Florida Network for Youth and Family Services
Compliance Monitoring Report for

Orange County Youth and Family Services
1800 East Michigan Ave.
Orlando, FL 32806-4900

Compliance Monitoring Services Provided by

FOREFRONT

EXECUTIVE SUMMARY

Forefront LLC conducted a joint QI and Florida Network of Youth and Family Services (FNYFS) contract monitoring visit for Orange County Youth and Family Services (OCYFS) CINS/FINS program located at 1800 East Michigan Avenue, Orlando, Florida location, for its FY 2021-2022 contract, on October 20-21, 2021. The contract monitoring review was conducted both onsite at the comptroller's office and virtually. 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. OCYFS 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 through June 30, 2022.

The review was conducted by Marcia Tavares, Consultant for Forefront LLC, and Peer Reviewers. Agency representatives from OCYFS present for the entrance interview were Tracy Salem, Division Manager; Shonda Upson, Senior Program Manager; Paulette Hinton, Residential Program Manager; Angela Patton, Family Counseling Program Manager; and other residential and non-residential staff members. The last onsite QI visit was conducted September 2, 2020.

In general, the Reviewer found that Orange County Youth and Family Services is in compliance with specific contract requirements. **The provider received an overall compliance rating of 100%** for achieving full compliance with all applicable indicators of the Administrative and Fiscal Contract Monitoring Tool. There were no corrective actions or recommendations made as a result of the monitoring visit.

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

2021-2022 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 10-20-2021-2022

Agency Name: Orange County Youth and Family Services	**Monitor Name: Marcia Tavares**
Contract Type: CINS/FINS	**Region/Office: 1800 E. Michigan Ave., Orlando, FL 32806**
Service Description: Comprehensive Compliance Monitoring I	**Site Visit Date(s): October 20-21, 2021**

Major Programmatic Requirements	Explain Rating: Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable	Ratings Based Upon: I = Interview; O = Observation; D = Documentation; PTV = Submitted Prior To Visit; (List Who and What)	Notes: Explain Unacceptable or Conditionally Acceptable: (Attach Supportive Documentation)
I. Administrative and Fiscal							
DJJ Quality Improvement Peer Reviewer a. Provider shall demonstrate that a minimum of two (2) staff members have been trained to be certified as DJJ QI Peer reviewers. Provider shall participate in a minimum of one (1) on-site quality assurance review of a similar type program in another judicial circuit during each 12-month period of the contract, if requested.	☐	☐	☒	☐	☐	D- The provider currently has nine (9) certified DJJ-QI Peer Reviewers namely: Stephanie Ware; Melissa Boeing; Patricia Fleurant; Elizabeth Aulds; Sudonna Harris; Tracy Salem; Paulette Hinton; Christine Morgan; and Rodney Dailey. Staff have participated and/or are scheduled to participate in QI Peer Reviews during the FY.	
Additional Contracts a. Provider shall provide a listing of all current federal, state, or local government contracts, as well as other contracts entered into with for profit and not-for-profit organizations. Such listing shall identify the awarding entity and contract start & end dates. **PTV**	☐	☐	☒	☐	☐	D- A list of ten contracts including Florida Network contracts (5) for FY2021-2022 was provided. The list includes name of program, description of services, amount funded and, and the funding agency. The program also maintains interagency agreements and Memorandums of Understanding (MOUs) with schools, mental health, and substance abuse providers. All the agreements reviewed had current contract/agreement dates.	
Limits of Coverage	☐	☐	☐	☒	☐	Documentation:	

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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**						D - Orange County, a political subdivision of the State of Florida, has an ongoing inter-local self-insurance program for workers' compensation, general liability, auto liability, and property. This program covers the employees, officials, and most of the constitutional officers of Orange County, Florida. The County's self-insured property deductible is $2,500 with a $1,000,000 limit. The County also purchases commercial property insurance. The property program consists of several layers with several insurance carriers participating with a limit of $1,000,000,000. Policy effective date 4/1/2021-4/1/2022. The County also elects to purchase excess liability coverage above and beyond the limits of the inter-local self-insurance program ($1,000,000). However, the limits of the self-insurance program and the purchasing of excess coverage should not be construed as a waiver of the County's	

