Florida Network for Youth and Family Services
Compliance Monitoring Report for

LSF NW – HOPE House
18377 Clinton Blvd.
Crestview, Florida 32506

Compliance Monitoring Services Provided by

FOREFRONT

EXECUTIVE SUMMARY

Forefront LLC conducted a joint Quality Improvement (QI) and Florida Network of Youth and Family Services (FNYFS) monitoring visit for the LSF NW – HOPE House for the FY 2021-2022 at its program office located at 18377 Clinton Blvd., Crestview, 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. LSF NW – HOPE House 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 LSF NW – HOPE House present for the entrance interview were Beth Deck, Regional Director; Cynthia Freshour, Quality Services Manager; Jenny Kendrick, YC Supervisor; and Chrissy Baker, Counselor. The last site QI visit was conducted March 3-4, 2021.

In general, the Reviewer found that LSF NW – HOPE House is in compliance with specific contract requirements. **LSF NW – HOPE House received an overall compliance rating of 100% for achieving full compliance with eleven indicators** of the CINS/FINS Monitoring Tool. There were no corrective actions as a result of the monitoring visit and no recommendations were made for any indicators rated as conditionally acceptable.

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

2021-2022 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 12-08-2021-2022

Agency Name: LSF NW – HOPE House	**Monitor Name: Marcia Tavares, Lead Reviewer**
Contract Type : CINS/FINS	**Region/Office: 18377 Clinton Blvd., Crestview, FL 32506**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): December 8-9, 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.	☐	☐	☒	☐	☐	Interview: The program currently has three staff members certified as DJJ QI Peer reviewers that serve cover the LSF NW HOPE and Currie House programs: Cyndy Freshour, Howard Jordan, and Kayrinah Hunter. The staff have participated and/or are scheduled for peer reviews this fiscal year.	**No recommendation or Corrective Action.**
Additional Contracts a. Provider shall provide a listing of all current federal, state, or local government contracts, as well as other contracts entered into with for profit and not-for-profit organizations. Such listing shall identify the awarding entity and contract start & end dates. **PTV**	☐	☐	☒	☐	☐	Documentation: A list of additional contracts for FY 2021- 2022 was provided by the provider. The list includes name, funding source, contract amount, and beginning date. The program also maintains interagency agreements and Memorandums of Agreement (MOUs) with schools, substance abuse, mental health partners, and other treatment providers. All of the agreements reviewed had recent contract/agreement dates.	**No recommendation or Corrective Action.**

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	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable		
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: Policies provided by Market Global Reinsurance Company and Umbrella policy by Century Surety Company. The provider's General Liability insurance provides limits of coverage of $1,000,000 each/$3,000,000 aggregate and $10,000 each for medical expenses. The providers Automobile insurance provides limits of coverage of $1,000,000 combined for each accident. The providers Excess/Umbrella Liability insurance provides limits of coverage of $4,000,000 each/aggregate. The provider's Professional Liability insurance provides limits of coverage of $1,000,000 each/$3,000,000 aggregate. The provider's Abuse/Molestation insurance provides limits of coverage	**No recommendation or Corrective Action.**

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						of $1,000,000 each/$3,000,000 aggregate. Coverage for the above policies is in effect for the current FY 2021-2022, 6/1/2021 – 6/1/2022. The certificate does list the Florida Network on the consolidate certificate of liability as a certificate holder.	
External/Outside Contract Compliance a. Provider has corrective action item(s) cited by an external funding source (Fiscal or Non-Fiscal). **ON SITE**	☐	☐	☐	☐	☒	**N/A –** During the Entrance Conference, the provider indicated that there are no outstanding corrective action item(s) cited by an external funding source.	**No recommendation or Corrective Action.**
Fiscal Practice a. Agency must have employee and fiscal policy/procedures manuals that are in compliance with GAAP and provide sound internal controls. Agency maintains fiscal files that are audit ready. **PTV**	☐	☐	☒	☐	☐	Documentation: Fiscal policies are in place signed by the VP of Finance and the CFO with a revision date of 6/30/2020. The procedures reviewed appear to be consistent with GAAP and provide for limited internal controls. Procedures are included for general ledger, cost accounting, payroll, petty cash, computer backup, and other relevant financial processes.	**No recommendation or Corrective Action.**

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	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable		
b. Agency maintains a general ledger and the corresponding source documents. General ledger must be set up to track the activity of the grant separately (standard account numbers / separate funds for each revenue source, etc.). **PTV**	☐	☐	☒	☐	☐	Documentation: Detailed General Ledger for the current FY 7/1/2021 through 10/31/2021. Agency maintains a detailed general ledger that is structured to track all funding sources as well as activities for the CINS/FINS and ICMS separately. The ledgers showed current balances and differences.	**No recommendation or Corrective Action.**
c. Petty cash ledger system is balanced and all cash disbursements are compliant with financial policies and allowable under the contract. (Disbursements/invoices are approved & monitored by management.) –**ON SITE**	☐	☐	☒	☐	☐	Observation and Documentation: No change in practice was reported for the agency since the last site program review. Reviewed petty cash Policy and Procedure. The Petty Cash fund does not exceed the established minimum. Petty cash is stored in a secure locked location in the building. The agency produced past documentation of monthly petty cash reconciliations. Petty cash is reconciled on a consistent basis (monthly/quarterly) by designated staff and reviewed by the Supervisor. Disbursements and invoices are approved by the Program Supervisor as required.	**No recommendation or Corrective Action.**

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	Explain Rating						
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d. Financial records and reports are current. Includes bank statements reconciled within 6 weeks of receipt. Vendor invoices past 6 months. Invoices are submitted on a monthly basis with supporting documentation. (Disbursements/invoices are approved & monitored by management). **ON SITE**	☐	☐	☒	☐	☐	Documentation: Reviewed Bank Statements and Bank Reconciliations for the past six months for account with Bank of America. Bank reconciliations are conducted each month for the activities and bank statements for the preceding month and are signed by two parties, the preparer, and a management reviewer. Checks disbursed are signed by two parties. Invoices are submitted on a monthly basis with supporting documentation. The agency maintains individual vendor files which are kept in secure file cabinets in the Program Administration office.	**No recommendation or Corrective Action.**
e. Agency maintains inventory in accordance with a written policy and FNYFS contractual requirements. If over $1,000 inventory has DJJ Property Inventory Number/Tag. In the event the provider has purchased computer equipment an Informational Resources Request (IRR) been submitted to DJJ. **PTV/ON SITE**	☐	☐	☐	☐	☒	N/A – The agency has not purchased any items with FNYFS monies since the last time on-site.	**No recommendation or Corrective Action.**
f. Agency submits payroll taxes and deposits (and retirement deposits as applicable), Employee IRS Form W-2 and Independent Contractors IRS Form 1099 forms prior to federal requirements. **ON SITE**	☐	☐	☒	☐	☐	Documentation: Provider submitted evidence of payroll taxes and deposits for quarters two and three of 2021. A Collection Details report showed funds deposited every	**No recommendation or Corrective Action.**

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						two weeks and an EFTPS Paid Tax report showed 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 Report including the current fiscal year to 10/31/2021. The report tracks all budget categories by current period actual and current period contract separately. Variances if applicable are identified. The program budget is reviewed and approved by the agency's Pres/CEO, Board, and Regional Director.	**No recommendation or Corrective Action.**
h. A Single Audit is performed as part of the annual audit if expenses are greater than $500,000. The agency must submit a Corrective Action Plan for findings cited in the management letter and single audit. An annual financial audit was completed within 120 days after the previous fiscal year/calendar year and that a copy was provided to the Network unless and extension has been requested and approved in writing. Copy of Audit is submitted to the FNYFS by December 31st. **Obtain from FNYFS**	☐	☐	☒	☐	☐	Documentation: Financial audit was conducted for the fiscal year beginning June 30, 2020 – 2019 by RSM US LLP. A letter dated December 28, 2020 stated no corrective action was needed. A copy was submitted directly to the Florida Network of Youth and Family Services.	**No recommendation or Corrective Action.**

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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: The agency provided multiple Policies and Procedures. No changes in Confidentiality and Security protocols. The policies have been applied consistently across the required areas that include Data Back Up Systems; Information Security; and Confidentiality. Policies are signed by the Regional Director with a revision date of 6/24/2020.	**No recommendation or Corrective Action.**

CONCLUSION

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

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 Lutheran Services Florida/Northwest – HOPE House
CINS/FINS Program

December 8-9, 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	Limited
1.05 Analyzing and Reporting Information	Limited
1.06 Client Transportation	Satisfactory
1.07 Outreach Services	Satisfactory

Percent of indicators rated Satisfactory: 71.43 %
Percent of indicators rated Limited: 28.57 %
Percent of indicators rated Failed: 0 %

