Florida Network for Youth and Family Services
Compliance Monitoring Report for

Crosswinds Youth Services

1407 Dixon Blvd.
Cocoa, FL 32922

Compliance Monitoring Services Provided by

FOREFRONT

EXECUTIVE SUMMARY

Forefront LLC conducted a joint Quality Improvement (QI) and Florida Network of Youth and Family Services (FNYFS) monitoring visit for Crosswinds Youth Services for the FY 2021-2022 at its program office located at 1407 Dixon Blvd., Cocoa, 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. Crosswinds Youth Services 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 Crosswinds Youth Services present for the entrance interview were Karen Locke, COO; John Weimann, Director of Counseling Services; and Lynn Cowart, CFO. The last QI visit was conducted November 4 - 5, 2020.

In general, the Reviewer found that Crosswinds Youth Services is in compliance with specific contract requirements. **Crosswinds Youth Services 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 11-17-2021

Agency Name: Crosswinds Youth Services	**Monitor Name: Ashley Davies, Lead Reviewer**
Contract Type: CINS/FINS	**Region/Office: 1407 Dixon Blvd., Cocoa, FL 32922**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): November 17 - 18, 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 following staff members have been trained as Certified QI Peer Reviewers: Lynn Cowart, Pierre Bandoo, John Weinman, and Raylene Coe. Two of them are active reviewers: Pierre Bandoo and Raylene Coe.	**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: The provider reported fourteen additional funding/contracts outside of FNYFS funding: Basic Center Grant, Brevard Family Partnership, United Way of Brevard County, FNYFS – Single Contract, FNYFS – Special Populations, FNYFS – DV respite, non-contract placements from other Florida CBC's on a case by case basis, FNYFS, DCF Emergency Solutions Grant, US Department of Housing and Urban Development, Brevard Family Partnership, and	**No recommendation or Corrective Action.**

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						Brevard County Board of County Commissioners Information on the aforementioned programs included type of program, funding source, program description, contract period, and funding amount.	
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 Wesco Insurance Company with limits of coverage of $1,000,000 each/$3,000,000 aggregate, $5,000 medical expenses. Effective 10/21/2021 through 10/21/2022. Automobile Liability through Wesco Insurance Company with combined single limit of $1,000,000 and medical payments of $5,000. Effective 10/21/2021 – 10/21/2022. Workers Compensation and Employers Liability through Associated Industries Ins. Co. with limits of coverage of $100,000 each accident, $100,000 each employee, and $500,000 policy limit.	**No recommendation or Corrective Action.**

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	Explain Rating						
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						Effective 5/1/2021 – 5/1/2022. Professional Liability and Sexual/Physical Abuse & Molestation through Wesco Insurance Company with limits of coverage of $1,000,000 each/$3,000,000 annual aggregate. Effective 10/21/2021 – 10/21/2022. Florida Network is listed as Loss Payee on the certificate.	
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: The agency has an Accounting Procedures Manual that is designed to be consistent with Generally Accepted Accounting Procedures (GAAP) and provide for limited internal controls. Records indicate that this manual was last updated June 2019 and was approved by the agency's CEO.	**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: Agency maintains a detailed cost accounting general ledger system with corresponding source documents. General Ledger (GL) is structured to track all funding sources and there are separate funds for each revenue source. The GL for the CINS/FINS cost center for the FY 2020-2021, was reviewed.	**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: Petty cash is stored in a secure location in the Shelter Manager's office. The agency designates an alternate custodian in the absence of the COO as needed. All cash disbursements are allowable and are documented on a Petty Cash listing. Receipts are submitted for reconciliation and record keeping. The established petty cash fund amount is $300 and may be increased if necessary. The agency provided reconciliations for the past six months. Copies of the petty cash process and fund reconciliations were reviewed. Petty cash is replenished 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)**
						reconciled weekly or on an as needed basis.	
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: Documents reviewed included Bank Statements and Bank Reconciliations for account with Bank of America for the period March 2021 through September 2021. Financial Statements are reported on a monthly basis. Statements are consistent with bank reconciliations and are also conducted on a monthly basis. These are generated within the first two weeks of the following month for the prior month's statements. The Agency's CFO oversees the process, and a Business Specialist documents the journal entries on a monthly basis. All accounts payable and cash receipts are still being recorded. The agency maintains individual vendor files which are kept in secure file cabinets in the finance office and disbursements are approved by management. Monthly invoices for the Florida Network are submitted with supporting documentation.	**No recommendation or Corrective Action.**

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e. Agency maintains inventory in accordance with a written policy and FNYFS contractual requirements. If over $1,000 inventory has DJJ Property Inventory Number/Tag. In the event the provider has purchased computer equipment an Informational Resources Request (IRR) been submitted to DJJ. **PTV/ON SITE**	☐	☐	☐	☐	☒	N/A – The agency has not purchased any items with FNYFS monies since the last time on-site.	**No recommendation or Corrective Action.**
f. Agency submits payroll taxes and deposits (and retirement deposits as applicable), Employee IRS Form W-2 and Independent Contractors IRS Form 1099 forms prior to federal requirements. **ON SITE**	☐	☐	☒	☐	☐	Documentation: The agency uses a contracted payroll service provider to do payroll. The agency uses Paycor for payroll and taxes. Evidence of the submission of the required quarterly payroll taxes was provided via copies of 941s, 4th quarter of 2020, and first 3 quarters of 2021 demonstrating the filing of payroll taxes. No overages or adjustments were documented on the last quarter's report. ADP also submits the W2s electronically.	**No recommendation or Corrective Action.**

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g. Budget to actual reports prepared and reviewed by appropriate management. Variance from the budget is investigated and explained. **PTV/ON SITE**	☐	☐	☒	☐	☐	Documentation: The Combined Funds Status Report was reviewed for the current fiscal year, July 1 – September 30, 2021. The CEO and CFO review the variances monthly and quarterly with the finance committee of the Board of Directors. Expenses are approved prior to expenditure to place controls on spending.	**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 audit was completed within 120 days after the previous fiscal year/calendar year and that a copy was provided to the Network unless and extension has been requested and approved in writing. Copy of Audit is submitted to the FNYFS by December 31st. **Obtain from FNYFS**	☐	☐	☒	☐	☐	Documentation: The agency has a single audit that was completed by Whittaker Cooper Financial Group for year ending June 30, 2020. Per the audit report, a management letter was not required. This document had no reported audit findings. As a result of this, a corrective action response plan was not required. The program reported a copy was submitted directly to the FNYFS.	**No recommendation or Corrective Action.**
i. Agency maintains confidentiality policy with written policies and procedures to ensure the security and privacy of all employee and client data. Personal information is not easily accessible. Agency maintains a backup system in case of accidental loss of financial information. Security procedures are in place to protect laptops. Obsolete	☐	☐	☒	☐	☐	Documentation: CINS/FINS residential and non-residential services Standard Operating Procedures for Confidentiality, Record Retention, Record Loss Prevention, Client	**No recommendation or Corrective Action.**

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Major Programmatic Requirements	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable		
documents are shredded, and computer hard drives are wiped prior to discarding. **ON SITE**						Record Management, and Mobile Computing and Storage Devices are maintained and were reviewed. No changes were made to these documents.	