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						sovereign immunity or the provisions of Section 768.28 of the Florida Statutes. Florida Network is listed on the Worker's Compensation certificate as certificate holder.	
External/Outside Contract Compliance a. Provider has corrective action item(s) cited by an external funding source (Fiscal or Non-Fiscal). **ON SITE**	☐	☐	☐	☐	☒	I - During the Entrance Conference, the provider indicated that there are no outstanding corrective action item(s) cited by an external funding source.	
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**	☐	☐	☒	☐	☐	D- Fiscal Policies and Procedures are maintained in the agency's Procurement Procedures Manual that appears to be consistent with GAAP and provide for limited internal controls. The Accounting Policies and Procedures were last reviewed November 18, 2020.	
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**	☐	☐	☒	☐	☐	D- General ledger (GL) for Department 062 (CINS/FINS) for the period October 2020 through August 2021 as of 8/30/2021. The agency maintains a detailed general ledger with corresponding source documents. The general ledger is structured to	

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						track all funding sources and there is a separate GL for the CINS/FINS program.	
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**	☐	☐	☒	☐	☐	I – The program is not allowed to access petty cash since supervisors and administrative assistants have credit cards to use for items that do not require a check request.	
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**	☐	☐	☒	☐	☐	D, I - Fiscal reconciliation transactions related to the CINS/FINS contract are handled by its Comptroller's office. The County monitors all fiscal transactions and expenditures related to children's program grants. An interview was conducted with Jamille Clemens, Grants Supervisor with the Orange County Comptroller's Office. Ms. Clemens stated in an interview that all CINS/FINS transactions are processed by the fiscal staff located on the campus where the shelter is located on a weekly basis. All expenditures and transactions are processed at that program level by Diana Mendez in the Youth and Family Services Division.	

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						Ms. Mendez, budget staff person with the Youth and Family Services division is required to process all invoices and fiscal transactions on a weekly basis, and they are reconciled each month with the Comptroller's office. The Comptroller's office is then required to reconcile all grant funding monthly on the grant cycle's fiscal year. The Comptroller must reconcile children's grant programs in the counties generic bank or large consolidated reconciliation account for all grants monthly. Reconciliations specific to the County's CINS/FINS contract were conducted monthly for the past six months April – September 2021 as required. All discrepancies are investigated by the Comptroller's management staff and justifications must be submitted for any programs that do not meet the budget revenue projections (programs that do not meet their contract unit of services or underperform) and over expenditures.	

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e. Agency maintains inventory in accordance with a written policy and FNYFS contractual requirements. If over $1,000 inventory has DJJ Property Inventory Number/Tag. In the event the provider has purchased computer equipment an Informational Resources Request (IRR) been submitted to DJJ. **PTV/ON SITE**	☐	☐	☐	☐	☒	D, I- Per the Division Program Manager, Orange County Youth and Families does not have any inventory for Florida Network.	
f. Agency submits payroll taxes and deposits (and retirement deposits as applicable), Employee IRS Form W-2 and Independent Contractors IRS Form 1099 forms prior to federal requirements. **ON SITE**	☐	☐	☒	☐	☐	Documentation- The agency provided copies of 2nd quarter Total Unemployment report as well as Form 941 Employer's Quarterly Federal Tax Return for the 2nd quarter of 2021. The tax payments are submitted and demonstrate that the agency submits payroll taxes to the appropriate authority as required. No balances due were reported on the 941s.	
g. Budget to actual reports prepared and reviewed by appropriate management. Variance from the budget are investigated and explained. **PTV/ON SITE**	☐	☐	☒	☐	☐	D- Agency provided CINS/FINS budget-to-actual report for period 7/1/2020 – 8/20/2021 with budget, expenditures, and balance remaining for the period. A review of these documents was conducted. The report tracks the P&L for the Florida Network programs separately. The variances for both the residential and non-residential programs reflected Net Income amounts.	