Standard 2: Intervention and Case Management

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

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

Standard 3: Shelter Care & Special Populations

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

Percent of indicators rated Satisfactory: 71.43 %
Percent of indicators rated Limited: 28.57 %
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: 82.76 %
Percent of indicators rated Limited: 17.24 %
Percent of indicators rated Failed: 0 %

Rating Definitions

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

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

Reviewers

Members

Marcia Tavares - Lead Reviewer Consultant-Forefront LLC/Florida Network of Youth and Family Services
Juan Youman – Regional Monitor, Department of Juvenile Justice
Tamika Gloston – Youth Crisis Center
Alecia Hassler – Capital City Youth Services
Shirley Moon – Thaise Educational and Exposure Tours

Methodology

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

Persons Interviewed

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

Documents Reviewed

	Accreditation Reports	X	Table of Organization		Visitation Logs
X	Affidavit of Good Moral Character	X	Fire Prevention Plan	X	Youth Handbook
X	CCC Reports	X	Grievance Process/Records	5	# Health Records
X	Logbooks		Key Control Log	5	# MH/SA Records
X	Continuity of Operation Plan	X	Fire Drill Log	5	# Personnel /Volunteer Records
	Contract Monitoring Reports	X	Medical and Mental Health Alerts	8	# Training Records
	Contract Scope of Services	X	Precautionary Observation Logs	17	# Youth Records (Closed)
X	Egress Plans	X	Program Schedules	5	# 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	X	Census Board

Comments

Due to COVID-19, this review was conducted via **hybrid (virtually and on-site)**.

Monitoring Purpose:

The purpose of this monitoring is to provide an annual quality improvement program review. This is to verify the agency adheres to all current CINS/FINS standards and contract compliance requirements for residential and non-residential services.

Strengths and Innovative Approaches

COVID-19 continues to impact the program and 2021 has been another challenging year for HOPE House. Yet, HOPE House has overcome many of the challenges presented because of the COVID pandemic. The youth are all back at school and no longer doing online classes. This has been a great stress reliever for them because they are able to interact with other students beyond the walls of HOPE House. The program has also been able to get back to some normal routines including outings to various places.

However, other issues have come to the surface. The program has seen an increase in the number of youths who have been exposed to domestic violence. It was discovered that five of seven clients the program had in shelter at one time had previously been exposed to DV. As the youth processed and talked about what they had seen, stories flowed about their own lives and what they had experienced. The staff believe COVID has pushed many to the wall because of the lack of coping skills of the families served. It was also noted there is an increase in suicidal ideation.

One of the biggest problems the program has experienced as a result of COVID-19 is getting new staff on board. It has experienced up to a two month wait to get clearances back from DJJ/DCF. Many applicants cannot wait that long to start working. Due to staff shortage, some staff have worked 12 hour shifts to cover the shelter. Everyone has pitched in to help, including the Administrative Assistant, Counselor, Dietary Specialist, and Manager. This has thrown everyone's schedule off and caused delays in training. There is a glimmer of hope as the program is finally getting some of those applicants on board and should see some return to a more "normal" schedule and was able to stop the 12 hour shifts for the most part.

One of the wonderful new programs implemented is called "Dress for Success". Youth are taken to a local resell store where everything is one dollar or less. They choose an outfit that would be appropriate for an interview for a professional job and then change into their new clothes upon return to the shelter. The transformation was amazing as one youth stated she had never felt beautiful before, and one young man was able to purchase and dress in a suit and could not stop smiling. Once the youth are "dressed for success" they talk about how to have a successful interview for a job.

The program has changed its approach on several things to create a greater family atmosphere. Since many of the youth have never sat at the table and had a meal with their family the program implemented a night where the food is served at the table family-style. The youth are taught how to pass the bowls of food around and serve themselves. This type of interaction encourages the youth to sit and talk to each other.

One of the agency's annual events is a weeklong hurricane drill. This year the program was not able to find a site to evacuate to so the drill was done as a "shelter in place". The youth did an amazing job of helping prepare the shelter for Hurricane Typhon and hosted the youth from Currie House for a fun day this summer. They planned the entire day and created events for all of the kids to participate in from learning how to do the Rubik's Cube to playing a variety of indoor and outdoor games. They planned and helped prepare the meal.

HOPE House recently received notice that it has been chosen for the HHS grant. This grant will pay for a Life Skills Coach and an Outreach Specialist. It will also help fund YCS positions.

Narrative Summary

Lutheran Services Florida NW HOPE House is managed by a Regional Director who oversees a Quality Services Manager and a Clinical Director. At the time of the review, there were three fulltime and two temporary vacant Youth Care Specialist (YCS) positions.

Lutheran Services Florida NW HOPE House provides residential and non-residential counseling and case management services over four counties, Walton, Escambia, Santa Rosa, and Okaloosa, across Circuit 1. The Clinical Director, who is a Licensed Mental Health Counselor (LMHC), oversees both programs. The residential counseling program consists of one master's level counselor. The non-residential counseling program also consists of one master's level counselor. The non-residential program also offers Intensive Case Management (ICM) services. ICM services are provided by an ICM Coordinator and a part-time ICM Case Manager. The Clinical Director oversees ICM services. The program has provided domestic violence and ICM services during the review period. At the time of the review, the program had not provided any staff secure, domestic minor sex trafficking, probation respite, or Family and Youth Respite Aftercare (FYRAC) services since the last QI review. The agency is currently maintaining paper files. This location does not offer Stop Now and Plan (SNAP) services. SNAP services for this circuit are provided at a sister shelter operated by the agency in the same circuit.

Lutheran Services Florida NW HOPE House residential program is led by a Quality Services Manager and a Youth Care Specialist (YCS) III. The shelter runs three shifts. The YCS III oversees each shift. The youth shelter is a residential home that has been converted into a shelter. There are three bedrooms upstairs; one of the bedrooms sleeps four youth and the other two bedrooms sleep two youth each. The bedroom that sleeps four youth is primarily used for the boys' room and the other two bedrooms are primarily used for the girls. The facility is licensed by the Department of Children and Families (DCF) for eight beds. At the time of the review, there were five CINS/FINS and two DCF youth in the shelter.

The overall findings for the QI Review for Lutheran Services Florida NW HOPE House are summarized as follows:

Standard 1: This standard has a total of seven indicators regarding management accountability. Three of the seven indicators in Standard 1 were rated satisfactory with no exceptions (1.01, 1.02, and 1.06), two were rated satisfactory with exception (1.03 and 1.07), and two received a Limited rating (1.04 and 1.05).

Standard 2: This standard has a total of ten indicators that relate to intervention and case management. Indicator 2.10 Stop Now and Plan (SNAP) was not applicable as this program does not provide SNAP services. Three of the nine applicable indicators were rated satisfactory with no exceptions (2.02, 2.04, and 2.06), five indicators were rated satisfactory with exceptions (2.01, 2.03, and 2.07-2.09), and indicator 2.05 received a Limited rating.

Standard 3: This standard has a total of seven indicators regarding shelter care. Three of the seven indicators were rated satisfactory with no exceptions (3.03, 3.05, and 3.06), two indicators were rated satisfactory with exceptions (3.01 and 3.02), and two indicators received a Limited rating (3.04 and 3.07).

Standard 4: This standard is comprised of five indicators. Four of the five indicators were rated satisfactory with no exceptions (4.01-4.04), and one indicator (4.05) was rated satisfactory with exceptions.

Summary of Deficiencies resulting in Limited Rating:

Standard 1:
Indicator 1.04 – Limited
•Two staff members hired after January 1, 2021 failed to complete DOJ Civil Rights and Federal Funds Training within the required 30-day time frame.
•Two first year staff did not complete a significant number of trainings required during the 90-day timeframe. One of the staff did not meet the 90-day timeframe for 14 of the 27 required trainings and the other staff was also late completing 11 of the 26 required trainings. Additionally, each staff was still missing a required training, Understanding Youth/Adolescent Development and SSMHSA, respectively.
•Two of four in-service staff did not complete all annual required trainings. One staff member had not completed biennial PREA or Sexual Harassment training, last completed 9/27/19 and 7/22/19, respectively, and annual child abuse training last completed 9/9/20 last completed 9/9/20. Another staff member's Suicide Part 2 annual training was last completed 3/27/2019 and annual child abuse training is overdue since last completed 10/12/2020.

Indicator 1.05 – Limited
•There is no evidence of community counseling record reviews that were completed for the last 2 quarters.
•Quarterly reviews of incidents/accidents were not conducted during the review period. Additionally, quarterly review of grievances was missing for one quarterly period.
•Monthly reviews of NetMIS data reports were not observed to be conducted regularly and was evident only on 2 of 4 staff meetings reviewed.
•There is no evidence of the program communicating critical performance data to the Board of Directors during the review period.

