Florida Network for Youth and Family Services
Compliance Monitoring Report for

Hillsborough County Children Services
3110 Clay Mangum Lane, Tampa, Florida 33618

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 Hillsborough County Children Services (HCCS) for the FY 2021-2022 at its program office located at 3110 Clay Mangum Lane, Tampa, 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. HCCS 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 2019 through June 30, 2022.

The review was conducted by Marcia Tavares, Consultant for Forefront LLC and Peer Reviewer(s). Agency representatives from HCCS present for the entrance interview were Patrick Minzie, Department Director; Sarah Grimmig, Youth Program Operations Manager; and Rhonda Rhodes, Clinical Services Manager. The last onsite QI visit was conducted July 29, 2020.

In general, the Reviewer found that Hillsborough County Children Services is in compliance with specific contract requirements. **HCCS received an overall compliance rating of 100% for achieving full compliance with all twelve (12) 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 09-01-2021-2022

Agency Name: Hillsborough County Children Services	**Monitor Name: Marcia Tavares**
Contract Type : CINS/FINS	**Region/Office: 3110 Clay Mangum Lane, Tampa, FL 33618**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): September 1-2, 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 nine (9) certified DJJ-QI Peer Reviewers namely: David Gray; Rhonda Rhodes, LCSW; Linda Sessions; Leah Saker; Julie A. Edison; Deborah Bianchi; Angel Colón; Jocie Fletcher; and Victor Garcia-Borbon. Multiple staff participated and/or are scheduled to participate in QI Peer Reviews during the current 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 4 additional contracts as of July 2021 was provided. The list includes the grant title/name, contract start and end date, the purpose, and the amount for the following funders: Eckerd (Residential Group Care), National School Lunch Program, Hillsborough County School Readiness Coalition, and Department of Children and Families. The program also maintains twelve (12) interagency agreements and Memorandums of Agreement (MOUs) with schools,	

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						mental health, and substance abuse providers. All of the agreements reviewed had current contract/agreement dates.	
Limits of Coverage a. Provider shall provide and maintain during this contract, the following minimum kinds of insurance: Worker's Compensation and Employer's liability insurance as required by Chapter 440, F.S. with a minimum of $100,000 per accident, $100,000 per person and $500,000 policy aggregate. Commercial General Liability with a limit of $500,000 per occurrence, and $1,000,000 policy aggregate. Automobile Liability Insurance shall be required and shall provide bodily injury and property damage liability covering the operation of all vehicles used in conjunction with performance of this contract, with a minimum limit for bodily injury of $250,000 per person; with a minimum limit for bodily injury of $500,000 per accident; with a minimum limit for property damage of $100,000 per accident and with a minimum limit for medical payments or $5,000-$10,000 per person. Florida Network is listed as payee or co-payee. **PTV**	☐	☐	☒	☐	☐	Documentation: Management & Budget - Certificate of Self-Insurance and Business Auto Insurance. Hillsborough County has elected to self- insure for General Liability, Workers' Compensation, and Property Insurance. This means that instead of purchasing commercial insurance policies, the County has budgeted funding to pay claims and recognize sufficient reserves for future claims. General Liability coverage and is authorized under FS 768.28. Under this statute, the County's Tort liability sovereign immunity has been waived to the following extent: $200,000 per person and $300,000 per occurrence. Workers' Compensation coverage is authorized under FS 440.38(6) and Hillsborough County is a qualified self-insurer.	

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						Damage and losses to property is paid from the self-insurance fund when properly reported and documented. Coverage includes damages in tort for money damages for injury or loss of property, personal injury, or death caused by the negligent or wrongful act or omission of the County and/or any employee while acting within their scope of office or employment. Auto insurance is provided by National Liability and Fire Insurance Company with combined single limits of coverage $1,000,000, effective through 10/1/21. Personal injury protection of $10,000 is covered by the policy. The Florida Network is listed as certificate holder on the Certificate of Liability Insurance (for auto policy).	
External/Outside Contract Compliance a. Provider has corrective action item(s) cited by an external funding source (Fiscal or Non-Fiscal). **ON SITE**	☐	☐	☐	☐	☒	N/A Interview-Per the Department Director, there are no current corrective actions cited by an external funding source.	
Fiscal Practice	☐	☐	☒	☐	☐	Documentation: Hillsborough County Clerk of the Circuit Court, BOCC	

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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**						Accounting Department, July 2004. Fiscal Policies and Procedures are issued and maintained by the Accounting Department. The procedures reviewed appear to be consistent with GAAP and provide for limited internal controls. Procedures are included for: cash collection and accounting; check disbursement; receipting system; bank deposits; collection security; armored car service; credit card services; electronic payments; escrow deposits; tax collection; and other general accounting procedures.	
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 FY21, October 2020 to September 2021, was provided and tracks the activities for the CINS/FINS program (13016) separately. The general ledger is structured to track all funding sources as well as activities for the CINS/FINS program. The GL includes the following items: fund code, fund name, cost center code, cost center name, account code, account name, sub-account name/code, revised budget,	

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						actual amount, encumbrance, and available 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**	☐	☐	☒	☐	☐	Observation/Documentation: Reviewed Board Policy and Procedure 2.17 which was approved by the county Board of Commissioners on April 1, 2019. Per the Youth Programs Operation Manager, the program does not have a petty cash fund for CINS/FINS. Instead, P-cards are used with the authorized user being the Residential Services 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**	☐	☐	☒	☐	☐	The Senior Accounting Manager provided copies of bank statements from January-June 2021 for a Wells Fargo Concentration account held by the County. The program has access to the account. Financial records and reports are maintained offsite by Hillsborough County Clerk of the Court. The County accountant does the bank reconciliations; copies are not provided to the program.	
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	☐	☐	☒	☐	☐	Documentation: There is no capital improvement in the current FY, therefore, no capital purchases were made for this grant. No DJJ inventory more than $1000	

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equipment an Informational Resources Request (IRR) been submitted to DJJ. **PTV/ON SITE**						was purchased since the last onsite review.	
f. Agency submits payroll taxes and deposits (and retirement deposits as applicable), Employee IRS Form W-2 and Independent Contractors IRS Form 1099 forms prior to federal requirements. **ON SITE**	☐	☐	☒	☐	☐	Documentation: The agency provided copies EFTPS payment history Q1, Q2, and Q3 for 2021 showing 941 payroll taxes paid. No balances were noted as due on the quarterly reports. The payment status indicated "settled" for all payments made.	
g. Budget to actual reports prepared and reviewed by appropriate management. Variance from the budget are investigated and explained. **PTV/ON SITE**	☐	☐	☒	☐	☐	Documentation: Agency provided a Budget to Actual Report for current FY 2021, as of September 21, 2021. A review of the report demonstrates the agency tracks the overall budget variances for the CINS/FINS program. Per the Department Director, the accountant and/or a team reconcile variances monthly. There is informal sharing between the team and directors. Invoices are submitted monthly with supporting documentation.	
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	☐	☐	☒	☐	☐	Documentation: The agency provided a copy of the most recent Single Audit prepared by the County Finance Department and audited by RSM US LLP 6/28/21 for the fiscal year ended	

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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**						September 30, 2020. Per the program director, the county has 6 months from the end of the FY to complete the audit; however, due to the COVID-19 pandemic, the audit was completed outside of that timeframe—3 months later. A separate Management Letter was issued by the auditor. The audit did not result in any findings or questioned costs. Consequently, there were no corrective actions required; management concurred with the two recommendations made by the auditing company listed below: • County should review its current policies and procedures over accounting and financial reporting including the year-end closing processes. • County consult with the Qualified Independent Consultant to perform an analysis to determine the amount required to be in the renewal and replacement account for the Water	

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						System. Any excess funds should then be reclassified from restricted to unrestricted for financial reporting purposes.	
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: Review of the following policies and procedures: Information Management policy 1.20, effective 11/1/2019 and Storing/Disposition of Client Records, policy 4.37, effective 8/1/2018. Both policies ensure the security and privacy of data and maintenance of a backup system in case of accidental loss.	

CONCLUSION

Hillsborough County Children Services has met the requirements for the CINS/FINS contract as a result of full compliance with twelve (12) applicable indicators of the Administrative and Fiscal Contract Monitoring Tool. One of the thirteen indicators was not applicable because HCCS does not have any outstanding corrective action item(s) cited by an external funding source. 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 Hillsborough County Children's Services - Tampa
CINS/FINS Program

September 1-2, 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	Satisfactory
3.07 Special Populations	Satisfactory

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

Standard 4: Mental Health/Health Services

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

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

Overall Rating Summary
Percent of indicators rated Satisfactory: 100 %
Percent of indicators rated Limited: 0 %
Percent of indicators rated Failed: 0 %

Rating Definitions

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

Satisfactory Compliance	No exceptions to the requirements of the indicator; limited, unintentional, and/or non-systemic exceptions that do not result in reduced or substandard service delivery; or exceptions with corrective action already applied and demonstrated.
Limited Compliance	Exceptions to the requirements of the indicator that result in the interruption of service delivery, and typically require oversight by management to address the issues systemically.
Failed Compliance	The absence of a component(s) essential to the requirements of the indicator that typically requires immediate follow-up and response to remediate the issue and ensure service delivery.
Not Applicable	Does not apply.