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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**	☐	☐	☒	☐	☐	D- Copy of financial audit conducted for year ending September 30, 2020 by Phil Diamond, CPA, LLP and dated March 22, 2021. No Management Letter was required as there were no findings required to be reported in a separate management letter. A copy of the financial audit is on file with the Reviewer.	
i. Agency maintains confidentiality policy with written policies and procedures to ensure the security and privacy of all employee and client data. Personal information is not easily accessible. Agency maintains a backup system in case of accidental loss of financial information. Security procedures are in place to protect laptops. Obsolete documents are shredded and computer hard drives are wiped prior to discarding. **ON SITE**	☐	☐	☒	☐	☐	D- Confidentiality Policy and Procedures include Employee records management; Financial and Risk Management; Security of Case Records, and Confidentiality. All sensitive information is saved on the U drive and daily back-ups are made to keep data back-up current. The Program Manager reported no employee had a laptop.	

CONCLUSION

Orange County Youth and Family Services has met the requirements for the CINS/FINS contract as a result of full compliance with all eleven (11) applicable indicators of the Administrative and Fiscal Contract Monitoring Tool. Two of the thirteen indicators were not applicable because: 1) there are no outstanding corrective action item(s) cited by an external funding source, and 2) Orange County Youth and Families does not have any inventory for Florida Network. Consequently, t**he overall compliance rate for this contract monitoring visit is 100%.** There are no corrective actions or recommendations made as a result of the contract monitoring. Overall, the provider is performing satisfactorily in meeting the fiscal and administrative terms of its contract. In addition, all of the 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 Orange County Youth and Family Services - Orlando
CINS/FINS Program

October 20-21, 2021

Compliance Monitoring Services Provided by

FOREFRONT

CINS/FINS Rating Profile

Standard 1: Management Accountability

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

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

Standard 2: Intervention and Case Management

2.01 Screening and Intake	Satisfactory
2.02 Needs Assessment	Satisfactory
2.03 Case/Service Plan	Satisfactory
2.04 Case Management & Service Delivery	Satisfactory
2.05 Counseling Services	Satisfactory
2.06 Adjudication/Petition Process	Satisfactory
2.07 Youth Records	Satisfactory
2.08 Sexual Orientation, Gender Identity, Gender Expression	Satisfactory
2.09 Special Populations	Satisfactory
2.10 Stop Now and Plan (SNAP)	Satisfactory

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

Standard 3: Shelter Care & Special Populations

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

Percent of indicators rated Satisfactory: 85.71 %
Percent of indicators rated Limited: 14.29 %
Percent of indicators rated Failed: 0 %

Standard 4: Mental Health/Health Services

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

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

Overall Rating Summary

Percent of indicators rated Satisfactory: 96.55 %
Percent of indicators rated Limited: 3.45 %
Percent of indicators rated Failed: 0 %

Rating Definitions

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

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

Reviewers

Members

Marcia Tavares - Lead Reviewer Consultant-Forefront LLC/Florida Network of Youth and Family S
Amanda Nelson – Regional Monitor, Department of Juvenile Justice
Heather Boudreau – Youth and Family Alternatives
Melissa Quinn – Boys Town
Hilda Reyes – Children's Home Society, Osceola

Methodology

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

Persons Interviewed

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

Documents Reviewed

	Accreditation Reports	X	Table of Organization		Visitation Logs
X	Affidavit of Good Moral Character	X	Fire Prevention Plan	X	Youth Handbook
X	CCC Reports	X	Grievance Process/Records	5	# Health Records
X	Logbooks		Key Control Log	4	# MH/SA Records
X	Continuity of Operation Plan	X	Fire Drill Log	7	# Personnel /Volunteer Records
X	Contract Monitoring Reports	X	Medical and Mental Health Alerts	9	# Training Records
	Contract Scope of Services	X	Precautionary Observation Logs	18	# Youth Records (Closed)
X	Egress Plans	X	Program Schedules	8	# Youth Records (Open)
X	Fire Inspection Report	X	List of Supplemental Contracts		# Other: ___
	Exposure Control Plan		Vehicle Inspection Reports		