CONCLUSION

Crosswinds Youth Services 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 Crosswinds Youth Services
CINS/FINS Program

November 17 - 18, 2021

Compliance Monitoring Services Provided by

FOREFRONT

CINS/FINS Rating Profile

Standard 1: Management Accountability

1.01 Background Screening	Satisfactory
1.02 Provision of an Abuse Free Environment	Satisfactory
1.03 Incident Reporting	Limited
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: 85.71 %
Percent of indicators rated Limited: 14.29 %
Percent of indicators rated Failed: 0 %

Standard 2: Intervention and Case Management

2.01 Screening and Intake	Satisfactory
2.02 Needs Assessment	Satisfactory
2.03 Case/Service Plan	Satisfactory
2.04 Case Management & Service Delivery	Satisfactory
2.05 Counseling Services	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)	Limited

Percent of indicators rated Satisfactory: 90 %
Percent of indicators rated Limited: 10 %
Percent of indicators rated Failed: 0 %

Standard 3: Shelter Care & Special Populations

3.01 Shelter Environment	Limited
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: 85.71 %
Percent of indicators rated Limited: 14.29 %
Percent of indicators rated Failed: 0 %

Standard 4: Mental Health/Health Services

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

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

Overall Rating Summary

Percent of indicators rated Satisfactory: 89.66 %
Percent of indicators rated Limited: 10.34 %
Percent of indicators rated Failed: 0 %

Rating Definitions

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

Satisfactory Compliance	No exceptions to the requirements of the indicator; limited, unintentional, and/or non-systemic exceptions that do not result in reduced or substandard service delivery; or exceptions with corrective
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
Melissa Johnson – Regional Monitor, Department of Juvenile Justice
Brittany Brown - Children's Home Society
Julie Edison - Hillsborough County
Myiah White - Urban League of Palm Beach County

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

X	Chief Executive Officer		Case Manager		Nurse – Full time
X	Chief Financial Officer		Counselor Non-Licensed		Nurse – Part time
	Chief Operating Officer		Advocate		# Case Managers
	Executive Director	X	Direct – Care Full time	1	# Program Supervisors
	Program Director		Direct – Part time		# Food Service Personnel
X	Program Manager		Direct – Care On-Call		# Healthcare Staff
	Program Coordinator		Intern		# Maintenance Personnel
X	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	7	# Personnel /Volunteer Records
X	Contract Monitoring Reports	X	Medical and Mental Health Alerts	7	# 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
X	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

Crosswinds has promoted Peter Phillips from Transitional Living Coordinator to Director of Residential Services. Peter has over 20 years of experience directing programs and working with young people.

Crosswinds has also added Case Managers to the shelter to help with the implementation of the Florida Network Nirvana assessment and provide more oversight.

Salaries for Youth Specialists have increased from $11.00 an hour to $12.00 an hour, with some staff (based on education, experience, and seniority) making $15.00 an hour.

Crosswinds has been using alternative scheduling to help recruit staff. There are now positions that have a 4-day work week and weekend only shifts.

Staff have taken part in several focus groups to help create a shelter program that addresses the needs of the youth, people we serve, and staff.

Crosswinds is working with local medical facilities and clinics that can respond to youth requiring testing, and/or medical intervention, as a result of being exposed to or infected with COVID-19.

The Wi-Fi and CCTV system was upgraded.

Jesse Jordan, Youth Ambassador was hired to work with youth and staff to develop and support additional programming for educational, recreational, and cultural activities that adhere to social distancing guidelines.

Referrals have been a challenge, but they have picked up their numbers significantly over the past few months with the return to more in-person learning.

The shelter has 6 vacancies for Youth Specialists.

Narrative Summary

Crosswinds Youth Services is a contracted member agency with the Florida Network of Youth and Family Services, Inc. to provide Children in Need of Services and Families in Need of Services (CINS/FINS). Crosswinds also provides a broad range of services to families and youth under 18 years of age with various risks. The agency serves many profiles, including youth that have run away, are truant, and/or ungovernable in Brevard County. Further, other programs and services include transitional housing and skills training for young adults, street outreach for homeless youth, assistance for youth aging out of the foster care system, and intervention services for youth that may be headed toward or involved in the juvenile justice system.

Crosswinds non-residential program services are provided to youth and families in Brevard County in the local schools, community locations (such as libraries, community centers, youth after school programs), or in their homes.

The overall findings for the QI review for Crosswinds Youth Services are summarized as follows:

Standard 1: This standard has a total of seven indicators regarding management accountability. Six of the indicators were rated satisfactory. Indicator 1.03 Incident Reporting was rated limited. There were also exceptions noted in indicators 1.04 Training Requirements and 1.06 Client Transportation. The exception noted in 1.04 was due to one staff not completing two required trainings in the required time frame. The exception noted in 1.06 was due to three single client transports not documenting supervisor approval and purpose of travel not noted on transportation logs. All other indicators in standard 1 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 (SNAP) was rated limited. All other indicators in standard 2 were rated satisfactory with no exceptions.

Standard 3: This standard has a total of seven indicators regarding shelter care. Six indicators were rated satisfactory with an exception noted in 3.04 Logbooks. The exception noted in 3.04 was due to two weeks of no Program Director or designee documenting a review of the logbook and staff, supervisors, and counselors not indicating the dates they reviewed when reviewing the logbook. Five other indicators in standard 3 were rated satisfactory with no exceptions. The Shelter Environment indicator was rated as Limited.

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 noted.

Summary of Deficiencies resulting in Limited Rating:

Standard 1: Indicator 1.03 Incident Reporting was rated a limited due to no documentation to verify a youth was placed on 1:1 supervision, one incident not being documented on an incident reporting form, none of the incidents being documented in the logbook, and not being able to determine if one incident was reviewed and signed by a supervisor.

Standard 2: Indicator 2.10 Stop Now and Plan (SNAP) was rated a limited due to 3 files not containing a pre TRF, 2 closed files not containing a post TRF, class “Shoot for your Goal” sheet not found for 2 classes,

none of the 3 classes documented a pre or post MoCE was completed, one of the classes did not have a pre evaluation for the teacher, and none of the classes had a post evaluation for the youth or teachers.