Standard 2:
Indicator 2.05 – Limited
A review of group logs between June and December 2021 revealed groups were not held 5 days per week, as required, during the following weeks: 05/31, 6/14, 6/28, 7/5, 7/26, 8/9, 8/16, 8/23, 8/30, 9/6, 9/27, 10/4, 10/11, 11/8, 11/22, and 11/29/2021.

Standard 3:
Indicator 3.04 – Limited
•Reviews of the logbook by staff, counselor, and supervisor do not document dates reviewed as required.
•Program supervisor's weekly reviews of the logbook with notes indicating dates reviewed, corrections and/or recommendations were not observed for the QI review period.

Indicator 3.07 – Limited
There is no documentation to support video footage was reviewed by the supervisor at any time during the past 6 months.

CINS/FINS QUALITY IMPROVEMENT TOOL

Quality Improvement Indicators:	Satisfactory (S)	Non-compliant (E)	No Eligible Items for Review (N)	No Practice (NP)	Not Applicable (N/A)	Review Based Upon Document Source	Notes Explain any items that have any deficiencies, exceptions or are not applicable.
Standard One – Management Accountability							
1.01: Background Screening (BS) and compliance with DJJ OIG statewide procedures regarding BS of employees, contractors and volunteers							
Provider has a written policy and procedure that meets the requirement for Indicator 1.01						**NO** If NO, explain here: The policy did not state the pass rate, score, or measure for the Predictive Index pre-assessment tool being used. Policy 1.01 was approved December 4, 2021 by the Regional Director.	
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 three new staff were hired since the last QI review. The agency uses the Predictive Index with a passing score of 7. All three staff met the criteria for completing the pre-screening assessment with passing scores.	
Background screening completed prior to hire/start date or exemption obtained prior to working with youth (if rated ineligible) for new hires, volunteers/interns, and contractors	X					The three new staff were background screened prior to hire date with eligible screening results. There were no eligible volunteers or interns utilized during the review period.	
Agency has evidence for employees who have had a break in service and who are in good standing and reemployed with the same agency without an additional suitability assessment or background screening if the break is less than 90 days.			X			None of the new staff were previously employed by the program.	
Five-year re-screening completed every 5 years from initial date of hire	X					There were two applicable five-year re-screening staff during the review period. Re-screenings were completed for the two staff who also had active prints on file with the clearinghouse.	

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 fax to the Background Screening Unit on 1/07/2021.	
Proof of E-Verify for all new employees obtained from the Department of Homeland Security	X					Documentation of approval of E-Verify work eligibility was provided for all three 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						**YES** If NO, explain here: Policy 1.02 was approved December 4, 2021 by the Regional Director.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Abuse Free Environment							
Agency has a code of conduct of policy and there is evidence that staff are aware of agency's code of conduct.	X					The program maintains a code of conduct policy which prohibits the use of physical abuse, profanity, threats, or intimidation that all staff must adhere to. Policy is reviewed with staff at hire.	
Child Abuse Registry telephone number is visible to youth and posted common areas of the facility	X					Child Abuse Registry Phone number was observed during the tour to be posted in the dayroom of the shelter.	
Youth were informed of the Abuse and Contact Number (see youth survey results)	X					A review of five residential files confirmed youth were informed of the Abuse Hotline number during orientation. The youth initialed and signed the orientation checklist documenting a review of the Abuse Hotline information.	
Management takes immediate action to address any incidents of threats or abuse			X			The program reported there were no incidents of abuse or threats identified and/ or reported during the review period needing management action.	
Grievance Process							
Agency has a formal grievance process	X					A review of the program's policy confirmed the agency has a formal grievance process in place.	
Locked box accessible to only management and available to youth in a common area	X					During the tour it was observed that the program has an accessible grievance box that is locked and located in the dayroom. The Quality Services Supervisor has a key to the box.	

Direct care does not handle the complaint/grievance unless assistance is asked for by the youth. Program director/supervisor will have access to and manage grievances unless it is towards themselves.	X					The program reported seven grievances filed by youth during the review period; five involved other youth and two involved staff. All grievances were resolved by the supervisor.	
72-hour resolution requirement by management. If this does NOT occur within the 72 hour period, there is sufficient documentation explaining the cause for the delay in resolution.	X					All seven grievances were resolved within the required 72-hour timeframe.	
1.03: Incident Reporting							
Provider has a written policy and procedure that meets the requirement for Indicator 1.03						**YES** If NO, explain here: Policy 1.03 was approved December 4, 2021 by the Regional Director.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
During the past 6 months, the program notified the Department's CCC (Central Communication Center) no later than two hours after any reportable incident occurred or within two hours of the program learning of the incident	X					There were twelve reportable incidents reported to the CCC during the review period. All twelve incidents were reported within the required two-hour time frame.	
The program completes follow-up communication tasks/special instructions as required by the CCC	X					All CCC incidents requiring follow up tasks documented they were completed and reports were successfully closed.	
Incidents are documented in the program logs and on incident reporting forms	X					All twelve incidents were documented in the program logs and on incident reporting forms.	
All incident reports are reviewed and signed by program supervisors/directors		X				All twelve incident reports reviewed were signed by the staff member completing the report.	Exception: Reviewer was unable to verify supervisor's signature and review dates for incident reports 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: Policy 1.04 was approved December 4, 2021 by the Regional Director.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
First Year Direct Care Staff							
All staff completed the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days from date of hire. *(Staff hired before January 1st were required to complete no later than December 31, 2020)*		X				Two applicable first year training records were reviewed. The two staff were hired after January 1, 2021 but did not complete the DOJ Civil Rights training within the required time-frame.	Limited Exception: Two staff members hired after January 1, 2021 failed to complete DOJ Civil Rights and Federal Funds Training within the required 30 day time frame.
All staff receives all mandatory training during the first 90 days of employment from date of hire.		X				There were two staff training files reviewed for first year training requirements within 90 days of hire. Both staff have exceeded the first 90 days but did not complete all mandatory trainings required during the timeframe.	Limited Exception: Both new hires did not complete a significant number of trainings required during the 90-day timeframe. One of the staff did not meet the 90 day timeframe for 14 of the 27 required trainings and the other staff was also late completing 11 of the 26 required trainings. Additionally, each staff was still missing a required training, Understanding Youth/Adolescent Development and SSMHSA, respectively.
Non-licensed Mental Health Clinical Shelter Staff (within first year of employment)							
Non-licensed mental health clinical shelter staff Assessment of Suicide Risk Training			X			There were no new non-licensed clinical staff hired during the review period.	

Documentation of non-licensed mental health clinical staff person's training in Assessment of Suicide Risk form or written confirmation by a licensed mental health professional of training (includes date, signature and license number of the licensed mental health professional supervisor).			X			No eligible non-licensed clinical staff requiring training.	
In-Service Direct Care Staff							
Direct care staff completes 24 hours of mandatory refresher Florida Network, SkillPro, and job-related training annually *(40 hours if the program has a DCF child caring license).*		X				There were four staff training files reviewed for in-service training requirements. Two of the four staff documented more than the required 40 hours of annual training and all required annual trainings.	Limited Exception: Two of four staff did not complete all trainings during the required timeframes. One staff member had not completed biennial PREA & Sexual Harassment training, last completed 9/27/19 and 7/22/19, respectively, and annual child abuse training. Another staff member's Suicide Part 2 annual training was last completed 3/27/2019 and annual child abuse training is overdue since last completed 10/12/2020.
Required Training Documentation							
The program maintains an individual training file for each staff, which includes an annual employee training hours tracking form and related documentation, such as certificates, sign-in sheets, and agendas for each training attended.	X					All six training files contained a spreadsheet documenting all trainings, dates completed, and training hours. Also, training files included any related documentation such as training certificates, sign-in sheets, and training worksheets.	
Provider has a written policy and procedure that meets the requirement for Indicator 1.05						**YES**	
						If NO, explain here:	

						Policy 1.05 was approved December 4, 2021 by the Regional Director.	
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 residential program conducted quarterly case records for the past two quarters, reviewing a total of 43 records.	Limited Exception: No evidence of community counseling record reviews were observed for the last 2 quarters.
The program conducts reviews of incidents, accidents, and grievances quarterly, at a minimum		X				Quarterly review of incidents/accidents was not evident. Grievances were reported once during the review period, on the CQI Program Report, for HOPE House in September 2021 and in June 2021 for the community counseling program.	Limited Exception: Quarterly reviews of incidents/accidents were not conducted during the review period. Additionally, reviews of grievances were missing for one quarterly period.
The program conducts an annual review of customer satisfaction data	X					Customer satisfaction data was reported on the June 2021 annual Companion Report.	
The program conducts an annual review of outcome data and (if applicable) there is evidence of annual reconciliation that occurs through communication from the Florida Network via email or phone call when corrections are needed and the information is corrected and submitted within the requested timeframes.	X					Outcome data is reviewed during monthly staff meetings. An email from the Florida Network's Program Information Manager in May 2021 confirmed receipt of the provider's annual JJIS reconciliation.	
The program conducts a monthly review of NetMIS data reports. The program submits NetMIS invoices by the fourth business day of the following reporting month.		X				The program documents review of NetMIS reports on staff meeting agendas. Staff meeting were conducted in May, July, September, and October 2021.	Limited Exception: Monthly reviews of NetMIS data reports were not observed to be conducted regularly and was evident only on 2 of 4 staff meetings reviewed.