Observations During Review

	Intake	X	Posting of Abuse Hotline		Staff Supervision of Youth
	Program Activities	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	X	Staff Interactions with Youth	X	Census Board

Comments

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

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

Strengths and Innovative Approaches
SHELTER UPDATES

•The program's shelter supervisor completed Crisis Prevention certification and is now the agency's new Crisis Prevention Intervention (CPI) instructor.
•The program received the 2020 "Excellence in Data" award winner for CINS/FINS program as a result of their outstanding Data Entry performance.
•As of June 1, 2021, the shelter's clinical team began working alongside the Florida Network on piloting the new Network Inventory of Risks, Victories, And Need Assessment (NIRVANA) tool.
•Counselors continue to enhance the Trauma Informed Care (TIC) sensory cart to ensure that age-appropriate sensory items are available for the kids during their counseling sessions.
•Science, Technology, Engineering, and Math (STEM) continue to be integrated into the program's youth academic curriculum during the school year and summer program.
•The camera system was upgraded to provide more clarity for viewing and new generators were installed for the youth shelter.
•The Learning Center Teachers are utilizing redirecting strategies which seem to be working for most students. Due to the off-campus restrictions, youth participated in several virtual school field trips such as the Orlando Shakes (live plays), paint with a twist, and museums.
•The nurse conducted Cardiopulmonary Resuscitation (CPR) training with the youth during summer school.
•Counselors continue to facilitate psychoeducational group sessions regarding COVID-19 to improve our youth's understanding of proper hand hygiene as well as overall hygiene practices due to the public safety concern related to COVID-19. Youth's fears and concerns are also discussed in these sessions. Personal Protection Equipment (PPE) have been distributed and continues to be available to all staff. This includes face shields, cloth masks, disposable masks, shoe covers, garments, gloves, hand sanitizer, signage, and protective shields.
•The program had zero incident of positive COVID-19 cases.
•County Risk Management Operations conducted safety training during the June 15 all staff meeting. This Situational Awareness training covered topics such as developing a strong sense of situational awareness, steps to take in different situations, and establishing good habits to promote personal safety at all times through preparation.

FAMILY COUNSELING UPDATES

•Family Counseling exceeded contract and served 329 youth & families.
•Family Counseling staff provided 100 bookbags filled with school supplies to clients.
•Management was able to purchase Trauma Informed Care sensory learning toys, games, and activities used to improve learning, communication, and mood to be used with clients during sessions. Management also purchased many therapeutic and inspirational books to enhance the counselor's skills during sessions.
•Staff participated in Back-to-School giveaways and Meet the Teacher events. This provided an opportunity for the staff to interact with the community and educated them on program services to increase referrals.
•Management participated in a community outreach event with Community Resource Connection and the

Neighborhood Center for Families. This event was a collaborative effort between law enforcement and social services to work together to eradicate gun violence and violent crime. Management had a table at the event and provided the community with brochures and information about Family Counseling and the SNAP program.
•Family Counseling continues to provide quality services to youth via WebEx Meeting, face-to-face, and in the home as requested.

Narrative Summary

Orange County Youth and Family Services (OCYFS) is sub-contracted with the Florida Network of Youth and Family Services (Florida Network) to provide temporary residential and non-residential services to youth and families through the Children in Need of Services/Families in Need of Services (CINS/FINS) program. The agency is located at 1758 E. Michigan Street, Orlando, Florida. OCYFS serves both male and female youth between the ages of ten to seventeen years that are locked out, runaway, ungovernable and/or truant, homeless, abused, neglected, or at-risk. The program is also contracted to provide services for Staff Secure Shelter and is a provider for youth referred through the Juvenile Justice Court System for domestic violence, probation respite, domestic minor sex trafficking, Family/Youth Respite Aftercare Services (FYRAC), and SNAP. The agency's accreditation by the Council of Accreditation (COA) was effective through February 28, 2025.