Standard 3: Indicator 3.01 was rated as Limited due to several of the findings observed to be completed by the end of the review and not previously. Furthermore, there was an involvement of hazardous materials discovered and two fire extinguishers were not replaced within the proper time.

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: A policy is in place titled 1-4 Background Screening. The policy was last reviewed in September 2021 and signed by the Chief Executive Officer.	
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 seven new staff were hired since the last QI review. The agency uses the Berke Assessment. All seven staff completed the Berke Assessment prior to hire and documented a passing score.	
Background screening completed prior to hire/start date or exemption obtained prior to working with youth (if rated ineligible) for new hires, volunteers/interns, and contractors	X					There were a total of seven staff hired since the last QI review. All seven staff 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 December 23, 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 seven 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 program has four policies relating to the Provision of an Abuse Free Environment. The four policies are 1-2 Abuse Reporting - by Client, 1-3 Abuse Reporting - by Staff, 1-8 Employee Conduct and Ethics, and 1-21 Grievances. The policies were last reviewed in September 2021 and signed by the Chief Executive Officer.	
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 policy 1-8 Employee Conduct & Ethics in place. The policy indicates all staff must adhere to the program's code of ethics. All staff review all program policies at hire.	
Child Abuse Registry telephone number is visible to youth and posted common areas of the facility	X					Child Abuse telephone number was observed posted in the dayroom of the shelter during the on-site tour of the facility.	
Youth were informed of the Abuse and Contact Number (see youth survey results)	X					The Florida Abuse Hotline number and procedures are documented in the Youth handbook given to each youth at intake. All five shelter files reviewed documented the youth received the handbook during their orientation to the program.	
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 1-21 Grievances outlines the program's formal grievance process.	
Locked box accessible to only management and available to youth in a common area	X					During the on-site tour it was observed that the program has an accessible grievance box that was locked and located in the dayroom of the shelter.	

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 three grievances submitted in the last six months. Each grievance was accessed and managed by the CYS Compliance Administrator. Grievances and findings are maintained in the Finance Department for a minimum period of one year.	
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					All three grievances reviewed were resolved within the 72 hour period. Documentation was provided to show each youth was satisfied with the resolution.	
1.03: Incident Reporting							
Provider has a written policy and procedure that meets the requirement for Indicator 1.03						**YES** The program has two policies relating to Incident Reporting. The two policies are 1-11 Incident Reporting and 1-18 Central Communication Center. The policies were last reviewed in September 2021 and signed by the Chief Executive Officer.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
During the past 6 months, the program notified the Department's CCC (Central Communication Center) no later than two hours after any reportable incident occurred or within two hours of the program learning of the incident	X					For all 3 reports reviewed, each was reported to the CCC within 2 hours following a reportable incident or within 2 hours of program learning of incident.	
The program completes follow-up communication tasks/special instructions as required by the CCC		X				For each report, no follow up was required by the CCC. However, one CCC report had documented the program was going to place the youth on 1:1 supervision.	Exception: There was no documentation available for review to verify this youth was placed on 1:1 supervision.

Incidents are documented in the program logs and on incident reporting forms		X				Two of the three incidents were documented on incident reporting forms.	Exceptions: One incident was not documented on an incident reporting form. None of the incidents were documented in the program's logbook.
All incident reports are reviewed and signed by program supervisors/directors		X				Two of the three incidents were reviewed and signed by program supervisors.	Exception: One incident did not have an incident reporting form so it could not be determined if the incident was reviewed and signed by program supervisors.
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: A policy is in place titled 1-23 Training Requirements. The policy was last reviewed in September 2021 and signed by the Chief Executive Officer.	
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 three newly hired staff training files reviewed. All three 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 three first year staff training files reviewed. Two of the three staff completed all mandatory training required during the first 90 days.	Exception: One staff completed the CINS/FINS Core training outside the 90 day requirement and this staff also did not complete Medication Administration training.
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 program has two policies relating to Analyzing and Reporting Information. The two policies are 1-15 Quality Improvement Initiatives and 1-27 Analyzing and Reporting Information. The policies were last reviewed in September 2021 and signed by the Chief Executive Officer.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
Case record review reports demonstrate reviews are conducted quarterly, at a minimum	X					A sample of case records are reviewed each month for both shelter and community counseling programs. The last five months, May through September 2021, were reviewed to confirm this practice.	
The program conducts reviews of incidents, accidents, and grievances quarterly, at a minimum	X					Incidents and accidents are discussed in the Quarterly Risk Management report. The last two quarterly reports were reviewed. Grievances are discussed at the monthly QIC meetings. The last six monthly meetings were reviewed.	
The program conducts an annual review of customer satisfaction data	X					A Customer Satisfaction Data Report was provided for the last fiscal year from July 2020 - June 2021. The report summarized all customer satisfaction surveys completed during that time frame.	
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					A monthly Data Snapshot Report, that reviews outcome data and NetMIS data, is reviewed every month by the CFO then an email is sent to all management and team leaders with the report attached and the analysis/statistics broken down by the CFO and compared to corresponding quarters of the previous FY. This report is then also reviewed at the monthly CQI meetings and President meetings. The last annual reconciliation was conducted with the Florida Network via email on May 4, 2021. All corrections were made and submitted in requested time frames.	

The program conducts a monthly review of NetMIS data reports. The program submits NetMIS invoices by the fourth business day of the following reporting month.	X					A monthly Data Snapshot Report, that reviews outcome data and NetMIS data, is reviewed every month by the CFO then an email is sent to all management and team leaders with the report attached and the analysis/statistics broken down by the CFO and compared to corresponding quarters of the previous FY. This report is then also reviewed at the monthly CQI meetings and President meetings. Invoices were provided for the last six months to show they were submitted to the Florida Network by the 4th business day each month.	
The Florida Network conducts monthly reconciliation by comparing NetMIS data to JJIS data. Agency has evidence that they have reconciled any differences noted.	X					The CFO conducts a monthly reconciliation between JJIS and NetMIS and corrects any errors if needed.	
The program has a process in place to review and improve accuracy of data entry & collection	X					NetMIS data reports from the Florida Network are reviewed monthly by key program leaders for reconciliation. Changes are then made as needed.	
There is documentation that findings are regularly reviewed by management and communicated to staff and stakeholders.	X					There is documentation findings are communicated to staff and stakeholders during monthly staff meetings, CQI meetings, and President meetings.	
There is evidence the program demonstrates that critical performance data reports are shared with the Board of Directors frequently. All final reports that include a Limited or Failed score is submitted electronically or by mail to the providers Executive Committee on the Board of Directors.	X					The Board of Directors receives a copy of all data reports relating to program performance.	

