agreements signed by the youth. The safety agreements included the number to the Abuse Hotline.	
Management takes immediate action to address any incidents of threats or abuse			X			There were no incidents of threats or abuse reported during the review period requiring management action.	
Grievance Process							
Agency has a formal grievance process	X					Policy CHS/7102 Providing an Abuse Free Environment outlines the program's formal grievance process.	
Locked box accessible to only management and available to youth in a common area	X					Pictures were provided that showed a grievance box with key entry lock, located in the dayroom.	
Direct care does not handle the complaint/grievance unless assistance is asked for by the youth. Program director/supervisor will have access to and manage grievances unless it is towards themselves.	X					There were two grievances submitted during this last review period. Both grievances were resolved by a supervisor.	
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					Both grievances submitted during this review period were addressed within 24 hours and acknowledged by the youth.	
1.03: Incident Reporting							
Provider has a written policy and procedure that meets the requirement for Indicator 1.03						**YES** If NO, explain here: The agency has a policy in place titled CHS/7103 Incident Reporting that addresses the requirements of this indicator. The policy was last reviewed on September 28, 2021 by the Director of Program Operations.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		

	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
During the past 6 months, the program notified the Department's CCC (Central Communication Center) no later than two hours after any reportable incident occurred or within two hours of the program learning of the incident	X					There were 2 CCC reports made during this review period, 5/23/21 and 4/26/21. Both were properly reported within the required time frame.	
The program completes follow-up communication tasks/special instructions as required by the CCC			X			Neither CCC reports required any follow-up tasks to be completed.	
Incidents are documented in the program logs and on incident reporting forms	X					Both incidents were reported through the agency's software, Aeries Web and documented in the log book.	
All incident reports are reviewed and signed by program supervisors/directors	X					Supervisor/Director electronic signatures were observed on all online incident reports.	

1.04: Training Requirements (Staff receives training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions)

Provider has a written policy and procedure that meets the requirement for Indicator 1.04	
	YES
	If NO, explain here:
	The agency has a policy in place titled CHS/7104 Training Requirements that addresses the requirements of this indicator. The policy was last reviewed on October 5, 2021 by the Director of Program Operations.

Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
First Year Direct Care Staff							
All staff completed the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days from date of hire. *(Staff hired before January 1st were required to complete no later than December 31, 2020)*	X					There were four newly hired staff training files reviewed. All four staff completed the DOJ Civil Rights and Federal Funds training in the first thirty days of hire.	
All staff receives all mandatory training during the first 90 days of employment from date of hire.	X					There were four first year staff training files reviewed. All four staff had completed all mandatory training required during the first 90 days.	

Non-licensed Mental Health Clinical Shelter Staff (within first year of employment)							
Non-licensed mental health clinical shelter staff Assessment of Suicide Risk Training			X			There were no non-licensed clinical staff requiring this training during this 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			There were no non-licensed clinical staff requiring this training during this 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					There were four in-service staff training files reviewed and all four documented over forty hours of training for the last completed training cycle. All four staff also documented all required trainings were completed.	
Required Training Documentation							
The program maintains an individual training file for each staff, which includes an annual employee training hours tracking form and related documentation, such as certificates, sign-in sheets, and agendas for each training attended.	X					In all training files there was a tracking form with all trainings, date completed, and hours. Also, training files included training certificates and training worksheets.	
Provider has a written policy and procedure that meets the requirement for Indicator 1.05						**YES** If NO, explain here: The agency has a policy in place titled CHS/7105 Reporting and Analyzing Data/Information that addresses the requirements of this indicator. The policy was last reviewed on September 28, 2021 by the Director of Program Operations. ☐ ☐	
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					Case record review reports were reviewed for the 4th quarter of 20-21 and the first quarter of 21-22. There are twelve files reviewed each time, six for the shelter and six for community counseling. Results are recorded on the Compliance and Quality Record Review Aggregation tool.	
The program conducts reviews of incidents, accidents, and grievances quarterly, at a minimum	X					Monthly program team meeting for the last six months, from April through September, show a review of incidents, accidents, and grievances.	
The program conducts an annual review of customer satisfaction data	X					Monthly program team meeting for the last six months, from April through September, show a review of customer satisfaction data.	
The program conducts an annual review of outcome data and (if applicable) there is evidence of annual reconciliation that occurs through communication from the Florida Network via email or phone call when corrections are needed and the information is corrected and submitted within the requested timeframes.	X					Outcome data is reviewed at the monthly team meetings. Meeting minutes for the last six months, April through September, were reviewed. The last annual reconciliation was conducted with the Florida Network via email on May 3, 2021. All corrections were made and submitted in requested time frames.	
The program conducts a monthly review of NetMIS data reports. The program submits NetMIS invoices by the fourth business day of the following reporting month.	X					Monthly program team meeting for the last six months, from April through September, show a review of NetMIS data reports. NetMIS invoices are submitted by the 4th business day of the following month. The last six months of invoices and emails were provided and reviewed.	
The Florida Network conducts monthly reconciliation by comparing NetMIS data to JJIS data. Agency has evidence that they have reconciled any differences noted.	X					NetMIS and JJIS data quality checks are conducted monthly by the data specialist and upon receipt of the data reports from the Florida Network. Documentation was provided to show that any differences were reconciled.	
The program has a process in place to review and improve accuracy of data entry & collection	X					NetMIS and JJIS data quality checks are conducted monthly by the data specialist and upon receipt of the data reports from the Florida Network.	

There is documentation that findings are regularly reviewed by management and communicated to staff and stakeholders.	**X**					Monthly team meetings as well as staff meetings are held to review data collected in order to review trends and identify areas needing improvements resulting from analysis of data collected. The program also shares performance with both local leadership and during board meetings. An update is given to the board each quarter on the performance of all programs.	
There is evidence the program demonstrates that critical performance data reports are shared with the Board of Directors frequently. All final reports that include a Limited or Failed score is submitted electronically or by mail to the providers Executive Committee on the Board of Directors.	**X**					The program has a process in place to share all performance data with the board quarterly. The program did not receive any limited or failed ratings in this report that would require it to be sent electronically or by mail to the board.	
There is evidence that strengths and weaknesses are identified, improvements are implemented or modified, and staff are informed and involved throughout the process.	**X**					CHS Quality Management department oversees the program outputs and outcomes for quality improvement purposes. Findings of data collected and reviewed are shared with staff, identifying strengths and weaknesses as well as improvements to be implemented or modified with staff input. Evidence of monthly staff meetings document practice. CHS 2000 Quality Plan, last updated January 14, 2021, also outlines the process.	
Provider has a written policy and procedure that meets the requirement for Indicator 1.06						**YES** If NO, explain here: The agency has a policy in place titled CHS/7106 Client Transportation that addresses the requirements of this indicator. The policy was last reviewed on September 28, 2021 by the Director of Program Operations. ☐ ☐	
Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	**X**					Program maintains a list of fifteen approved drivers for FY 2021-2022 that was last revised 08/17/2021.	
Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	**X**					All staff listed as drivers are covered under the agency's insurance policy and have a valid driver's license.	