Reviewer

Members

Marcia Tavares - Lead Reviewer Consultant-Forefront LLC/Florida Network of Youth and Family Services
Melissa Johnson – Regional Monitor, Department of Juvenile Justice
Raylene Coe - Crosswinds Youth Services
Diane Lindsay - Tampa Housing Authority
Daniela Velez - Children's Home Society Osceola

Methodology

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

Persons Interviewed

	Chief Executive Officer		Case Manager	X	Nurse – Full time
	Chief Financial Officer	X	Counselor Non-Licensed		Nurse – Part time
	Chief Operating Officer		Advocate		# Case Managers
	Executive Director	X	Direct – Care Full time	2	# Program Supervisors
X	Program Director		Direct – Part time		# Food Service Personnel
X	Program Manager		Direct – Care On-Call	1	# Healthcare Staff
	Program Coordinator		Intern		# Maintenance Personnel
	Clinical Director		Volunteer		# Other (listed by title): ___
X	Counselor Licensed		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	6	# Health Records
X	Logbooks		Key Control Log	4	# MH/SA Records
X	Continuity of Operation Plan	X	Fire Drill Log	13	# Personnel /Volunteer Records
X	Contract Monitoring Reports	X	Medical and Mental Health Alerts	6	# Training Records
	Contract Scope of Services	X	Precautionary Observation Logs	15	# Youth Records (Closed)
X	Egress Plans	X	Program Schedules	11	# 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	X	Tool Inventory and Storage	X	Facility and Grounds
	Recreation	X	Toxic Item Inventory & Storage	X	First Aid Kit(s)
	Searches		Discharge		Group
X	Security Video Tapes		Treatment Team Meetings		Meals
	Social Skill Modeling by Staff		Youth Movement and Counts	X	Signage that all youth welcome
	Medication Administration		Staff Interactions with Youth		
	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

Hillsborough County Children Services (HCCS) is a Hillsborough County operated department that focuses on keeping children, young adults, and families protected and empowered to live safe, healthy lives. Services provided include: Children in Need of Services/Families in Need of Services (CINS/FINS); Child Care; Case Management & Case Staffing; Safe Place; and Residential Group Care. The CINS/FINS program for runaway and ungovernable children and their families, offers counseling services to reunite families and prevent runaway behavior, as well as short-term residential respite and shelter. Emergency shelter care is available for dependent, abused, or neglected children. For long-term foster care of adolescent females, there is a pre-independent living group home program. Additionally, there are training classes for parents to improve parenting skills. The agency also provides services to specialized populations who meet the criteria for staff secure shelter, domestic minor sex trafficking, intensive case management, and youth referred by the Juvenile Justice Court System for domestic violence, probation respite, and Family/Youth Respite Aftercare Services (FYRAC). HCCS is currently accredited by the Council of Accreditation (COA) and was successfully reaccredited on May 3, 2021.

Since the last onsite QI review July 30, 2020, HCCS focused its efforts on improving digital and technology-based solutions to support faster interventions for families, improve responsiveness to customer needs, create greater agility in responding to contractual requirements, and reduce reliance on paper. Despite the ongoing challenges of the pandemic, the programs continue to provide face-to-face services without having to shut down its operations. The county has been a technology resource for the program and supported the capacity to implement use of Microsoft Teams during the early phase of the pandemic to facilitate communication among team members as well as connecting with youth and families to provide services. Program staff are county employees and were involved in supporting county vaccination efforts and activities.

In order to adhere to CDC guidelines, the program had to lower its residential census which may result in a waitlist; however, no shelter closures were necessitated. Additionally, administrative staff began working remotely and had returned to a hybrid schedule in July for about 3 weeks but had to reverse back to remote work due to the recent rise in COVID cases.

Despite the pandemic, the agency continues to build relationships with community partners. The county has seen a rise in youth related domestic violence resulting in youth arrests which allowed the program to make strides with the civil citation process. HCCS is one of two CINS/FINS providers to offer the civil citation program. The agency has a formal MOU with Tampa police, Hillsborough Sherriff's office, and law enforcement. Youth are diverted from the juvenile detention system because it's their first offense and are brought to the program by law enforcement officers.

Narrative Summary

The Hillsborough County Department of Children's Services provides both Residential and Non-Residential CINS/FINS services for youth and their families in Hillsborough County, Florida. The program located at 3110 Clay Mangum Lane, Tampa, Florida is under the leadership of the Hillsborough County Government. The Department Director oversees the residential and community counseling components of the program, including the volunteer and outreach initiatives. The shelter is licensed for 22 beds by the Department of Children and Families effective through July 31, 2022. Another shelter houses foster care youth and is licensed for 30 beds, also effective through July 31, 2022. The agency's administrative offices and youth shelters are housed in buildings located on a beautiful, large campus.

During the QI review, it was observed that the HCCS policies and procedures do not have signatures of approval, just effective dates, review dates and expiration dates. Policy Section 1.19 outlines the protocol for the establishment and review of policies and procedures. HCCS policies and procedures will be reviewed and revised at least every two to three years or when practices, procedures, legal requirements, or regulations change. Within the three-year time frame or as needed, HCCS program managers or their designees are responsible for reviewing, updating, or establishing policies under their area(s) of responsibility. The program manager or designee works with their QI workgroup to prepare a draft of the new or revised procedure. The updated policy is then submitted to the QI Committee Chair who forwards the draft policy to legal for review. If the legal review is completed and no edits are required, the QIC Chair completes the bottom section of the Revised Procedures Coversheet and forwards the policy and coversheet to the Department Director for approval.

The program has implemented a new model shifting from Health and Wellness to the Family Systems Trauma model. This model focuses on trauma-informed treatment planning that preserves the safety of the child and family first and then incorporate a plan to heal the consistent interactional trauma by involving the entire family, so that the child's trauma heals and also the trauma of the parents and the other family members.

<u>The overall findings for the QI Review for HCCS are summarized as follows:</u>

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 (1.01-1.03, and 1.05-1.07). Indicator 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 ten indicators was not applicable as HCCS is not contracted to provide SNAP services. Five of the nine applicable indicators were rated satisfactory with no exceptions (2.02, and 2.04 - 2.07). The remaining four indicators were rated satisfactory with exceptions (2.01, 2.03, 2.08, and 2.09).

Standard 3 has a total of seven indicators regarding shelter care. Four of the seven indicators were rated satisfactory with no exceptions (3.01 – 3.03), and three of the indicators were rated satisfactory with exceptions (3.04, 3.05, and 3.07). □

Standard 4 is comprised of five indicators. All five indicators were rated satisfactory with no exceptions.
□
Summary of Deficiencies resulting in Limited or Failed Rating (If Applicable): None of the indicators reviewed resulted in a Limited or Failed rating.□
□

CINS/FINS QUALITY IMPROVEMENT TOOL

Quality Improvement Indicators: Add an "**X**" in the applicable column *Satisfactory* *Non- Compliant (E.g. Exceptions)* ***No Eligible Items for Review*** ***No Practice*** ***Not Applicable***	**Satisfactory (S)**	**Non-compliant (E)**	**No Eligible Items for Review (N)**	**No Practice (NP)**	**Not Applicable (N/A)**	**Review Based Upon** **Document Source** *For example: Interview/Surveys, Observation, and/or Type of* *Documentation* *E.g. 4 out of 4 files reviewed contained "....." or 2 out of 4 files had a completed needs assessment.*	**Notes** **Explain any items that have any deficiencies, exceptions or are not applicable. For example: Items marked 'No' or 'N/A' on the worksheets need to be explained clearly below E.g. 2 out 4 files reviewed were missing the completed needs assessment**
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:** **Indicate policy number, authorized signee, date(s) of last review/revision/approval:** Policy 3.05 - Employee Screenings, effective date 10/1/19; policy 3.09 – Volunteers effective 2/11/20; and policy 3.19 - Pre-employment Assessment, effective date 10/1/18.	**Add any exceptions below:**
Agency utilizes an employee suitability prescreening assessment with a passing rate criterion prior to an offer of hire for direct care staff working with youth or the agency has provided an explanation for staff hired with a non-passing/low score.	**X**					A total of two new staff were hired since the last onsite QI review. One of the two staff met the criteria for pre-screening assessment. The agency uses the Berke Assessment and completed the screening prior to hire for the one applicable staff.	

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					During the review period, there were two new staff hired and five new interns providing volunteer services. The two new staff and five volunteers were background screened prior to hire and/or volunteer service 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			There were no eligible employees reemployed during the review period who had a break in service.	
Five-year re-screening completed every 5 years from initial date of hire	X					Program employee roster shows six staff were eligible for 5-year rescreening. The agency provided timely 5-year re-screening results and clearinghouse roster that shows effective retained prints for all six staff.	
Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?	X					The agency submitted the Annual Affidavit of Compliance with Level 2 Screening via email to the Background Screening Unit on 1/15/2021.	
Proof of E-Verify for all new employees obtained from the Department of Homeland Security	X					Documentation of E-Verify work eligibility was provided for the two new staff hired.	
1.02: Provision of an abuse free environment to ensure safety and abuse free environment for youth in care							
Provider has a written policy and procedure that meets the requirement for Indicator 1.02						**YES** **If NO, explain here:** **Indicate policy number, authorized signee, date(s) of last review/revision/approval:** Policy 3.18- Six Pillars of Attestation, effective 2/23/2018. The policy regarding Child Abuse and Reporting is addressed in three different policies: 1) Employees Involved in Reports of Child Abuse 4.07 (1/15/17); 2) Reporting Criminal Behavior, Child Abuse of Neglect 6.04 (1/25/19); and 3) Abuse Reporting 4.07 (3/1/18).	**Add any exceptions below:**
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
Abuse Free Environment							

