FLORIDA NETWORK
of youth and family services

Florida Network for Youth and Family Services
Compliance Monitoring Report for

Florida Keys Children Shelter
Jelsema Shelter

73 High Point Road
Tavernier, FL 33070

Compliance Monitoring Services Provided by

FOREFRONT

EXECUTIVE SUMMARY

Forefront LLC conducted a joint Quality Improvement (QI) and Florida Network of Youth and Family Services (FNYFS) monitoring visit for the Florida Keys Children's Shelter (FKCS) for the FY 2021-2022 at its program office located at 73 Highpoint Road, Tavernier, 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. FKCS 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 2020 through June 30, 2022.

The review was conducted by Marcia Tavares, Consultant for Forefront LLC, and Peer Reviewer(s). Agency representatives from FKCS present for the entrance interview were Ben Kemmer, CEO; Alvin Bentley, COO; Nathaly Milla, Residential Coordinator; Katherine Raskob, Counseling Services Coordinator; Karen Martinez, Staff Assistant Coordinator; Katya Andrade, Office Manager; and counseling staff for the residential and community counseling programs. The last QI visit was conducted on January 20-21, 2021.

In general, the Reviewer found that the FKCS is in compliance with specific contract requirements. **FKCS received an overall compliance rating of 100% for achieving full compliance with all eleven (11) applicable indicators** of the CINS/FINS Monitoring Tool. There are no corrective actions cited or recommendations made as a result of the contract monitoring visit.

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

2021-2022 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 11-03-2021-2022

Agency Name: Florida Keys Children Shelter	**Monitor Name: Marcia Tavares, Lead Reviewer**
Contract Type: CINS/FINS	**Region/Office: 73 High Point Rd., Tavernier, FL 33070**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): November 3-4, 2021**

Major Programmatic Requirements	**Explain Rating**					**Ratings Based Upon:** **I = Interview** **O = Observation** **D = Documentation** **PTV = Submitted Prior To Visit** **(List Who and What)**	**Notes** **Explain Unacceptable or Conditionally Acceptable:** **(Attach Supportive Documentation)**
	Unacceptable	**Conditionally Unacceptable**	**Fully Met**	**Exceeded**	**Not Applicable**		
I. Administrative and Fiscal							
DJJ Quality Improvement Peer Reviewer a. Provider shall demonstrate that a minimum of two (2) staff members have been trained to be certified as DJJ QI Peer reviewers. Provider shall participate in a minimum of one (1) on-site quality assurance review of a similar type program in another judicial circuit during each 12-month period of the contract, if requested.	☐	☐	☒	☐	☐	The provider currently has seven certified DJJ-QI Peer Reviewers: Ben Kemmer, Alvin Bentley, Katherine Raskob, Paivi Johnson, Erin Flannery, Nathaly Milla, and Karen Martinez. Ms. Johnson has already participated in a QI Review for the FY 2021-2022 and additional staff is also scheduled to participate prior to the end of the FY.	
Additional Contracts a. Provider shall provide a listing of all current federal, state, or local government contracts, as well as other contracts entered into with for profit and not-for-profit organizations. Such listing shall identify the awarding entity and contract start & end dates. **PTV**	☐	☐	☒	☐	☐	Documentation: A list of fourteen additional contracts for FY2021-2022 was provided for funding from federal, state, and county government. The provider receives funding from DCF (for residential/group home services), DHHS-Basic Center grant, DHHS-Street Outreach grant, Monroe County, State of Florida Nutrition, Sheriff Shared Asset, All Stars Program, Guidance Clinic, City of Key West, Keys Children's Foundation, Katherine Wells Foundation, ORC	

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						Foundation, Community Foundation, and Helen's Hope Foundation. The listing includes name of program, description of services, amount funded, source, and date. The program also maintains interagency agreements and Memorandums of Agreement (MOUs) with schools, mental health, and substance abuse providers. All of the agreements reviewed were active.	
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	☐	☐	☒	☐	☐	Documentation: General Liability through Harleysville Insurance Company, for limits of coverage $1,000,000 each $3,000,000 aggregate, $100,000 damage to rented premises, and $5,000 medical expense any one person. The policy is effective 3/1/21-3/1/22. Workers Compensation through Ascendant Commercial Insurance Company with limits of $1,000,000 each and $1,000,000 policy limit, effective for 4/30/21 through 4/30/2022.	

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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**						Automobile insurance through Harleysville Insurance Company, for combined limits of liability for $1,000,000 and $5,000 medical payments. Policy effective for 3/1/21-3/1/22. Florida Network is listed on the Insurance Certificate as certificate holder.	
External/Outside Contract Compliance a. Provider has corrective action item(s) cited by an external funding source (Fiscal or Non-Fiscal). **ON SITE**	☐	☐	☐	☐	☒	During the Entrance Conference, the provider indicated that there are no outstanding corrective action item(s) cited by any external funding sources.	
Fiscal Practice a. Agency must have employee and fiscal policy/procedures manuals that are in compliance with GAAP and provide sound internal controls. Agency maintains fiscal files that are audit ready. **PTV**	☐	☐	☒	☐	☐	Documentation: Fiscal Policies and Procedures are contained in the agency's Accounting Policy and Procedures Manual with a review date of May 2, 2019. The procedures reviewed appear to be consistent with GAAP and provide for limited internal controls. Procedures are included for: general accounting procedures including general ledger and computer back-up; cash management procedures: accounts receivable;	

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						payroll; property, plant, and equipment procedures; accounts payable; procedures for liability; and management reporting.	
b. Agency maintains a general ledger and the corresponding source documents. General ledger must be set up to track the activity of the grant separately (standard account numbers / separate funds for each revenue source, etc.). **PTV**	☐	☐	☒	☐	☐	Documentation: Detailed General Ledger for the current FY, for the period July – September 30, 2021. The agency maintains a detailed general ledger that is structured to track all funding sources as well as activities for the CINS/FINS program. The GL includes the following items: type of transaction, date, account number, name, memo, split, amount, and balance.	
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**	☐	☐	☒	☐	☐	Documentation: Reviewed petty cash Policy and Procedure 2.03 which is included in the Fiscal Policies and Procedures manual. The fund which does not exceed $300 is utilized for purchases under $50 unless approval is granted by Management. Petty cash is stored in a safe in the Residential Coordinator's office. The fund is reconciled weekly and submitted to the Executive Administrative	

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	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable		
						Assistant/Human Resources for refunding. Disbursements and invoices are approved by the residential program coordinator.	
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**	☐	☐	☒	☐	☐	Reviewed Bank Statements and Bank Reconciliations for April - September 2021 for the program's Operating account and Cash/Bank Savings account held with Centenial Bank. Bank reconciliations are conducted by the Finance Manager each month for the activities and bank statements for the preceding month. The bank statements were all found to be reconciled consistently within six weeks of receipt and were signed by the CEO and COO. Financial Statements are reported monthly and were found to be current. Checks disbursed are signed by two designees. Invoices are submitted monthly with supporting documentation. The agency maintains individual vendor files which are kept in secure file cabinets in the Executive Admin Assistant's office.	

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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**	☐	☐	☐	☐	☒	**Not applicable** No DJJ inventory	
f. Agency submits payroll taxes and deposits (and retirement deposits as applicable), Employee IRS Form W-2 and Independent Contractors IRS Form 1099 forms prior to federal requirements. **ON SITE**	☐	☐	☒	☐	☐	Documentation: Provider contracts with ADP for its payroll services. Electronic filings of the 1099 Tax Return and 941s are conducted by ADP. The most recent 941 filings for the 1st and 2nd quarters of 2021 were reviewed. The 941 reports demonstrate that the provider is submitting its payroll taxes as required in a timely manner with no balances due indicated on the returns.	
g. Budget to actual reports prepared and reviewed by appropriate management. Variance from the budget are investigated and explained. **PTV/ON SITE**	☐	☐	☒	☐	☐	Documentation: Agency's Budget vs Actual report for the current FY to date was reviewed. The reports demonstrate that the provider tracks budget variances for the CINS/FINS program separately on a monthly basis. Variance to date indicates a net income in the program. Financial reports are sent to the Board Treasurer monthly for review and the	

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	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable		
						CEO/Finance Manager presents the same at the agency's Board meetings. Meeting minutes and agendas demonstrate this practice.	
h. A Single Audit is performed as part of the annual audit if expenses are greater than $750,000. The agency must submit a Corrective Action Plan for findings cited in the management letter and single audit. An annual financial audit was completed within 120 days after the previous fiscal year/calendar year and that a copy was provided to the Network unless and extension has been requested and approved in writing. Copy of Audit is submitted to the FNYFS by December 31st. **Obtain from FNYFS**	☐	☐	☒	☐	☐	Documentation: The most recent completed Financial Audit was reviewed. Accounting firm, Verdeja, DeArmas, Trujillo issued a letter on 12/18/20 stating they reviewed the provider's accounting policies and found them to be adequate. The financial audit was completed for the year ending 6/30/2020 and 2019. The audit disclosed no matters that are reportable for the current year. A copy of the financial audit is on file with the Reviewer.	
i. Agency maintains confidentiality policy with written policies and procedures to ensure the security and privacy of all employee and client data. Personal information is not easily accessible. Agency maintains a backup system in case of accidental loss of financial information. Security procedures are in place to protect laptops. Obsolete documents are shredded and computer hard drives are wiped prior to discarding. **ON SITE**	☐	☐	☒	☐	☐	Documentation: Policy and Procedure number: 1.17 (Confidentiality-HIPAA), E.2 (Confidentiality), 1.04 (Computer Back-Up), and 8.04 (Record Retention) were reviewed. Daily back-ups are made to keep data back-up current and monthly offsite storage of	

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	Explain Rating						
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						the back-up disk is maintained by the CFO during ordinary circumstances.	