Agency's Transportation policy prohibit transporting a client without maintaining at least one other passenger in the vehicle during the trip and include exceptions in the event that a 3rd party is NOT present in the vehicle while transporting	X					The agency's policy CHS/7106 prohibits transporting a client without maintaining at least one other passenger in the vehicle during the trip and includes exceptions when a 3rd party cannot be present.	
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					Transportation logs were reviewed from April 2021 through September 2021. There were 20 single client transports documented. All 20 transports documented a supervisor approval was obtained prior to the transport taking place.	
The 3rd party an approved volunteer, intern, agency staff, or other youth	X					The 3rd party present on transports reviewed for the last six months was either an agency staff member or another youth. In addition, cameras were also installed in each vehicle that capture audio and video in absence of a 3rd party.	
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					All transportation logs provided included initials of the driver, date and time, mileage, number of passengers, purpose of travel, and location, where applicable.	
Provider has a written policy and procedure that meets the requirement for Indicator 1.07						**YES** If NO, explain here: The agency has a policy in place titled CHS/7107 Outreach and Interagency Agreements that addresses the requirements of this indicator. The policy was last reviewed on September 28, 2021 by the Director of Program Operations.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
The program has a lead staff member designated to participate in local DJJ board and council meetings with evidence that includes minutes of the event or other verification of staff participation	X					DJJ board and council meeting minutes were provided along with the name of the designated staff members which are either the Director of Program Operations or the Residential Program Manager.	

Outreach and prevention services are provided by designated staff and include increasing community awareness, offering informational and educational CINS/FINS services to youth and families.	X					The program provided a list of outreach events ranging from 4/1/2021-9/30/2021. The reviewer requested documentation for six of the events. Documentation was provided to show efforts to increase community awareness for CINS/FINS services.	
The program maintains written agreements with other community partners which include services provided and a comprehensive referral process.	X					Agency maintains a list of five inter-agency agreements.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.01						**YES** If NO, explain here: The agency has a policy in place titled CHS/7201 Screening Eligibility for Services and Intake Assessment that addresses the requirements of this indicator. The policy was last reviewed on October 4, 2021 by the Director of Program Operations.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
Shelter youth: Eligibility screening is completed immediately for all shelter placement inquiries. If staff on duty cannot complete the screening, an on-call supervisor is contacted and eligibility is determined within 30 minutes from initial inquiry.	X					There were five shelter files reviewed, two open and three closed. All five files documented an eligibility screening was completed immediately.	
Community counseling: Eligibility screening is completed within 3 business days of referral by a trained staff using the NetMIS form	X					There were five community counseling files reviewed, two open and three closed. All five files documented an eligibility screening was completed within three days of the referral.	
There is evidence all referrals for service is screened for eligibility and is logged in NetMIS within 72 hours of screening completion.	X					All ten Files were screened for eligibility and logged into NetMIS within 72 Hours of Screening Completion. There were three secret shopper calls made to the agency. Out of the three calls there were two screenings completed.	Exception: Out of the two screenings completed as a result of the secret shopper calls, neither were entered into NetMIS within 72 hours.
Youth and parents/guardians receive the following in writing:						All ten Files showed evidence that parent/guardians received available service options, and rights and	

a. Available service options b. Rights and responsibilities of youth and parents/guardians	X					responsibilities of youth and parents, in writing.	
The following is also available to the youth and parents/guardians: a. Possible actions occurring through involvement with CINS/FINS services (case staffing committee, CINS petition, CINS adjudication) b. Grievance procedures	X					All ten Files explained possible actions occurring through involvement with CINS/FINS services and grievance procedures.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.02						**YES** If NO, explain here: The agency has a policy in place titled CHS/7202 Needs Assessment that addresses the requirements of this indicator. The policy was last reviewed on October 5, 2021 by the Director of Program Operations.	
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					All five shelter files showed that the Needs Assessment was initiated within 72 Hours of Admission.	
Non-Residential youth: Needs Assessment is done within 2 to 3 face-to-face contacts after the initial intake **OR** updated, if most recent assessment is over 6 months old	X					All five community counseling files documented the Needs Assessment was completed within 2 to 3 face-to-face contacts or phone calls due to Covid-19.	
Needs Assessment is conducted by a bachelor’s or master’s level staff member	X					All ten Needs Assessments were conducted by a bachelor's or master's level staff member.	
Needs Assessment includes a supervisor’s review signature upon completion	X					All ten Needs Assessments included a supervisor's review signature upon completion.	
Suicide Risk as a Result of the Needs Assessment							

Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
Youth was identified with an elevated risk of suicide as a result of the Needs Assessment	X					Two of the ten files identified the youth with an elevated risk of suicide as a result of the Needs Assessment.	
If yes, the youth was referred for an Assessment of Suicide Risk conducted by or under the direct supervision of a licensed mental health professional	X					Both files documented the youth were referred for an Assessment of Suicide Risk conducted by or under the direct supervision of a licensed mental health professional.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.03						**YES** If NO, explain here: The agency has a policy in place titled CHS/7203 Service/Case Plans - Implementation, Review, and Revision that addresses the requirements of this indicator. The policy was last reviewed on October 3, 2021 by the Director of Program Operations.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
Case/Service plan is developed within 7 working days of Needs Assessment	X					There were ten files reviewed, five shelter (two open and three closed) and five community counseling (two open and three closed). All ten files had a Case/Service Plan developed within seven working days of the Needs Assessment.	
Case plan service Plan includes: 1. Individualized and prioritized need(s) and goal(s) identified by the Needs Assessment 2. Service type, frequency, location 3. Person(s) responsible 4. Target date(s) for completion and Actual completion date(s) 5. Signature of youth, parent/ guardian, counselor, and supervisor 6. Date the plan was initiated	X					In all ten files the Case/Service Plan included: individualized and prioritized needs and goals identified by the Needs Assessment, service type, frequency, and location; target dates for completion, signature of youth, parent/guardian, counselor, and supervisor; and the date the plan was initiated. All five closed files reviewed documented actual completion dates.	