The Florida Network conducts monthly reconciliation by comparing NetMIS data to JJIS data. Agency has evidence that they have reconciled any differences noted.	X					A review of monthly email communication with the Florida Network's Program Information Manager supported practice of conducting monthly NetMIS and JJIS reconciliation as required.	
The program has a process in place to review and improve accuracy of data entry & collection	X					The Clinical Director reviews information in JJIS and NetMIS monthly to ensure accuracy of data entry and collection. Any differences are reconciled at that time by the Clinical Director.	
There is documentation that findings are regularly reviewed by management and communicated to staff and stakeholders.	X					There was documentation observed in staff meeting minutes that findings are communicated to staff and stakeholders.	
There is evidence the program demonstrates that critical performance data reports are shared with the Board of Directors frequently. All final reports that include a Limited or Failed score is submitted electronically or by mail to the providers Executive Committee on the Board of Directors.		X				The Regional Director indicated program information is presented at Board Meetings; however, evidence of sharing critical program performance data was not provided.	Limited Exception: There is no evidence of the program communicating critical performance data to the Board of Directors during the review period.
There is evidence that strengths and weaknesses are identified, improvements are implemented or modified, and staff are informed and involved throughout the process.	X					There is evidence in monthly YCS meeting minutes that strengths and weaknesses are identified, improvements are implemented, and staff are informed and involved throughout the process.	
Provider has a written policy and procedure that meets the requirement for Indicator 1.06						**YES** If NO, explain here: Policy 1.06 was approved December 4, 2021 by the Regional Director.	
Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	X					The program provided a list of staff approved to transport youth.	
Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	X					There was documentation all drivers had a valid Florida driver's license and are covered under the agency's insurance policy.	

Agency's Transportation policy prohibit transporting a client without maintaining at least one other passenger in the vehicle during the trip and include exceptions in the event that a 3rd party is NOT present in the vehicle while transporting	X					The program's policy titled 1.06 Client Transportation prohibits transporting a youth without another passenger in the vehicle. There are provisions in place in case a 3rd party is not present in the vehicle.	
In the event that a 3rd party cannot be obtained for transport, the agency's supervisor or managerial personnel consider the clients' history, evaluation, and recent behavior	X					Transportation logs and logbook entries were reviewed for the last six months. There were ten single client transports reviewed. There was documentation of supervisor's approval, prior to the transport taking place, documented on the Transportation Logs and also in the log book.	
The 3rd party an approved volunteer, intern, agency staff, or other youth	X					The 3rd party present on transports reviewed for the last six months was either an agency staff member or another youth.	
There is documentation of use of vehicle that notes name or initials of driver, date and time, mileage, number of passengers, purpose of travel and location.	X					Transportation logs reviewed for the last six months documented the date, time, mileage, number of passengers, destination, and drivers initials. All transportation logs were completed as required.	
Provider has a written policy and procedure that meets the requirement for Indicator 1.07						**YES** If NO, explain here: Policy 1.07 was approved December 4, 2021 by the Regional Director.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
The program has a lead staff member designated to participate in local DJJ board and council meetings with evidence that includes minutes of the event or other verification of staff participation	X					Meeting minutes and agendas were provided to show a staff member from the program attends the local DJJ Board and Council Meeting.	
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				An interview with outreach staff member was conducted and flyers for community events were provided; however, verification of engagement was not presented.	Exception: Documentation of DJJ Meetings (email invite & Zoom Links) were provided but attendance could not be verified.

The program maintains written agreements with other community partners which include services provided and a comprehensive referral process.	X					The program provided fourteen interagency agreements. The agreements include collaborative services with law enforcement, runaway switchboard, counseling, emergency shelter, mental health, and mentorship.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.01						**YES** If NO, explain here: Policy 2.01 was approved December 4, 2021 by the Regional Director.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
Shelter youth: Eligibility screening is completed immediately for all shelter placement inquiries. If staff on duty cannot complete the screening, an on-call supervisor is contacted and eligibility is determined within 30 minutes from initial inquiry.	X					Five residential files were reviewed, two open and three closed. All screenings were completed immediately upon contact with the referral source. Eligibility was determined immediately upon referral.	
Community counseling: Eligibility screening is completed within 3 business days of referral by a trained staff using the NetMIS form	X					Five community counseling files were reviewed, two open and three closed. All screenings were completed immediately upon contact with the referral source. Eligibility was determined immediately upon referral.	
There is evidence all referrals for service is screened for eligibility and is logged in NetMIS within 72 hours of screening completion.	X					Of the ten files reviewed, all screenings were completed immediately upon contact with the referral source. Eligibility was determined immediately upon referral. Upon reviewing the screenings in the file, they all had NetMIS IDs documented on the screening and were logged in NetMIS within 72 hours of screening completion.	
Youth and parents/guardians receive the following in writing: a. Available service options b. Rights and responsibilities of youth and parents/guardians	X					All ten files reviewed included both a youth and parent/guardian rights and responsibilities form which was signed by youth and parent/guardian. The youth are given an informed consent and introduction to services form that details available services. After interviewing the QA manager it was also learned that parent/guardians are given a written packet of information detailing the available service options.	

The following is also available to the youth and parents/guardians: a. Possible actions occurring through involvement with CINS/FINS services (case staffing committee, CINS petition, CINS adjudication) b. Grievance procedures		X				Of the ten files reviewed, only five files included a check in a box indicating that the family received a CINS/FINS pamphlet. All ten files included a signed form that detailed the grievance procedure. This form was signed by the youth. After interviewing the QA manager, it was reported that CINS/FINS brochures are given to parent/guardians. It was also reported that parent/guardians are given a written packet of information that includes grievance procedures.	Exception: Five of the ten files reviewed do not include a parent/guardian signature indicating receipt of the CINS/FINS Packet to inform them of possible actions occurring through involvement with CINS/FINS.
Provider has a written policy and procedure that meets the requirement for Indicator 2.02						**YES** If NO, explain here: Policy 2.02 was approved December 4, 2021 by the Regional Director.	
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					Needs assessments were initiated within 72 hours of admission in all five residential files reviewed. Many were initiated before 72 hours.	
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					Needs assessments were completed within 2 to 3 face-to-face contacts in all five community counseling files reviewed.	

Needs Assessment is conducted by a bachelor's or master's level staff member	X					All ten needs assessments were conducted by a master's level staff member.	
Needs Assessment includes a supervisor's review signature upon completion	X					A supervisor's review signature was included on the needs assessment form in the ten files reviewed.	
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					Of the 10 files reviewed, all files were correctly screened for elevated risk of suicide. Five files were identified as having elevated risk of suicidality.	
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					Of the 5 files reviewed with elevated suicide risk, all were correctly assessed for suicide risk.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.03						**YES** If NO, explain here: Policy 2.03 was approved December 4, 2021 by the Regional Director.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
Case/Service plan is developed within 7 working days of Needs Assessment	X					All ten files had a Service Plan developed within seven working days of the needs assessment.	
Case plan service Plan includes: 1. Individualized and prioritized need(s) and goal(s) identified by the Needs Assessment 2. Service type, frequency, location 3. Person(s) responsible 4. Target date(s) for completion and Actual completion date(s) 5. Signature of youth, parent/ guardian, counselor, and supervisor 6. Date the plan was initiated		X				All ten files reviewed included individualized and/or prioritized needs and goals, service type, frequency/location, person(s) responsible, target date(s) for completion, signature of counselor/supervisor, and the date the plan was initiated. Two of the files did not include a youth signature; however, one was too young to sign and the other youth refused to sign. Four of the files did not include an actual physical parent/guardian signature but it was documented that the case plan was reviewed with the parent over the phone. Of the six closed files reviewed, three files were missing one or multiple goal completion dates.	Exception: Three closed files reviewed were missing one or multiple goal completion dates.