Agency has a code of conduct of policy and there is evidence that staff are aware of agency's code of conduct.	X					Policy-3.18 Code of Conduct effective 2/23/18. Staff signs the Code of Conduct/Six Pillars of Attestation form upon hire. The form is maintained in each employee's personnel file electronically.	
Child Abuse Registry telephone number is visible to youth and posted common areas of the facility	X					The abuse number is posted in the general comments area of the day room of the girl's and boy's cottage. Both cottage E and cottage F have general client rules posted on a bulletin board behind protective glass in the halls leading to the bedrooms.	
Youth were informed of the Abuse and Contact Number (see youth survey results)	X					All nine youth surveyed indicated knowledge of the location of the abuse hotline number in the facility.	
Management takes immediate action to address any incidents of threats or abuse			X			No incidents of abuse or threats were identified or reported during the period reviewed.	
Grievance Process							
Agency has a formal grievance process	X					The agency has a a policy 6.07 for Client Grievances.	
Locked box accessible to only management and available to youth in a common area	X					During the tour of the cottages, accessible grievances boxes were observed to be locked, mounted on the wall in the common area, and contained grievance forms.	
Direct care does not handle the complaint/grievance unless assistance is asked for by the youth. Program director/supervisor will have access to and manage grievances unless it is towards themselves.	X					According to the agency's policy, the Residential Services Coordinator processes grievances unless that individual is named in the grievance, then the RSC's supervisor handles the grievance.	
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 4 grievances reviewed during the reporting period - all from July 2021. The agency resolved each within 72 hours to each youth's apparent satisfaction as signified by their signature on the resolution documentation provided. A "test" grievance was deposited in the box by a Forefront Team member on 9/2/21 and was retrieved by the Residential Services Coordinator (RSC) three days later on 9/5/21. As instructed, the RSC acknowledged receipt of the "test" grievance via a phone call to the Lead Reviewer.	

1.03: Incident Reporting							
Provider has a written policy and procedure that meets the requirement for Indicator 1.03						**YES** **If NO, explain here:** **Indicate policy number, authorized signee, date(s) of last review/revision/approval:** 6.04 Reporting Criminal Behavior, Child Abuse or Neglect. effective 1/25/19.	**Add any exceptions below:**
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**					A total of 15 incident reports were accepted by the CCC during the reporting period and all were reported to the CCC within 2 hours of the incident occurrence or upon program staff learning of the incident.	
The program completes follow-up communication tasks/special instructions as required by the CCC	**X**					Of the 15 incidents accepted by the CCC, 11 were subject to follow-up by the program. The program timely completed all 11 follow-up communications and tasks with the CCC.	
Incidents are documented in the program logs and on incident reporting forms	**X**					All 15 incidents accepted by the CCC were found recorded in the log book.	
All incident reports are reviewed and signed by program supervisors/directors	**X**					The program provided all 15 incident reports signed by program supervisors/directors indicating they had been reviewed.	
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:** **Indicate policy number, authorized signee, date(s) of last review/revision/approval:** Policy1.17 - Required Staff Training, revised 8/1/2019.	**Add any exceptions below:**
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
First Year Direct Care Staff							

All staff completed the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days from date of hire. *(Staff hired before January 1st were required to complete no later than December 31, 2020)*	X					Training records for 2 applicable new hires during the review period were reviewed. Both of the newly hired staff members completed the DOJ Civil Rights and Federal Funds training within 30 days of their hire date.	
All staff receives all mandatory training during the first 90 days of employment from date of hire.		X				Of the two new hires, only one had 90 days to complete mandatory training; the other was hired before January 2021 and had 120 days to complete mandatory training. Both staff completed in excess of the 80 training hours required during the first year. The agency's new Dining Administrator had 120 days to complete mandatory new-hire training applicable to "all staff" in the standard, but did not complete Confidentiality training at all and did not timely complete CINS/FINS Core training, the latter of which was completed 5 months after the 120 day time frame.	Exception: One of two first year staff did not complete CINS/FINS Core during the applicable 120-day time frame and had not completed the required annual Confidentiality training prior to the end of the staff's training year.
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 new 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			As stated above, there were no applicable non-licensed mental health shelter staff during the review period.	
In-Service Direct Care Staff							
Direct care staff completes 24 hours of mandatory refresher Florida Network, SkillPro, and job-related training annually *(40 hours if the program has a DCF child caring license).*	X					Training documentation supported the program staff well-exceeded the minimun requirements of the standard and all 4 in-service staff had completed in excess of 40 hours of training annually. Training included required Florida Network and SkillPro training as well as job-related training.	
Required Training Documentation							

The program maintains an individual training file for each staff, which includes an annual employee training hours tracking form and related documentation, such as certificates, sign-in sheets, and agendas for each training attended.	X					The program maintains individual training records on each staff member reviewed. These records were composed of a list of "Bridge" trainings attended, a spreadsheet of trainings attended, a list of DJJ trainings attended, as well as certificates of completion, and sign-in sheets with hours completed for each but not cumulative.	
Provider has a written policy and procedure that meets the requirement for Indicator 1.05						**YES** **If NO, explain here:** **Indicate policy number, authorized signee, date(s) of last review/revision/approval:** Policy 1.05 - Quality Improvement, effective 11/1/2019 and Quality Improvement Plan (QIP) for FY20-23.	**Add any exceptions below:**
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					The program provided documentation of 2nd and 3rd quarter (January-June 2021) case record reviews for the residential and community based program showing reviews completed for a total of 187 and 220 cases, respectively.	
The program conducts reviews of incidents, accidents, and grievances quarterly, at a minimum	X					Incidents, accidents, and grievances are reviewed monthly and trend data is included in a Metrics Report on a quarterly basis and discussed at management team meetings. The Metrics report for FY2021 was reviewed for quarters 1-3.	
The program conducts an annual review of customer satisfaction data	X					Metrics report for FY2021, quarters 1-3, showed customer satisfaction data is reviewed quarterly. The program noted that the Florida Network began tracking the current annual client satisfaction data in July 2021.	
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					Program outcomes/service utilization is monitored by management and reported on the Metrics report for FY 2021, quarters 1-3. The findings are reviewed by management and communicated to staff and stakeholders.	

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 data reports received from the Florida Network are sent to the agency's management team and discussed at monthly management meetings and QI committee meetings. Minutes of the meetings held during the report period supported this practice. Invoices for Mar-August 2021 were reviewed and were found to be submitted timely after review and approval by each program manager is communicated via emails.	
The Florida Network conducts monthly reconciliation by comparing NetMIS data to JJIS data. Agency has evidence that they have reconciled any differences noted.	X					Program managers are responsible for verifying NetMIS and JJIS data and reconciling any differences noted. Monthly emails during the review period support review and approval by the program managers.	
The program has a process in place to review and improve accuracy of data entry & collection	X					NetMIS/JJIS data is checked by the Business Analyst through comparison of the daily planning meeting and information in the electronic system to ensure it matches. Program managers reviews and approves the data monthly for accuracy and/or discrepancies. Errors are corrected prior to submission of monthly invoices.	
There is documentation that findings are regularly reviewed by management and communicated to staff and stakeholders.	X					Findings are discussed at monthly QI Committee meetings. Minutes of meetings held February, April, and July 2021 supported discussion of findings.	
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			Typically there are about two Board of County Commissions (BOCC) meetings a month. The Department Director (DD) attends the meetings and would actively participate on the agenda as needed to share program information. Performance data report called Quarterly Community Reports is sent to the BOCC, County leadership, and the department through MailChimp. The most recent was sent on July 15, 2021.	
There is evidence that strengths and weaknesses are identified, improvements are implemented or modified, and staff are informed and involved throughout the process.	X					The agency's QI committee determines necessary action based on a review of data collected. Recommendations for corrective actions and/or policy changes are made by the committee.	

Provider has a written policy and procedure that meets the requirement for Indicator 1.06						**YES** **If NO, explain here:** **Indicate policy number, authorized signee, date(s) of last review/revision/approval:** Policy 6.47 Transporting Clients, effective 11/4/19	**Add any exceptions below:**
Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	**X**					Agency provided a list of 21 staff approved to drive clients in agency vehicles.	
Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	**X**					The agency provided supporting documentation of insurance and standard-appropriate valid drivers' licenses of the eligible staff covered under its insurance policy.	
Agency's Transportation policy prohibit transporting a client without maintaining at least one other passenger in the vehicle during the trip and include exceptions in the event that a 3rd party is NOT present in the vehicle while transporting	**X**					The agency's policy does not specifically prohibit transporting a client without at least one other passenger in the vehicle. However, it is strongly discouraged and supervisor approval is required when a 3rd party cannot be present during the transport.	
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 provided transportation records for 80 trips and in each of the 25 instances of single youth transport, the agency provided documentation of the requisite supervisor approval.	
The 3rd party is an approved volunteer, intern, agency staff, or other youth	**X**					The agency's policy provides that an approved volunteer, additional staff member or another youth can be included as a 3rd party for the purposes of transport.	
There is documentation of use of vehicle that notes name or initials of driver, date and time, mileage, number of passengers, purpose of travel and location.	**X**					The agency records provided driver name, date and time, milieage, vehicle condition, number of passengers and the destination as the purpose of travel for each of the 80 transports for which documentation was reviewed.	
Provider has a written policy and procedure that meets the requirement for Indicator 1.07						**YES** **If NO, explain here:** **Indicate policy number, authorized signee, date(s) of last review/revision/approval:** Policy 1.22 Community Outreach and Partnerships, effective 3/18/2020	**Add any exceptions below:**
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items	No Practice	Not Applicable		