CONCLUSION

FKCS has met the requirements for the CINS/FINS contract as a result of full compliance with all eleven (11) applicable indicators of the Administrative and Fiscal Contract Monitoring Tool. Two (2) of the thirteen (13) indicators were not applicable because: 1) the provider does not have any outstanding corrective action item(s) cited by any external funding sources, and 2) the agency does not have any program inventory or recent computer purchases made with DJJ funds. Consequently, t**he overall compliance rate for this contract monitoring visit is 100%.** There are no corrective actions cited or recommendations made as a result of the contract monitoring visit. Overall, the provider is performing satisfactorily in meeting the fiscal and administrative terms of its contract. In addition, the majority of indicators reviewed were carried out in a manner which meets the standard as described in the report findings.

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

Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Florida Keys Children's Shelter - Tavernier
CINS/FINS Program

November 3-4, 2021

Compliance Monitoring Services Provided by

FOREFRONT

CINS/FINS Rating Profile

Standard 1: Management Accountability

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

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

Standard 2: Intervention and Case Management

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

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

Standard 3: Shelter Care & Special Populations

3.01 Shelter Environment	Satisfactory
3.02 Program Orientation	Satisfactory
3.03 Room Assignment	Satisfactory
3.04 Log Books	Satisfactory
3.05 Behavior Management Strategies	Satisfactory
3.06 Staffing and Youth Supervision	Limited
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: 96.55 %
Percent of indicators rated Limited: 3.45 %
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

Marcia Tavares - Lead Reviewer Consultant-Forefront LLC/Florida Network of Youth and Family Services
Christine Calvert – Regional Monitor, Department of Juvenile Justice
Tiffany Martin – Florida Network of Youth and Family Services
Rebecca Montrose – Lutheran Services Florida Southwest
Terence Washington II – Prevention Central

Methodology

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

Persons Interviewed

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

Documents Reviewed

	Accreditation Reports	X	Table of Organization		Visitation Logs
X	Affidavit of Good Moral Character	X	Fire Prevention Plan	X	Youth Handbook
X	CCC Reports	X	Grievance Process/Records	5	# Health Records
X	Logbooks		Key Control Log	5	# MH/SA Records
X	Continuity of Operation Plan	X	Fire Drill Log	9	# Personnel /Volunteer Records
X	Contract Monitoring Reports	X	Medical and Mental Health Alerts	7	# Training Records
	Contract Scope of Services	X	Precautionary Observation Logs	17	# Youth Records (Closed)
X	Egress Plans	X	Program Schedules	8	# Youth Records (Open)
X	Fire Inspection Report	X	List of Supplemental Contracts		# Other: ___
	Exposure Control Plan		Vehicle Inspection Reports		

Observations During Review

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

Florida Keys Children's Shelter (FKCS) contracts with the Florida Network to operate the Child in Need of Services and Family in Need of Services (CINS/FINS) program in Monroe County, Florida. The program is located at the Tavernier's Jelsema Center, at the north-end of the county next to the Tavernier Government Center. Funding through CINS/FINS allows the agency to serve both male and female youth up to seventeen years old that are locked out, runaway, ungovernable and/or truant, homeless, abuse, neglected, or at-risk. The agency also provides services to special populations who meet the criteria for Staff Secure shelter, Domestic Minor Sex Trafficking, and youth referred by the Juvenile Justice Court System for domestic violence, probation respite, and Family/Youth Respite Aftercare Services (FYRAC). FKCS is not contracted to provide Intensive Case Management (ICM) services or SNAP.

In addition to the CINS/FINS Program, the agency operates the Poinciana Emergency Shelter (birth through 10 years) and Poinciana Group Home (11-17 years old) in Key West, for children who have been removed from their families/homes as a result of abuse or neglect. It also provides street outreach through Project Lighthouse where staff conducts outreach in areas where homeless youth congregate with the goal of getting these youth help and providing a safe shelter.

FKCS is currently accredited by the Council of Accreditation (COA) and was recently re-accredited through July 31, 2024. The Council on Accreditation (COA) partners with human service organizations worldwide to improve service delivery outcomes by developing, applying, and promoting accreditation standards.

Notably, the Florida Keys Children's Shelter has enhanced its residential and community outreach teams:
• New Residential Program Specialist – Karen Martinez (BSW), is a recent addition to FKCS and works closely with the team of youth support staff. With a bachelor's degree in Social Work from Florida International University, she has created a lifestyle of fulfilling service in a variety of capacities.
• New Residential Coordinator – Nathaly Milla joined FKCS in July and leads the team of youth support staff. With a bachelor's degree in International Relations from Florida International University, she possesses outstanding leadership skills, is innovative, flexible, and team oriented.
• New Community-Based Counselor – Kim Youngblood, also joined the FKCS team at the beginning of the summer. She has a Bachelor of Science degree in Human Resource Management from Wilmington College in Ohio and brings over 10 years of successful experience in leadership, training and volunteering with Upper Keys youth and their families.

Also of note, the Florida Keys Children's Shelter enriched its administrative team and bid farewell to their student executive board member:
• New Grant Writer – Baldwin Davis, came on board in June to a newly-created position, focusing solely on strategic grant exploration and fulfillment. He was awarded his Master of Arts from Southbank University in London and brings a wealth of knowledge, credentials, skills, and experience to the FKCS Team.
• FKCS Board Member Departure – Mary Ryder has graduated from high school and will now move on to her university studies in Gainesville, Florida. The agency was thrilled to have had her as part of the team

wish her much success in her college endeavors. They are currently seeking a student to replace Mary's seat on the executive board.

The fully launched residential coaching program, with the continuation of three critical coaching positions - Life Skills, Education, and Recreation – remains truly effective, even with the added challenges posed by the ongoing COVID-19 pandemic. All current and future coaches have college degrees and specific expertise that empower the organization to better support the youth who live there. With the retention of our higher pay scale, FKCS has recruited these qualified professionals on their team long-term with the support of one of our largest funders, the Ocean Reef Community Foundation, who once again granted $50,000 to aid the third year of this coaching program.

Narrative Summary

FKCS is located at 73 High Point Rd, Tavernier, FL. The agency has an eleven-member Board of Directors/Trustees with representatives from the upper, middle, and lower Keys, to oversee the agency's goals, objectives, and activities. The FKCS building houses the CINS/FINS shelter on the first floor and the agency's administrative offices on the second floor. The shelter provides separate female and male dormitories to children under 18 years of age that are locked out, runaway, ungovernable and/or truant, homeless, abuse, neglected, or at risk.

The program has a Senior Management team that is comprised of a Chief Executive Officer, Chief Operating Officer (COO), Financial Manager, Counseling Services Coordinator, Residential Program Coordinator, and Office Manager. At the time of the onsite QI review, there were three staff vacancies reported.

The overall findings for the QI Review for AGENCY/PROGRAM NAME are summarized as follows:

Standard 1 has a total of seven indicators regarding Management Accountability. Six of the seven indicators in Standard 1 were rated satisfactory with no exceptions (1.01, 1.02, 1.03, 1.05, 1.06, and 1.07) and one (1.04) was rated satisfactory with exceptions.

Standard 2 has a total of ten indicators that relate to intervention and case management. One of the indicators – SNAP is not applicable as FKCS is not currently a SNAP provider. Six of the nine applicable indicators were rated satisfactory with no exceptions (2.01, 2.02, 2.04, 2.06, 2.07, and 2.08), and three were rated satisfactory with exceptions (2.03, 2.05, and 2.09).

Standard 3 has a total of seven indicators regarding shelter care. Five of the seven indicators were rated satisfactory with no exceptions (3.01, 3.02, 3.03, 3.05, and 3.07), one was rated satisfactory with exception (3.04), and one was rated Limited (3.06).

Standard 4, Mental Health and Health Services, is comprised of five indicators. All five indicators were rated satisfactory with no exceptions (4.01 - 4.05).

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

Standard 3:
Indicator 3.06 – Limited

After reviewing the video surveillance system, it was observed that on November 1st , one of the five random dates selected, bed checks were conducted every 15 minutes for the male rooms. However, there was one (1) missed female bed check not conducted by the female staff. Staff documented in logbook on November 1, 2021, that the bed check for 4:00am was conducted but after the review of the surveillance camera, it was observed the bed check was not conducted. The incident was reported to CCC and report was accepted.

CINS/FINS QUALITY IMPROVEMENT TOOL

Quality Improvement Indicators:	Satisfactory (S)	Non-compliant (E)	No Eligible Items for Review (N)	No Practice (NP)	Not Applicable (N/A)	Review Based Upon Document Source	Notes Explain any items that have any deficiencies, exceptions or are not applicable.
Standard One – Management Accountability							
1.01: Background Screening (BS) and compliance with DJJ OIG statewide procedures regarding BS of employees, contractors and volunteers							
Provider has a written policy and procedure that meets the requirement for Indicator 1.01						**YES** If NO, explain here: The provider's policy number 1.12 was last approved on 8/20/21 by the Chief Executive Officer (CEO) and Chief Operations Officer (COO).	
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					Since January 2019, FKCS has utilized a self-created pre-employment suitability questionnaire screening tool that has a pass rate of 70% and includes 11 questions, one of which is a bonus question. The tool was used to evaluate five new staff hired during the review period; all five staff met or exceeded the pass rate.	
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					A total of nine background screening files were reviewed for five new hires and four staff who met the criteria for 5-year background re-screening. The agency did not have any eligible volunteers or interns during the review period. The five new hire personnel had timely DJJ background screenings completed prior to their hire/start dates.	
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			None of the new employees hired were prior employees with a break in service less than 90 days with the agency.	
Five-year re-screening completed every 5 years from initial date of hire	X					Four applicable staff with 5-year re-screenings were found to maintain valid retained prints on file with the Clearing House.	

Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?	X					The provider submitted its Annual Affidavit of Compliance with Level 2 Screening Standards on December 23, 2020 prior to the January 31, 2021 deadline.	
Proof of E-Verify for all new employees obtained from the Department of Homeland Security	X					The program provided E-verify documentation for all five new staff, verifying authorization to work.	
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 provider has multiple policies and procedures as follows: Code of Conduct; Abuse Reporting policies #1.07.01 to 1.07.03; and Grievance Process #3.22. The policies were approved by the CEO and COO on 8/30/21.	
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 Code of Conduct (policy E.1) is a part of the agency's personnel policy and procedures and is signed and dated by each employee during their initial orientation.	
Child Abuse Registry telephone number is visible to youth and posted common areas of the facility	X					Observation during onsite tour of the facility revealed posted Abuse Hotline numbers in the administration offices, in the dormitory hallways, dining room, and in all common areas of the shelter. The number is also included in the Residential Handbook which is provided to all clients upon admission.	
Youth were informed of the Abuse and Contact Number (see youth survey results)	X					Six youth were provided a survey. All youth stated the abuse hotline is available for them to report abuse at the shelter. Youth also stated they are able to show or tell someone where this number is located.	
Management takes immediate action to address any incidents of threats or abuse			X			No incident of threats or abuse by staff requiring management action was reported by Human Resources or the program managers interviewed during the visit.	
Grievance Process							
Agency has a formal grievance process	X					The agency has a formal grievance process, policy # 3.22.	

Locked box accessible to only management and available to youth in a common area	X					Each wing of the shelter (boys and girls) has grievance forms and grievance box accessible to youth to complete a grievance. The grievance policy is posted on a board in the common lounge area along with rules and behavior management system.	
Direct care does not handle the complaint/grievance unless assistance is asked for by the youth. Program director/supervisor will have access to and manage grievances unless it is towards themselves.	X					The residential coordinator has possession of the keys to the grievance boxes. Supervisor and manager manage grievances according to agency policy and practice and direct care staff do not handle the grievances.	
72-hour resolution requirement by management. If this does NOT occur within the 72 hour period, there is sufficient documentation explaining the cause for the delay in resolution.	X					There were only two grievances for the review period. One was completed right after the other. Both were resolved in less than 72 hours. Neither grievance had the youth signature as it was noted on the grievance that the youth ran away prior to signing.	
1.03: Incident Reporting							
Provider has a written policy and procedure that meets the requirement for Indicator 1.03						**YES** If NO, explain here: The provider's policy and procedure 1.13 was approved on 8/30/21 by the CEO and COO.	
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					There were a total of twenty CCC reports reviewed for this review period. All reports were called into CCC within 2 hours of discovery of the incident. There is a finding that did not result in an exception as one incident did not have the call time to CCC documented on the agency CCC incident report form; however, the reporting time was listed on the DJJ incident report and in the program's logbook.	
The program completes follow-up communication tasks/special instructions as required by the CCC	X					According to emails, CCC Incident forms, and CCC final reports agency consistently completes follow up tasks/ special instructions.	
Incidents are documented in the program logs and on incident reporting forms	X					All incidents were documented on the program incident reporting forms.	

All incident reports are reviewed and signed by program supervisors/directors	X					All incident reports were reviewed and signed by a supervisor.	
1.04: Training Requirements (Staff receives training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions)							
Provider has a written policy and procedure that meets the requirement for Indicator 1.04						**YES** If NO, explain here: The provider's policy and procedures for Training Requirements #5.01 was reviewed and approved by CEO/COO on 8/30/21.	
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				Four new hire training records were reviewed for training compliance. Three files have the USDOJ Civil Rights training completed with 30 days of hire.	Exception: One training record did not have USDOJ training completed within 30 days of hire as required. The staff was hired in March 2021 but did not complete the training until June 2021.
All staff receives all mandatory training during the first 90 days of employment from date of hire.		X				Three files have all mandatory trainings during the first 90 days of hire.	Exception: One file did not demonstrate having CPR and First Aid completed during the first 90 days. The training was completed 5 months after hire.
Non-licensed Mental Health Clinical Shelter Staff (within first year of employment)							
Non-licensed mental health clinical shelter staff Assessment of Suicide Risk Training			X			The program did not hire any non-licensed mental health shelter staff during the review period.	

Documentation of non-licensed mental health clinical staff person's training in Assessment of Suicide Risk form or written confirmation by a licensed mental health professional of training (includes date, signature and license number of the licensed mental health professional supervisor).			X			No eligible staff during 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				Three direct care files were reviewed all files had a minimum of 40 hours of Florida Network, Skill Pro and job related training. However one staff did not meet the timeframe for completing PREA biennially.	Exception: One staff completed PREA on 10/15/21, five months after it was due. It should have been done by 5/8/2021.
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					All new hire and in service files that were reviewed include certificates, transcripts (Bridge & Skill Pro), sign in sheets, and agendas for supporting documentation.	
Provider has a written policy and procedure that meets the requirement for Indicator 1.05						**YES** If NO, explain here: The program has multiple policies and procedures to address the requirement of Indicator: Statistical Information #1.20; Case Record Review # 3.50; Service Satisfaction Questionnaires # 3.55; Outcome Goals #1.21; Incident Reporting # 1.13; and Risk Management and Internal Quality Monitoring # 1.23. All policies and procedures were reviewed and approved by the CEO and COO 8/30/2021.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		

Case record review reports demonstrate reviews are conducted quarterly, at a minimum	X					Case record reviews are conducted separately by the residential and community counseling programs. Quarterly case record reviews were held for the quarters April-June and July-September 2021. The residential program completed a total of 58 record reviews and community counseling program completed 38 record reviews during the two quarters reviewed.	
The program conducts reviews of incidents, accidents, and grievances quarterly, at a minimum	X					The executive leadership team conducts quarterly reviews of all issues regarding employee/client safety and risk management. Risk Prevention and Management (RPM) Quarterly Reports for April-June and July-September 2021 were reviewed. These reports include data for incidents, accidents and grievances and are also reviewed at monthly leadership meetings as well as monthly board meetings.	
The program conducts an annual review of customer satisfaction data	X					A review of the provider's survey results prepared for COA's annual report was completed for FY2021. Surveys were conducted for youth, personnel, consumers, stakeholders, staff, community, and advisory board.	
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					Outcomes data is reviewed monthly at leadership meetings as well as CBC staff meetings and occasionally at shelter staff meetings. Leadership meetings were held monthly during the past 6 months May - October 2021. Agendas and minutes for the leadership meetings include a discussion of quality improvement, outcomes, and safety; staff meetings include agenda items for outcomes, file review trends, program updates, and JJIS/NetMIS data reconciliation. As for the annual reconciliation, documentation shows the program completed the required reconciliation and received acknowledgement of completion via email from the Florida Network. Annual reconciliation is also reviewed as part of the end of the fiscal year leadership meeting where the report from Jennifer/Florida Network (June) is discussed re: errors/discrepancies, if any.	

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					NetMIS outcome data is reviewed monthly and is presented at the leadership meetings and CBC staff meetings. Data accuracy/data integrity is primarily the responsibility of a data team including the CEO, COO, Chief Learning and Evaluation Officer, and office manager. The office manager sends emails to the data team to confirm data check and accuracy prior to invoice uploads.	
The Florida Network conducts monthly reconciliation by comparing NetMIS data to JJIS data. Agency has evidence that they have reconciled any differences noted.	X					Upon receipt of the certification and LLOS reports from the Florida Network (FN), the COO sends emails to the data team when errors are identified on the reports. Email responses from the data team indicates the data is reconciled and COO sends a confirmation email to Jennifer at the Florida Network. Emails for the past 6 months from the COO to the FN demonstrated this practice. Additionally, the data reconciliation reports for the past two months did not show any records needing reconciliation.	
The program has a process in place to review and improve accuracy of data entry & collection	X					Data accuracy/data integrity is primarily the responsibility of a data team including the CEO, COO, Chief Learning and Evaluation Officer, and office manager. Data records identified from the reconciliation reports as needing reconciliation is communicated to the data team and confirmation of reconciliation is sent via email to the COO who responds to the FN.	
There is documentation that findings are regularly reviewed by management and communicated to staff and stakeholders.	X					A review of agendas and minutes for the RPM and leadership meetings as well as staff meetings held between April-September 2021 was conducted. The agenda and minutes for these meetings include a discussion of Florida Network data and/or data integrity and JJIS/NetMIS data reconciliation.	
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 CEO prepares performance data reports and attends monthly Board meetings to share this information with the Board of Directors.	

There is evidence that strengths and weaknesses are identified, improvements are implemented or modified, and staff are informed and involved throughout the process.	X					Documentation supported data collection and frequent meetings held by management to review and discuss findings and trends identified. It was also evident that this information was disseminated and communicated to staff and staff are involved in identifying and addressing areas needing improvement.	
Provider has a written policy and procedure that meets the requirement for Indicator 1.06						**NO** If NO, explain here: The current policy #10.03 does not explicitly prohibit transporting a client without maintaining at least one other passenger in the vehicle during the trip. The provider's policy and procedure #10.03 was last reviewed on 8/30/21 and approved by the CEO and COO.	
Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	X					Agency maintains a list of approved drivers.	
Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	X					Agency maintains a list of approved drivers that are covered under company insurance.	
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					There is a finding that did not result in an exception. Policy 10.03 states the best practice is to have a third party present in the vehicle while transporting client and reflects obtaining a supervisor's consent if a third party can not be present; however, the policy does not explicitly prohibit transporting a client without maintaining at least one other passenger in the vehicle during the trip.	
In the event that a 3rd party cannot be obtained for transport, the agency's supervisor or managerial personnel consider the clients' history, evaluation, and recent behavior	X					The agency's policy reflects in the event a 3rd party cannot be obtained for transport, the agency's supervisor or managerial personnel consider the clients' history, evaluation, and recent behavior. A review of travel logs from April and May of 2021 revealed single transport approval was documented in the logbook.	