There is evidence that strengths and weaknesses are identified, improvements are implemented or modified, and staff are informed and involved throughout the process.	X					Monthly meeting minutes from various different meetings provided by the program showed strengths and weaknesses being identified and discussed with staff. There were also Quality Improvement/Corrective Action Plans put into place for any program areas identified as needing improvement. Each one of these Corrective Action Plans were reviewed during various monthly meetings and a chronological record was maintained with each Corrective Action Plan that documented each time the Plan was discussed and documented the progress or actions taken during that discussion.	
Provider has a written policy and procedure that meets the requirement for Indicator 1.06						**YES** If NO, explain here: A policy is in place titled 5-12 Transportation of Youth. The policy was last reviewed in September 2021 and signed by the Chief Executive Officer.	
Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	X					The agency maintains a list of staff approved to drive youth.	
Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	X					Employee Drivers License and Driving Record are validated at a minimum of two times per year. Staff are covered under the agency's insurance policy.	
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 5-12 Transportation of Youth 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 for the last six months. There were 80 single client transports documented. All but 3 transports documented a supervisor approval was obtained prior to the transport taking place.	Exception: Three transports did not document a supervisor approval 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.	

There is documentation of use of vehicle that notes name or initials of driver, date and time, mileage, number of passengers, purpose of travel and location.		X				A Transportation Log is maintained in each vehicle used to transport youth. This documentation provided staff initials, date and time, mileage, number of passengers, program, and travel location.	Exception: The transportation log does not note the purpose of travel.
Provider has a written policy and procedure that meets the requirement for Indicator 1.07						**YES** If NO, explain here: A policy is in place titled 1-14 Public Awareness and Targeted Outreach Services. The policy was last reviewed in September 2021 and signed by the Chief Executive Officer.	
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					Meeting agendas and minutes were provided to show participation in Circuit 18 Juvenile Justice Advisory Board meetings over the last six months. There was documentation a staff participated in the JAC Advisory Board meetings over the last six months.	
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 agency provided an outreach report which included title of event, date of event, number of youth and adults in event, purpose of event, and what area event took place in the community. Report was provided for the last six months and included outreach events at local schools and community events each month.	
The program maintains written agreements with other community partners which include services provided and a comprehensive referral process.	X					Agency has thirty-five formal interagency agreements with community partners including local schools, mental health and substance abuse facilities, and sheriff's department. All agreements were current.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.01						**YES** If NO, explain here: A policy is in place titled 2-2 Screening and Intake. The policy was last reviewed in September 2021 and signed by the Chief Executive Officer.	
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, three open and two 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.	
Youth and parents/guardians receive the following in writing: a. Available service options b. Rights and responsibilities of youth and parents/guardians	X					All ten files showed evidence that parent/guardians received available service options, and rights and 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: A policy is in place titled 2-3 Needs Assessment. The policy was last reviewed in September 2021 and signed by the Chief Executive Officer.	
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 5 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.	
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							
Youth was identified with an elevated risk of suicide as a result of the Needs Assessment			X			None of the ten files reviewed 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			None of the ten files reviewed identified the youth with an elevated risk of suicide as a result of the Needs Assessment.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.03						**YES** If NO, explain here: A policy is in place titled 2-4 Service Planning. The policy was last reviewed in September 2021 and signed by the Chief Executive Officer.	
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 (three open and two 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)	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.	

5. Signature of youth, parent/ guardian, counselor, and supervisor 6. Date the plan was initiated							
Case/service plans are reviewed for progress/revised by counselor and parent (if available) every 30 days for the first three months and every 6 months after	X					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 program has two policies relating to Case Management and Service Delivery. The two policies are 2-5 Services and 2-6 Case Management. The policies were last reviewed in September 2021 and signed by the Chief Executive Officer.	
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 (three open and two 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)						There were five community counseling files reviewed (two closed and three 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.	

6. Makes referrals to the case staffing to address problems and needs of the youth/family 7. Accompanies youth and parent/guardian to court hearings and related appointments 8. Refers the youth/family for additional services when appropriate 9. Provides case monitoring and reviews court orders 10. Provides case termination notes 11. Provides follow-up after 30 days of exit 12. Provides follow-up after 60 days of exit	X					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 four files applicable for providing follow-up after thirty days of exit and three files after sixty days of exit. All follow-ups were completed as required.	
The program maintains written agreements with other community partners that include services provided and a comprehensive referral process	X					Agency has thirty-five formal interagency agreements with community partners including local schools, mental health and substance abuse facilities, and sheriff's department. All agreements were current.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.05						**YES** If NO, explain here: The program has two policies relating to Counseling Services. The two policies 2-7 Counseling/Youth Records and 3-8 Group Counseling. The policies were last reviewed in September 2021 and signed by the Chief Executive Officer.	
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 (three open and two 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:						All groups reviewed were at least thirty minutes in	

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					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. In addition, a sample of case records are reviewed each month for both shelter and community counseling programs.	
						YES	
						If NO, explain here:	

Provider has a written policy and procedure that meets the requirement for Indicator 2.06						A policy is in place titled 2-10 Case Staffing Committee. The policy was last reviewed in September 2021 and signed by the Chief Executive Officer.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
Case Staffing Initiation and Notifications							
If parent/guardian initiates, staffing is held within 7 days					X	Parent/guardian did not initiate either case staffing.	
The youth, family and case staffing committee are contacted within a minimum of five working days a. Notification to youth/family no less than 5 working days prior to staffing b. Notification to committee no less than 5 working days prior to staffing	X					Notification was sent via email to the committee and youth/family no less than five days prior to the case staffing.	
Case Staffing Committee							
Must include: a. DJJ rep. or CINS/FINS provider b. Local school district representative	X					In the 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 every month.	
The program has an internal procedure for the case staffing process, including a schedule for committee meetings	X					The program has policy 2-10 Case Staffing Committee in place that outlines procedures for the process, including a schedule for the meetings.	
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.	
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: A policy is in place titled 2-7 Counseling/Youth Records. The policy was last reviewed in September 2021 and signed by the Chief Executive Officer.	
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: A policy is in place titled 3-34 Sexual Orientation, Gender Identity, and Gender Expression. The policy was last reviewed in September 2021 and signed by the Chief Executive Officer.	
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			X			A review of the Florida Network's SOGIE Report as of October 4, 2021 revealed there were no youth who fell under the requirements of this indicator since the last QI review.	