Rating Criteria	Satisfactory	Non-compliant	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 agency has designated its Operations Manager as the person to attend the monthly Circuit 13 Juvenile Justice Advisory Board meetings. The agency provided meeting minutes for these meetings held: 1-15-21 (42 attendees); 2-19-21 (28 attendees); 3-19-21 (40 attendees); 4-16-21 (30 attendees); 5-21-21 (28 attendees).	
Outreach and prevention services are provided by designated staff and include increasing community awareness, offering informational and educational CINS/FINS services to youth and families.	X					The agency's Operations Manager also regularly attends monthly "Community Alliance" meetings as verified by review of meeting minutes from 2-9-21; 3-9-21; 4-13-21; and 6-8-21. In addition, the agency provided records of a total of 24 NetMIS Outreach performed during the reporting period. There were no meeting minutes provided for these Outreach: four (4) Children's Committee meetings: 2-5-21 (25 adult attendees); 3-5-21 (16 adult attendees); 5-7-21 (28 adult attendees) and 6-4-21 (21 adult attendees). The NetMIS Outreach records also reflect that the agency attended one (1) CCL Provider's meeting (51 adult attendees), as well as a Tampa Police Department meeting (30 in adult attendees). Eight (8) separate outreach records show only one adult attendee, six (6) distinct outreach records include three or fewer adult attendees; while four (4) separate outreach records do not reflect the number of attendees.	
The program maintains written agreements with other community partners which include services provided and a comprehensive referral process.	X					Agency provided 12 Memorandums of Understanding with other community partners setting forth processes and agreements as required by the indicator.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.01						**YES** **If NO, explain here:** **Indicate policy number, authorized signee, date(s) of last review/revision/approval:** Policy 9.01 Screening and Eligibillity, effective 11/01/2019. Policy 9.08 Informing Clients of their Rights and Responsabilities, effective 12/1/2018.	**Add any exceptions below:**
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items	No Practice	Not Applicable		

Rating Criteria	Satisfactory	Non-compliant	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 5 residential files were reviewed for 2 open and 3 closed youth. Five out of the 5 residential youth files reviewed had screenings completed immediately upon referral. Three Secret Shopper calls were made to the agency between September 2-4, 2021. Two of the three calls resulted in an immediate screening and acceptance within 30 minutes. One screening was not completed due to shift change.	
Community counseling: Eligibility screening is completed within 3 business days of referral by a trained staff using the NetMIS form	X					A total of 5 community counseling files were reviewed for 2 open and 3 closed youth. Five out of the 5 community counseling youth files reviewed had their screening completed within 3 business days of the referral.	
There is evidence all referrals for service is screened for eligibility and is logged in NetMIS within 72 hours of screening completion.		X				Two of the 10 youth files reviewed were screened for eligibility after the effective date, August 1, 2021, of this indicator. Both screenings were logged in NetMIS within 72 hours of screening completion. Three Secret Shopper calls were made to the agency between September 2-4, 2021. Two of the three calls resulted in an immediate screening but none of the screenings were entered into Netmis.	Exception: Two of the three Secret Shopper calls made to the agency resulted in an immediate screening: however, none of the two screenings were entered into Netmis as required.
Youth and parents/guardians receive the following in writing: a. Available service options b. Rights and responsibilities of youth and parents/guardians	X					All 10 youth files reviewed had a consent form signed by the parents and the youth indicating they had received the available service options and rights and responsibilities of the 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)	X					All 10 files reviewed supported that the youth and parent had received information regarding possible actions ocurring through involvement with CINS/FINS (case staffing committee, CINS petition, and CINS adjudication). Additionally, grievance procedures were provided during intake to all 10 youth.	

b. Grievance procedures							
Provider has a written policy and procedure that meets the requirement for Indicator 2.02						**YES** **If NO, explain here:** **Indicate policy number, authorized signee, date(s) of last review/revision/approval:** Policy 4.03 Needs/Bio Psychosocial Assessments, effective date 11/01/2019	**Add any exceptions below:**
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Completion of Needs Assessment							
Shelter Youth: Needs Assessment initiated within 72 hours of admission	**X**					All 5 residential youth files reviewed contained initiation dates on the Needs Assessment and were found to occur within 72 hours of admission.	
Non-Residential youth: Needs Assessment is done within 2 to 3 face-to-face contacts after the initial intake **OR** updated, if most recent assessment is over 6 months old	**X**					All 5 community counseling youth files reviewed contained information indicating the Needs Assessment was completed within 2-3 face-to-face contacts after the initial intake.	
Needs Assessment is conducted by a bachelor's or master's level staff member	**X**					The Needs Assessments were completed by a bachelor's or master's level staff member in all 10 files reviewed.	
Needs Assessment includes a supervisor's review signature upon completion	**X**					All 10 Needs Assessments reviewed were signed and dated by a supervisor.	
Suicide Risk as a Result of the Needs Assessment							
Youth was identified with an elevated risk of suicide as a result of the Needs Assessment			**X**			None of the 10 youth files reviewed were identified during screening/intake as a suicide risk.	
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**			Not applicable to the 10 youth files reviewed.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.03						**YES** **If NO, explain here:** **Indicate policy number, authorized signee, date(s) of last review/revision/approval:** Policy 4.17 Treatment Plans, effective 02/19/2019	**Add any exceptions below:**
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		

Case/Service plan is developed within 7 working days of Needs Assessment		X				Service plans were completed within 7 working days of completion of the Needs Assessment in 9 out of the 10 youth files reviewed.	Exception: The service plan was not initiated within seven (7) days of completion of the Needs Assessment in one of the 5 community counseling youth files reviewed.
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 10 youth files reviewed included all elements required by the indicator. Two of the 10 service plans were recently initiated and completion dates were not applicable for some of the goals; however, the plan contained an area to document this information.	
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				Applicable to 1 out of the 5 residential youth files and all 5 community counseling files reviewed. Reviews were completed at 14 and 28 days in the residential youth file. One of the 5 applicable community counseling service plans was not reviewed at all and progress note indicated the youth and mother were not complying with the services. Additionally, 2 of the 5 community counseling youth files reviewed demonstrated reviews every 30 days for the first three months.	Exception: Two of the 5 applicable community counseling service plans were not reviewed on time within the required 60-day timeframe.
Provider has a written policy and procedure that meets the requirement for Indicator 2.04						**YES** **If NO, explain here:** **Indicate policy number, authorized signee, date(s) of last review/revision/approval:** Policy # 4.15 Case Management and Service Delivery, effective date 7/1/2018	**Add any exceptions below:**
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Counselor/Case Manager is assigned	X					Each of the 10 records reviewed showed a counselor or case manager was assigned to the youth.	

The Counselor/Case Manager completes the following as applicable: 1. Establishes referral needs and coordinates referrals to services based upon the on-going assessment of the youth's/family's problems and needs 2. Coordinates service plan implementation 3. Monitors youth's/family's progress in services 4. Provides support for families 5. Monitors out-of-home placement (if necessary) 6. Makes referrals to the case staffing to address problems and needs of the youth/family 7. Accompanies youth and parent/guardian to court hearings and related appointments 8. Refers the youth/family for additional services when appropriate 9. Provides case monitoring and reviews court orders 10. Provides case termination notes 11. Provides follow-up after 30 days of exit 12. Provides follow-up after 60 days of exit	X					All applicable youth files established referral needs to service based upon the ongoing assessment of youth/family and needs for service based on the Need Assessment. For 2 out of the 10 files reviewed there was documentation of referrals to case staffing to address problems and needs of the youth and family. The 5 residential files reviewed demonstrated monitoring out-of-home placement. Support was provided and documentation were in applicable case notes. None of the files required accompanying youth and family to court hearing and appointments. There was a total of 4 open and 6 closed cases reviewed. Four of the 10 files did not require termination notes as they were still open. The 6 closed youth files reviewed had follow up completed after the 30 days of exit on time and 2 applicable files had their follow-up after 60 days of exit completed on time.	
The program maintains written agreements with other community partners that include services provided and a comprehensive referral process	X					Agency provided 12 Memorandums of Understanding with other community partners including referral services for education, counseling, tutoring, food preparation, and substance abuse.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.05						**YES** **If NO, explain here:** **Indicate policy number, authorized signee, date(s) of last review/revision/approval:** Policy # 4.08 Individual, Group and Family Counseling, effective 01/11/2018	**Add any exceptions below:**
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		

Youth and families receive counseling services, in accordance with the youth's case/service plan, to address needs identified during the assessment process	X					All 10 youth files reviewed contained counseling services in accordance with the youth's service plan and addressed needs identified during the assessment process.	
Shelter Program							
Shelter programs provides individual and family counseling	X					All 5 residential youth files reviewed demonstrated individual and family counseling was provided.	
Group counseling sessions held a minimum of five days per week	X					The group logs from May 2021- August 2021 demonstrated the program provides group counseling sessions a minimum of five days per week. Whenever a group session was not conducted, there was documentation indicating why it had been suspended and/or replaced by another activity.	
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					The group logs from May 2021-August 2021 demonstrated the length of at least 30 minutes or more, opportunity for youth engagement, clear and relevant topics, and a leader and/or facilitator.	
Community Counseling							
Community counseling programs provide therapeutic community-based services designed to provide the intervention necessary to stabilize the family. Services are provided in the youth's home, a community location, the local provider's counseling office or virtually if written documentation is provided in the youth's file for reasons why it is in the best interest of the youth and family.	X					All 5 community counseling youth records reviewed contained therapeutic community-based services provided by the assigned staff. Information was found through progress notes, referrals, and consent forms.	
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 10 youth files reviewed contained coordination of services for needs identified.	