Case/service plans are reviewed for progress/revised by counselor and parent (if available) every 30 days for the first three months and every 6 months after	X					None of the shelter files were applicable for a thirty day review for progress of the Case/Service Plans due to the youth being in the program less than thirty days. All five community counseling files were applicable for thirty day reviews and documented all were completed as required.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.04						**YES** If NO, explain here: The agency has a policy in place titled CHS/7204 Case Management and Service Delivery/Family Involvement that addresses the requirements of this indicator. The policy was last reviewed on October 3, 2021 by the Director of Program Operations.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
Counselor/Case Manager is assigned	X					There were ten files reviewed, five shelter files (two open and three closed) and five community counseling files (two open and three closed). All ten files had a counselor assigned.	
The Counselor/Case Manager completes the following as applicable: 1. Establishes referral needs and coordinates referrals to services based upon the on-going assessment of the youth's/family's problems and needs 2. Coordinates service plan implementation 3. Monitors youth's/family's progress in services 4. Provides support for families 5. Monitors out-of-home placement (if necessary) 6. Makes referrals to the case staffing to address problems and needs of the youth/family 7. Accompanies youth and parent/guardian to court hearings and related appointments 8. Refers the youth/family for additional services when appropriate 9. Provides case monitoring and reviews court orders	X					There were five community counseling files reviewed (three closed and two open) and five shelter files reviewed (three closed and two open). All ten files establish referral needs and coordinated referrals to services based upon the ongoing assessment of the youth's/family's problems and needs, coordinated service plan implementation, monitored youth's/family's progress in service, and provided support to families. None of the files were applicable for monitoring out-of-home placement. None of the files were applicable for referring the youth and family to the case staffing committee. None of the files were applicable for accompanying youth/guardian to court hearings and related appointments. All ten files referred the youth/family for additional services. All five applicable files provided case termination documentation. There were five files applicable for providing follow-up after thirty days of exit and five files after sixty days of exit. All follow-ups were completed as required.	

10. Provides case termination notes 11. Provides follow-up after 30 days of exit 12. Provides follow-up after 60 days of exit							
The program maintains written agreements with other community partners that include services provided and a comprehensive referral process	X					The program had five Interagency Agreements with other community partners that were all up-to-date, included services provided, and allowed for a comprehensive referral process.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.05						**YES** If NO, explain here: The agency has a policy in place titled CHS/7205 Counseling Services that addresses the requirements of this indicator. The policy was last reviewed on October 4, 2021 by the Director of Program Operations.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
Youth and families receive counseling services, in accordance with the youth's case/service plan, to address needs identified during the assessment process	X					There were ten files reviewed, five shelter files (two open and three closed) and five community counseling files (two open and three closed). Service plans and case notes maintained demonstrated all ten youth received counseling services to address needs identified during the assessment process.	
Shelter Program							
Shelter programs provides individual and family counseling	X					All five shelter files reviewed demonstrated individual and/or family counseling was offered.	
Group counseling sessions held a minimum of five days per week	X					All five shelter files reviewed documented group sessions at least five days per week.	
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					All groups reviewed were at least thirty minutes in length, had an opportunity for engagement, had a clear and relevant topic, and had a clear leader.	
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					All five community counseling files reviewed documented therapeutic services were provided by agency staff and were documented in the case notes. Referral needs were established and provided to all five youth.	
Counseling Services							
Reflect all case files for coordination between presenting problem(s), psychosocial assessment, case/service plan, case/service plan reviews, case management, and follow-up	X					All ten files reviewed documented coordination between presenting problems, the needs assessment, service plan, service plan reviews, case management, and follow-up.	
Maintain individual case files on all youth and adhere to all laws regarding confidentiality	X					An individual youth file was maintained for all ten youth files reviewed.	
Case notes maintained for all counseling services provided and documents youth's progress	X					All ten youth files included case notes that documented services provided including counseling and the youth's progress.	
On-going internal process that ensures clinical reviews of case records and staff performance	X					All ten files reviewed were signed by the supervisor and/or licensed professional.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.06						**YES** If NO, explain here: The agency has a policy in place titled CHS/7206 Adjudication/CINS Petition Process-Case Staffing Committee that addresses the requirements of this indicator. The policy was last reviewed on October 4, 2021 by the Director of Program Operations.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
Case Staffing Initiation and Notifications							
If parent/guardian initiates, staffing is held within 7 days					X	Parent/guardian did not initiate either case staffing.	
The youth, family and case staffing committee are contacted within a minimum of five working days						Notification was sent via email to the committee and youth/family no less than five days prior to the case staffing.	

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						
Case Staffing Committee							
Must include: a. DJJ rep. or CINS/FINS provider b. Local school district representative	X					In the two case staffing files reviewed the CINS/FINS provider and local school district representative were present as members of the case staffing committee.	
Other members may include: a. State Attorney's Office b. Others requested by youth/ family c. Substance abuse representative d. Law enforcement representative e. DCF representative f. Mental health representative	X					Other members were present as needed.	
The program has an established case staffing committee, and has regular communication with committee members	X					The program has an established case staffing committee that meets on the third Thursday of every month. The meetings are currently being held via Zoom. The agenda and case specific information are sent out with the meeting invitation to all committee members prior to the meeting.	
The program has an internal procedure for the case staffing process, including a schedule for committee meetings	X					The program has an established case staffing committee that meets on the third Thursday of every month. The meetings are currently being held via Zoom. The agenda and case specific information are sent out with the meeting invitation to all committee members prior to the meeting.	
As a result of the Case Staffing							
The youth and family are provided a new or revised plan for services	X					Both files documented the youth and family were provided a new or revised plan for services.	
Written report is provided to the parent/guardian within 7 days of the case staffing meeting, outlining recommendations and reasons behind the recommendations	X					Both files documented a written report was provided to the parent within seven days of the staffing.	
If applicable, the program works with the circuit court for judicial intervention for the youth/family					X	Neither file was applicable for judicial intervention.	

Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
Case Manager/Counselor completes a review summary prior to the court hearing					X	Neither file was applicable for judicial intervention.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.07						**YES**	
						If NO, explain here:	
						The agency has a policy in place titled CHS/7207 Youth Records and Case Management Services that addresses the requirements of this indicator. The policy was last reviewed on October 4, 2021 by the Director of Program Operations.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
All records are clearly marked 'confidential'.	X					During the on-site tour of the facility files were observed to be marked "confidential".	
All records are kept in a secure room or locked in a file cabinet that is marked "confidential"	X					During the on-site tour of the facility files were observed to be stored in locked file cabinets marked "confidential".	
When in transport, all records are locked in an opaque container marked "confidential"	X					During the on-site tour of the facility a locked, opaque container marked "confidential" was observed to transport files.	
All records are maintained in a neat and orderly manner so that staff can quickly and easily access information	X					All ten files reviewed were observed to be organized and maintained in a neat and orderly manner so staff can easily access information.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.08						**YES**	
						If NO, explain here:	
						The agency has a policy in place titled CHS/7211 Special Populations that addresses the requirements of this indicator. The policy was last reviewed on September 30, 2021 by the Director of Program Operations.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
Use of youth's preferred name/ pronoun: a. Youth are addressed according to their preferred name and gender pronouns b. Youth's preferred name and gender pronouns are used in logbook and on all outward-facing documents and census boards	X					A review of the Florida Network's SOGIE Report as of October 4, 2021 revealed there were two youth who fell under the requirements of this indicator. Both youth were shelter youth and both files were closed. Both youth were addressed by preferred name/pronoun and preferred name/pronoun was used in logbook and outward facing documents.	

Youth in need of specialized support is referred to qualified resources (as applicable)	**X**					One youth was referred for specialized support through counseling services, the other youth did not require any type of specialized support.	
Youth preference is considered and documented for room assignment and youth is not roomed in isolation due to sexual orientation, gender identity, or gender expression	**X**					Both youth's preference for room assignment was honored by the program and neither youth was roomed in isolation.	
Youth is provided hygiene products, undergarments and clothing that affirms their gender identity or gender expression	**X**					Both youth were provided hygiene products and clothing that affirmed their gender identity.	
The agency has signage and brochures/publication placed in common areas indicating that all youth are welcome regardless of sexual orientation, gender identity, and gender expression	**X**					During the on-site tour of the facility, there were signage observed throughout the facility indicating that all youth are welcome.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.09						**YES**	
						If NO, explain here:	
						The agency has a policy in place titled CHS/7211 Special Populations that addresses the requirements of this indicator. The policy was last reviewed on September 30, 2021 by the Director of Program Operations.	

Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Staff Secure							
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? **(If no, select rating "No eligible items for review")**			**NO**			The provider has not served any youth meeting the criteria for staff secure since the last QI review.	
Staff Secure policy and procedure outlines the following: a. In-depth orientation on admission b. Assessment and service planning c. Enhanced supervision and security with emphasis on control and appropriate level of physical intervention	**X**					Reviewed policy CHS/7211 titled Special Populations.	

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

Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
Agency has evidence that the FNYFS was contacted for approval prior to admission for all Domestic Minor Sex Trafficking (DMST) placements.			X			No applicable youth files to review.	
There is evidence the youth was entered into NetMIS as a Special Populations youth at admission and a Human Trafficking Screening Tool (HTST) was completed.			X			No applicable youth files to review.	

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

Youth admitted to DV Respite placement have a pending DV charge and have evidence of being screened by JAC/Detention, but do not meet criteria for secure detention	X					There were three closed files reviewed. All three files had a face sheet indicating a pending DV charge and all three were screened by the JAC and did not meet criteria for secure detention.	
Data entry into NetMIS and JJIS within (3) business days of intake and discharge	X					All three files had evidence of data entry within three business days of intake and within three business days of discharge.	
Youth in program do not have length of stay in DV Respite placement that exceeds 21 days. If more than 21 days, documentation exists in youth file of transition to CINS/FINS or Probation Respite placement, if applicable.		X				All three youth were transferred to a CINS bed.	Exception: After three days in the program all three youth were transferred to a CINS bed. However, this practice was clarified as of July 1, 2021. The program no longer follows the practice of transferring youth after three days.
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					All three files had Service Plans that focused on anger management and family coping skills.	
All other services provided to Domestic Violence Respite youth are consistent with all other general CINS/FINS program requirements	X					All three youth received all other general CINS/FINS required services.	
Probation Respite							
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? **(If no, select rating "No eligible items for review")**	**YES**						
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
All probation respite referrals are submitted to the Florida Network.	X					There was one closed Probation Respite youth file reviewed. Approval by the Florida Network was obtained for the youth and located in the file.	

Probation Respite Referral come from DJJ Probation and are all youth referred on probation regardless of adjudication status	X					Referral came from a probation officer and a DJJ face sheet was present in the file showing probation status of the youth.	
Data entry into NetMIS and JJIS within (3) business days of intake and discharge	X					There was evidence of data entry within three business days of intake and discharge in the file.	
Length of stay is no more than fourteen (14) to thirty (30) days? (Placement beyond thirty (30) days requires the approval of the JPO and/or CPO)		X				The youth was transferred to a CINS bed.	Exception: After three days in the program all three youth were transferred to a CINS bed. However, this practice was clarified as of July 1, 2021. The program no longer follows the practice of transferring youth after three days.
All case management and counseling needs have been considered and addressed	X					All case management and counseling needs identified were addressed.	
All other services provided to Probation Respite youth are consistent with all other general CINS/FINS program requirements	X					The youth received all other general CINS/FINS required services.	
Intensive Case Management (ICM)							
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? **(If no, select rating “No eligible items for review”)**					N/A	This program does not provide Intensive Case Management Services.	

Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
Youth receiving services was court ordered					X	This program does not provide Intensive Case Management Services.	
Services for youth and family include: **a. Two (2) direct contacts per month** **b. Two (2) collateral contacts per week** **c. Direct and collateral contacts not obtained must have documentation to support attempts made to obtain them. All reasonable attempts (at minimum of three) must be made to reach all contacts (direct and collateral) and documented in the case file and NetMIS.**					X	This program does not provide Intensive Case Management Services.	
Assessments include: a. A Child Behavior Checklist (CBCL) is completed within 14 days of intake and at discharge (if applicable) b. An approved self-report assessment that was completed at intake c. An approved self-report assessment that was completed every 90 days following intake and at discharge (if applicable)					X	This program does not provide Intensive Case Management Services.	
Case plan demonstrates a strength-based, trauma-informed focus					X	This program does not provide Intensive Case Management Services.	