b. Youth's preferred name and gender pronouns are used in logbook and on all outward-facing documents and census boards							
Youth in need of specialized support is referred to qualified resources (as applicable)			X			A review of the Florida Network's SOGIE Report as of October 4, 2021 revealed there were no youth who fell under the requirements of this indicator since the last QI review.	
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			A review of the Florida Network's SOGIE Report as of October 4, 2021 revealed there were no youth who fell under the requirements of this indicator since the last QI review.	
Youth is provided hygiene products, undergarments and clothing that affirms their gender identity or gender expression			X			A review of the Florida Network's SOGIE Report as of October 4, 2021 revealed there were no youth who fell under the requirements of this indicator since the last QI review.	
The agency has signage and brochures/publication placed in common areas indicating that all youth are welcome regardless of sexual orientation, gender identity, and gender expression	X					During the on-site tour of the facility, there was signage observed 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 program has five polices relating to Special Populations. The five policies are 3-27 Staff Secure Services, 3-31 Domestic Violence Respite, 3-32 Domestic Minor Sex Trafficking, 3-33 Probation Respite, and 3-35 Family-Youth Respite Aftercare Services (FYRAC). The policies were last reviewed in September 2021 and signed by the Chief Executive Officer.	
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 d. Parental involvement e. Collaborative aftercare	X					Reviewed policy 3-27 Staff Secure Services.	
Program only accept youth that meet legal requirements of F.S. 984 for being formally court ordered in to Staff Secure Services			X			No applicable youth files to review.	
Staff Assigned: a. One staff secure bed and assigned staff supervision to one staff secure youth at any given time b. Program assign specific staff during each shift to monitor location/ movement of staff secure youth c. Agency clearly documents the specific staff person assigned to the staff secure youth in the logbook or any other means on each shift			X			No applicable youth files to review.	
Agency provides a written report for any court proceedings regarding the youth's progress			X			No applicable youth files to review.	
Domestic Minor Sex Trafficking (DMST)							
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? **(If no, select rating "No eligible items for review")**			NO			The provider has not served any youth meeting the criteria for DMST since the last QI review.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		

Agency has evidence that the FNYFS was contacted for approval prior to admission for all Domestic Minor Sex Trafficking (DMST) placements.			X			No applicable youth files to review.	
There is evidence the youth was entered into NetMIS as a Special Populations youth at admission and a Human Trafficking Screening Tool (HTST) was completed.			X			No applicable youth files to review.	
Services provided to these youth specifically designated services designed to serve DMST youth			X			No applicable youth files to review.	
Did the placement of DMST youth require additional supervision for the safety of the youth or the program? If so, did the agency provide the appropriate level of supervision and safety measures?			X			No applicable youth files to review.	
Length of Stay: a. Youth in program do not have length of stay in DMST placement that exceeds seven (7) days b. Agency has approval for stays and support beyond seven (7) days for DMST placements that are obtained on a case-by-case basis? (If applicable.)			X			No applicable youth files to review.	
Agency has evidence that staff assigned to DMST youth under this provision are to enhance the regular services available through direct engagement in positive activities designed to encourage the youth to remain in shelter			X			No applicable youth files to review.	
All other services provided to DMST youth are consistent with all other general CINS/FINS program requirements			X			No applicable youth files to review.	
Domestic Violence							

Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? **(If no, select rating "No eligible items for review")**	**YES**						
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Youth admitted to DV Respite placement have a pending DV charge and have evidence of being screened by JAC/Detention, but do not meet criteria for secure detention	**X**					There were two closed files reviewed. Both files had a face sheet indicating a pending DV charge and both were screened by the JAC and did not meet criteria for secure detention.	
Data entry into NetMIS and JJIS within (3) business days of intake and discharge	**X**					Both files had evidence of data entry within three business days of intake and within three business days of discharge.	
Youth in program do not have length of stay in DV Respite placement that exceeds 21 days. If more than 21 days, documentation exists in youth file of transition to CINS/FINS or Probation Respite placement, if applicable.	**X**					One youth did not exceed 21 days in the program. The other youth was transferred to a CINS bed on the 21st day in the program.	
Case plan in file reflects goals focusing aggression management, family coping skills, or other intervention design to reduce reoccurrence of violence in the home	**X**					Both files had Service Plans that focused on anger management and family coping skills.	
All other services provided to Domestic Violence Respite youth are consistent with all other general CINS/FINS program requirements	**X**					Both youth received all other general CINS/FINS required services.	
Probation Respite							
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? **(If no, select rating "No eligible items for review")**			**NO**			The provider has not served any youth meeting the criteria for Probation Respite since the last QI review.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
All probation respite referrals are submitted to the Florida Network.			**X**			No applicable youth files to review.	

Probation Respite Referral come from DJJ Probation and are all youth referred on probation regardless of adjudication status			X			No applicable youth files to review.	
Data entry into NetMIS and JJIS within (3) business days of intake and discharge			X			No applicable youth files to review.	
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			No applicable youth files to review.	
All case management and counseling needs have been considered and addressed			X			No applicable youth files to review.	
All other services provided to Probation Respite youth are consistent with all other general CINS/FINS program requirements			X			No applicable youth files to review.	
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**			The provider has not served any youth meeting the criteria for FYRAC since the last QI review.	
Agency has evidence that all FYRAC referrals have documented approval from the Florida Network office			**X**			The provider has not served any youth meeting the criteria for FYRAC since the last QI 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**			The provider has not served any youth meeting the criteria for FYRAC since the last QI review.	
Life Management Sessions meets the following criteria: a. Sessions are face-to-face, sixty (60) minutes in length and focus on strengthening the family unit b. Individual Sessions are with the youth and family and focus to engage, identify strengths and needs of each member that help to improve family functioning			**X**			The provider has not served any youth meeting the criteria for FYRAC since the last QI review.	
Group Sessions: a. Focus on the same issues as individual/family sessions with the overall goal of strengthening relationships and prevention domestic violence			**X**			The provider has not served any youth meeting the criteria for FYRAC since the last QI review.	