Case/service plans are reviewed for progress/revised by counselor and parent (if available) every 30 days for the first three months and every 6 months after		X				Seven of the ten files reviewed required a service plan review and five of the seven included all required reviews. Two files did not include one or multiple reviews and evidence was not noted elsewhere in the files.	Exception: For one residential file, a 30 and 60 day case plan review was not documented on the case plan. A 30-day case plan review was not documented on the case plan in the second residential file.
Provider has a written policy and procedure that meets the requirement for Indicator 2.04						**YES** If NO, explain here: Policy 2.04 was approved December 4, 2021 by the Regional Director.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
Counselor/Case Manager is assigned	X					All ten files reviewed had a counselor assigned.	
The Counselor/Case Manager completes the following as applicable: 1. Establishes referral needs and coordinates referrals to services based upon the on-going assessment of the youth's/family's problems and needs 2. Coordinates service plan implementation 3. Monitors youth's/family's progress in services 4. Provides support for families 5. Monitors out-of-home placement (if necessary) 6. Makes referrals to the case staffing to address problems and needs of the youth/family 7. Accompanies youth and parent/guardian to court hearings and related appointments 8. Refers the youth/family for additional services when appropriate 9. Provides case monitoring and reviews court orders 10. Provides case termination notes	X					Referral needs were established and services were coordinated based on the assessment in five applicable closed files. All ten files showed evidence of coordinated service plan implementation, monitoring of youth's/family's progress in service, and support provided to families. Out-of-home placements were monitored for five applicable residential files. None of the files needed referrals to case staffing committee. Staff accompanied youth to related appointment for one applicable file. All ten files provided case monitoring and reviews. All six closed files included termination documentation. There were three files applicable for 30 and 60 day follow-ups post exit. All follow-up calls were completed as required.	

11. Provides follow-up after 30 days of exit 12. Provides follow-up after 60 days of exit							
The program maintains written agreements with other community partners that include services provided and a comprehensive referral process	X					The program has written agreements with Okaloosa Walton First Call for Help, Healthy Families Santa Rosa/Walton, C.O.P.E. Center, Big Brothers/Big Sisters, Children's Home Society, Bridgeway Center Emergency Services Unit, and various local police departments. Agreements included services provided and a comprehensive referral process.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.05						**YES** If NO, explain here: Policy 2.05 was approved December 4, 2021 by the Regional Director.	
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					Of the 10 files reviewed, 9 received some combination of group, individual, and family services. Several files only completed 1-2 individual or family counseling sessions; however, several attempts were made to schedule and reschedule sessions. One residential file documented that the youth/family only attended the case planning and assessment sessions but multiple attempts were made to schedule individual/family sessions. All sessions were relevant to the needs identified during the assessment process.	
Shelter Program							
Shelter programs provides individual and family counseling	X					All five residential files reviewed demonstrated individual and/or family counseling was offered.	

Group counseling sessions held a minimum of five days per week		X				After reviewing the group log for June 2021 until the beginning of December 2021, group was not documented as being held 5 days per week.	Limited Exception: A review of group logs between June and December 2021 revealed groups were not held 5 days per week during the following weeks: 05/31, 6/14, 6/28, 7/5, 7/26, 8/9, 8/16, 8/23, 8/30, 9/6, 9/27, 10/4, 10/11, 11/8, 11/22, and 11/29/2021.
Group counseling sessions consist of: a. Length of at least 30 minutes b. Opportunity for youth engagement c. Clear and relevant topic (informational/developmental/ educational) d. Clear leader or facilitator	X					A group log/schedule provided by the agency indicated that all group are held at either 4:00 pm or 7:00 pm depending on the content scheduled for that day. Groups provided during the review period were held for 30 minutes. All topics were documented on this calendar and included topics such as anger management, conflict resolution, and psychoeducation about drug use/substance abuse. Every group session has the initials of the leader and the youth participants included.	
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					Of the 5 community counseling files reviewed, all provided community-based counseling services to provide family stabilization. Services in these files were primarily provided at local provider's office. There were no virtual services provided in any of the files reviewed. A review of agency policy # 2.05 indicated that community counseling is provided in office, in clients' homes, in schools, libraries, churches, etc.	
Counseling Services							
Reflect all case files for coordination between presenting problem(s), psychosocial assessment, case/service plan, case/service plan reviews, case management, and follow-up	X					All ten files reviewed documented coordination between presenting problems, the needs assessment, service plan, service plan reviews, case management, and follow-up.	

Maintain individual case files on all youth and adhere to all laws regarding confidentiality	X					An individual file was maintained for each youth. All files reviewed were marked with a confidential stamp. Files are kept in a confidential and locked filing cabinet and room, or kept in an opaque box for transport.	
Case notes maintained for all counseling services provided and documents youth's progress	X					Case notes were documented for all 10 files reviewed.	
On-going internal process that ensures clinical reviews of case records and staff performance	X					Regular staffing meetings are held with the Clinical Director and documented on a staffing form.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.06						**YES** If NO, explain here: Policy 2.06 was approved December 4, 2021 by the Regional Director.	
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 case staffing records were reviewed. None of the three files reviewed were initiated by the parent.	
The youth, family and case staffing committee are contacted within a minimum of five working days a. Notification to youth/family no less than 5 working days prior to staffing b. Notification to committee no less than 5 working days prior to staffing	X					Of the 3 files reviewed, all indicated that family/case staffing committee members were notified of the date/time of the case staffing within a minimum of five working days of the staffing	
Case Staffing Committee							
Must include: a. DJJ rep. or CINS/FINS provider b. Local school district representative	X					The three case staffings held included a DJJ and school district representative on the case staffing committee.	
Other members may include: a. State Attorney's Office b. Others requested by youth/ family c. Substance abuse representative d. Law enforcement representative e. DCF representative f. Mental health representative	X					Each case staffing meeting held had at least one additional member requested by youth/family.	

The program has an established case staffing committee, and has regular communication with committee members	X					The program has an established committee that meets on a regular basis.	
The program has an internal procedure for the case staffing process, including a schedule for committee meetings	X					A review of agency policy # 2.06 details that a membership roster is kept of each county's case staffing committee. Those members are contacted when a case staffing committee meeting is scheduled.	
As a result of the Case Staffing							
The youth and family are provided a new or revised plan for services	X					All 3 files included a revised plan for services on the case staffing committee recommendations form.	
Written report is provided to the parent/guardian within 7 days of the case staffing meeting, outlining recommendations and reasons behind the recommendations	X					A case staffing committee recommendations form is included in each of the 3 files. They are all signed by the parent/guardian. A review of agency policy # 2.06 indicates that the parent is given this form at the end of the case staffing meeting. If the provider is unable to give the parent the form at the end of the meeting, it is mailed to them within 7 days.	
If applicable, the program works with the circuit court for judicial intervention for the youth/family			X			This was not applicable to any of the files. A review of agency policy # 2.06 indicates that the program does work with the circuit court for judicial intervention, if applicable.	
Case Manager/Counselor completes a review summary prior to the court hearing			X			This was not applicable to any of the files reviewed.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.07						**YES** If NO, explain here: Policy 2.07 was approved December 4, 2021 by the Regional Director.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
All records are clearly marked 'confidential'.	X					All ten youth files reviewed were clearly marked with a confidential stamp.	
All records are kept in a secure room or locked in a file cabinet that is marked "confidential"	X					A tour of the facility revealed files are kept in a secure room in a locked file cabinet.	

When in transport, all records are locked in an opaque container marked "confidential"		X				When in transport, records are locked in an opaque container (opaque rolling banker/lock box with numerical code). However, a confidential stamp/label was not clearly identified on this container.	Exception: Container used to transport files offsite was not observed to be stamped/labeled "confidential" as required.
All records are maintained in a neat and orderly manner so that staff can quickly and easily access information	X					All files were maintained in a consistent manner and were neat and orderly.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.08						**YES** If NO, explain here: Policy 2.08 was approved 12/4/2021 by the Regional Director.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Use of youth's preferred name/ pronoun: a. Youth are addressed according to their preferred name and gender pronouns b. Youth's preferred name and gender pronouns are used in logbook and on all outward-facing documents and census boards			X			The provider has policy 2.08 in place to ensure all youth are provided a safe environment and therapeutic case planning regardless of the youth's actual or perceived sexual orientation, gender identity, or gender expression. The program did not serve any youth who met the criteria for review of this indicator.	
Youth in need of specialized support is referred to qualified resources (as applicable)			X			No eligible youth served.	
Youth preference is considered and documented for room assignment and youth is not roomed in isolation due to sexual orientation, gender identity, or gender expression			X			No eligible youth served.	
Youth is provided hygiene products, undergarments and clothing that affirms their gender identity or gender expression			X			No eligible youth served.	

The agency has signage and brochures/publication placed in common areas indicating that all youth are welcome regardless of sexual orientation, gender identity, and gender expression		X				A tour of the facility showed signage only in the youth care station and not other visible or common areas of the facility.	Exception: SOGIE signage was not posted in multiple and/or visible locations including the facility entrance and common youth areas.
Provider has a written policy and procedure that meets the requirement for Indicator 2.09						**YES** If NO, explain here: Policy 2.09 was approved 12/4/2021 by the Regional Director.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Staff Secure							
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? **(If no, select rating "No eligible items for review")**			**NO**			The provider has not served any youth meeting the criteria for staff secure since the last QI review.	
Staff Secure policy and procedure outlines the following: a. In-depth orientation on admission b. Assessment and service planning c. Enhanced supervision and security with emphasis on control and appropriate level of physical intervention d. Parental involvement e. Collaborative aftercare	**X**					Reviewed Staff Secure policy # 2.09. The policy addresses the requirement of the indicator.	
Program only accept youth that meet legal requirements of F.S. 984 for being formally court ordered in to Staff Secure Services			**X**			No applicable staff secure youth were served during the QI review period.	
Staff Assigned: a. One staff secure bed and assigned staff supervision to one staff secure youth at any given time b. Program assign specific staff during each shift to monitor location/ movement of staff secure youth			**X**			No applicable youth were served during the QI review period.	