Agency has evidence that ICMS has a strength-based perspective in one or more of the following areas; engaging the family, advocating on their behalf, initiating change agent activities, helping to access supports in the community, teaching problem solving skills, modeling productive behaviors, and/or successful completion of youth and family developmental milestones					X	This program does not provide Intensive Case Management Services.	
Family and Youth Respite Aftercare Services (FYRAC)– Non-residential Only							
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? **(If no, select rating "No eligible items for review")**			**NO**			The provider has not served any youth meeting the criteria for FYRAC since the last QI review.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Youth is referred by DJJ for a domestic violence arrest on a household member, and/or the youth is on probation regardless of adjudication status and at risk of violating			X			No applicable youth files to review.	
Agency has evidence that all FYRAC referrals have documented approval from the Florida Network office			X			No applicable youth files to review.	
Intake and initial assessment sessions meets the following criteria: a. Face-to-face gathering of family history and demographic information b. Includes development of the service plan and is documented through signature of the youth and his/her parent/guardian as well as orientation to the program			X			No applicable youth files to review.	
Life Management Sessions meets the following criteria:						No applicable youth files to review.	

a. Sessions are face-to-face, sixty (60) minutes in length and focus on strengthening the family unit b. Individual Sessions are with the youth and family and focus to engage, identify strengths and needs of each member that help to improve family functioning			X				
Group Sessions: a. Focus on the same issues as individual/family sessions with the overall goal of strengthening relationships and prevention domestic violence b. Shall be no more than eight (8) youth at one (1) time and shall be for a minimum of sixty (60) minutes per session			X			No applicable youth files to review.	
Youth and family participate in services for thirteen (13) sessions or ninety (90) consecutive days of services, or there is evidence in the youth's file that an extension is granted by DJJ circuit Probation staff			X			No applicable youth files to review.	
2.10: STOP NOW AND PLAN (SNAP)							
Provider has a written policy and procedure that meets the requirement for Indicator 2.10						**N/A** If NO, explain here: This program does not provide SNAP services.	
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	This program does not provide SNAP services.	
Needs assessment is completed at initial intake, or within two face-to-face sessions					X	This program does not provide SNAP services.	
SNAP Assessments						This program does not provide SNAP services.	

a. Child Behavior Checklist (CBCL) is completed by the caregiver (pre & post) b. Teacher Report Form (TRF) completed by the teacher (pre & post) c. Tool for Parenting Self Efficacy (TOPSE) completed by the caregiver (pre & post) d. Prevention Assessment Tool (PAT) (pre & post) There must be at least three (3) documented attempts in the youths' file to obtain all pre-assessment (listed above) information.					X		
SNAP discharge report summary					X	This program does not provide SNAP services.	
SNAP Boys/SNAP Girls **Parent** Group Evaluation Form					X	This program does not provide SNAP services.	
SNAP Boys/SNAP Girls **Child** Group Evaluation Form					X	This program does not 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	This program does not 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	This program does not 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	This program does not provide SNAP services.	
“Class Goal” sheet					X	This program does not provide SNAP services.	
Measure of Classroom Environment (MoCE) (Pre and Post) is used to identify baseline and treatment outcomes of reported classroom dynamics.					X	This program does not provide SNAP services.	
Pre and Post Evaluations					X	This program does not provide SNAP services.	
One SNAP® Fidelity Adherence Checklist completed per classroom in a 13 – week SNAP in Schools group and uploaded to Dropbox					X	This program does not provide SNAP services.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.01						**YES** If NO, explain here: The agency has a policy in place titled CHS/7301 Shelter Environment that addresses the requirements of this indicator. The policy was last reviewed on September 30, 2021 by the Director of Program Operations.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		

Facility Inspection	X					An on-site tour of the facility revealed the furnishings were in good repair. The program was free of insect infestation. Bathrooms and shower areas were clean and functional. There was no graffiti observed. Lighting is adequate. Exterior areas are free of debris and the grounds are free of hazards. Doors are secure, with in and out access limited to staff, and key control is in compliance. Egress plans, client rules, grievance forms, Abuse Hotline information, DJJ Incident Reporting Number are posted. Agency vehicles are locked and are equipped with first aid kits, fire extinguishers, glass breakers, seat belt cutter, and air bag deflators. Interior areas do not contain contraband and are free from hazardous unauthorized metal/foreign objects. Chemicals are listed, approved, inventoried, and stored securely and MSDS are maintained on each item. The washers/dryers are operational and maintained. The current DCF license is displayed that is valid January 24, 2021 until January 23, 2022. Each youth has their own bed with clean linens.	
Additional Facility Inspection Narrative (if applicable)							

Fire and Safety Health Hazards	**X**					The annual fire inspection was completed on February 1, 2021, the program failed that fire inspection and a re-inspection was completed on March 11, 2021 which documented the deficiency had been cleared. The annual fire sprinkler system inspection was done on April 7, 2021 with satisfactory findings. The Fire Alarm System Certificate was issued on April 1, 2021 and expires March 31, 2022. The annual fire extinguisher inspection was on April 1, 2021. The annual fire suppression system inspection was completed on November 5, 2020 with satisfactory findings. At least one fire drill was observed to be completed in two minutes or less monthly. Mock drills were observed to be completed quarterly. Residential Group Care and Food Service inspections were completed on September 20, 2021 with satisfactory ratings, and menus are posted.	
Additional Fire and Safety Health Hazards Narrative (if applicable)							
Youth Engagement							
a. Youth are engaged in meaningful, structured activities (e.g., education, recreation, counseling services, life and social skill training) seven days a week during awake hours. Idle time is minimal. b. At least one hour of physical activity is provided daily. c. Youth are provided the opportunity to participate in a variety of faith-based activities. Non-punitive structured activities are offered to youth who do not choose to participate in faith-based activities. d. Daily programming includes opportunities for youth to complete homework and access a variety of age appropriate, program approved books for reading. Youth are allowed quiet time to read.	**X**					After reviewing the daily schedule it was observed that youth are engaged in meaningful, structured activities seven days a week during awake hours and idle time is minimal. Youth are provided at least one hour of physical activity daily. Upon request youth may participate in faith-based activities. Youth are provided opportunities for homework and have access to a variety of books. Daily schedule is posted and accessible.	

e. Daily programming schedule is publicly posted and accessible to both staff and youth.							
Provider has a written policy and procedure that meets the requirement for Indicator 3.02						**YES** If NO, explain here: The agency has a policy in place titled CHS/7302 Program Orientation that addresses the requirements of this indicator. The policy was last reviewed on September 30, 2021 by the Director of Program Operations.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
Youth received a comprehensive orientation and handbook provided within 24 hours	X					An orientation was provided within 24-hours in all five shelter files reviewed. A handbook was provided to each youth.	
Orientation includes the following: a. Youth is given a list of contraband items b. Disciplinary action is explained c. Dress code explained d. Review of access to medical and mental health services e. Procedures for visitation, mail and telephone f. Grievance procedure g. Disaster preparedness instructions h. Physical layout of the facility i. Sleeping room assignment and introductions j. Suicide prevention- alerting staff of feelings or awareness of others having suicidal thoughts	X					Orientation was observed to include a list of contraband items, disciplinary action is explained, dress code is explained, review of access to medical and mental health services, procedures for visitation, mail and telephone, grievance procedure, disaster preparedness instructions, physical layout of the facility, sleeping room assignment, introductions, and suicide prevention in all five shelter files reviewed.	