Orange County Youth and Family is under the leadership of the Youth and Family Services Manager, a Senior Program Manager, a residential Program Manager, and a Family Counseling Program Manager. The shelter is licensed for 20 beds by the Department of Children and Families effective through December 20, 2021.

The overall findings for the QI review for Orange County Youth and Family are summarized as follows:
Standard 1 has a total of seven indicators regarding management accountability. Five of the seven indicators in Standard 1 were rated satisfactory (1.01-1.03, 1.05, and 1.07) and two were rated satisfactory with exceptions (1.04 and 1.06).

Standard 2 has a total of ten indicators that relate to intervention and case management. Six of the ten indicators were rated satisfactory with no exceptions (2.02 - 2.07) and four were rated satisfactory with exception (2.01, and 2.08 - 2.10).

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

Standard 4, addressing mental health and health services, is comprised of five indicators. Three of the five indicators were rated satisfactory with no exceptions (4.02, 4.03, and 4.05) and two indicators were rated satisfactory with exceptions (4.01 and 4.04).

Summary of Deficiencies resulting in Limited or Failed Rating:

Standard 3:

Indicator 3.06 – Limited
Five dates of video surveillance and documented bed checks were reviewed as follows: 9/22/2021 - 12am-2am; 9/26/2021 - 2am-4am; 10/2/2021 - 4am - 6am; 10/8/2021 - 1am-3am; and 10/11/2021 - 3am-5am. On 10/8/2021, a bed check appeared to be logged on the Resident Accountability Checklist by staff at 1:45 a.m.

On video, however, it shows that bed check was conducted at 1:57 a.m. There was also a check logged by same staff at 2:30 a.m. but video shows that check was completed at 2:36 a.m. Note, the camera system time is off by two minutes and is consequently two minutes later in comparison to real time. CCC was called at 3:03 pm but report was not accepted as it was not clear the time documented by staff in the logbook. It was written over (possibly 1:55 am) and may be the time observed on the video adding two minutes difference between camera time and real time.

In addition to the discrepancies observed between documented bed checks and video recording mentioned above, fifteen minute bed checks did not occur consistently on three of the five randomly selected overnight shifts as follows: on 9/21/21-9/22/21, eight bed checks exceeded 15-minute intervals; 10/10/21-10/11/21, eleven bed checks exceeded 15-minute intervals; and on 10/7/21-10/8/21, eight bed checks exceeded 15-minute intervals.

CINS/FINS QUALITY IMPROVEMENT TOOL

Quality Improvement Indicators:	Satisfactory (S)	Non-compliant (E)	No Eligible Items for Review (N)	No Practice (NP)	Not Applicable (N/A)	Review Based Upon Document Source	Notes Explain any items that have any deficiencies, exceptions or are not applicable.
Standard One – Management Accountability							
1.01: Background Screening (BS) and compliance with DJJ OIG statewide procedures regarding BS of employees, contractors and volunteers							
Provider has a written policy and procedure that meets the requirement for Indicator 1.01						**YES** If NO, explain here: Agency has a policy titled Background Screening. Agency maintains a record of program manager's signature of approval dated 12/30/2020 for all policies and procedures. Division policy for Background Screening includes waiving background screening and suitability assessment for re-employment of staff with break in service that is less than 90 days.	
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					One new staff was hired since the last onsite QI review. The agency uses the Criteria Score Report pre-assessment tool and completed the screening prior to hire for the new staff. The staff received a passing score on the tool.	
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					One new hire was background screened prior to hire date. The provider did not use any volunteers or interns who met the criteria for background screening.	
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			During the QI period, the program did not have any new staff re-hired after a break in service.	