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

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				
Agency has evidence that staff assigned to DMST youth under this provision are to enhance the regular services available through direct engagement in positive activities designed to encourage the youth to remain in shelter			X			No applicable youth were served during the QI review period.	
All other services provided to DMST youth are consistent with all other general CINS/FINS program requirements			X			No applicable youth were served during the QI review period.	
Domestic Violence							
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? **(If no, select rating "No eligible items for review")**	**YES**						
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Youth admitted to DV Respite placement have a pending DV charge and have evidence of being screened by JAC/Detention, but do not meet criteria for secure detention	**X**					There were three closed files reviewed. All three files had a face sheet indicating a pending DV charge, were screened by JAC, and did not meet criteria for secure detention.	
Data entry into NetMIS and JJIS within (3) business days of intake and discharge		**X**				Two of the three files reviewed were entered into NetMIS within 3 business days of intake and discharge. A review of the JJIS prevention module revealed no JJIS lags in data entry.	Exception: One of the three DV youth records reviewed had a late (1 day) intake entry into NetMIS.

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 files reviewed exceed 21 days in the program.	
Case plan in file reflects goals focusing aggression management, family coping skills, or other intervention design to reduce reoccurrence of violence in the home	X					One of the three files had a Service Plan that focused on anger management and family coping skills. The remaining two records were discharged prior to development of the service plans because the youth ran away the following day after intake.	
All other services provided to Domestic Violence Respite youth are consistent with all other general CINS/FINS program requirements	X					Case notes demonstrate the 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					The provider served one eligible youth meeting the criteria for Probation Respite since the last QI review. An email sent to the Florida Network documented approval by the Network.	
Probation Respite Referral come from DJJ Probation and are all youth referred on probation regardless of adjudication status	X					The program provided an email copy showing name of JPO referring youth for services.	
Data entry into NetMIS and JJIS within (3) business days of intake and discharge	X					A review of the Data Entry Lag Report and DJJ Probation Module revealed no lags in data entry.	
Length of stay is no more than fourteen (14) to thirty (30) days? (Placement beyond thirty (30) days requires the approval of the JPO and/or CPO)	X					The youth's length of stay did not exceed 30 days.	

All case management and counseling needs have been considered and addressed	X					Service Plan demonstrated goals focused on behavior and family coping skills.	
All other services provided to Probation Respite youth are consistent with all other general CINS/FINS program requirements	X					Case notes demonstrate the 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					There were three ICM files reviewed, 1 open and 2 closed. One of the three youth was referred by the case staffing committee and two court ordered by the truancy court.	
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					One of the three youth had two direct contacts per month and the remaining two had only one face-to-face contact; however, three attempts made to make contacts were noted in each record. All three records documented more than eight collateral contacts each month.	
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	X					All three files documented a Child Behavior Checklist was completed within fourteen days of intake. All had evidence of a Youth Self-Report assessment completed at intake and one applicable file had one completed every 90 days and at discharge. One family voluntarily terminated services and could not be reached to complete the Self-Report assessment. The open record has been in the program for less	

c. An approved self-report assessment that was completed every 90 days following intake and at discharge (if applicable)						than 90 days.	
Case plan demonstrates a strength-based, trauma-informed focus	X					All three case plans demonstrated a 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					All three files contained documentation of engaging the family, advocating on behalf of the family, helping access support in the community, teaching problem solving skills, and modeling productive behavior.	
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					Two applicable FYRAC youth records were reviewed, one open and one closed. Both youth were referred by DJJ for a domestic violence arrest.	
Agency has evidence that all FYRAC referrals have documented approval from the Florida Network office	X					Email approvals from the Florida Network were on file for both FYRAC youth served during the review period.	

Intake and initial assessment sessions meets the following criteria: a. Face-to-face gathering of family history and demographic information b. Includes development of the service plan and is documented through signature of the youth and his/her parent/guardian as well as orientation to the program	X					Both records included intake, assessment, and service plan documentation that was completed during a face-to-face intake session.	
Life Management Sessions meets the following criteria: a. Sessions are face-to-face, sixty (60) minutes in length and focus on strengthening the family unit b. Individual Sessions are with the youth and family and focus to engage, identify strengths and needs of each member that help to improve family functioning		X				The program conducts individual sessions with FYRAC youth and families. As of the review, five sessions were completed for the open record and twelve sessions were completed for the closed record with documentation showing a thirteenth session was canceled by the parent/guardian. Nine of the twelve sessions reviewed in the closed record were held for at least sixty minutes.	Exception: Three of the 12 individual sessions provided to one youth were not held for 60 minutes as required; two were for 45 minutes and one was only 30 minutes long.
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	The agency does not conduct group FYRAC sessions, only individual sessions.	
Youth and family participate in services for thirteen (13) sessions or ninety (90) consecutive days of services, or there is evidence in the youth's file that an extension is granted by DJJ circuit Probation staff	X					The closed record reviewed showed twelve sessions were successfully completed and the family canceled a thirteenth session that was scheduled.	
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: LSF NW - HOPE House is not contracted to provide SNAP services.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible**	**No Practice**	**Not Applicable**		

Rating Criteria	Satisfactory	Non-compliant	Items for Review	No Practice	Not Applicable		
SNAP Clinical Groups							
Youth are screened to determine eligibility of services					X	Not a SNAP provider.	
Needs assessment is completed at initial intake, or within two face-to-face sessions					X	Not a SNAP provider.	
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	Not a SNAP provider.	
SNAP discharge report summary					X	Not a SNAP provider.	
SNAP Boys/SNAP Girls **Parent** Group Evaluation Form					X	Not a SNAP provider.	
SNAP Boys/SNAP Girls **Child** Group Evaluation Form					X	Not a SNAP provider.	
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	Not a SNAP provider.	

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	Not a SNAP provider.	
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	Not a SNAP provider.	
"Class Goal" sheet					X	Not a SNAP provider.	
Measure of Classroom Environment (MoCE) (Pre and Post) is used to identify baseline and treatment outcomes of reported classroom dynamics.					X	Not a SNAP provider.	
Pre and Post Evaluations					X	Not a SNAP provider.	
One SNAP® Fidelity Adherence Checklist completed per classroom in a 13 – week SNAP in Schools group and uploaded to Dropbox					X	Not a SNAP provider.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.01						**YES** If NO, explain here: Policy 3.01 was approved 12/4/2021 by the Regional Director.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Facility Inspection	X					A tour of the facility was conducted during the QI Review. Furnishings were in good repair. The program was free of insect infestation. Grounds were landscaped and maintained. Bathrooms were clean and functional. No graffiti was observed. Lighting was adequate.	

Additional Facility Inspection Narrative (if applicable)	Exterior areas were free of debris and grounds were free of hazards. Dumpster and garbage cans were covered. Doors were secured with key access required. Egress plans were posted in several locations. The client rules, abuse hotline information, and DJJ incident reporting information was posted on a bulletin board in the dayroom. Blank grievance forms were available located next to the locked grievance box in the dayroom. The program has two vans used for transporting youth which were equipped with major safety equipment as required. Interior areas of the vans did not contain contraband and were free of hazardous items. Chemicals were stored behind locks and inventories and MSDS were maintained. The washers and dryers were operational and clean of lint. A current DCF license was displayed. Each youth has their own individual bed with clean, covered mattress, pillow, and sufficient linens. The program has a locked cabinet that serves as a safe place for youth to keep their personal belongings.						
Fire and Safety Health Hazards		**X**				Date of fire inspection(s) reviewed: 8/30/2021 All fire and safety equipment was inspected and approved for proper use within the past 12 months. There were 12 fire drills conducted between June 2021 and November 2021. Eight out of 12 drills were completed within 2 minutes or less. One of the twelve drills did not have a drill date. Emergency drills are documented on the Episodic Care and Emergency Drill form. One mock drill was submitted titled Annual Hurricane Drill 2021.	Exception: Three of the twelve drills were completed in 3 minutes, greater than the 2 minutes required. Since June 2021, none of the 3 shifts had completed emergency drills on a quarterly basis and both the first and the third shift completed only 1 drill during the timeframe.
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.						The daily programming/activity schedule reflects time for groups, recreation and down time 7 days a week including holidays. This schedule is posted on the bulletin board in the day room. The schedule includes time for youth in care to participate in 1 hour of physical activity. Exercise videos are an alternative if going outside is not an option. Bible study and church outings are offered to youth based on their faith. Youth that do not want to participate in faith based activities are allowed to sit in another area to engage in quiet non disruptive activities (reading, coloring, etc.). The program allows time for youth in care to complete	

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					The program allows time for youth in care to complete homework and promote literacy by providing time to read. The day room have an array of age appropriate books to choose from. Programming/activity schedules are posted on the bulletin board in the day room.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.02						**YES** If NO, explain here: Policy 3.02 was approved 12/4/2021 by the Regional Director.	
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				There were four residential files reviewed, two closed and two open. An orientation checklist was observed in three of the four files reviewed and completed on the day of admission.	Exception: One of four youth records reviewed did not contain evidence of a completion of a comprehensive orientation.
Orientation includes the following: a. Youth is given a list of contraband items b. Disciplinary action is explained c. Dress code explained d. Review of access to medical and mental health services e. Procedures for visitation, mail and telephone	X					The orientation checklist was completed in three of the four files reviewed and documented all required topics were covered. Although one file was missing the orientation checklist, reviewer observed documentation in the file that supported all orientation topics, with the exception of disciplinary actions, were reviewed with the youth.	