b. Shall be no more than eight (8) youth at one (1) time and shall be for a minimum of sixty (60) minutes per session							
Youth and family participate in services for thirteen (13) sessions or ninety (90) consecutive days of services, or there is evidence in the youth's file that an extension is granted by DJJ circuit Probation staff			X			The provider has not served any youth meeting the criteria for FYRAC since the last QI review.	
2.10: STOP NOW AND PLAN (SNAP)							
Provider has a written policy and procedure that meets the requirement for Indicator 2.10						**YES** If NO, explain here: The program has five policies relating to Stop Now and Plan (SNAP). The five policies are 6-1 SNAP Group Delivery, 6-2 SNAP Fidelity, 6-3 SNAP Intake, 6-4 SNAP Discharge, and 6-5 SNAP in Schools. The policies were last reviewed in September 2021 and signed by the Chief Executive Officer.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
SNAP Clinical Groups							
Youth are screened to determine eligibility of services	X					There were two open and two closed files reviewed. All four files had a NetMIS Screening form and SNAP Brief Intake Screening form.	
Needs assessment is completed at initial intake, or within two face-to-face sessions	X					Needs Assessment was initiated at intake in all four files.	
SNAP Assessments a. Child Behavior Checklist (CBCL) is completed by the caregiver (pre & post) b. Teacher Report Form (TRF) completed by the teacher (pre & post) c. Tool for Parenting Self Efficacy (TOPSE) completed by the caregiver (pre & post)						A pre CBCL was completed in all four files. Both closed files had a post CBCL. One of the four files had a pre TRF completed by the teacher. A pre TOPSE in all four files. Both closed files had a post TOPSE. All four files had a pre PAT Assessment completed at intake. Both closed files had post PAT Assessment	Exceptions: Three of the four files did not have a pre TRF completed by the teacher and there was no documentation a TRF was sent to the teacher to complete. None of the files reviewed had any progress or

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				completed at discharge.	chronological notes so it could not be determined if there were at least 3 attempts to obtain the missing TRF's. Neither closed file had a post TRF completed by the teacher and neither file contained documentation a TRF was sent to the teacher to complete.
SNAP discharge report summary	X					Both closed files had a SNAP discharge report summary.	
SNAP Boys/SNAP Girls **Parent** Group Evaluation Form	X					Both closed files had a Parent Group Evaluation Form.	
SNAP Boys/SNAP Girls **Child** Group Evaluation Form	X					Both closed files had a Child Group Evaluation Form.	
SNAP for Schools & Communities							
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
All cycles conducted outside of the school setting is reviewed by the Florida Network prior to the facilitation of services.			X			All cycles reviewed were conducted in a school. There were three different classrooms reviewed.	
Each classroom or community setting group session has the following: a. a minimum of 45 minutes in length b. children ages 6-11 years of age with a minimum of five (5) children present c. one trained SNAP facilitator as well as a teacher or community facilitator in each session.	X					Each session reviewed was 45 minutes long; children were between the ages of 6-11; there were more than 5 children present for each session; there was a SNAP facilitator and teacher present for each session.	

Weekly attendance sheet with youth names and/or identifying number completed with signatures of teacher and facilitator(s) (For a total of 13 attendance sheets)	X					All 13 weekly attendance sheets were present with youth names, and teacher and facilitator signatures.	
"Class Goal" sheet		X				"Class Shoot for Your Goal" sheet was completed for one class.	Exception: "Class Shoot for Your Goal" sheet was not found for the other two classes reviewed.
Measure of Classroom Environment (MoCE) (Pre and Post) is used to identify baseline and treatment outcomes of reported classroom dynamics.		X				There were three different classrooms reviewed.	Exception: None of the three classes reviewed documented a pre or post MoCE was completed.
Pre and Post Evaluations		X				All three classes had a pre evaluation for the youth. Two of the three classes had a pre evaluation for the teacher.	Exceptions: One of the classes did not have a pre-evaluation for the teacher. None of the three classes had a post evaluation for the youth or teachers.
One SNAP® Fidelity Adherence Checklist completed per classroom in a 13 – week SNAP in Schools group and uploaded to Dropbox	X					There was one Fidelity Adherence Checklist completed for each class.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.01						**YES** If NO, explain here: The program has seven policies relating to Shelter Environment. The seven policies include 3-6 Daily Schedule, 3-7 Faith Based Opportunities, 3-9 Linens, 3-14 Shelter Environment, Cleanliness, and Maintenance, 3-15 Food Services, 3-30 Sleeping Rooms, and 4-1 Emergency Drills. The policies were last reviewed in September 2021 and signed by the Chief Executive Officer.	
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. All bathrooms and shower areas were clean and functional by the end of the review. There was no graffiti observed. Lighting is adequate. Exterior areas are free of debris. The grounds were free of hazards by the end of the review. 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. Each youth has their own bed with clean linens. Health Department Group Care Inspection was completed on January 13, 2021. The staff did not have the ability to test the emergency back up lighting without the aid of Maintenance and a fire drill was initiated in communication with the Fire Department to complete testing.	Limited Exceptions: During the shelter tour, the following was initially observed and updated during the review: two first aid kits in two vans contained expired items which were replaced. Two van key chains (that held the multipurpose tool, seatbelt cutter, window punch, and flashlight) were initially missing and located. One van had exposed metal inside and a piece of metal inside the van. The metal was part of the seating that was clipped back into the seat and covered. Mildew in the boy's bathroom was noted and cleaned. The Chemical Closet inventory list did not reflect the current chemical supplies and was updated. One bedroom had an exposed curtain cord which was taken out.
Additional Facility Inspection Narrative (if applicable)							

Fire and Safety Health Hazards		X				Fire Inspections (Bldg. A, B, C) were completed on 1/15/21, Fire Safety Equipment Inspections (Bldg. A, B, C) were completed on 11/9/21, Fire Sprinkler inspection was completed on 11/9/21, Alarm System inspection was completed on 11/24/20, and Kitchen hood inspection was completed on 11/5/21 and 11/9/21. At least one fire drill was completed monthly on each shift since May 2021. Mock Drills were also completed monthly and each shift was reviewed for quarterly compliance. Menus were posted and signed by a licensed dietician. The Food Service Inspection was completed through the Health Department Group Care Inspection on 1/13/21 and no violations were observed at the time of inspection.	Limited Exception: Two fire extinguishers in Bldg. A and Bldg. C did not pass inspection. Confirmation was received that the fire extinguishers were replaced on 11/18/21 during this review.
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					The daily schedule reveals that youth are engaged in meaningful, structured activities seven days a week. The schedule also provides for at least one hour of physical activity. Youth are given the opportunity to participate in faith based activities with non-punitive activities offered for those who choose not to participate. Youth are given the time to do homework and read appropriate program approved books. The daily schedule is publicly posted and accessible to staff and youth.	

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: A policy is in place titled 3-12 Orientation. The policy was last reviewed in September 2021 and signed by the Chief Executive Officer.	
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					Orientation checklists were completed in all five files, covered required elements, and signed by the youth and staff.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.03						**YES** If NO, explain here: A policy is in place titled 3-5 Classification. The policy was last reviewed in September 2021 and signed by the Chief Executive Officer.	
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					Five shelter files were reviewed, two open and three closed. The Client Room Assignment section on the admission form was completed in all five files and documented all required information.	