Maintain individual case files on all youth and adhere to all laws regarding confidentiality	X					All 10 files reviewed demonstrated individual case files on the youth and adhering to all laws regarding confidentaility.	
Case notes maintained for all counseling services provided and documents youth's progress	X					All 10 files reviewed contained case notes for counseling services provided and the youth's progress.	
On-going internal process that ensures clinical reviews of case records and staff performance	X					All 10 files reviewed demonstrated on-going internal process that includes clinical reviews of case records by the supervisor.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.06						**YES** **If NO, explain here:** **Indicate policy number, authorized signee, date(s) of last review/revision/approval:** Policy 4.29, Case Staffing Referrals and Services, effective 1/15/2020.	**Add any exceptions below:**
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Case Staffing Initiation and Notifications							
If parent/guardian initiates, staffing is held within 7 days	X					Three of the 5 files reviewed for case staffing were requested by the parent and the staffing was held within 7 days of the request.	
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					All 5 files reviewed demonstrated notification to the committee, and youth and family 5 days prior to the case staffing.	
Case Staffing Committee							
Must include: a. DJJ rep. or CINS/FINS provider b. Local school district representative	X					The case staffing committee included a DJJ representative, CINS/FINS provider, and their local school district representative present in all 5 files reviewed.	
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			X			No additional parties other than the case stafing committee members, the youth/family, and the state attorney's office were present during the case staffing meetings in the 5 files reviewed.	

f. Mental health representative							
The program has an established case staffing committee, and has regular communication with committee members	X					Case staffing committee consist of: Hillsborough County School District, Department of Juvenile Justice, Youth Advocate Program, Pace Center for Girls, Tamapa Housing Authority, Hillsborough County Department of Children's Services and DJJ Assistance General Counsel. There is regular communication with these committee members.	
The program has an internal procedure for the case staffing process, including a schedule for committee meetings	X					Policy 4.28 outlines the program's internal procedure for case staffing process.	
As a result of the Case Staffing							
The youth and family are provided a new or revised plan for services	X					All 5 files reviewed demonstrated new and/or revised plans for services following the case staffing committee's recommendations.	
Written report is provided to the parent/guardian within 7 days of the case staffing meeting, outlining recommendations and reasons behind the recommendations	X					All 5 files demonstrated the parent/guardian is provided a report of the committee recommendations at the end of the case staffing meeting.	
If applicable, the program works with the circuit court for judicial intervention for the youth/family			X			None of the 5 youth records reviewed needed judicial intervention for the youth/family.	
Case Manager/Counselor completes a review summary prior to the court hearing			X			Not applicable for the 5 youth files reviewed.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.07						**YES** **If NO, explain here:** **Indicate policy number, authorized signee, date(s) of last review/revision/approval:** **Policy #4.37 Storing/ Disposition of Client Records, effective 8/1/2018.**	**Add any exceptions below:**
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
All records are clearly marked 'confidential'.	X					All hard copy youth files are stamped with the word "Confidential" in the front.	
All records are kept in a secure room or locked in a file cabinet that is marked "confidential"	X					During the in-person tour, files were observed to be stored in a locked room in locked file cabinets marked "Confidential".	
When in transport, all records are locked in an opaque container marked "confidential"	X					When the youth's records are transported they are locked in a secured opague locked box marked "confidential".	

All records are maintained in a neat and orderly manner so that staff can quickly and easily access information	X					All 10 youth records reviewed were observed to be organized and maintained for easy access of information.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.08						**YES** **If NO, explain here:** **Indicate policy number, authorized signee, date(s) of last review/revision/approval:** Policy 6.02 SOGIGE, effective 1/30/2020	**Add any exceptions below:**
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Use of youth's preferred name/ pronoun: a. Youth are addressed according to their preferred name and gender pronouns b. Youth's preferred name and gender pronouns are used in logbook and on all outward-facing documents and census boards	X					Two applicable residential youth files, one open and one closed, were reviewed. One of the two youth's file clearly documented expressed preference for being called another name and use of gender related pronoun which was consistently used in the logbook and all outward-facing documents. Per the counselor, the other youth did not express a preference for name and/or gender pronoun although it was noted the youth's gender identity is female.	
Youth in need of specialized support is referred to qualified resources (as applicable)			X			None of the two files reviewed required specialized support/services.	
Youth preference is considered and documented for room assignment and youth is not roomed in isolation due to sexual orientation, gender identity, or gender expression	X					The two youth's preference for room assignment was honored by the program and youth was not roomed in isolation.	
Youth is provided hygiene products, undergarments and clothing that affirms their gender identity or gender expression			X			None of the two youth records indicated youth requested items that affirm their gender identity.	
The agency has signage and brochures/publication placed in common areas indicating that all youth are welcome regardless of sexual orientation, gender identity, and gender expression	X					SOGIE signage is located in cottage E and Cottage F in the day room. The signs are on the walls next to the youth care worker office. The signs are directly across from the seating area in the day room.	
						YES **If NO, explain here:**	

Provider has a written policy and procedure that meets the requirement for Indicator 2.09						Indicate policy number, authorized signee, date(s) of last review/revision/approval: Policy 4.36, Specialized Populations Services, effective 1/15/2019.	Add any exceptions below:
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Staff Secure							
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? **(If no, select rating "No eligible items for review")**			**NO**			The provider has not served any youth meeting the criteria for staff secure since the last QI review.	
Staff Secure policy and procedure outlines the following: a. In-depth orientation on admission b. Assessment and service planning c. Enhanced supervision and security with emphasis on control and appropriate level of physical intervention d. Parental involvement e. Collaborative aftercare	**X**					Program policy 4.36, Specialized Populations Services, outlines the requirement for provision of Staff Secure services.	
Program only accept youth that meet legal requirements of F.S. 984 for being formally court ordered in to Staff Secure Services			**X**			No eligible youth served.	
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 eligible youth served.	
Agency provides a written report for any court proceedings regarding the youth's progress			**X**			No eligible youth served.	

Domestic Minor Sex Trafficking (DMST)							
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? **(If no, select rating "No eligible items for review")**			**NO**			The provider has not served any youth meeting the criteria for DMST since the last QI review.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Agency has evidence that the FNYFS was contacted for approval prior to admission for all Domestic Minor Sex Trafficking (DMST) placements.			**X**			No eligible youth served.	
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 eligible youth served.	
Services provided to these youth specifically designated services designed to serve DMST youth			**X**			No eligible youth served.	
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 eligible youth served.	
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 eligible youth served.	

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 eligible youth served.	
All other services provided to DMST youth are consistent with all other general CINS/FINS program requirements			X			No eligible youth served.	
Domestic Violence							
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? **(If no, select rating "No eligible items for review")**	**YES**						
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Youth admitted to DV Respite placement have a pending DV charge and have evidence of being screened by JAC/Detention, but do not meet criteria for secure detention	**X**					One open and two closed Domestic Violence (DV) youth records were reviewed. One of the closed records was a domestic violence civil citation referral that was referred by law enforcement. A DJJ face sheet was present in the two files that were screened and referred by JAC.	
Data entry into NetMIS and JJIS within (3) business days of intake and discharge		**X**				One of the three DV youth records reviewed was entered into NetMIS within 3 business days as required and all three records were discharged and entered into NetMIS and JJIS within the required 3 days timeframe.	Exception: Two of the 3 DV youth records reviewed did not meet the NetMIS intake data entry timeframe of 3 business days.
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; however, one youth needed an extended stay and was transitioned to CINS/FINS.	

Case plan in file reflects goals focusing aggression management, family coping skills, or other intervention design to reduce reoccurrence of violence in the home	X					Case plans in the three youth records reflect goals for reducing violence and coping skills.	
All other services provided to Domestic Violence Respite youth are consistent with all other general CINS/FINS program requirements	X					Case notes demonstrate all three 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")**	**YES**						
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
All probation respite referrals are submitted to the Florida Network.	X					Two closed probation respite youth records were reviewed. Approvals by the Florida Network were obtained for each youth as evidenced by approval emails.	
Probation Respite Referral come from DJJ Probation and are all youth referred on probation regardless of adjudication status	X					A DJJ Face sheet was present in all 3 files showing probation status of each youth.	
Data entry into NetMIS and JJIS within (3) business days of intake and discharge	X					Data entry timeframes were met as evidenced by NetMIS youth listings report and JJIS prevention module log.	
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					Probation exit date for each youth record did not exceed 30 days length of stay.	
All case management and counseling needs have been considered and addressed	X					Case plans in the three youth records reflect goals for reducing violence and coping skills.	
All other services provided to Probation Respite youth are consistent with all other general CINS/FINS program requirements	X					Case notes demonstrate all three youth received shelter services consistent with CINS/FINS program requirements.	
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")**	**YES**						
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Youth receiving services was court ordered	**X**					Three open youth records were reviewed. All three youth were referred by the case staffing committee and court ordered.	
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**					Case notes for all 3 youth demonstrate each youth and family had a minimum of 2 direct contacts per month and 2 collateral contacts per week.	
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**				The three youth records reviewed contained a CBCL completed within 14 days of intake and an approved self-report completed at intake. One of the three records had evidence of completion of a self report at 90 days.	Exception: Two of the 3 ICM records reviewed did not have a 90-day self report completed as required.
Case plan demonstrates a strength-based, trauma-informed focus	**X**					Case plans in the three youth records reflect strength-based trauma-informed focus.	