The 3rd party an approved volunteer, intern, agency staff, or other youth	X					The agency policy reflects the 3rd party can be an approved volunteer, intern, agency staff, or other 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					There is a finding that did not result in an exception as there were 2 entries entered in the travel log with no date, although a date field is present. This travel was however listed in the logbook and dates for 4/25/21 with matching corresponding details. In May there were two entries that were missing dates in the travel log but that date was listed in the logbook.	
Provider has a written policy and procedure that meets the requirement for Indicator 1.07						**YES** If NO, explain here: The provider's policies and procedures 9.01 was reviewed and approved by CEO & COO on 08/30/21.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
The program has a lead staff member designated to participate in local DJJ board and council meetings with evidence that includes minutes of the event or other verification of staff participation	X					The program has several staff that attend and participate in local DJJ Board and council meetings with evidence that includes meeting sign-in sheets and agendas. The program submitted these supporting documents from the following meetings: Advisory Board Meetings, Monroe County Community Alliance Meeting, Upper & Middle Keys Interagency Meeting and Interagency Meeting.	
and families. Outreach and prevention services are provided by designated staff and include increasing community awareness, offering informational and educational CINS/FINS services to youth	X					Outreach and prevention services are provided by designated staff. This information is noted in NetMIS as evidenced by entries of outreach event.	
The program maintains written agreements with other community partners which include services provided and a comprehensive referral process.	X					Agency also has an array of MOU's with various agencies in the community.	
						YES If NO, explain here:	

Provider has a written policy and procedure that meets the requirement for Indicator 2.01						The agency has written policies 2.01 Initial Screening/ Assessment Process, 3.03 Program Services, 2.06 Orientation to the Program, and 3.22 Grievance Procedure. These policies were last reviewed and signed on August 30, 2021 by the CEO and COO.	
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				A total of five residential files (two open and three closed) were reviewed. All files were immediately screened for eligibility during intake. Three Secret Shopper calls were made to the agency and three screenings were completed. One of the three screenings was provided a response of acceptance into the program within 30 minutes of the call being made.	Exception: Two of the three screenings did not provide a response of acceptance into the program within 30 minutes of the call being made.
Community counseling: Eligibility screening is completed within 3 business days of referral by a trained staff using the NetMIS form	X					A total of five community youth files (two open and three closed) were reviewed. Four of the files were screened within 3 business days of referral. One file was completed after the required 3 business days, however attempts to contact family were documented in file.	
There is evidence all referrals for service is screened for eligibility and is logged in NetMIS within 72 hours of screening completion.		X				All five shelter youth files and five community counseling youth files contained documentation showing the screening being entered into NetMIS within 72 hours of completion. Additionally, three Secret Shopper calls were made to the agency. None of the three screenings resulting from the Secret Shopper calls were entered into NetMIS in 72 hours.	Exception: None of the three screenings resulting from the Secret Shopper calls were entered into NetMIS in 72 hours.
Youth and parents/guardians receive the following in writing: a. Available service options	X					All five shelter youth files and five community counseling youth files confirmed receipt of available service options and rights and responsibilities. Receipt was confirmed via signature or by verbal consent with case note documenting parent and youth receipt.	

b. Rights and responsibilities of youth and parents/guardians							
The following is also available to the youth and parents/guardians: a. Possible actions occurring through involvement with CINS/FINS services (case staffing committee, CINS petition, CINS adjudication) b. Grievance procedures	X					All five shelter youth files and five community youth files confirmed parent and youth received information regarding possible actions occurring through involvement with CINS/FINS services and grievance procedures. Receipt of information was confirmed by signature or by verbal consent with case note documenting parent and youth receipt.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.02						**YES** If NO, explain here: The agency has written policy 2.05, Needs Assessment, to address this indicator. This policy was last reviewed and signed on August 30, 2021 by the CEO and COO.	
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					A total of five residential files (two open and three closed) were reviewed. All files had a completed Needs Assessment 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					A total of five community youth files (three open and two closed) were reviewed. All files had a completed Needs Assessment within 2-3 face-to-face meeting.	
Needs Assessment is conducted by a bachelor's or master's level staff member	X					A total of five shelter youth files and five community counseling youth files were reviewed. All files had a Needs Assessment completed by a bachelor's or master's level staff.	
Needs Assessment includes a supervisor's review signature upon completion	X					All five shelter youth files and five community counseling youth files included a supervisor's review signature on the completed Needs Assessment.	
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					Four out of the five shelter youth files reviewed identified youth with elevated risk of suicide as a result of the Needs Assessment. None of the five community counseling youth files reviewed identified youth with elevated risk of suicide.	
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					All four of the youth identified with an elevated risk of suicide were referred for Assessment of Suicide Risk under the direct supervision of a licensed mental health provider.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.03						**YES** If NO, explain here: The agency has written policies 2.02 Service Plans, 2.03 Service Plan Implementation and Review, and 2.04 Revised Service Plans. These policies were reviewed and approved on August 30, 2021, signed by CEO and COO.	
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					All five shelter youth files and five community counseling youth files had a service plan developed within 7 days of Needs Assessment being completed.	
Case plan service Plan includes: 1. Individualized and prioritized need(s) and goal(s) identified by the Needs Assessment 2. Service type, frequency, location 3. Person(s) responsible 4. Target date(s) for completion and Actual completion date(s) 5. Signature of youth, parent/ guardian, counselor, and supervisor 6. Date the plan was initiated		X				All ten files reviewed had service plans individualized and prioritized needs and goals identified by Needs Assessment. All of the service plans had the following: service type, frequency, location, person responsible, target date for completion, actual completion date, and signature of counselor and supervisor. All service plans also had initiated dates listed on the plans. The five residential files were signed by the youth. Due to the pandemic, verbal consents were obtained from parents and documented in case notes. The five community counseling files had verbal consents obtained by youth and parent and were documented in the file case notes. Case notes clearly detailed the review of service plan with the parent and youth.	Exception: One of the five community counseling youth files is still in care and had a service plan target date as lapsed more than 60 days ago.

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				Three applicable shelter youth files and two out of four applicable community counseling youth files reviewed contained service plan reviews within required 30, 60, and 90 day timeframes. The service plan was reviewed with youth and parent and revised as needed. Files contained verbal consent documentation for parent signature.	Exception: Two of four applicable community counseling files did not have service plan reviews completed within the required 30, 60, and 90 day timeframes.
Provider has a written policy and procedure that meets the requirement for Indicator 2.04						**YES** If NO, explain here:	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**	The agency has written policies 3.01 - 24 Hour Agency Access, 3.02- Referrals, 3.03- Program Services, 3.04 - Exit Planning, Aftercare, and Follow Up, and 3.05 - Family Involvement. These policies were last reviewed and signed on August 30, 2021 by CEO and COO.	
Counselor/Case Manager is assigned	X					Five shelter youth files (two open, three closed) and five community counseling youth files (two open, three closed) were reviewed. Each of the files had an identified counselor assigned to the case.	
The Counselor/Case Manager completes the following as applicable: 1. Establishes referral needs and coordinates referrals to services based upon the on-going assessment of the youth's/family's problems and needs 2. Coordinates service plan implementation 3. Monitors youth's/family's progress in services 4. Provides support for families 5. Monitors out-of-home placement (if necessary) 6. Makes referrals to the case staffing to address problems and needs of the youth/family 7. Accompanies youth and parent/guardian to court hearings and related appointments 8. Refers the youth/family for additional services when appropriate 9. Provides case monitoring and reviews court orders	X					All ten files met the following requirements: Establishing/completing referrals based on needs and on-going assessment, coordinating service plan implementation, monitoring youth/family progress, providing support for families, case monitoring, case termination, and 30 and 60 day follow up when applicable.	

10. Provides case termination notes 11. Provides follow-up after 30 days of exit 12. Provides follow-up after 60 days of exit							
The program maintains written agreements with other community partners that include services provided and a comprehensive referral process	X					Written agreements were on file with community partners to assist in the referral process for the following services: education, substance abuse, health/medical, emergency shelter, homelessness, recreation, law enforcement, and mental health.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.05						**YES** If NO, explain here:	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable	The agency has written policies 1.17 Confidentiality, 1.14 Client Case Record, 3.55 Case Record Review, 3.05 Family Involvement, and 3.06 Case Staffing Committee. These policies were last reviewed and signed on August 30, 2021 by the CEO and COO.	
Youth and families receive counseling services, in accordance with the youth's case/service plan, to address needs identified during the assessment process	X					A total of 10 files were reviewed for five residential youth (three closed, two open) and five community youth (three closed, two open). All ten files had case notes that reflected youth and family receiving counseling services.	
Shelter Program							
Shelter programs provides individual and family counseling	X					Five shelter files were reviewed (3 closed, 2 open). Case notes in each file documented individual and family sessions with youth and parent.	
Group counseling sessions held a minimum of five days per week		X				Group counseling forms were presented to document occurrences of group counseling during each week. In the last six months group counseling was completed multiple times per week, sometimes multiple times per day, but did not always complete group counseling on five separate days throughout the week.	Exception: Groups were not held 5 days per week during one week in June, one week in July, and 2 weeks in September. On some days more than one group was conducted; however, per Florida Network Policy # 4.00, group counseling sessions must be conducted a minimum of five days per week.

Group counseling sessions consist of: a. Length of at least 30 minutes b. Opportunity for youth engagement c. Clear and relevant topic (informational/developmental/ educational) d. Clear leader or facilitator	X					Group Counseling forms were reviewed showing documentation of groups. The group form has sections to list youth who participated, topic, facilitator, and a duration. Each group form reviewed noted a clear, relevant topic, youth engagement opportunity, length of time, and facilitator of group.	
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					Five files were reviewed (3 closed, 2 open). All five files had notes indicating interventions were provided to youth and family in many different formats to best meet the needs of the youth and family.	
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 reviewed files had notes indicating counseling was provided to youth and family that focused on presenting problems, needs assessment and service plans.	
Maintain individual case files on all youth and adhere to all laws regarding confidentiality	X					All reviewed files reviewed were marked "confidential" on the physical file. Each file also contained documentation of providing youth and parent with information regarding privacy and HIPPA.	
Case notes maintained for all counseling services provided and documents youth's progress	X					All reviewed files provided evidence of counseling services as documented by case notes. Youth's progress was also detailed by counselors in the case notes.	
On-going internal process that ensures clinical reviews of case records and staff performance	X					The agency conducts clinical reviews of case records and staff performance. Supervisors review cases and document reviews on an ongoing monthly basis.	
						YES	
						If NO, explain here:	

Provider has a written policy and procedure that meets the requirement for Indicator 2.06						The agency has written policies 3.06 Case Staffing Committee, 3.07 Schedule of Case Staffing Committee Meetings, 3.08 Requesting a Case Staffing Committee Meeting, and 3.09 Written Report from the Case Staffing Committee. These policies were last reviewed and signed on August 30, 2021 by CEO and COO.	
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					During the review period there was one (1) case referred to case staffing that was adjudicated CINS. The case staffing was held within 7 days as requested by the parent.	
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 of case staffing was sent to parent and committee less than 5 days prior to staffing per the request of the parent. Both the parent and committee confirmed availability for the case staffing.	
Case Staffing Committee							
Must include: a. DJJ rep. or CINS/FINS provider b. Local school district representative	X					The case reviewed had a DJJ representative and school district representative present in the case staffing.	
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			The case reviewed did not have representatives present from State Attorney's office, substance abuse program, law enforcement, DCF, or mental health program.	
The program has an established case staffing committee, and has regular communication with committee members	X					The program has a case staffing committee that includes a DJJ and school district representative. The program maintains communication with its committee members. Emails and case notes reviewed show the program provides regular communication regarding meetings.	