Documentation of each component of orientation, including orientation topics and dates of presentation, as well as signatures of the youth and staff involved is maintained in the individual youth record	X					Observation of all five shelter files showed documentation of orientation, including topics, dates of presentation, as well as signatures of the youth and staff involved.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.03						**YES** If NO, explain here: The agency has a policy in place titled CHS/7303 Youth Room Assignment that addresses the requirements of this indicator. The policy was last reviewed on September 30, 2021 by the Director of Program Operations.	
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 g. Presence of medical, mental or physical disabilities h. Suicide risk i. Sexual aggression and predatory behavior j. Sexual orientation gender identity/ expression k. Acute health symptoms requiring quarantine or isolation	X					Review of available information about the youth's history, status and exposure to trauma, initial collateral contacts, initial observation of interaction with youth, risk factors, sexual orientation, and health symptoms were documented in all five shelter files reviewed.	

An alert is immediately entered into the program's alert system when a youth is admitted with special needs and risks such as risk of suicide, mental health, substance abuse, physical health or security risk factors	X					Alerts for youth with risk factors were observed in all five shelter files reviewed documented in the youth's file and on the alert board for the open files.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.04						**YES** If NO, explain here: The agency has a policy in place titled CHS/7304 Log Books that addresses the requirements of this indicator. The policy was last reviewed on September 30, 2021 by the Director of Program Operations.	
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					Logbook reviews were conducted for full weeks, Sunday-Saturday, for the following dates: Week 1 - March ; Week 3 – April; Week 4 – May; Week 1 – June; Week 2 – July; and Week 3 – August. In reviewing the program's manual logbooks, entries that could impact the safety and security of the youth and/or program were highlighted.	
All entries are brief, legibly written in ink and include: • Date and time of the incident, event or activity • Names of youth and staff involved • Brief statement providing pertinent information • Name and signature of person making the entry	X					All entries are brief, legible and written in ink. In reviewing the logbook, entries included dates, activities/events, name of youth and staff involved, a brief statement providing pertinent information, and the name and signature of the person making the entry.	
Recording errors are struck through with a single line. The staff person must initial and date the correction. The use of whiteout and erasures is prohibited.	X					All errors reviewed for the selected dates were recorded correctly.	

The program director or designee reviews the facility logbook(s) every week and makes a note chronologically in the logbook indicating the dates reviewed and if any correction, recommendations and follow-up are required and sign/date the entry	X					The program director or designee was observed to review the program logbook weekly and provided recommendations. All reviews were documented chronologically and included a date and time.	
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					During the logbook review, there was clear evidence of staff reviewing the logbook at the beginning of each shift and documenting accordingly.	
At the beginning of their shift, oncoming supervisor and shelter counselor reviews the logbook of all shifts since their last log entry and makes a signed and dated entry and into log book indicating the dates reviewed.		X				The on-coming supervisor documented a review of the logbook of all shifts since their last log entry making a signed and dated entry indicating dates reviewed. The residential counselors documented a review of the logbook.	Exception: Residential counselors failed to indicate dates or shifts reviewed. There were six weeks of entries reviewed and none indicated dates or shifts reviewed.
Logbook entries include: a. Supervision and resident counts b. Visitation and home visits	X					Observed logbook entries included supervision and resident counts, and visitation and home visits.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.05						**YES** If NO, explain here: The agency has a policy in place titled CHS/7305 Behavior Management Strategies/Interventions that addresses the requirements of this indicator. The policy was last reviewed on September 30, 2021 by the Director of Program Operations.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		

The program has a detailed written description of the BMS, and it is explained during program orientation	X					The behavior management description is clearly identified in the consumer handbook and given to youth at orientation/intake. The program uses a level system that outlines goals responsibilities and rewards for each youth. Once the behavioral goal is achieved for the day the youth is documented on the point sheets, the youth receives a reward.	
Behavior Management Strategies MUST include: a. Supervisors are trained BMS is designed to teach youth new behaviors and help youth understand the natural consequences for their actions b. Behavioral interventions are applied immediately, with certainty, and reflect the severity of the behavior c. BMS uses a wide variety of awards/incentives to encourage participation and completion of the program d. Appropriate consequences and sanctions are used by the program and consequences for behavior are logical and designed to promote skill-building for the youth e. Counseling, verbal intervention and de-escalation techniques are used prior to physical intervention (Only techniques approved by the Florida Network and DJJ are used if physical intervention is required) f. Only staff discipline youth. Group discipline is not imposed g. Room restriction is not used as part of the system or for youth who are physically and/or emotionally out of control	X					The program's behavior interventions utilize the least amount of force necessary to address the situation and basic rights of youth are not violated. Staff will respond to the youth's inappropriate behavior by utilizing verbal interventions and de-escalation techniques. Staff will take youth aside individually to review the behaviors and explore more appropriate ways to handle the situation. Through the level system the youth are provided a wide variety of incentives such as outings, personal DVD players, video game systems and media use. The program also allows the youth to accumulate points daily that can be used once a week at the Point Store. Any violation of program expectations results in a freeze of privileges and level rewards. While on a reward freeze youth remain eligible to earn points but cannot cash them in at the Point Store. Youth must request to meet with the supervisor in order to have rewards returned. Prohibited techniques are group punishment; isolation; physical or chemical restraint; denial of food, clothing, and shelter, prescribed medication or any other basic client rights; humiliation or verbal threats. Room restriction, time out and/or seclusion are also prohibited, unless room restriction is being utilized as part of a system that ensures the least restrictive means possible to maintain the safety and security of the youth and others in the program.	

h. Youth should never be denied basic rights such as meals, clothing, sleep, services, exercise, or correspondence privileges							
Program's Use of the BMS							
All staff are trained in the theory and practice of administering BMS rewards and consequences	X					Documentation of staff being trained in the theory and practice of the Behavior Management System was observed in staff training files.	
There is a protocol for providing feedback and evaluation of staff regarding their use of BMS rewards and consequences	X					Program supervisor monitors point cards to evaluate and provide feedback to staff during staff meetings on use of behavior management system and on youth engagement.	
Supervisors are trained to monitor the use of rewards and consequences by their staff	X					Documentation of monitoring the Behavior Management System was observed in staff training files.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.06						**YES** If NO, explain here: The agency has a policy in place titled CHS/7306 Staffing and Youth Supervision that addresses the requirements of this indicator. The policy was last reviewed on September 30, 2021 by the Director of Program Operations.	

Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
The program maintains minimum staffing ratios as required by Florida Administrative Code and contract. • 1 staff to 6 youth during awake hours and community activities • 1 staff to 12 youth during the sleep period	X					Reviewed monthly staff schedules from April – October 2021. Reviewed five random nights of video surveillance: September 15 12am – 1am, September 20 2am – 3am, September 26 4am – 5am, October 2 3am -4am, and October 8 1am - 2am. Program maintains staffing ratios as required by Florida Administrative Code and contract. Program maintains 1 staff to 6 youth during awake hours and 1 staff to twelve youth during the sleep period.	
All shifts must always provide a minimum of two staff present	X					All shifts consistently maintain a minimum of 2 staff present.	

Program staff included in staff-to-youth ratio includes only staff that are background screened and properly trained youth care workers, supervision staff, and treatment staff	X					All staff included in ratio were trained and screened.	
The staff schedule is provided to staff or posted in a place visible to staff	X					It was observed that the staff schedule is provided to staff and posted in the medication room.	
There is a holdover or overtime rotation roster which includes the telephone numbers of staff who may be accessed when additional coverage is needed	X					There is a holdover overtime rotation roster that includes contact information of staff in the medication room.	
Staff observe youth at least every 15 minutes while they are in their sleeping room, either during the sleep period or at other times, such as during illness or room restriction	X					Reviewed the five random nights of video surveillance listed above. Reviewed corresponding bed checks in log book for the above dates and times. Staff consistently observe youth every ten minutes while in their sleeping rooms.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.07						**YES** If NO, explain here: The agency has a policy in place titled CHS/7307 Video Surveillance System that addresses the requirements of this indicator. The policy was last reviewed on September 30, 2021 by the Director of Program Operations.	

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	X					Sign is visibly posted on wall on the outside of the building on left side of entrance door. Videos are retained for a minimum of thirty days but up to thirty-four days depending on amount of recording. The video system was observed to record date, time, location based on set up, and images in which faces are easily identifiable. The camera system has a backup battery. Sixteen total cameras are used in the CINS/FINS wing. Of the sixteen, fifteen are on the interior and one on the exterior of the building. All sixteen cameras are visibly mounted and can be seen on the video surveillance monitor. No cameras are mounted in bathrooms or sleeping	

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						rooms.	
A list of designated personnel who can access the video surveillance system is maintained (includes off-site capability per personnel)?	X					Both the Director of Program Operations and Residential Program Manager can access the video surveillance system. The list is posted in the video monitoring room.	
Supervisory review of video is conducted a minimum of once every 14 days and timeframes reviewed are noted in the logbook. The reviews assess the activities of the facility and include a review of random sample of overnight shifts	X					Video Surveillance Review log was reviewed from 1/31/2021 - 10/2/2021. Supervisory review of video is conducted by the Program Manager at a minimum of every fourteen days and assesses the activities of the facility including random samples of overnight shifts.	
Grant the requesting of video recordings to yield a result within 24-72 hours from program quality improvement visits and when an investigation is pursued after an allegation of an incident	X					Policy CHS/7307 indicates third party review can be made available during investigations and in conjunction with specific incidents.	
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			Policy CHS/7307 indicates service orders will be made within 24 hours of discovery. The program had no service orders during this review period.	
						YES	
						If NO, explain here:	

Provider has a written policy and procedure that meets the requirement for Indicator 4.01						The agency has a policy in place titled CHS/7401 Healthcare Admission Screening that addresses the requirements of this indicator. The policy was last reviewed on October 4, 2021 by the Director of Program Operations.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
Preliminary Healthcare Screening							
Screening includes : a. Current medications b. Existing (acute and chronic) medical conditions c. Allergies d. Recent injuries or illnesses e. Presence of pain or other physical distress f. Observation for evidence of illness, injury, physical distress, difficulty moving, etc. g. Observation for presence of scars, tattoos, or other skin markings h. Acute health symptoms requiring quarantine or isolation	X					Reviewed five shelter youth files. Each of the youth files contained a health screening form completed on date of youth's admission. Each health screening form contained all required elements.	
Referral and Follow-up							
Youth with chronic medical conditions have a referral to ensure medical care (e.g. diabetes, pregnancy, seizure disorder, cardiac disorders, asthma, tuberculosis, hemophilia, head injuries, etc.)			X			None of the five youth had a chronic medical condition identified.	
When needed, the parent is involved with the coordination and scheduling of follow-up medical appointments			X			Reviewed shelter policy which addresses practices required for referral/follow-up. None of the five youth presented with chronic conditions requiring a referral to ensure medical care.	
All medical referrals are documented on a daily log.			X			Reviewed shelter policy which addresses practices required for referral/follow-up. None of the five youth presented with chronic conditions requiring a referral to ensure medical care.	

Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
The program has a thorough referral process and a mechanism for necessary follow-up medical care as required and/or needed	X					The program's policy coupled with staff interviews state the program will work with the youth's parent/guardian to ensure the youth receives proper medical care and follow-up.	
Provider has a written policy and procedure that meets the requirement for Indicator 4.02						**YES** If NO, explain here: The agency has a policy in place titled CHS/7402 Identification of Suicide Risk in Shelter that addresses the requirements of this indicator. The policy was last reviewed on October 4, 2021 by the Director of Program Operations.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
Suicide Risk Screening and Approval							
Suicide risk screening occurred during the initial intake and screening process. Suicide screening results reviewed and signed by the supervisor and documented in the youth's case file.	X					Reviewed five shelter youth files. All five files contained a suicide risk screening completed during the screening and initial intake screening process that was signed by a supervisor.	
The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	X					Reviewed documentation that confirmed the program's suicide risk assessment was approved by the Florida Network of Youth and Family Services.	
Supervision of Youth with Suicide Risk							
Youth are placed on the appropriate level of supervision based on the results of the suicide risk assessment.	X					Reviewed five shelter youth files, two were applicable. Both youth were appropriately placed on supervision based upon suicide risk assessment.	
Staff person assigned to monitor youth documented youth's behavior at 30 minute or less intervals	X					Observation logs documented youth on sight and sound were monitored according to policy.	
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					Both applicable files documented the youth's supervision level was not changed until the youth received a follow-up suicide risk assessment completed by a qualified professional.	
						YES If NO, explain here:	