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							
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					The three orientation checklists reviewed included all orientation components and were signed and dated by the youth and staff.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.03						**YES** If NO, explain here: Policy 3.03 was approved 12/4/2021 by the Regional Director.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
A process is in place that includes an initial classification of the youths, to include:							
a. Review of available information about the youth's history, status and exposure to trauma b. Initial collateral contacts, c. Initial interactions with and observations or the youth d. Separation of younger youth from older youth, e. Separation of violent youth from non-violent youth f. Identification of youth susceptible to victimization g. Presence of medical, mental or physical disabilities h. Suicide risk	X					There were four residential files reviewed, two closed and two open. The program utilizes the Shelter Intake Assessment Form to document the initial classification process and room assignment. All four files included this form completed in its entirety and were signed by a staff member and supervisor. This form documented all required elements.	

i. Sexual aggression and predatory behavior j. Sexual orientation gender identity/ expression k. Acute health symptoms requiring quarantine or isolation							
An alert is immediately entered into the program's alert system when a youth is admitted with special needs and risks such as risk of suicide, mental health, substance abuse, physical health or security risk factors	X					Alerts for the four youth were documented on the intake forms and the applicable color-coded dots were placed on each file.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.04						**YES** If NO, explain here: Policy 3.04 was approved 12/4/2021 by the Regional Director.	
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 provider uses an electronic logbook. Logbook entries reviewed were for May 2-8, 2021, June 6-12, 2021, August 1-7, 2021, September 5-11, 2021, and October 3-9, 2021. A review of the log book found entries that could impact the security and safety of the youth and/or program are highlighted.	
All entries are brief, legibly written in ink and include: • Date and time of the incident, event or activity • Names of youth and staff involved • Brief statement providing pertinent information • Name and signature of person making the entry	X					All entries were found to be brief and legible, including the date and time of event, name of youth and staff involved, brief statement providing pertinent information, and the first initial and last name of the person making the entry	
Recording errors are struck through with a single line. The staff person must initial and date the correction. The use of whiteout and erasures is prohibited.			X			There were no observable errors documented in the e-logbook to assess practice.	

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				There was no documentation of the program supervisor or designee reviewing the facility logbook every week and making a note chronologically with recommendations and signed the entry.	Limited Exception: Program supervisor's weekly reviews of the logbook with notes indicating dates reviewed, corrections and/or recommendations were not observed for the review period.
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				There was documentation staff reviewing the logbook when signing in for duty; entries were signed and dated.	Limited Exception: Staff reviews of the logbook do not include the dates that were reviewed in the logbook.
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				There was documentation of the oncoming supervisor and the shelter counselor reviewing the log book of all shifts since their last entry that were signed and dated.	Limited Exception: Oncoming supervisor and shelter counselor's review of the logbook does not include the dates that were reviewed in the logbook.
Logbook entries include: a. Supervision and resident counts b. Visitation and home visits	X					Logbook entries reviewed were observed to document resident counts, visitation, and home visits.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.05						**YES** If NO, explain here: Policy 3.05 was approved 12/4/2021 by the Regional Director.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
The program has a detailed written description of the BMS, and it is explained during program orientation	X					The program has a written description of the behavior management system that is explained and given to the youth at intake. This was found in five reviewed files.	
Behavior Management Strategies MUST include:						The BMS is designed to teach new behaviors and help youth understand the natural consequences for	

a. Supervisors are trained BMS is designed to teach youth new behaviors and help youth understand the natural consequences for their actions b. Behavioral interventions are applied immediately, with certainty, and reflect the severity of the behavior c. BMS uses a wide variety of awards/incentives to encourage participation and completion of the program d. Appropriate consequences and sanctions are used by the program and consequences for behavior are logical and designed to promote skill-building for the youth e. Counseling, verbal intervention and de-escalation techniques are used prior to physical intervention (Only techniques approved by the Florida Network and DJJ are used if physical intervention is required) f. Only staff discipline youth. Group discipline is not imposed g. Room restriction is not used as part of the system or for youth who are physically and/or emotionally out of control h. Youth should never be denied basic rights such as meals, clothing, sleep, services, exercise, or correspondence privileges	**X**					their actions. Behavioral interventions are applied immediately by staff and reflect the severity of the behavior. The BMS provides constructive discipline that encourages youth to meet behavioral expectations. Physical intervention techniques approved by Florida Network and DJJ are used as a last resort. Youth have the opportunity to give feedback regarding the use of rewards and consequences. Youth are not denied basic rights such as meals, clothing, sleep, services, exercises or correspondence privileges. The BMS has a variety of awards/incentives to encourage participation and completion of the program.	
Program's Use of the BMS							
All staff are trained in the theory and practice of administering BMS rewards and consequences	**X**					There was documentation of all staff being trained in the theory and practice of administering BMS rewards and consequences.	

There is a protocol for providing feedback and evaluation of staff regarding their use of BMS rewards and consequences	X					A review of staff meeting minutes revealed staff are provided feedback during monthly meetings concerning the BMS.	
Supervisors are trained to monitor the use of rewards and consequences by their staff	X					A review of staff training files revealed supervisors are trained to monitor the use of behavioral interventions by their staff.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.06						**YES** If NO, explain here: Policy 3.06 was approved 12/4/2021 by the Regional Director.	
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					A review of staff schedules for the review period and log book entries documented required staffing ratios were met for awake hours and sleeping hours.	
All shifts must always provide a minimum of two staff present	X					The staff schedules reviewed for the last six months documented at least two staff were present on all shifts.	
Program staff included in staff-to-youth ratio includes only staff that are background screened and properly trained youth care workers, supervision staff, and treatment staff	X					All staff that were included in staff-to-youth ratios had an eligible background screening completed and had been appropriately trained.	
The staff schedule is provided to staff or posted in a place visible to staff	X					During the facility tour, the schedule was observed posted in the YCS office area.	
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 roster, listing staff and their contact information in case additional staff coverage is needed. This information is also located in the “Pass Down” folder.	

Staff observe youth at least every 15 minutes while they are in their sleeping room, either during the sleep period or at other times, such as during illness or room restriction	X					A review of the video surveillance system for the following dates and times showed consistent fifteen-minute checks by staff: November 10th, 12am-2am; November 14th, 2am-4am; November 19th, 4am-6am; November 26th, 1am-3am; and December 6th, 3am-5am. The log book also confirmed staff were constantly observing the youth every fifteen minutes and documenting observations in real time. Physical layout of sleeping arrangements: There are 3 bedrooms on the 2nd floor of the facility. Bedrooms are across and adjacent to each other.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.07						**YES** If NO, explain here: Policy 3.07 was approved 12/4/2021 by the Regional Director.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Surveillance System							
The agency, at a minimum, shall demonstrate: a. A written notice that is conspicuously posted on the premises for the purpose of security b. System can capture and retain video photographic images which must be stored for a minimum of 30 days c. System can record date, time, and location; maintain resolution that enables facial recognition d. Back-up capabilities consist of cameras' ability to operate during a power outage	X					A sign is posted on the outside of the front door stating there are cameras in use inside the building. The surveillance system is capable of maintaining at least 30 of days footage. All cameras are visible and can be seen without needing to move objects out the way. These cameras are located in any area where residents and clients gather. Cameras are not located in the youth bedrooms or bathrooms.	