The program has an internal procedure for the case staffing process, including a schedule for committee meetings	X					The case staffing meeting is convened within seven working days from receipt of the written request from the parent/guardian.	
As a result of the Case Staffing							
The youth and family are provided a new or revised plan for services	X					The case that was reviewed had a new service plan provided as a result of the case staffing.	
Written report is provided to the parent/guardian within 7 days of the case staffing meeting, outlining recommendations and reasons behind the recommendations	X					The case reviewed has a letter provided to the youth and family that outlined the committee's recommendations and the reasons behind the recommendations.	
If applicable, the program works with the circuit court for judicial intervention for the youth/family	X					The case reviewed contained correspondence and documentation involving the court.	
Case Manager/Counselor completes a review summary prior to the court hearing	X					The case reviewed had review summary completed before court.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.07						**YES** If NO, explain here: The agency has written policies 1.14 Client Case Records and 1.17 Confidentiality. These policies were last reviewed and signed on August 30, 2021 by CEO and COO.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
All records are clearly marked 'confidential'.	X					During the review there were five (5) residential files and five (5) community counseling files reviewed. All files were stamped confidential.	
All records are kept in a secure room or locked in a file cabinet that is marked "confidential"	X					All records are kept in a locked room adjacent to the youth lounge in the shelter.	
When in transport, all records are locked in an opaque container marked "confidential"	X					An opaque container, marked confidential, with a locking mechanism is used to transport files offsite.	
All records are maintained in a neat and orderly manner so that staff can quickly and easily access information	X					All 10 cases reviewed were maintained in a neat and orderly manner with cover pages and list of the content and order of documents in each section.	
						YES If NO, explain here:	

Provider has a written policy and procedure that meets the requirement for Indicator 2.08						The agency has a policy and procedure # 3.61 that was last approved and signed on 8/30/2021 by the CEO and COO.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Use of youth's preferred name/ pronoun: a. Youth are addressed according to their preferred name and gender pronouns b. Youth's preferred name and gender pronouns are used in logbook and on all outward-facing documents and census boards			**X**			The program reported there were no youth served who identified as other sexual orientation or gender identity during the review period. It was observed, during a tour of the facility, the agency has postings throughout the facility so all youth feel welcome regardless of their sexual orientation or gender. In addition, educational publication is accessible for youth in the lobby, youth lounge, and on each dorm wing.	
Youth in need of specialized support is referred to qualified resources (as applicable)			**X**			No applicable youth served.	
Youth preference is considered and documented for room assignment and youth is not roomed in isolation due to sexual orientation, gender identity, or gender expression			**X**			No applicable youth served.	
Youth is provided hygiene products, undergarments and clothing that affirms their gender identity or gender expression			**X**			No applicable youth served.	
The agency has signage and brochures/publication placed in common areas indicating that all youth are welcome regardless of sexual orientation, gender identity, and gender expression			**X**			No applicable youth served.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.09						**NO** If NO, explain here: Policy # 3.13.2 (Probation Respite) is missing requirement for NetMIS/JJIS entry within 3 business days of intake & discharge. Policy # 3.67 (FYRAC) does not specify youth and family will participate in 13 sessions or 90 consecutive days as required.	

						The agency has multiple written policies and procedures for specialized services: 3.13.1 - Staff Secure; 3.13 - Domestic Violence; 3.13.2 -Probation Respite; 3.13.3 - DMST; and 3.67 - FYRAC; 3.13.4. The policies were last approved and signed by the CEO and COO on 8/30/21.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Staff Secure							
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? **(If no, select rating "No eligible items for review")**			**NO**				
Staff Secure policy and procedure outlines the following: a. In-depth orientation on admission b. Assessment and service planning c. Enhanced supervision and security with emphasis on control and appropriate level of physical intervention d. Parental involvement e. Collaborative aftercare	**X**					Reviewed Staff Secure policy # 3.13.1. The policy addresses the requirement of the indicator.	
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 were served during the QI review period.	
Staff Assigned: a. One staff secure bed and assigned staff supervision to one staff secure youth at any given time b. Program assign specific staff during each shift to monitor location/ movement of staff secure youth c. Agency clearly documents the specific staff person assigned to the staff secure youth in the logbook or any other means on each shift			**X**			No applicable youth were served during the QI review period.	

Agency provides a written report for any court proceedings regarding the youth's progress			X			No applicable youth were served during the QI review period.	
Domestic Minor Sex Trafficking (DMST)							
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? **(If no, select rating "No eligible items for review")**			NO				
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Agency has evidence that the FNYFS was contacted for approval prior to admission for all Domestic Minor Sex Trafficking (DMST) placements.			X			No applicable youth were served during the QI review period.	
There is evidence the youth was entered into NetMIS as a Special Populations youth at admission and a Human Trafficking Screening Tool (HTST) was completed.			X			No applicable youth were served during the QI review period.	
Services provided to these youth specifically designated services designed to serve DMST youth			X			No applicable youth were served during the QI review period.	
Did the placement of DMST youth require additional supervision for the safety of the youth or the program? If so, did the agency provide the appropriate level of supervision and safety measures?			X			No applicable youth were served during the QI review period.	
Length of Stay: a. Youth in program do not have length of stay in DMST placement that exceeds seven (7) days b. Agency has approval for stays and support beyond seven (7) days for DMST placements that are obtained on a case-by-case basis? (If applicable.)			X			No applicable youth were served during the QI review period.	

Agency has evidence that staff assigned to DMST youth under this provision are to enhance the regular services available through direct engagement in positive activities designed to encourage the youth to remain in shelter			X			No applicable youth were served during the QI review period.	
All other services provided to DMST youth are consistent with all other general CINS/FINS program requirements			X			No applicable youth were served during the QI review period.	
Domestic Violence							
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? **(If no, select rating "No eligible items for review")**	**YES**						
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Youth admitted to DV Respite placement have a pending DV charge and have evidence of being screened by JAC/Detention, but do not meet criteria for secure detention	**X**					Two closed Domestic Violence (DV) youth records were reviewed. Both youth were screened and referred by JAC.	

Data entry into NetMIS and JJIS within (3) business days of intake and discharge		X				Two DV records reviewed were entered into NetMIS within 3 business days of intake and discharge. However, JJIS data entry requirement was not met for both youth records. One of the two late JJIS entries was a result of the program staff not having access to the JJIS delinquency system. As directed by the Lead Reviewer, staff contacted Megan at the FN; Megan assisted the program in getting access to the data entry for DV respite. FKCS will submit the request forms immediately to Katrina Thompson for processing the request.	Exceptions: One of two DV youth records reviewed had a discharge date of 8/23/21 but discharge was not entered in JJIS until 10/5/21. The second DV record (intake 3/31/21) did not have a DV entry in JJIS because staff indicated FKCS did not have permission to enter youth into the JJIS delinquency system and the JPO stated it could not be entered as a DV Respite due to youth being on secure detention prior to DV referral.
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					None of the three youth's length of stay in the DV program exceeded 21 days. One of the two youth had a 21-day DV stay and was transferred to CINS/FINS on the 21st day. Documentation in the progress notes indicated transition to CINS/FINS and termination from DV respite.	
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					One of the two youth had a case plan that reflected goals for reducing violence and coping skills. The other youth had an arrest warrant and was removed by law enforcement within seven days of intake, prior to the implementation of a case plan.	
All other services provided to Domestic Violence Respite youth are consistent with all other general CINS/FINS program requirements	X					Case notes demonstrate both youth received shelter services consistent with CINS/FINS program requirements.	
Probation Respite							

Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? **(If no, select rating "No eligible items for review")**			**NO**				
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
All probation respite referrals are submitted to the Florida Network.			**X**			No applicable youth were served during the QI review period.	
Probation Respite Referral come from DJJ Probation and are all youth referred on probation regardless of adjudication status			**X**			No applicable youth were served during the QI review period.	
Data entry into NetMIS and JJIS within (3) business days of intake and discharge			**X**			No applicable youth were served during the QI review period.	
Length of stay is no more than fourteen (14) to thirty (30) days? (Placement beyond thirty (30) days requires the approval of the JPO and/or CPO)			**X**			No applicable youth were served during the QI review period.	
All case management and counseling needs have been considered and addressed			**X**			No applicable youth were served during the QI review period.	
All other services provided to Probation Respite youth are consistent with all other general CINS/FINS program requirements			**X**			No applicable youth were served during the QI review period.	
Intensive Case Management (ICM)							
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? **(If no, select rating "No eligible items for review")**					**N/A**	FKCS is not contracted to provide ICM services.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Youth receiving services was court ordered					**X**	FKCS is not contracted to provide ICM 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**	FKCS is not contracted to provide ICM 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**	FKCS is not contracted to provide ICM services.	
Case plan demonstrates a strength-based, trauma-informed focus					**X**	FKCS is not contracted to provide ICM 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**	FKCS is not contracted to provide ICM 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**				
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Youth is referred by DJJ for a domestic violence arrest on a household member, and/or the youth is on probation regardless of adjudication status and at risk of violating			**X**			No applicable youth were served during the QI review period.	
Agency has evidence that all FYRAC referrals have documented approval from the Florida Network office			**X**			No applicable youth were served during the QI review period.	
Intake and initial assessment sessions meets the following criteria: a. Face-to-face gathering of family history and demographic information b. Includes development of the service plan and is documented through signature of the youth and his/her parent/guardian as well as orientation to the program			**X**			No applicable youth were served during the QI review period.	
Life Management Sessions meets the following criteria: a. Sessions are face-to-face, sixty (60) minutes in length and focus on strengthening the family unit b. Individual Sessions are with the youth and family and focus to engage, identify strengths and needs of each member that help to improve family functioning			**X**			No applicable youth were served during the QI review period.	
Group Sessions: a. Focus on the same issues as individual/family sessions with the overall goal of strengthening relationships and prevention domestic violence			**X**			No applicable youth were served during the QI review period.	