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					Case plans for all three youth demonstrate goals and interventions are strength based, trauma informed focused, and strives to engage the youth/family.	
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")**	**YES**						
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					Three closed youth records were reviewed. All three youth were referred by DJJ for domestic violence arrest.	
Agency has evidence that all FYRAC referrals have documented approval from the Florida Network office	X					Approvals by the Florida Network were obtained for each youth as evidenced by approval emails.	
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				All three records included an initial assessment conducted face-to-face during intake. Only one of the three records included the development of the service plan.	Exception: The service plans for two of the three youth were not developed during the intake.
Life Management Sessions meets the following criteria:						Two applicable youth records document the required life management and individual sessions. The third	

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					youth's stay was terminated	
Group Sessions: a. Focus on the same issues as individual/family sessions with the overall goal of strengthening relationships and prevention domestic violence b. Shall be no more than eight (8) youth at one (1) time and shall be for a minimum of sixty (60) minutes per session			X			No group sessions were provided.	
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					All three youth were discharged prior to serving 90 consecutive days.	
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:** HCCS is not a SNAP Provider. **Indicate policy number, authorized signee, date(s) of last review/revision/approval:**	**Add any exceptions below:**
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
SNAP Clinical Groups							
Youth are screened to determine eligibility of services					X		
Needs assessment is completed at initial intake, or within two face-to-face sessions					X		

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) There must be at least three (3) documented attempts in the youths' file to obtain all pre-assessment (listed above) information.					X		
SNAP discharge report summary					X		
SNAP Boys/SNAP Girls **Parent** Group Evaluation Form					X		
SNAP Boys/SNAP Girls **Child** Group Evaluation Form					X		
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		
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		

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		
"Class Goal" sheet					X		
Measure of Classroom Environment (MoCE) (Pre and Post) is used to identify baseline and treatment outcomes of reported classroom dynamics.					X		
Pre and Post Evaluations					X		
One SNAP® Fidelity Adherence Checklist completed per classroom in a 13 – week SNAP in Schools group and uploaded to Dropbox					X		
Provider has a written policy and procedure that meets the requirement for Indicator 3.01						**YES** **If NO, explain here:** **Indicate policy number, authorized signee, date(s) of last review/revision/approval:** Policy 5.02 – Safety and Sanitation Inspections, effective 4/1/2018, and policy 6.84 – Residential Youth Living, effective 8/1/2018.	**Add any exceptions below:**
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		

Facility Inspection		**X**				Date of facility inspection(s) reviewed: The facility inspection was conducted via in-person tour on 9/2/2021. A Forefront team member conducted the onsite facility inspection and found that the grounds were clean, the furnishings in good repair, and the grounds are landscaped and well-maintained. The tour included the main lobby area, Cottages E & F, the common/living areas, male/female bedrooms, kitchen area, laundry room, staff offices, and exterior areas. The reviewer noted that some of the light film covering the windows were peeling. The bathroom and shower areas are functional but noted that there is a tile in the shower in the boy's Cottage E that needs to be repaired and/or replaced and mold on one of the ceilings to be addressed. Some blinds have cords (or bearded ropes). The kitchen has a clean and maintained food storage area. All food storage areas were clear. The campus has ended it's food service program through the cafeteria. All food is brought into the facility multiple times a day and delivered to each cottage, respectively. Staff cart food and place it accordingly into refrigerators located in each cottage. Refrigerators are maintaining appropriate temperatures for both the cool storage and the freezer in both cottages. Cold food is stored properly, marked and labeled.	Exception: • Repair and/or replacement of tile in the shower is needed in the boy's Cottage E • There is mold on ceilings in bathroom of Cottage E • There are blinds that have cords or bearded ropes instead of being cordless • There does not appear to be an inspected and tagged fire extinguisher located in the Prius; the other fire extinguisher found in other minivan had a tag that was expired and needs to be re-inspected. • There is no airbag deflator tool in the minivans • One of the minivans appear to have a soiled interior

Additional Facility Inspection Notes	The reviewer did not see that food is being dated appropriately in both refrigerators in both cottages. Pantry/dry storage is not applicable due to program having food brought in multiple times of day. No evidence of graffitti on walls, window, or doors. There is sufficient light to complete tasks performed; the dumpters were secured, and vehicles were secured. There were three vehicles inspected - one was inoperable. Fire extinguishers were found in two of the three vehicles. All other tools were stored in a clipboard type of tin box that is checked out with the keys on each transport session. None of the tools were equipped with an air bag deflator. The minivan requires cleaning in the interior of the vehicle. Each cottage has a knife for life in both cottage E and F. Access is limited to the staff and key control is in compliance. The abuse hotline, egress maps for the facility, DJJ Incident Reporting #, SOGIE, and general client rules are visibly posted in common areas and the cottages. In addition, the DCF Child Care License and COA documents are posted in the windows of the direct care workers. The DCF Child Care License certificate was issued on 8/1/21 and expires on 7/31/22 and the COA certificate was issued 5/3/21. The agency submitted their chemical inventory spreadsheet dated 5/2021 - 7/2021 which is reviewed weekly by the staff. All items appeared to be accounted for and neatly maintained in storage area. Washer and dryers are functional. Each youth has their own individual bed that has clean sheets and pillows and clients have access to a space for personal items, if needed. One metal wand is located in the direct care worker office in both cottages E and F. The metal wand was not operating in cottage E. The flashlights were not working in cottage E. The RSC was able to locate new batteries and replace the batteries in the flashlight and they were now operating properly.	• Knife-for-life tool used needs to be upgraded to more effective multifunction self-rescue tool as wire cutters were not found • It was not easy to comprehend new chemicals and MSDS sheets. • Metal wand in cottage E was not operating because it needed new batteries.

Fire and Safety Health Hazards	**X**					Date of fire inspection(s) reviewed: Piper Fire Protection completed annual sprinkler inspection on 5/6/21. Protegis Fire Safety completed the fire extinguisher inspections on 3/18/21; State Alarms Systems, Inc. began the alarm systems inspections on 7/21/21 and commenced on 7/22/21; All Florida Fire Equipment completed kitchen overhead hood inspection on 3/16/21. There were several fire extinguishers located throughout the administrative, education, medical and all the resident cottages. Both cottages E and F have two fire extinguishers that been inspected and are located and easy accessible areas in each cottage. Both cottages have detailed egress maps displayed in the common areas with floorplans of the entire cottage. The Department of Health inspection was completed on 3/16/21 and no deficiencies were identified which places the agency as a Satisfactory Residential Group Care Inspection. Department of Health - County Health Department Food Inspection was completed on 4/1/21 with no violations documented. The agency completes a fire drill at least once a month within 2 minutes or less (random dates were reviewed between the months of February - June 2021). Mock emergency drills were conducted on the following dates: 2/28/21 (managerial scenarios - staff only), 3/27/21 (managerial scenarios - staff only), 4/1/21 (4 staff/12 youth - absconded youth from neighboring school, further follow-up not needed), 5/18/21 - alert due to alligator sighting, 6/28/21 & 6/29/21 (managerial scenarios - staff only), 7/6/21 - preparation for Tropical Storm Elsa. The Department of Health inspection was completed on 3/16/21 - no violations or deficiencies documented or observed.	

Additional Fire and Safety Health Hazards Notes	Department of Health Food Inspection was completed on 4/1/21 and no violations were documented. Food are properly stored, labeled, and marked in the kitchen. According to Department of Health report, all refrigerators in the facilities are kept at 40 degrees Farenheit or below equipped with thermometers. The milk was between 35 - 40 degrees Farenheit. The water in the refrigerator were gauged between 110 - 115 degrees Farenheit. Both freezer and fridge were documented as equipment in compliance.	
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**					Agency provides youth activites that are meaningful and structured inclusive of physical activity at least once per week. Monthly calendars were reviewed for the months of February - August 2021 which reflects a variety of activities to keep the youth engaged. Youth are provided an opportunity to participate in faith-based activities. Daily programming includes a homework hour from 6pm - 7pm. The daily programming calendar is visibly posted in the commom areas for both staff and youth.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.02						**YES** **If NO, explain here:** **Indicate policy number, authorized signee, date(s) of last review/revision/approval:** Policy 9.07, Residential Youth Orientation, effective 1/15/2019.	**Add any exceptions below:**
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Youth received a comprehensive orientation and handbook provided within 24 hours	**X**					A total of four files were reviewed - two open and two closed. Youth received a comprehensive orientation and handbook 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						A total of four files were reviewed - two open and two closed. The program orientation list contained all elements of the indicator and was observed in all four files.	

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						
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					A documentation of each component was found in the files for the clients and accessible. The Suicide Prevention plan is outlined in the Youth Handbook and a tour is given when the youth comes in to the facility (the egress map is posted in the common areas). All required signatures were reviewed.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.03						**YES** **If NO, explain here:** **Indicate policy number, authorized signee, date(s) of last review/revision/approval:** Policy 9.07, Residential Youth Orientation, effective 1/15/2019.	**Add any exceptions below:**
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
A process is in place that includes an initial classification of the youths, to include:							
a. Review of available information about the youth's history, status and exposure to trauma b. Initial collateral contacts, c. Initial interactions with and observations or the youth d. Separation of younger youth from older youth,						A total of four files were reviewed - two open and two closed. The room assignment procedure is implemented during the intake process. The intake form documented the youth's history, status, age and exposure to trauma to determine youth assignment.	

e. Separation of violent youth from non-violent youth f. Identification of youth susceptible to victimization g. Presence of medical, mental or physical disabilities h. Suicide risk i. Sexual aggression and predatory behavior j. Sexual orientation gender identity/ expression k. Acute health symptoms requiring quarantine or isolation	X						
An alert is immediately entered into the program's alert system when a youth is admitted with special needs and risks such as risk of suicide, mental health, substance abuse, physical health or security risk factors	X					Any alerts were documented in the file to identify if the youth is admitted with a special needs and at risk of suicide, mental health, substance abuse, physical health, or security risk factors. For example, the staff member noted on the file and indicated the need for an individual room if there is a safety risk.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.04						**YES** **If NO, explain here:** **Indicate policy number, authorized signee, date(s) of last review/revision/approval:** Policy 6.86, Logbooks, effective 7/1/2019.	**Add any exceptions below:**
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Log book entries that could impact the security and safety of the youth and/or program are highlighted	X					The staff highlight logbook entries that could impact security and safety to youth and/or program.	
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					The logbook was reviewed for timeframes: Week 2 - March; Week 3 - April; Week 4 - May; Week 1 - June; Week 2 - July; Week 3 - August The agency utilizes an electronic database, NoteActive. All of the entries are brief, legibly written including the date, time, names of the youth, staff and brief statement providing pertinent information including the staff's name and their signature.	