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					Reviewed the Admission Forms for the five shelter files. Alerts for the youth were documented on the intake forms in all five files.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.04						**YES** A policy is in place titled 3-28 Log Book. The policy was last reviewed in September 2021 and signed by the Chief Executive Officer.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Log book entries that could impact the security and safety of the youth and/or program are highlighted	X					The Program utilizes the Electronic Log Book. Entries that impacted the safety and security of the youth or program were observed to be highlighted.	
All entries are brief, legibly written in ink and include: • Date and time of the incident, event or activity • Names of youth and staff involved • Brief statement providing pertinent information • Name and signature of person making the entry	X					Logbook entries were reviewed for the first week of May 2021, third week of June 2021, fourth week of July 2021, first week of August 2021, second week of September 2021, and second week of October 2021. Entries included all the required elements.	
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					Errors were observed to be struck through with a single line and initialed.	
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				For logbook entries reviewed from July through October 2021,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.	Exception: For logbook entries reviewed for May and June 2021, there was not a weekly review of the logbook by the Program Director or Designee.

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				In the logbook entries reviewed there was documentation staff reviewed the logbook for at least the previous two shifts and made a signed and dated entry into the logbook.	Exception: Staff do not always indicate the dates reviewed.
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				In the logbook entries reviewed there was documentation Supervisors and Shelter Counselors reviewed the logbook of all previous shifts and made a signed and dated entry into the logbook.	Exception: Supervisors and Counselors do not always indicate the dates reviewed.
Logbook entries include: a. Supervision and resident counts b. Visitation and home visits	X					Entries were observed for counts, visitation, and home visits.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.05						**YES** If NO, explain here: A policy is in place titled 3-2 Behavior Management/Motivation System. The policy was last reviewed on September 2021 and signed by the Chief Executive Officer.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
The program has a detailed written description of the BMS, and it is explained during program orientation	X					The Program utilizes the Crosswinds Behavior Model based on the Girls and Boys Town Model. The program has a written description of the behavior management plan designed to promote positive youth behavior, accountability, and social responsibility that includes positive incentives to encourage participation. The behavior management system is outlined in the Youth Handbook and in the intake paperwork.	
Behavior Management Strategies MUST include:						All Direct Care staff must achieve 40 hours of competency in the BMS within one year and are	

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 h. Youth should never be denied basic rights such as meals, clothing, sleep, services, exercise, or correspondence privileges	X					provided an overview of the model by Supervisory staff who provide continuous guidance and training in behavior change techniques and teaching strategies to ensure the least restrictive alternative to change behavior. The program uses a motivation system called the Assessment System where the youth use a point card, earning points for appropriate behaviors and losing points for inappropriate behaviors and forfeiting privileges if they fall into negative total points until they are able to earn enough points to get back to zero or above. The goal is to continue to promote positive behaviors by encouraging the youth to earn points and move to the Achievement System, the least restrictive Motivation System in the shelter. Counseling, verbal intervention and de-escalation techniques are used prior to physical intervention which is only used as a last resort in emergency or crisis situations to protect youth from harming themselves or others. The System does not allow for group discipline, room restriction, and does not deny the youth of basic rights.	
Program's Use of the BMS							
All staff are trained in the theory and practice of administering BMS rewards and consequences	X					Four training files for new hires were reviewed and documented the staff are receiving ongoing training on the program's BMS.	

There is a protocol for providing feedback and evaluation of staff regarding their use of BMS rewards and consequences	X					Reviewed policy 3-2 Behavior Management Motivation System.	
Supervisors are trained to monitor the use of rewards and consequences by their staff	X					Supervisors are trained to monitor the use of rewards and consequences by their staff.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.06						**YES** If NO, explain here: A policy is in place titled 3-19 Staffing and Youth Supervision. The policy was last reviewed in September 2021 and signed by the Chief Executive Officer.	
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					There were five random samples of video surveillance reviewed, Oct. 20, 2021 12-1 a.m., Oct. 26, 2021 2-3 a.m., Oct. 30, 2021 4-5 a.m., Nov. 5, 2021 1-2 a.m., and Nov. 14, 2021 3-4 a.m. A review of the above video surveillance sample, staff schedules, and log book entries documented the required staffing ratios were met for awake hours and sleeping hours.	
All shifts must always provide a minimum of two staff present	X					The random sample above, log book entries, and staff schedules documented two staff were present on these overnight and day shifts.	
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 program staff are background screened and properly trained.	
The staff schedule is provided to staff or posted in a place visible to staff	X					The schedule was observed posted and visible to staff.	

There is a holdover or overtime rotation roster which includes the telephone numbers of staff who may be accessed when additional coverage is needed	X					The program contains a holdover and overtime roster with staff names and numbers.	
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					With the random sample above, youth were observed sleeping in their rooms by staff every 15 minutes. Observations were noted in both the boys and girls halls.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.07						**YES** If NO, explain here: A policy is in place titled 5-14 Video Surveillance. The policy was last reviewed in September 2021 and signed by the Chief Executive Officer.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Surveillance System							
The agency, at a minimum, shall demonstrate: a. A written notice that is conspicuously posted on the premises for the purpose of security b. System can capture and retain video photographic images which must be stored for a minimum of 30 days c. System can record date, time, and location; maintain resolution that enables facial recognition d. Back-up capabilities consist of cameras' ability to operate during a power outage e. Have cameras placed in interior and exterior general locations of the shelter where youth and staff congregate and where visitors enter and exit. Cameras are never placed in bathrooms or sleeping quarters.	X					The video surveillance system covers all the required elements for providing notice of surveillance, capturing and retaining photographic images for a minimum of 30 days, record date time, and location, maintain resolution that enables facial recognition, maintains back up capabilities, providing cameras in interior and exterior general locations of the shelters, and are visible. Cameras are never placed in bathrooms or sleeping quarters.	

f. All cameras are visible							
A list of designated personnel who can access the video surveillance system is maintained (includes off-site capability per personnel)?	X					A list of all designated personnel that can access the video surveillance was observed.	
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					A supervisory review of video is routinely conducted a minimum of once every 14 days and documented in the logbook. The review 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					Reviewed Policy 5-14 Video Surveillance.	
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 5-14 Video Surveillance indicates service orders will be made within 24 hours of discovery. The program had no service orders during this review period.	
Provider has a written policy and procedure that meets the requirement for Indicator 4.01						**YES** If NO, explain here: A policy is in place titled 3-17 Healthcare Admission Screening. The policy was last reviewed in September 2021 and signed by the Chief Executive Officer. □ □	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible**	**No Practice**	**Not Applicable**		

Rating Criteria	Satisfactory	Non-compliant	Items for Review	Not 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					All five shelter files reviewed contained the CINS/FINS Intake Screening completed on the day of intake. Two of the five youth were taking medications at the time of the admission according to the intake screening. None of the youth were admitted with chronic medication conditions. One youth had a documented allergy and the allergy was documented on the Client Special Need/Meal document. The program used a COVID-19 screening form to delineate if youth had any acute health symptoms requiring quarantine or isolation.	
Referral and Follow-up							
Youth with chronic medical conditions have a referral to ensure medical care (e.g. diabetes, pregnancy, seizure disorder, cardiac disorders, asthma, tuberculosis, hemophilia, head injuries, etc.)			X			None of the youth were admitted with chronic medical conditions. There had been no youth admitted with chronic conditions since the last review.	
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.	