b. Shall be no more than eight (8) youth at one (1) time and shall be for a minimum of sixty (60) minutes per session							
Youth and family participate in services for thirteen (13) sessions or ninety (90) consecutive days of services, or there is evidence in the youth's file that an extension is granted by DJJ circuit Probation staff			X			No applicable youth were served during the QI review period.	
2.10: STOP NOW AND PLAN (SNAP)							
Provider has a written policy and procedure that meets the requirement for Indicator 2.10						**N/A** If NO, explain here: FKCS is not contracted to provide SNAP services. N/A	
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	FKCS is not contracted to provide SNAP services.	
Needs assessment is completed at initial intake, or within two face-to-face sessions					X	FKCS is not contracted to provide SNAP services.	
SNAP Assessments a. Child Behavior Checklist (CBCL) is completed by the caregiver (pre & post) b. Teacher Report Form (TRF) completed by the teacher (pre & post) c. Tool for Parenting Self Efficacy (TOPSE) completed by the caregiver (pre & post) d. Prevention Assessment Tool (PAT) (pre & post)					X	FKCS is not contracted to provide SNAP services.	

There must be at least three (3) documented attempts in the youths' file to obtain all pre-assessment (listed above) information.							
SNAP discharge report summary					X	FKCS is not contracted to provide SNAP services.	
SNAP Boys/SNAP Girls **Parent** Group Evaluation Form					X	FKCS is not contracted to provide SNAP services.	
SNAP Boys/SNAP Girls **Child** Group Evaluation Form					X	FKCS is not contracted to provide SNAP services.	
SNAP for Schools & Communities							
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
All cycles conducted outside of the school setting is reviewed by the Florida Network prior to the facilitation of services.					X	FKCS is not contracted to provide SNAP services.	
Each classroom or community setting group session has the following: a. a minimum of 45 minutes in length b. children ages 6-11 years of age with a minimum of five (5) children present c. one trained SNAP facilitator as well as a teacher or community facilitator in each session.					X	FKCS is not contracted to provide SNAP services.	
Weekly attendance sheet with youth names and/or identifying number completed with signatures of teacher and facilitator(s) (For a total of 13 attendance sheets)					X	FKCS is not contracted to provide SNAP services.	
"Class Goal" sheet					X	FKCS is not contracted to provide SNAP services.	
Measure of Classroom Environment (MoCE) (Pre and Post) is used to identify baseline and treatment outcomes of reported classroom dynamics.					X	FKCS is not contracted to provide SNAP services.	
Pre and Post Evaluations					X	FKCS is not contracted to provide SNAP services.	

One SNAP® Fidelity Adherence Checklist completed per classroom in a 13 – week SNAP in Schools group and uploaded to Dropbox					X	FKCS is not contracted to provide SNAP services.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.01						**YES** If NO, explain here: The agency has a policy and procedure #3.14- #4.02 Shelter Environment that was last reviewed on 8-15-21 and approved on 8/30/2021 by the CEO and COO.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Facility Inspection	X					The Program tour was conducted on 11/2/2021 and shelter was found to be clean and organized.	
Additional Facility Inspection Narrative (if applicable)	The grounds was free of debris and beautiful; well maintained landscaping was observed along the front of the building. All of the toilets and showers observed during the tour were clean and functional. The shelter is well lit throughout. Some of the lighting (dormitory hallways) have been updated to LED fixtures. No debris or hazard was observed on exterior. No graffiti was found on the walls or furnishings. All agency vehicles and staff vehicles are locked and secure. Three vans are currently being used by the program: 2019 Honda Odyssey, 2015 Chevrolet, and 2016 Toyota Sienna. All three vans were equipped with a first aid kit, fire extinguisher, and flashlight. Two of the three had a multi-function tool that includes glass breaker/air bag deflator and seat belt cutter. The Toyota van was missing the multifunction tool during inspection but the provider had extra units on hand and promptly added the device to the van upon notification. Program has 2 main sets of keys (one includes med room key) and a spare set. Two sets are used on each shift and a drop box is used to deposit keys after each shift. Incoming staff signs out the key upon retrieval. Egress plans are located throughout facility in common areas and behind the door in each bedroom. A copy of the floor plan is also included in the resident handbook. Client rules are posted on a board enclosed in a cabinet at the entrance to each dorm wing. A board in the youth lounge includes abuse hotline and DJJ incident reporting number. Grievance forms are accessible at the entrance to each dorm wing and a grievance box is mounted on a wall adjacent to the girl's dorm. DCF Child Care License is displayed in lobby area and the license is effective for one year as of 2/1/2021. All interior areas does not contain contraband and is free from hazardous unauthorized metal/foreign objects. All chemicals are maintained in a locked chemical cabinet and each item is inventoried at minimum once per week from period reviewed of 5/1-10/24/21. One set of washer and dryer is located in laundry rooms on each wing. All beds were equipped with sheets, pillows, and comforters. Each youth has an individual dresser for clothing. Other valuable items are stored in a locked storage cubby inside the locked file room.						
Fire and Safety Health Hazards	X					Date of fire inspection(s) reviewed: 1/12/2021	

Additional Fire and Safety Health Hazards Narrative (if applicable)	Annual facility fire inspection was conducted and the facility is in compliance with local fire marshal and fire safety code within jurisdiction. The agency completed a minimum of 1 fire drill per month within 2 minutes or less. Date of fire drills reviewed were: 5/8, 5/6, 5/11, 6/1, 6/10, 6/22, 7/2, 7/5, 7/31, 8/2, 8/10, 8/17, 8/31, 9/1, 9/20, 10/5, 10/22, 10/16. The agency completed a minimum of 1 mock emergency drill per shift per quarter. All annual fire safety equipment inspections are valid and up to date as of 1/12/21. Dates of mock drills reviewed were: 5/3, 5/7, 5/12, 6/1, 6/10, 6/22, 7/2, 7/3, 8/2, 8/3, 8/31, 9/1, 9/20, 9/14 10/5, 10/14, 10/28. The agency has a current satisfactory Residential Group Care inspection report from the Department of Health as of 10/22/21. The agency has a current satisfactory food service inspection report from the Department of Health and Food menus posted, current, and signed by licensed Dietician on 9/27/21. All cold food is properly stored, marked, as well as labeled. Dry storage and pantry area is clean and food properly stored. Refrigerators/freezers are clean and maintained at required temperatures. Fridge temperature showed a reading of 37 degrees and freezer temperature showed a reading of minus 3 degrees.						
Youth Engagement							
a. Youth are engaged in meaningful, structured activities (e.g., education, recreation, counseling services, life and social skill training) seven days a week during awake hours. Idle time is minimal. b. At least one hour of physical activity is provided daily. c. Youth are provided the opportunity to participate in a variety of faith-based activities. Non-punitive structured activities are offered to youth who do not choose to participate in faith-based activities. d. Daily programming includes opportunities for youth to complete homework and access a variety of age appropriate, program approved books for reading. Youth are allowed quiet time to read. e. Daily programming schedule is publicly posted and accessible to both staff and youth.	**X**					Youth are engaged in meaningful, structured activities such as groups, specialized treatment services, life and social skills training, recreation, and community service time. At least one of physical activity is provided daily during recreation/outdoor activity times. 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. Daily programming includes opportunities for youth to complete homework during the homework time daily. Daily programming schedule is publicly posted on a board in the common area.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.02						**YES** If NO, explain here: The agency has a policy and procedure #2.06, Program Orientation that was approved on 8-15-21 and signed on 8-30-21 by the CEO and COO.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible**	**No Practice**	**Not Applicable**		

Rating Criteria	Satisfactory	Non-Compliant	Items for Review	No Practice	Not Applicable		
Youth received a comprehensive orientation and handbook provided within 24 hours	X					Three closed records and two open records were reviewed. It is the program's current practice to review the resident handbook with each youth at the time of intake and document orientation within 24 hours.	
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					In all five files reviewed there was a comprehensive orientation completed during the intake process that includes all items required by the indicator. Youth and parent/guardian acknowledge orientation to the program by their signature on the resident/parent handbook form; grievance process and rules are also explained. Included in the agency's handbook is the layout/map of the facility, BMS program, emergency/disaster procedures, and youth is explained suicide prevention alerting staff of feelings or awareness of others having suicidal thoughts.	
Documentation of each component of orientation, including orientation topics and dates of presentation, as well as signatures of the youth and staff involved is maintained in the individual youth record	X					All five youth files contained a completed orientation checklist covering each component of orientation topics and signed by youth and staff conducting orientation.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.03						**YES** If NO, explain here: The agency has a policy and procedure #3.14,Youth Room Assignment, that was last approved on 8-15-21 and signed on 8-30-21 by the CEO and COO.	