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					The recording errors are struck through with a single line. Whiteout or erasures were not observed.	
The program director or designee reviews the facility logbook(s) every week and makes a note chronologically in the logbook indicating the dates reviewed and if any correction, recommendations and follow-up are required and sign/date the entry	X					The RSC reviews the facility logbook every week and notates the dates reviewed and provides any updates or corrections/follow-ups.	
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				Staff did not consistently review the logbook to the previous two shifts, as outlined in the policy.	Exception: Direct care staff not clearly notating review of previous two shifts (at minimum) with evidence of date and signature at time of entry.
At the beginning of their shift, oncoming supervisor and shelter counselor reviews the logbook of all shifts since their last log entry and makes a signed and dated entry and into log book indicating the dates reviewed.	X					The oncoming supervisor and shelter counselor reviews the logbook of all shifts since their last log entry and makes a signed and dated entry into log book indicating the dates reviewed.	
Logbook entries include: a. Supervision and resident counts b. Visitation and home visits	X					The supervision and resident counts are included as well as visitation and home visits.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.05						**YES** **If NO, explain here:** **Indicate policy number, authorized signee, date(s) of last review/revision/approval:** Policy 4.02, Behavior Management System, effective 3/30/20.	**Add any exceptions below:**
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		

The program has a detailed written description of the BMS, and it is explained during program orientation	X					The agency currently utilizes a point-system that is explained during program orientation and outlined in the client handbook.	
Behavior Management Strategies MUST include: a. Supervisors are trained BMS is designed to teach youth new behaviors and help youth understand the natural consequences for their actions b. Behavioral interventions are applied immediately, with certainty, and reflect the severity of the behavior c. BMS uses a wide variety of awards/incentives to encourage participation and completion of the program d. Appropriate consequences and sanctions are used by the program and consequences for behavior are logical and designed to promote skill-building for the youth e. Counseling, verbal intervention and de-escalation techniques are used prior to physical intervention (Only techniques approved by the Florida Network and DJJ are used if physical intervention is required) f. Only staff discipline youth. Group discipline is not imposed g. Room restriction is not used as part of the system or for youth who are physically and/or emotionally out of control	X					As outlined in their policy, the BMS utilizes a variety of incentives to encourage positive behavior and implement appropriate consequences. Appropriate counseling, verbal interventions, and de-escalation techniques are utilized prior to any physical interventions.	

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					The staff has received training in the theory and practice of administering BMS rewards and consequences as confirmed by the Operations Manager.	
There is a protocol for providing feedback and evaluation of staff regarding their use of BMS rewards and consequences	X					Per the Operations Manager, the youth feedback includes the grievance box and continual staff discussion and meetings regarding the BMS system.	
Supervisors are trained to monitor the use of rewards and consequences by their staff		X				There are three supervisors who oversee the cottages for the youth. The agency was able to provide proof of BMS training for one of the three supervisors.	Exception: The program was unable to provide proof of BMS training for two of the three supervisors.
Provider has a written policy and procedure that meets the requirement for Indicator 3.06						**YES** **If NO, explain here:** **Indicate policy number, authorized signee, date(s) of last review/revision/approval:** Policy 6.13, Staffing and Client Supervision, effective 7/1/2019.	**Add any exceptions below:**
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
The program maintains minimum staffing ratios as required by Florida Administrative Code and contract. • 1 staff to 6 youth during awake hours and community activities • 1 staff to 12 youth during the sleep period	X					Reviewed random staff schedules and cross-referenced to NoteActive Logbook. A review of staff schedules and logbook entries documented the required staffing ratios were met for the awake hours and sleeping hours.	
All shifts must always provide a minimum of two staff present	X					All shifts provided 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					Only staff that are background screened and properly trained are included on the staff schedules and shifts.	

The staff schedule is provided to staff or posted in a place visible to staff	X					Per the Operations Manager, the staff schedule is visibly posted in the cottages in the shelter office.	
There is a holdover or overtime rotation roster which includes the telephone numbers of staff who may be accessed when additional coverage is needed	X					There is a holdover/overtime rotation and a staff telephone book that can be accessed when additional coverage is needed - located in shelter office in cottages.	
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					The agency's policy is to conduct bed checks every 10 minutes. A random sample of times for the following video surveillance bed checks were conducted on dates 6/11/21, 6/14/21, 6/19/21, & 6/27/21. Staff adhered to the QI indicator's requirement of observing youth at least every 15 minutes while in their sleeping room during their sleeping period. Physical layout of sleeping arrangements: Due to COVID-19 restrictions, the youth census has been reduced to ensure client safety.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.07						**YES** **If NO, explain here:** **Indicate policy number, authorized signee, date(s) of last review/revision/approval:** Policy 5.18, Video Camera Surveillance System, effective 7/1/2019.	**Add any exceptions below:**
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Surveillance System							
The agency, at a minimum, shall demonstrate: a. A written notice that is conspicuously posted on the premises for the purpose of security b. System can capture and retain video photographic images which must be stored for a minimum of 30 days						The property has a comprehensive camera system that is operational at the time of this review. Cameras are mounted in the day room only. Each day room has a camera facing the entrance and a camera in the kitchen area. The system can capture and retain video photographic images which must be stored for a minimum of 30 days. It is capable of recording the date, time, and location. All cameras are visible and postings in the facility indicate that cameras are on the premises.	

c. System can record date, time, and location; maintain resolution that enables facial recognition d. Back-up capabilities consist of cameras' ability to operate during a power outage e. Have cameras placed in interior and exterior general locations of the shelter where youth and staff congregate and where visitors enter and exit. Cameras are never placed in bathrooms or sleeping quarters. f. All cameras are visible	X						
A list of designated personnel who can access the video surveillance system is maintained (includes off-site capability per personnel)?	X					The Operations Manager provided a list of 7 designated personnel who can access the video surveillance system.	
Supervisory review of video is conducted a minimum of once every 14 days and timeframes reviewed are noted in the logbook. The reviews assess the activities of the facility and include a review of random sample of overnight shifts	X					The supervisory review of the video is conducted a minimum of once every 14 days and noted in the logbook. The previous reviews document that the camera system has been down as it is able to continue to record but not viewed. The agency is working with their outside provider to complete the repair. Reviewer observed video supervisor log from June 2021 - July 2021 which reflected documentation of camera being down.	
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 agency grants the request of video recordings to yield a result within 24-72 hours from program quality improvement visits and when an invesigation 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					Staff confirmed that camera service orders are made within 24 hours of discovery of camera malfunctioning or being inoperable. During the QI Review the Department Director advised recordings requested during the month of August were not available as the Network Video Recorder for the video surveillance system has been down since July and the county has a third party vendor who has made a few attempts to repair the system. All efforts made to obtain repairs are documented and maintained. Email communication was provided demonstrating work orders, attempted repairs, request for new equipment, and approval of final purchase order to acquire and install new system. It is anticipated the new system will be installed by the end of September 2021.	
Provider has a written policy and procedure that meets the requirement for Indicator 4.01						**YES** **If NO, explain here:** **Indicate policy number, authorized signee, date(s) of last review/revision/approval:** Policy 7.13 - Residential Health Screenings, effective 6/1/2019	**Add any exceptions below:**
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Preliminary Healthcare Screening							
Screening includes : a. Current medications b. Existing (acute and chronic) medical conditions c. Allergies d. Recent injuries or illnesses e. Presence of pain or other physical distress f. Observation for evidence of illness, injury, physical distress, difficulty moving, etc. g. Observation for presence of scars, tattoos, or other skin markings	X					All five youth records contained a preliminary health screening completed at the time of the youth's admission to the shelter. The preliminary screening is documented on the Florida Network of Youth and Family Services CINS/FINS Intake Form. All five screenings were completed by non-health care staff. Four of the five Intake forms were signed by the nurse on the last page of the intake form indicating the screening was reviewed. The intake screening for one youth was not signed by the nurse. All five youth had a nursing assessment completed. The nursing assessment addressed the youth's current medications, existing medical conditions, allergies, recent injuries or illnesses, presence of pain or other physical distress, observation for evidence of illness,	

h. Acute health symptoms requiring quarantine or isolation						injury, physical distress, and the observation for the presence of scars, tattoos, or other skin markings. There was no where on the assessment to document acute health symptoms requiring quarantine or isolation. An interview with the nurse indicated if the youth required quarantine or isolation, it would be documented on the intake form. The nurse explained at the current time, all youth receive a COVID screening at time of admission and are kept isolated until the tests results are received.	
Referral and Follow-up							
Youth with chronic medical conditions have a referral to ensure medical care (e.g. diabetes, pregnancy, seizure disorder, cardiac disorders, asthma, tuberculosis, hemophilia, head injuries, etc.)	**X**					None of the youth records randomly selected required medical referrals or follow-up medical care while at the shelter. Two additional records were reviewed. Both youth were identified as needing a dental exam. The second youth was also identified as needing a physical exam.	
When needed, the parent is involved with the coordination and scheduling of follow-up medical appointments	**X**					The two additional records reviewed provided documentation to support the nurse followed-up with the youth's parent to coordinate the needed services.	
All medical referrals are documented on a daily log.	**X**					Two additional records reviewed supported the nurse documented the referrals made to the parent.	
The program has a thorough referral process and a mechanism for necessary follow-up medical care as required and/or needed	**X**					The program has a nurse responsible for referral and follow up of medical care for youth. The youth who required the dental exam and the physical exam were released from the shelter prior to the parent being able to make the appointments.	
Provider has a written policy and procedure that meets the requirement for Indicator 4.02						**YES** **If NO, explain here:** **Indicate policy number, authorized signee, date(s) of last review/revision/approval:** Policy 4.19 - Suicide Prevention and Intervention - effective 1/15/2020.	**Add any exceptions below:**
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Suicide Risk Screening and Approval							