Five-year re-screening completed every 5 years from initial date of hire	X					Program employee roster shows six program staff were eligible for 5-year rescreening. The agency maintained active retained prints for all six staff meeting the requirement for rescreening.	
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 two Annual Affidavit of Compliance with Level 2 Screening via email to DJJ Background Screening Unit, one for the Orange County shelter program on 1/12/2021 and the other for Family Counseling submitted on 1/6/2021.	
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 one new staff hired.	
1.02: Provision of an abuse free environment to ensure safety and abuse free environment for youth in care							
Provider has a written policy and procedure that meets the requirement for Indicator 1.02						**YES** If NO, explain here: Policy entitled Provision of an Abuse Free Environment was last approved on 12/30/2020. Agency maintains a record of program manager's signature of approval for all policies and procedures.	
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					Expectation for code of conduct is written in the agency's policy and in the information they provide to their clients.	
Child Abuse Registry telephone number is visible to youth and posted common areas of the facility	X					Child abuse hotline telephone number was observed during a tour to be visible to youth and posted in the common areas of the facility.	
Youth were informed of the Abuse and Contact Number (see youth survey results)	X					All youth are given a copy of the youth handbook during orientation which includes the abuse hotline information. Four youth surveyed indicated knowledge of the abuse hotline and three were aware of the location of the hotline telephone number in the facility. All four youth stated they feel safe at the shelter.	
Management takes immediate action to address any incidents of threats or abuse			X			No incidents of abuse or threats by staff was identified and/or reported during the review period needing management action.	
Grievance Process							

Agency has a formal grievance process	X					Agency has a policy entitled Grievance Policy that details a formal grievance process.	
Locked box accessible to only management and available to youth in a common area	X					During onsite tour it was observed that the program has an accessible grievance box that is locked and located in a common area alongside grievance forms.	
Direct care does not handle the complaint/grievance unless assistance is asked for by the youth. Program director/supervisor will have access to and manage grievances unless it is towards themselves.	X					Two grievances were reported during the review period. As indicated by the grievance policy only program manager or designee will address the grievance and access to the grievance box is limited to the manager and/or designee.	
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					The two grievances were reviewed and resolved by the program manager within 72 hours.	
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 entitled Incident Reporting was last approved on 12/30/2020. Agency maintains a record of program manager's signature of approval for all policies and procedures.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
During the past 6 months, the program notified the Department's CCC (Central Communication Center) no later than two hours after any reportable incident occurred or within two hours of the program learning of the incident	X					A total of nine CCC reports were reported to DJJ CCC during the review period. All nine incidents were reported no later than two hours after the incident occurred or within two hours of the program learning about the incident.	

The program completes follow-up communication tasks/special instructions as required by the CCC			X			All nine incidents were closed by CCC with no follow-up tasks required.	
Incidents are documented in the program logs and on incident reporting forms	X					All nine incidents were documented in the program logs and on the incident reporting forms.	
All incident reports are reviewed and signed by program supervisors/directors	X					All nine incident reports reviewed were signed by program supervisor.	
1.04: Training Requirements (Staff receives training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions)							
Provider has a written policy and procedure that meets the requirement for Indicator 1.04						**NO** If NO, explain here: Current policy for Training Requirements was not updated to address the revisions made to QI Indicator 1.04 (effective 8/1/2021) regarding mandatory trainings required during the first 90 days and 30-day timeframe for completing Civil Rights training. Policy entitled Training Requirements was approved by the program manager on 12/30/2020.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
First Year Direct Care Staff							
All staff completed the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days from date of hire. *(Staff hired before January 1st were required to complete no later than December 31, 2020)*	X					There were four first year training records reviewed for three CINS/FINS staff and one SNAP staff. All four first year staff completed the required DOJ Civil Rights training within the required timeframe.	
All staff receives all mandatory training during the first 90 days of employment from date of hire.		X				One of the three CINS/FINS staff had 90 days to complete mandatory training. The other two staff were hired prior to January 1, 2021 and had 120 days to complete mandatory training. All three staff completed an excess of 80 training hours required annually. Two of the three staff completed all mandatory trainings required during the first 90 or 120-day timeframe as applicable to their hire dates.	Exception: One of the three new hires did not complete the DJJ SkillPro Suicide Prevention Part 2 training during the first year of employment.