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**					There were five files reviewed, two open and three closed files. Program completes screening process and intake process which gathers information of youth's history, status and exposure to trauma, initial collateral contacts, observation of youth separation of younger youth from older youth, gender, history of violence, disabilities, physical size, strength, suicide risk, sexual orientation and/or identification. During intake process, the CINS/FINS intake form is completed and based on information youth collected on history, youth is assigned a room and bed assignment. Form is signed by staff and reviewed and approved by supervisor. It was observed and reported that each room has two beds but if a youth requires a single bed it is possible in the facility. One observation was that it was unclear during intake and classification whether or not acute health symptoms requiring quarantine or isolation were identified and documented as it was not specifically noted on the intake form. The program supervisor stated if that were the case, the nurse would quarantine youth and documentation would follow in the youth's file and logbook.	
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**					The program ensures 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.	
						YES	
						If NO, explain here:	

Provider has a written policy and procedure that meets the requirement for Indicator 3.04						The agency has a policy & procedure #3.04, #3.47 Logbook Requirements that was approved on 8-1-21 and signed on 8-30-21 by the CEO and COO.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Log book entries that could impact the security and safety of the youth and/or program are highlighted	X					A review of the program logbooks from Week 1 - April, Week 3 - May, Week 4 - June, Week 1 - July, Week 2 - August, and Week 3 - September was conducted. Staff highlighted all security and safety issues that could impact the youth at the program. Staff highlighted when supervisor gave permission for staff to transport youth, discharges, intakes, staff reading of logbooks, youth returning from pass or going on pass, and outings.	
All entries are brief, legibly written in ink and include: • Date and time of the incident, event or activity • Names of youth and staff involved • Brief statement providing pertinent information • Name and signature of person making the entry	X					All entries are brief and legibly written in ink and include date, time of incident event or activity. All entries include names of youth and staff involved. Entries also has brief statements providing pertinent information name and signature of person making the entry.	
Recording errors are struck through with a single line. The staff person must initial and date the correction. The use of whiteout and erasures is prohibited.	X					All errors reviewed were struck through with a line and staff initials. No use of whiteout was observed.	
The program director or designee reviews the facility logbook(s) every week and makes a note chronologically in the logbook indicating the dates reviewed and if any correction, recommendations and follow-up are required and sign/date the entry	X					Program director or designee reviews the logbook weekly and writes an entry.	

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				All direct care staff reviews the logbook at the beginning of each shift but entries do not consistently document the dates reviewed.	Exception: All direct care staff reviews the logbook at the beginning of each shift; however, there is no evidence of which specific dates were 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				Oncoming supervisor and counselor typically reviews the logbook at the beginning of their shift and makes notes; however, the counselor does not reference specific dates reviewed.	Exception: There is no evidence of which specific dates were reviewed when the counselor reviews the logbook at the beginning of their shift.
Logbook entries include: a. Supervision and resident counts b. Visitation and home visits	X					Supervision and resident counts are documented and visitation and home visits are documented.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.05						**YES** If NO, explain here: The agency has a policy & procedures #3.30, Behavior Management Strategies, that was approved on 7-15-21 and signed on 8-30-21 by the CEO & COO.	
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 resident hand book has a detailed written description of the BMS and it is explained during program orientation.	
Behavior Management Strategies MUST include: a. Supervisors are trained BMS is designed to teach youth new behaviors and help youth understand the natural consequences for their actions						The program has three levels to their BMS system: Orientation, Level 1 and Level 2. Supervisors are trained to monitor the use of the behavioral interventions by their staff to include the expected behaviors, rewards, youth development system, social skills, and general philosophy. There were two training certificates reviewed of supervisors receiving necessary trainings to monitor program's BMS.	

						necessary trainings to monitor program's BMS system. Behavioral interventions are applied immediately reflecting the severity of the behavior. Each BMS level has certain incentives youth can earn when that level is achieved. The program has in place consequences or sanctions for rule violations which are directly related to the seriousness of the inappropriate behavior exhibited. Consequences are fairly applied, timely and consistent. The program's policy prohibits group discipline, room restriction, or denial of basic rights.	
b. Behavioral interventions are applied immediately, with certainty, and reflect the severity of the behavior c. BMS uses a wide variety of awards/incentives to encourage participation and completion of the program d. Appropriate consequences and sanctions are used by the program and consequences for behavior are logical and designed to promote skill-building for the youth e. Counseling, verbal intervention and de-escalation techniques are used prior to physical intervention (Only techniques approved by the Florida Network and DJJ are used if physical intervention is required) f. Only staff discipline youth. Group discipline is not imposed g. Room restriction is not used as part of the system or for youth who are physically and/or emotionally out of control	**X**						

h. Youth should never be denied basic rights such as meals, clothing, sleep, services, exercise, or correspondence privileges							
Program's Use of the BMS							
All staff are trained in the theory and practice of administering BMS rewards and consequences	**X**					All staff are trained in the theory and practice of administering BMS reward points and consequences. Training was verified in the four new hire training records reviewed.	
There is a protocol for providing feedback and evaluation of staff regarding their use of BMS rewards and consequences	**X**					There is a protocol for providing feedback and evaluation of staff regarding their use of positive and negative consequences. Program supervisor monitors point cards to evaluate and provide feedback to staff during staff meetings on use of behavior management system and on youth engagement.	
Supervisors are trained to monitor the use of rewards and consequences by their staff	**X**					The 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: The agency has policies & procedures, #1.15, #3.46, and #4.12, Staffing and Youth Supervision, that are approved on 8-15-21 and signed on 8-30-21 by the CEO & COO.	
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**					The program maintains minimum staffing ratios as required by Florida Administrative Code and contract. There is 1 staff to 6 youth during awake hours and community activities and 1 staff to 12 youth during sleep hours.	

All shifts must always provide a minimum of two staff present	X					All shifts consistently maintain a minimum of two staff present.	
Program staff included in staff-to-youth ratio includes only staff that are background screened and properly trained youth care workers, supervision staff, and treatment staff	X					All 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.	
The staff schedule is provided to staff or posted in a place visible to staff	X					A minimum of two staff were observed to be scheduled on all shifts for the 6-month period.	
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 maintains a roster with contact numbers of staff to call to ensure operation within the required staff-to-youth supervision.	

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				A review of the video surveillance system was completed for a total of 5 randomly selected days and all days were reviewed for two hours during the over night shifts as follows: October 8th - 12am-2am, October 17th - 2am-4am, October 23rd - 4am-6am, October 27th - 1am-3am, and November 1st - 3am-5am. All bed checks were conducted every 15 minutes for the male and female rooms on all dates except November 1st.	Limited Exception: After reviewing the video surveillance system it was observed that on November 1st all bed checks were conducted every 15 minutes for the male rooms. However, there was one (1) missed female bed check not conducted by the female staff. Staff documented in logbook on November 1, 2021 that the bed check for 4:00am was conducted but after the review of the surveillance camera, it was observed the bed check was not conducted. The incident was reported to DJJ CCC and accepted with reference number CCC Incident #202107907.
Provider has a written policy and procedure that meets the requirement for Indicator 3.07						**YES** If NO, explain here: The agency has a policy & procedures #4.23 Video Surveillance that was approved on 8-15-21 and signed on 8-30-21 by the CEO & COO.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Surveillance System							
The agency, at a minimum, shall demonstrate:						Camera signage is posted at the entrance outside of the facility. The camera system can capture and	

a. A written notice that is conspicuously posted on the premises for the purpose of security b. System can capture and retain video photographic images which must be stored for a minimum of 30 days c. System can record date, time, and location; maintain resolution that enables facial recognition d. Back-up capabilities consist of cameras' ability to operate during a power outage e. Have cameras placed in interior and exterior general locations of the shelter where youth and staff congregate and where visitors enter and exit. Cameras are never placed in bathrooms or sleeping quarters. f. All cameras are visible	X					retain video for a minimum of 30 days as evidenced by reviewing video footage from the date of 10/5/21. Camera system can record date, time, location, and maintain resolution that enables facial recognition. The program has a generator and battery back up for the camera system in case of power outages. The camera system is located in the staff monitoring station. Cameras are in the interior and exterior general locations of the shelter where youth and staff congregate and where visitors enter as well as exit. There are a total of 24 cameras at the shelter and they are all visible. In addition to these cameras the program is planning to add another camera in the back yard to capture visual for the new Tiki Hut.	
A list of designated personnel who can access the video surveillance system is maintained (includes off-site capability per personnel)?	X					A list of designated personnel also includes Residential Coordinator, CEO & COO.	
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					There is a log of supervisory checks/camera reviews from 3/12/21 through 10/19/21. All checks reviewed for the period demonstrate supervisory checks a minimum of every 14 days and time frames reviewed were noted.	

Grant the requesting of video recordings to yield a result within 24-72 hours from program quality improvement visits and when an investigation is pursued after an allegation of an incident	X					The shelter has a process for third party reviews of video recordings after a request from quality improvement visits or when an investigation is pursued after an allegation of an incident.	
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			All cameras were operational and working during the review and no recent work orders were conducted.	
Provider has a written policy and procedure that meets the requirement for Indicator 4.01						**YES** If NO, explain here: Program policy 2.01 titled Initial Screening/ Assessment Process was approved by the CEO and COO on August 30, 2021. The policy includes all requirements of the indicator.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Preliminary Healthcare Screening							
Screening includes : a. Current medications b. Existing (acute and chronic) medical conditions c. Allergies d. Recent injuries or illnesses e. Presence of pain or other physical distress f. Observation for evidence of illness, injury, physical distress, difficulty moving, etc. g. Observation for presence of scars, tattoos, or other skin markings	X					Two open and three closed youth records were reviewed for a healthcare screening admission. Each record documented a screening completed on the day of admission and included a review of current medications, existing medical conditions, allergies, recent injuries or illnesses, and/or presence of pain of other physical distress. Documentation included observations for evidence of illness, injury, pain, physical distress, difficulty moving, presence of scars, tattoos, skin markings, and acute health symptoms which may require quarantine or isolation.	