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 program has several policies addressing suicide prevention. Policy 4-12 is titled Suicide Prevention. The policy was last reviewed in September 2021. Policy 4-2 is titled Mental Health and Substance Abuse Emergency Care Plan – Prevention and Emergency Identification. The policy was last reviewed in September 2021. Policy 4-3 is titled Mental Health and Substance Abuse Emergency Care Plan – Level 1 Response – Mental Health and/or Substance Abuse. The policy was last reviewed in September 2021. Policy 4-4 is titled Mental Health and Substance Abuse Emergency Care Plan – Level 2 Response – Behavioral. The policy was last reviewed in September 2021. Policy 4-5 is titled Mental Health and Substance Abuse Emergency Care Plan – Documentation and Review. The policy was last reviewed in September 2021. Policy 4-14 is titled Suicide Prevention Plan – Identification. The policy was last reviewed in September 2021. All of the policies are signed by the Chief Executive Officer.	
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					Based on the results of the risk screening, all five youth were placed on sight-and-sound supervision until assessment by the LMHC.	
Staff person assigned to monitor youth documented youth's behavior at 30 minute or less intervals	X					The Suicide Precautions Observation Logs for all five youth were completed as required for the duration the youth was placed on constant supervision. Staff assigned to monitor the youth consistently documented the youth's behavior at thirty-minute intervals.	
Supervision level was not changed/reduced until a licensed professional or a non-licensed mental health professional under the supervision of a licensed professional completed a further assessment OR Baker Act by local law enforcement	X					All five youth received an Assessment of Suicide Risk (ASR) completed by the LMHC within the required timeframe. All five youth were maintained on constant supervision until the LMHC completed the ASR removing the youth from constant supervision and stepping the youth down to standard supervision.	
Provider has a written policy and procedure that meets the requirement for Indicator 4.03						**YES** If NO, explain here: The program has policy 4-7 titled Medication Storage Access, Inventories and Disposal. The policy was last reviewed in September 2021. The policy addresses inventory of medication, disposal, and reporting. The program also has policy 4-6 titled Medication Verification at Admission and Consent. The policy was last reviewed in September 2021. The policy addresses the four options staff should complete to verify medication brought to the shelter. The policies were signed by the Chief Executive Officer.	
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						During the tour of the program, the location of the Pyxis machine along with storage of medication was observed. There were no issues identified as a result of the tour. A list of staff authorized to assist in the delivery of medication was hung in the medication room. Observations made during the tour supported the program has a refrigerator designated for medication. Temperature requirements for the medication refrigerator were met.	

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						
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	X					A list of staff authorized to assist in the delivery of medication was hung in the medication room. The first three names on the list are the designated Super Users. Two of the five youth took medication while at the shelter. The Medication Distribution Record (MDR) for both youth were completed correctly. One youth refused to take her medication and the MDR and refusal form were completed as required. All medications were verified by calling the pharmacy. The program does not accept youth that are prescribed injectable medications. All staff have been trained in the use of epi-pens.	

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							
Medication Inventory							
a. For controlled substances, a perpetual inventory with running balances is maintained as well as a shift-to shift count verified by a witness and documented b. Over-the-counter medications that are accessed regularly are inventoried weekly by maintaining a perpetual inventory c. Syringes and sharps (needles, scissors, etc.) are secured, and counted and documented weekly	X					The program did not have any youth taking controlled substances during the review period. Over-the-counter (OTC) medication inventories were reviewed and documented. OTC's are inventoried perpetually and weekly by the RN. The Sharps inventory was reviewed. The inventory was completed on a weekly basis from May 2021 through November 8, 2021. The inventory included the number of sharp objects, items borrowed, and items disposed.	
There are monthly reviews of medication management practice via Knowledge Portal or Pyxis Med-Station Reports.	X					RN completes monthly reviews of medication management via the Knowledge Portal.	
Medication discrepancies are cleared after each shift.	X					At the time of the review there were no open discrepancies. Staff interviewed knew the procedures for closing out a discrepancy accurately.	
Provider has a written policy and procedure that meets the requirement for Indicator 4.04						**YES** If NO, explain here: The program has policy 4-11 titled Medical and Mental Health Alert Processes. The policy was last reviewed in September 2021. The policy was signed by the Chief Executive Officer.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		

Youth with a medical, mental health, or food allergy was appropriately placed on the program's alert system	X					Five shelter files were reviewed. The program uses a dot system, with color-coded dots corresponding with the different alerts. All files had the appropriate color-coded dots placed on the file.	
Alert system includes precautions concerning prescribed medications, medical/mental health conditions	X					Precautions were noted on Medication Distribution Logs and side effect sheets in the five files reviewed.	
Staff are provided sufficient training, information and instructions to recognize/respond to the need for emergency care for medical/mental health problems	X					Seven staff training files were reviewed. All 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					Program uses a color-coded dot system to identify alerts. Intake and Assessment Forms are maintained in the youth's file and document all alerts and the reasons for the alerts. Then the applicable color-coded dots are placed on the youth's file. The applicable color-coded dots are also placed next to the youth's name on the census board in the shelter.	
Provider has a written policy and procedure that meets the requirement for Indicator 4.05						**YES** If NO, explain here: The program has policy 4-9 titled Episodic/Emergency Care. The policy was last reviewed in September 2021. The policy was signed by the Chief Executive Officer.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Off-site Emergency Services							
a. If off-site emergency medical or dental care was provided, an incident report was submitted for the medical or dental care b. Upon youth return, there is a verification receipt of medical clearance via discharge instructions with follow-up is present in file c. Youth's parent/guardian was notified			X			There were no youth requiring off-site emergency medical care since the last review.	

d. A daily log is maintained for 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 seven staff training files confirmed this.	
The program has a Knife-for-life and wire cutters accessible to staff in a secure location(s)	X					During the on-site tour knife-for-life and wire cutters were observed.	
First aid kit/supplies are fully equipped and inventoried	X					During the on-site tour first aid kits in the shelter were observed to be fully stocked and inventoried.	