Non-licensed Mental Health Clinical Shelter Staff (within first year of employment)							
Non-licensed mental health clinical shelter staff Assessment of Suicide Risk Training	X					The program hired one non-licensed mental health clinical shelter staff during the QI review period who completed the Assessment of Suicide Risk Training.	
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					All trainings and supervised Assessments of Suicide Risk were completed and signed by the Licensed Mental Health Counselor.	
In-Service Direct Care Staff							
Direct care staff completes 24 hours of mandatory refresher Florida Network, SkillPro, and job-related training annually *(40 hours if the program has a DCF child caring license).*		X				Three (3) in-service employee training files were reviewed. All three had completed an excess of 40 hours annually and two of the three completed all required annual training.	Exception: One of the three in-service staff was missing the annually required DJJ SkillPro Child Abuse training.
Required Training Documentation							
The program maintains an individual training file for each staff, which includes an annual employee training hours tracking form and related documentation, such as certificates, sign-in sheets, and agendas for each training attended.	X					Separate training files were maintained for each staff containing a list of all trainings completed, dates completed, and hours. The training files also included training certificates, training participation forms, and training worksheets.	
Provider has a written policy and procedure that meets the requirement for Indicator 1.05						**NO** If NO, explain here: Current policy needs to be updated to include requirements of the indicator regarding monthly and annual reconciliation of NetMIS/JJIS data; Internal process of verifying data accuracy prior to submitting invoices to the FN by the 4th of each month; staff designated to conduct data verification process; communication to the Board of Directors of program's critical data reports .	

						The agency has a PQI Plan for the current fiscal year and a policy titled Performance and Quality Improvement. Agency maintains a record of program manager's signature of approval by the family counseling program manager signed 9/30/21 and shelter program manager dated 12/30/20.	
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					Documentation of quarterly case record reviews for the residential program and quarterly reviews for the family counseling program supported reviews were conducted during the 2nd and 3rd quarters of FY 2020-2021, for a total of 39 and 40 files, respectively.	
The program conducts reviews of incidents, accidents, and grievances quarterly, at a minimum	X					Accidents, incidents, and grievances are reviewed quarterly and documented on a Quarterly Risk Management Review Report that include other metrics collected such as abuse calls, physical restraints, program staffing, facility observation and grievances. The report is reviewed at staff and management meetings. Documentation for 3rd and 4th quarters through September 2021 demonstrated practice.	
The program conducts an annual review of customer satisfaction data	X					Outcomes report for FY2020-2021 is a quarterly compilation rolled up into an annual report of program outcomes and customer satisfaction data.	
The program conducts an annual review of outcome data and (if applicable) there is evidence of annual reconciliation that occurs through communication from the Florida Network via email or phone call when corrections are needed and the information is corrected and submitted within the requested timeframes.	X					Program outcomes/service utilization is monitored by management and reported on the Outcomes report for FY 2020-2021 and 1st quarter FY 2021-2022. The outcomes are reviewed and captured on monthly management reports and communicated to staff and stakeholders.	
The program conducts a monthly review of NetMIS data reports. The program submits NetMIS invoices by the fourth business day of the following reporting month.	X					NetMIS and JJIS data is reviewed monthly by the program managers and reported on the monthly management reports. Program managers confirm review of data accuracy monthly prior to submission of invoices by the 4th of each month.	