Provider has a written policy and procedure that meets the requirement for Indicator 4.03						The agency has a policy in place titled CHS/7403 Medications that addresses the requirements of this indicator. The policy was last reviewed on October 5, 2021 by the Director of Program Operations.	
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					Observation by video of the medical room found all medication was stored in a Pyxis Med-Station Medication Cabinet that is inaccessible to youth and stored in accordance with required guidelines. Oral medications are stored separately from topical medications located in the locked medical cabinet. There is a secure refrigerator in the medical room used only for medical purposes and maintained at 36 degrees F. All narcotic and controlled medications are stored in the Pyxis Med-Station medication cabinet. The Pyxis Med-Station was appropriately labeled for staff to be able to access medications in case of a malfunction.	
Medication Distribution							

a. Agency maintains a minimum of 2 Super Users for the Med-Station b. Only designated staff delineated in User Permissions have access to secured medications, with limited access to controlled substances (narcotics) c. A Medication Distribution Log shall be used for distribution of medication by non-licensed and licensed staff d. Agency verifies medication using one of four methods listed in the FNYFS Operations Manual e. When nurse is on duty, medication processes are conducted by the nurse f. The delivery process of medications is consistent with the FNYFS Medication Management and Distribution Policy g. Agency does not accept youth currently prescribed injectable medications, except for epi-pens h. Non-licensed staff have received training in the use of epi-pens provided by a registered nurse	X					The program recently hired a nursing agency to oversee healthcare services in the program. A Registered Nurse (RN) from the agency began coming to the program on October 11, 2021. The contract with the agency was executed in July 2021. However, due to Covid-19 related issues and delays in the background screening process services did not begin in the program until October 2021. After the last QI review the program hired a nurse who started and worked for one day and quit. That is when the program made the decision to go with a nursing agency. Reviewed documentation that confirmed the program has a policy in place for Medication Distribution. The program maintains a minimum of two Super Users for the Med-Station. Only authorized staff are allowed to have access to secured medications, with limited access to controlled substances (narcotics). The program reported all staff have permission and are trained to distribute medication to youth. Two applicable youth files were reviewed and each had a Medication Distribution Log which is used by non-licensed and licensed staff. An interview with the Residential Shift Leader reported all medication controlled, and over the counter are inventoried during each shift change between two staff. When the program receives a new youth with medication, the label is checked for the correct information and the pharmacy is called to verify the medication. The program does not accept youth currently prescribed injectable medications, except for epi-pens. All non-licensed staff are trained in the use of epi-pens.	
Medication Inventory							
a. For controlled substances, a perpetual inventory with running balances is maintained as well as a shift-to shift count verified by a witness and documented						Documentation reviewed confirmed the program has a perpetual inventory with running balances that is maintained as well as shift-to shift counts for all prescribed medications. The shift-to-shift counts are completed by two staff members. Interview with the	

b. Over-the-counter medications that are accessed regularly are inventoried weekly by maintaining a perpetual inventory c. Syringes and sharps (needles, scissors, etc.) are secured, and counted and documented weekly	X					Residential Shift Leader reported over-the-counter medications are inventoried weekly by maintaining a perpetual inventory. The program does not have any syringes or sharps.	
There are monthly reviews of medication management practice via Knowledge Portal or Pyxis Med-Station Reports.	X					There are monthly reviews of medication management practice. The program pulls five reports daily, Profile Override Report by Med, Device Activity Log, Active Orders Report, Discrepancies Report, and Profile Override Report by User.	
Medication discrepancies are cleared after each shift.			X			The program did not have any medication discrepancies at the time of the review.	
Provider has a written policy and procedure that meets the requirement for Indicator 4.04						**YES** If NO, explain here: The agency has a policy in place titled CHS/7404 Medical/Mental Health Alert Process that addresses the requirements of this indicator. The policy was last reviewed on October 4, 2021 by the Director of Program Operations.	

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 review of five youth files which consisted of three closed and two open was conducted for the Medical and Mental Health Alert Process. Each reviewed file included a general alert form reviewed by the program's staff. The program has an alert board in the medical station area, which identifies each youth's special alerts such as mental health, medical, and allergies. A review of the program's alert board in comparison with the youth's general alert form for the two open files confirmed each youth's color-coded sticker was accurate.	

Alert system includes precautions concerning prescribed medications, medical/mental health conditions	X					The program's alert system includes precautions concerning the prescribed medications, and medical/mental health conditions are documented on the alert form in youth's file. An alert board located in the intake office also documents the youth's name and alert in a confidential manner. A nutritional alert clipboard is in the kitchen which includes a list of youth who have an allergy or other kind of nutritional alert.	
Staff are provided sufficient training, information and instructions to recognize/respond to the need for emergency care for medical/mental health problems	X					Staff are required to complete and maintain certification of CPR/First Aid training. All eight staff training files reviewed confirmed the staff had current CPR and First Aid certifications.	
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					The program has a policy and procedures in place to address a medical and mental health alert system that ensures information concerning a youth's medical condition, allergies, common side effects of prescribed medication, foods, and medications that are contraindicated, or other pertinent mental health treatment information is communicated to all staff. Each day staff are required to check the census board at the beginning of their shift and review the chart and medication log for those youth identified as having a medical condition.	
Provider has a written policy and procedure that meets the requirement for Indicator 4.05						**YES** If NO, explain here: The agency has a policy in place titled CHS/7405 Emergency/Episodic Care that addresses the requirements of this indicator. The policy was last reviewed on October 4, 2021 by the Director of Program Operations.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
Off-site Emergency Services							
a. If off-site emergency medical or dental care was provided, an incident report was submitted for the medical or dental care						The program has a policy and procedures in place to address off-site emergency medical or dental care. There were four youth files reviewed for off-site emergency medical or dental care. An incident report	

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					was shown to be submitted for the medical or dental case. Upon the youth's return to the program there is verification of a medical clearance, and the youth's parents was notified. The program maintains a daily log for all emergency care provided.	
All staff are trained on emergency medical procedures	X					All staff are trained on emergency medical procedures through CPR/FIRST AID/AED training. All eight staff training files confirmed this.	
The program has a Knife-for-life and wire cutters accessible to staff in a secure location(s)	X					There are three knife-for-lifes in the program-- one on the van keychain, one on the staff key chain and one in the medication room.	
First aid kit/supplies are fully equipped and inventoried	X					The program has three first aid kits that are inventoried weekly. The kits are located in the pantry, in the medication room and a mobile kit used in the van.	