h. 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					One of five records reviewed documented a chronic condition; however, the youth was established with a community provider and did not require a referral.	
When needed, the parent is involved with the coordination and scheduling of follow-up medical appointments			X			None of the youth records reviewed indicated a need for referral for medical condition. The nurse confirmed there were no youth applicable for a chronic condition follow up since the last annual review.	
All medical referrals are documented on a daily log.			X			No eligible referrals during review period.	
The program has a thorough referral process and a mechanism for necessary follow-up medical care as required and/or needed	X					An interview with the nurse explained the process would be to first contact the parent/guardian to inquire about established patient status. If a referral or physical is needed the youth would be brought to a local clinic by the program staff.	
Provider has a written policy and procedure that meets the requirement for Indicator 4.02						**YES** If NO, explain here: Program policy 4.14 titled Suicide Assessment and Precautions was approved by CEO and COO on August 30, 2021 and the Mental Health/ Substance Abuse Services Plan was signed by the licensed mental health counselor (LMHC), residential coordinator, and CEO on January 11, 2021.	
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					Five reviewed records each documented a suicide risk screening was completed on the day of admission during the initial intake and screening process. The intake paperwork was signed and dated by the supervisor indicating a review as required in each record.	
The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	X					The program uses the Assessment of Suicide Risk form. This is a Department and Network approved form.	
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					Each of the five records were applicable for placement on sight and sound supervision. Each record documented the youth was assessed by a licensed professional or a non-licensed professional working under the direct supervision of the licensed professional within twenty-four hours. All youth were placed on the appropriate level of supervision as determined by the suicide risk assessment results and supervision levels were not changed until assessment was completed.	
Staff person assigned to monitor youth documented youth's behavior at 30 minute or less intervals	X					Each of the five youth records contained supervision logs maintained for the duration the youth was placed on increased supervision. Each log documented youth behaviors at ten-minute intervals, exceeding the thirty-minute requirement.	
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 youth were placed on the appropriate level of supervision as determined by the suicide risk assessment results and supervision levels were not changed until assessment was completed.	
Provider has a written policy and procedure that meets the requirement for Indicator 4.03						**YES** If NO, explain here: Program policy 3.41 titled Medication Distribution and Storage and policy 3.42 titled Disposal of Medications were approved by the CEO and COO on August 30, 2021.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Medication Storage							

a. All medications are stored in a Pyxis Med-Station 4000 Medication Cabinet that is inaccessible to youth (when unaccompanied by authorized staff) b. Pyxis machine is stored in accordance with guidelines in FS 499.0121 and policy section in Medication Management c. Oral medications are stored separately from injectable epi-pen and topical medications d. Medications requiring refrigeration are stored in a secure refrigerator that is used only for this purpose, at temperature range 2-8 degrees C or 36-46 degrees F. (If the refrigerator is not secure, the room is secure and inaccessible to youth.) e. Narcotics and controlled medications are stored in the Med Station						The program stores all medications in a Pyxis Med-Station Cabinet inaccessible to youth. The cart is stored within the medical clinic in accordance with Florida Statute. The program's nurse and residential coordinator are designated "Super Users" for the Med-Station. The program stores oral medications in a separate drawer from topical medications and epinephrine auto injectors. Additionally, the program stores all controlled medications and narcotics within the secured Med-Station. A review of youth records and an interview with the program nurse confirmed the program maintains perpetual inventories with running balances for all controlled substances. The program uses a Medication Distribution Log to document all medication distributed by a non-licensed staff. Medication is only distributed by non-licensed staff when the nurse is off duty. The program policy clearly outlines a medication and delivery system aligned with Florida Network Policies. The interviewed nurse explained all new staff are trained on the process and annually thereafter. Additionally, the program maintains a list of staff trained and authorized to assist in medication distribution and the use of epinephrine auto injectors. Only designated staff with proper user permissions have access to secured medications, and limited access to controlled medications. The program practice is to count all medications each day at the end of each shift. These three counts are conducted regardless of medication class. Medication perpetual inventories and count practices were confirmed during record reviews. A review of policy, records, and the interviewed nurse	

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					verified all medication discrepancies must be cleared after each shift. Observations during the annual review verified the program has a small locked refrigerator used for the storage of medications; however, the program did not have any youth requiring refrigerated medications on the day of observations. The program's practice for verifying medications is to have all non-licensed staff call either the local pharmacy or twenty-four-hour pharmacy to confirm medication status. When the licensed nurse accepts medications the label and type of medication is inspected for accuracy. The program's policy stipulates epinephrine auto injectors are the only injectable medications accepted. Reviewed inventory lists confirmed the program conducts weekly sharp and over the counter (OTC) medication inventories. Additionally, the interviewed nurse and documentation supported the program conducts a full medical room inventory monthly and reviews medication management practices weekly through the Pyxis Med-Station Report review. The program is required to have three Med-Station keys in the event the Pyxis system malfunctions; however, the program was only able to produce two of the three required keys during the annual review. The missing Top Panel Key for the Pyxis was located and reported to the Lead Reviewer on November 8th.	
Medication Distribution							
a. Agency maintains a minimum of 2 Super Users for the Med-Station						. The program uses a Medication Distribution Log to document all medication distributed by a non-licensed staff. Medication is only distributed by non-licensed staff when the nurse is off duty. The program policy	no exceptions noted.

b. Only designated staff delineated in User Permissions have access to secured medications, with limited access to controlled substances (narcotics) c. A Medication Distribution Log shall be used for distribution of medication by non-licensed and licensed staff d. Agency verifies medication using one of four methods listed in the FNYFS Operations Manual e. When nurse is on duty, medication processes are conducted by the nurse f. The delivery process of medications is consistent with the FNYFS Medication Management and Distribution Policy g. Agency does not accept youth currently prescribed injectable medications, except for epi-pens h. Non-licensed staff have received training in the use of epi-pens provided by a registered nurse	X					clearly outlines a medication and delivery system aligned with Florida Network Policies. The interviewed nurse explained all new staff are trained on the process and annually thereafter. Additionally, the program maintains a list of staff trained and authorized to assist in medication distribution and the use of epinephrine auto injectors. Only designated staff with proper user permissions have access to secured medications, and limited access to controlled medications.	
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					Reviewed inventory lists confirmed the program conducts weekly sharp and over the counter (OTC) medication inventories. Additionally, the interviewed nurse and documentation supported the program conducts a full medical room inventory monthly and reviews medication management practices weekly through the Pyxis Med-Station Report review. The program practice is to count all medications each day at the end of each shift. These three counts are conducted regardless of medication class. Medication perpetual inventories and count practices were confirmed during record reviews. A review of policy, records, and the interviewed nurse verified all medication discrepancies must be cleared after each shift.	
There are monthly reviews of medication management practice via Knowledge Portal or Pyxis Med-Station Reports.	X					Pyxis Med-Station Report reviews are completed weekly by the program nurse.	
Medication discrepancies are cleared after each shift.	X					A review of policy, records, and the interviewed nurse verified all medication discrepancies must be cleared after each shift.	
Provider has a written policy and procedure that meets the requirement for Indicator 4.04						**YES** If NO, explain here: Program policy 7.03 titled Medical and Mental Health Alerts was approved by the CEO and COO on August 30, 2021.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Youth with a medical, mental health, or food allergy was appropriately placed on the program's alert system	X					A review of five youth records reflected each was applicable for a medical, mental health, and/or food allergy alert. The program practice is to place all youth alerts on the youth record and on a daily youth report. The daily youth report is printed and provided to program staff and the kitchen staff. Each youth record alert coincided with the record alerts as required.	

Alert system includes precautions concerning prescribed medications, medical/mental health conditions	X					The program's alert system includes alerts for alleged sexual offender, sexual aggression, sexual assault victim, substance abuse, one to one supervision, sight and sound supervision, close supervision, mental health medications and concerns, health medications or concerns, physical aggression, runaway behaviors, and special diet. Additionally, the internal alert system contains details of youth medical conditions, common side effects to prescribed medications, food and medication contraindications, and mental health treatment.	
Staff are provided sufficient training, information and instructions to recognize/respond to the need for emergency care for medical/mental health problems	X					Observations during the program tour reflected the program also uses an alert board to facilitate in the sharing of alert information. An interview with the licensed nurse, the daily alert list, and record reviews confirmed the program's practice for sharing alerts. The interviewed nurse reported staff are trained upon hire and annually thereafter on alert policies.	
A medical and mental health alert system is in place that ensures information concerning a youth's medical condition, allergies, common side effects of prescribed medications, foods and medications that are contraindicated, or other pertinent mental health treatment information, is communicated to all staff	X					The program's alert system includes alerts for alleged sexual offender, sexual aggression, sexual assault victim, substance abuse, one to one supervision, sight and sound supervision, close supervision, mental health medications and concerns, health medications or concerns, physical aggression, runaway behaviors, and special diet. Additionally, the internal alert system contains details of youth medical conditions, common side effects to prescribed medications, food and medication contraindications, and mental health treatment.	
Provider has a written policy and procedure that meets the requirement for Indicator 4.05						**YES** If NO, explain here: Program policy 4.19 titled Emergency Medical and Dental Care and policy 4.22 titled Episodic/Emergency care were approved by the CEO and COO on August 30, 2021.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Off-site Emergency Services							

a. If off-site emergency medical or dental care was provided, an incident report was submitted for the medical or dental care b. Upon youth return, there is a verification receipt of medical clearance via discharge instructions with follow-up is present in file c. Youth's parent/guardian was notified d. A daily log is maintained for emergency care provided	X					Three closed applicable records were reviewed for off-site emergency care. All three-youth received emergency medical treatment at the local emergency room. Each incident had a corresponding internal incident and a report was submitted to the Department's Central Communication Center as required. The program provided documentation to support the youth was medically cleared and receipt of discharge instructions. All youth were only applicable for a follow up in the event the need persisted; however, all issues were resolved and follow up medical care was not needed. The reviewed incident reports and Episodic Care/Emergency Care Log confirmed the parent/guardian was notified of off-site care in each instance.	
All staff are trained on emergency medical procedures	X					The program's training plan includes training in "recognizing medical emergencies, first-aid, cardiopulmonary resuscitation (CPR) and emergency preparedness". These trainings are provided to all program staff upon hire and annually thereafter.	
The program has a Knife-for-life and wire cutters accessible to staff in a secure location(s)	X					Observations made during the annual review reflected the program has a knife for life located on each of the two living units within a locked utility room and one in the staff station. Additionally, the program has one wire cutter located in the staff station.	
First aid kit/supplies are fully equipped and inventoried	X					First aid kits were located in the medication room, staff monitoring station, administration hallway, and one in each of the three vans used by the program. An interview with the program nurse reflected first-aid supplies are restocked as needed and reviewed documentation verified the first aid supply inventories were conducted monthly.	