Suicide risk screening occurred during the initial intake and screening process. Suicide screening results reviewed and signed by the supervisor and documented in the youth's case file.	X					Four out of four youth records contained a completed suicide risk screening completed during the intial screening process.	
The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	X					HCCS uses the Assessment of Suicide, Homicide, Assault Risk tool effective July 2012 that was approved by the Florida Network. It does not appear any revisions have been made to the suicide risk assessment.	
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					All four youth records contained documentation to support youth were observed during the intake process as evidenced by the completed Staff Observation Post Admission Form. One youth was placed on constant sight and sound based on suicide screening results. The observation log supports staff documented observations made about the youth at least every ten minutes. After the first Assessment of Suicide risk was completed, the youth was placed on Elevated supervision and visual checks were completed hourly as required. A second Assessment of Suicide risk was completed to move the youth back to standard supervision.	
Staff person assigned to monitor youth documented youth's behavior at 30 minute or less intervals	X					One youth was placed on constant sight and sound based on suicide screening results. The observation log supports staff documented observations made about the youth at least every ten minutes.	
Supervision level was not changed/reduced until a licensed professional or a non-licensed mental health professional under the supervision of a licensed professional completed a further assessment OR Baker Act by local law enforcement	X					The suicide risk assessments were completed by a non-licensed clinical staff who documented speaking with a LCSW at the time the assessments were completed. The LCSW signed the assessments within seven days. Supervision level is not changed until further assessment is completed.	
						YES	
						If NO, explain here:	

Provider has a written policy and procedure that meets the requirement for Indicator 4.03						**Indicate policy number, authorized signee, date(s) of last review/revision/approval:** Multiple policies as follows: Policy 7.01, Storage, Access, Inventory, and Disposal, effective 11/1/2017 Policy 7.02, Controlled Substance Accountability and Inventory, effective 10/23/19 Policy 7.03, Medication Documentation, effective 10/24/2019 Policy 7.04, Medication Administration, effective 6/26/2019	**Add any exceptions below:**
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Medication Storage							
a. All medications are stored in a Pyxis Med-Station 4000 Medication Cabinet that is inaccessible to youth (when unaccompanied by authorized staff) b. Pyxis machine is stored in accordance with guidelines in FS 499.0121 and policy section in Medication Management c. Oral medications are stored separately from injectable epi-pen and topical medications d. Medications requiring refrigeration are stored in a secure refrigerator that is used only for this purpose, at temperature range 2-8 degrees C or 36-46 degrees F. (If the refrigerator is not secure, the room is secure and inaccessible to youth.) e. Narcotics and controlled medications are stored in the Med Station	X					An in-person tour of the medication room was conducted. The tour and pictures of the Pyxis Med-Station supports it is maintained in an area inaccessible to youth. Medications were stored in the Pyxis Med-Station as required. Oral medications were stored separately from injectable and topical medications. Controlled medication is also maintained in the Pyxis Med-Station. The program maintains a separate refrigerator for medications requiring refrigeration. Documentation supported the temperature of the refrigerator is checked on a regular basis. The Pyxis keys are labeled and maintained in the medication room in the event staff need access to medication in the event there is a malfunction with the med-station. The program has four separate keys and they were labeled as required.	

f. Pyxis keys with the following labels are accessible to staff in the event they need to access medications if there is a Pyxis malfunction: a TOP COVER b BACK PANEL- LEFT TALL CABINET LOCK- LEFT, c BACK PANEL- RIGHT TALL CABINET LOCK- RIGHT							
Medication Distribution							
a. Agency maintains a minimum of 2 Super Users for the Med-Station b. Only designated staff delineated in User Permissions have access to secured medications, with limited access to controlled substances (narcotics) c. A Medication Distribution Log shall be used for distribution of medication by non-licensed and licensed staff d. Agency verifies medication using one of four methods listed in the FNYFS Operations Manual e. When nurse is on duty, medication processes are conducted by the nurse f. The delivery process of medications is consistent with the FNYFS Medication Management and Distribution Policy g. Agency does not accept youth currently prescribed injectable medications, except for epi-pens h. Non-licensed staff have received training in the use of epi-pens provided by a registered nurse	**X**					The shelter has three super users - Nurse and two YSC II staff. All super users are included on the staff permitted to distribute medications list. A medication distribution log was used to document all medications taken by the youth while at the shelter. During the nurse interview, the nurse verified the program verifies medication using one of the approved methods listed in the FNYFS operations manual. The nurse indicated they do not accept youth currently prescribed injectable medications. Training documentation supported all staff on the staff medication approval list were trained in the use of epi-pens.	
Medication Inventory							

a. For controlled substances, a perpetual inventory with running balances is maintained as well as a shift-to shift count verified by a witness and documented b. Over-the-counter medications that are accessed regularly are inventoried weekly by maintaining a perpetual inventory c. Syringes and sharps (needles, scissors, etc.) are secured, and counted and documented weekly	X					The Controlled Substance Accountability form was reviewed for three youth. All three accountability forms were completed as required, demonstrating perpetual and shift-to-shift counts. Over-the Counter medications were inventoried weekly by maintaining a perpetual inventory. The program does not maintain any syringes. Items such as nail clippers, pill cutter, scissors, shaving razors, and tweezers are inventoried weekly on the over-the-counter perpetual inventory sheet.	
There are monthly reviews of medication management practice via Knowledge Portal or Pyxis Med-Station Reports.	X					There are weekly reviews of the medication management practice through Pyxis Med-Station Reports. The reports are maintained in the same binder as the vehicle first aid kits, temperature logs, and inventory lists. There is a report generation date and time on each weekly profile to support the review is completed weekly.	
Medication discrepancies are cleared after each shift.			X			Medication discrepancies were not found in reviewing the MARs. During an interview with the nurse, it was confirmed there have not been any instances of medication discrepancies. There were no reports of medical discrepancies reported to the CCC.	
Provider has a written policy and procedure that meets the requirement for Indicator 4.04						**YES** **If NO, explain here:** **Indicate policy number, authorized signee, date(s) of last review/revision/approval:** Policy 7.07 - Medical, Mental Health, Substance Abuse Screening & Alerts - effective 9/11/2020	**Add any exceptions below:**
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Youth with a medical, mental health, or food allergy was appropriately placed on the program's alert system	X					Pictures of all four youth files supported the appropriate alerts were documented on each file.	
Alert system includes precautions concerning prescribed medications, medical/mental health conditions	X					The alert system alerts staff to review the individual file which contains documentation to address precautions concerning prescribed medication, and medical and/or mental health conditions.	

Staff are provided sufficient training, information and instructions to recognize/respond to the need for emergency care for medical/mental health problems	X					Training documentation supported all staff received sufficient training and instructions to recognize/respond to the emergency needs of the youth.	
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					Policy 7.07 details the color-coded alert system. The alert system assigns certain alerts to specific colors. Colored dots are placed on each youth's file as applicable. The colored dots alert staff to review the individual youth's file to ascertain the information concerning the youth's medical condition, allergies, and pertinent mental health treatment.	
Provider has a written policy and procedure that meets the requirement for Indicator 4.05						**YES** **If NO, explain here:** **Indicate policy number, authorized signee, date(s) of last review/revision/approval:** Policy 7.15 - Medical Emergencies - effective 9/11/20	**Add any exceptions below:**
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 youth records reviewed. All three youth required off-site emergency services. Documentation supported parental notification was made in all three incidents. Follow up care was documented on the Medical Care form and in the nurse progress notes for two applicable youth. One youth went home and did not return to the facility after the medical visit. All three incidents were reported to the Central Communications Center (CCC). All three incidents were documented in the daily log.	
All staff are trained on emergency medical procedures	X					Training documentation supported all staff received training on emergency medical procedures.	
The program has a Knife-for-life and wire cutters accessible to staff in a secure location(s)	X					The program has a knife-for-life but no wire cutters. It was recommended the knife-for-life tool be replaced with a more updated tool.	

First aid kit/supplies are fully equipped and inventoried	X					Pictures of first aid kits and in-person tour supported there is a first aid located in each cottage. A review of all first aid kits on site in cottages E and F were conducted. Both first aid kits had all general items and none of the items enclosed were expired.The program has two vehicle first aid kits with breakable tabs.	