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							
A list of designated personnel who can access the video surveillance system is maintained (includes off-site capability per personnel)?	X					The program maintains a list of staff who can access the video surveillance system. The list consisted of supervisory staff.	
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 program supervisor/designee is responsible for conducting random video review every 14 days. No supporting documentation was provided to support practice within the past 6 months.	Limited Exception: There is no documentation to support video footage was reviewed by the supervisor at any time within the past 6 months.
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 program has procedures in place per policy 3.07 - Video Surveillance System to handle requests of video recordings within 24 – 72 hours.	
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			There were no formal camera service order/repair requests during the review period. However, the program has procedures in place to ensure service orders are made within 24 hours of discovery and includes documentation requirements.	
Provider has a written policy and procedure that meets the requirement for Indicator 4.01						**YES** If NO, explain here: Policy 4.01 was approved 12/4/2021 by the Regional Director.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		

Preliminary Healthcare Screening							
Screening includes : a. Current medications b. Existing (acute and chronic) medical conditions c. Allergies d. Recent injuries or illnesses e. Presence of pain or other physical distress f. Observation for evidence of illness, injury, physical distress, difficulty moving, etc. g. Observation for presence of scars, tattoos, or other skin markings h. Acute health symptoms requiring quarantine or isolation	X					A total of two open and three closed residential records were reviewed. The health screening section of the CINS/FINS Intake Form was completed in all five files and included all required elements.	
Referral and Follow-up							
Youth with chronic medical conditions have a referral to ensure medical care (e.g. diabetes, pregnancy, seizure disorder, cardiac disorders, asthma, tuberculosis, hemophilia, head injuries, etc.)	X					Two of the five files presented youth with a chronic condition that was identified and noted. However, these medical conditions were previously existent and did not require referral for current medical services.	
When needed, the parent is involved with the coordination and scheduling of follow-up medical appointments			X			None of the youth reviewed required follow-up medical appointments.	
All medical referrals are documented on a daily log.	X					Each youth has a form in their file to document all referrals and the program maintains a log for offsite medical services.	
The program has a thorough referral process and a mechanism for necessary follow-up medical care as required and/or needed	X					The agency has procedures in place to include the parent in any follow- up medical appointment or referrals when needed.	

Provider has a written policy and procedure that meets the requirement for Indicator 4.02						**YES** If NO, explain here: Policy 4.02 was approved 12/4/2021 by the Regional Director.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Suicide Risk Screening and Approval							
Suicide risk screening occurred during the initial intake and screening process. Suicide screening results reviewed and signed by the supervisor and documented in the youth's case file.	**X**					A total of one open and four closed residential records were reviewed. Each of five files contained a suicide risk screening completed during the initial intake process and signed by a supervisor.	
The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	**X**					The agency's suicide risk assessment was approved by the Florida Network.	
Supervision of Youth with Suicide Risk							
Youth are placed on the appropriate level of supervision based on the results of the suicide risk assessment.	**X**					Each of the five youth were placed on sight-and-sound supervision until they were assessed by a licensed mental health professional. Each file contained a suicide risk assessment completed within 24 hours.	
Staff person assigned to monitor youth documented youth's behavior at 30 minute or less intervals	**X**					A review of observation logs found youth were monitored at least every thirty minutes while on sight-and-sound supervision.	
Supervision level was not changed/reduced until a licensed professional or a non-licensed mental health professional under the supervision of a licensed professional completed a further assessment OR Baker Act by local law enforcement	**X**					All five of the youth were removed from sight-and-sound supervision once a suicide risk assessment was completed by a licensed professional.	
Provider has a written policy and procedure that meets the requirement for Indicator 4.03						**YES** If NO, explain here: Policy 4.03 was approved 12/4/2021 by the Regional Director.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Medication Storage							

a. All medications are stored in a Pyxis Med-Station 4000 Medication Cabinet that is inaccessible to youth (when unaccompanied by authorized staff) b. Pyxis machine is stored in accordance with guidelines in FS 499.0121 and policy section in Medication Management c. Oral medications are stored separately from injectable epi-pen and topical medications d. Medications requiring refrigeration are stored in a secure refrigerator that is used only for this purpose, at temperature range 2-8 degrees C or 36-46 degrees F. (If the refrigerator is not secure, the room is secure and inaccessible to youth.) e. Narcotics and controlled medications are stored in the Med Station f. Pyxis keys with the following labels are accessible to staff in the event they need to access medications if there is a Pyxis malfunction: a TOP COVER b BACK PANEL- LEFT TALL CABINET LOCK- LEFT, c BACK PANEL- RIGHT TALL CABINET LOCK- RIGHT	**X**					A virtual tour of the facility found the Pyxis Med-station was located in the Youth Care Specialist office area inaccessible to youth. All youth medications are stored in the Pyxis Med-Station 4000 Medication Cabinet inaccessible to youth. Topical and oral medications, injectable epi-pens and topical medications are stored separately. The agency has a refrigerator designated for medication needing refrigeration only and the temperature is between 38 and 40 degrees Fahrenheit. If there is a malfunction with the Pyxis machine the program has emergency keys in the program's safe to use.	
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)						The agency has a total of five Super Users for the Med-Station and seven staff designated to have access to secured medication, with limited access to control substances. Each of these staff received training from the registered nurse. Non-licensed staff use a Medication Distribution Log for the distribution of medication. The registered nurse revealed the agency does not accept youth currently prescribed injectable medications, except for epi-pens. When it comes to medication verification the registered nurse	

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					comes to medication verification the registered nurse checks the prescription bottle for current date, name of medicine, physician who prescribed the medication, the number of pills and dosage of each pill. Pill identification and pharmacy where the prescription was filled is verified by the RN. If a nurse is not present during the intake of the client with a prescription, the staff member calls the pharmacy and verifies with the pharmacist.	
Medication Inventory							
a. For controlled substances, a perpetual inventory with running balances is maintained as well as a shift-to shift count verified by a witness and documented b. Over-the-counter medications that are accessed regularly are inventoried weekly by maintaining a perpetual inventory c. Syringes and sharps (needles, scissors, etc.) are secured, and counted and documented weekly	X					The program has a perpetual inventory with running balances maintained as well as a shift-to-shift count verified by a witness and documented for all controlled substances. The program conducts a weekly inventory of all over-the-counter medications that are accessed regularly. Sharps and syringes are counted weekly and documented on the inventory.	
There are monthly reviews of medication management practice via Knowledge Portal or Pyxis Med-Station Reports.	X					The registered nurse conducts monthly reviews of medication management practice via Pyxis Med-Station Reports.	

Medication discrepancies are cleared after each shift.	X					The program's practice is that medication discrepancies are cleared after each shift. When a discrepancy occurs the registered nurse looks in the client's medication dispensing administration sheet and verify each discrepancy with the count in the Pyxis, check the prescription bottle, and how much was in the prescription bottle when accepted in the facility. Then a count down from the first day dispense is conducted.	
Provider has a written policy and procedure that meets the requirement for Indicator 4.04						**YES** If NO, explain here: Policy 4.04 was approved 12/4/2021 by the Regional Director.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Youth with a medical, mental health, or food allergy was appropriately placed on the program's alert system	X					A review of two open and three closed residential youth found each of the youth had a medical or mental health condition or food allergies. Each of the youth were appropriately placed on the program's alert system.	
Alert system includes precautions concerning prescribed medications, medical/mental health conditions	X					The alert system observed includes all of the required information.	
Staff are provided sufficient training, information and instructions to recognize/respond to the need for emergency care for medical/mental health problems	X					In all of the five files the alerts provided sufficient information concerning the youth in the program for staff.	
A medical and mental health alert system is in place that ensures information concerning a youth's medical condition, allergies, common side effects of prescribed medications, foods and medications that are contraindicated, or other pertinent mental health treatment information, is communicated to all staff	X					The program has a medical and mental health alert system in place to ensure information concerning youth's medical conditions, allergies, common side effects of prescribed medications, food and medication that are contraindicated, or other pertinent mental health treatment information is communicated to all staff. The program alerts are documented on the youth's Plan of Care, in the logbook, and in the kitchen. The program uses a dry erase board to document medications youth are taking.	
						YES	

Provider has a written policy and procedure that meets the requirement for Indicator 4.05						If NO, explain here: Policy 4.05 was approved 12/4/2021 by the Regional Director.	
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					There was one applicable closed residential file reviewed for episodic care. The youth was upset and injured his hand. First aid was applied by staff. The youth's parent/guardian was notified. The emergency care was documented on a daily log.	
All staff are trained on emergency medical procedures		X				Seven of eight staff reviewed had current First Aid and CPR certifications.	Exception: One of the eight staff training files reviewed revealed the staff did not have a current CPR and First Aid certification.
The program has a Knife-for-life and wire cutters accessible to staff in a secure location(s)	X					The program has a total of three knife-for-life and wire cutters accessible to staff in secure locations in the building and two in each vehicle.	
First aid kit/supplies are fully equipped and inventoried	X					The program has total of five First Aid kits. Three of the kits are in the facility and the other two are reserved for the vehicles.	