The Florida Network conducts monthly reconciliation by comparing NetMIS data to JJIS data. Agency has evidence that they have reconciled any differences noted.	X					Documentation of monthly emails sent to Jennifer at the Florida Network supports reconciliation of NetMIS/JJIS data via NetMIS certifications and LLOS reports. The annual data reconciliation was completed and emailed to the Florida Network on 4/28/2021 for FY 2019-2020.	
The program has a process in place to review and improve accuracy of data entry & collection	X					Monthly and quarterly program reviews includes data verification and documentation of findings.	
There is documentation that findings are regularly reviewed by management and communicated to staff and stakeholders.	X					There is documentation that findings are regularly reviewed through quarterly risk management reviews, quarterly program reviews, and quarterly data reviews and communicated to management and staff.	
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					Program information is always presented at the round table or during the presentation at the Children's Cabinet, an Orange County board that is for all providers that work in Orange County. A review of monthly meeting minutes February - September 2021 was reviewed.	
There is evidence that strengths and weaknesses are identified, improvements are implemented or modified, and staff are informed and involved throughout the process.	X					Risk management data is collected and reviewed quarterly and includes abuse calls, incidents, accidents, and grievances. Quarterly program reviews include Data/COA verification of critical standards to verify services provided. Program data verification is a review of all backup programmatic data submitted through the review process. Findings of reviews are discussed, and questions/issues are clarified. Non-compliance is addressed formally in a written response including responses to recommendations. Critical issues identified requires a corrective action plan in writing to the Senior Program Manager (SPM) within 10 business days of the review report. SPM has 30 days to validate action plan and initiate response.	
Provider has a written policy and procedure that meets the requirement for Indicator 1.06						**YES** If NO, explain here: Policy entitled Client Transportation was approved by the program manager 12/30/2020.	

Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	X					All staff have been approved by administrative personnel to drive clients(s) in agency or approved vehicles.	
Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	X					The agency provides a commercial automobile insurance policy for those who drive agency vehicles. Human resources identifies employees eligible to drive on behalf of the agency upon hire and is responsible for notifying the insurance carrier and receive authorization for driving privileges. The agency conducts an annual check of all regular full time and part-time employees' motor vehicle history.	
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					Agency's Transportation Policy prohibits the transporting of a client without maintaining at least one other passenger in the vehicle during the trip and in the event a 3rd party cannot be obtained for transport the client's and employee's recent and past behavior is considered.	
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					Reviewed 6 months of transportation logs that report a total of 45 single client transports all of which were approved prior to transport by the supervisor or designee, considering the clients' history evaluation and recent behavior.	
The 3rd party an approved volunteer, intern, agency staff, or other youth	X					Third party present during transports were found to be another agency staff or 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				The transportation log included the name of the driver, date and time, and location.	Exception: Purpose of travel is not included on the Trip Plan form or Van Log form. Staff does not consistently document mileage on trip plan form although mileage is recorded in the vehicle log. Some transports indicate "zero" clients when there was evidence 1 youth was being transported from the JAC.
						YES	

Provider has a written policy and procedure that meets the requirement for Indicator 1.07						If NO, explain here: Policy entitled Interagency Agreements and Outreach was approved by the program manager on 12/28/2020.	
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					Two individuals are designated to participate in these meetings.	
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					Documentation was reviewed for DJJ Council meetings, as well as 5 other local outreach events.	
The program maintains written agreements with other community partners which include services provided and a comprehensive referral process.	X					The agency has 8 community partnerships, which include education, health, and at risk programs.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.01						**YES** If NO, explain here: Policy entitled Intake and Assessment Process was reviewed 12/28/20 and approved 2/28/21 by the Family Counseling Program Manager.	
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 (two open and three closed) were reviewed and the screenings were completed immediately in all 5 files. Four Secret Shopper calls were made to the agency. Two of the four calls resulted in an immediate screening and acceptance.	Exception: Four Secret Shopper calls were made to the agency. Two of the four calls did not result in an immediate screening.

Community counseling: Eligibility screening is completed within 3 business days of referral by a trained staff using the NetMIS form	X					All five community counseling files (two open and three closed) reviewed were screened within the required timeframe.	
There is evidence all referrals for service is screened for eligibility and is logged in NetMIS within 72 hours of screening completion.		X				A total of 10 files were reviewed, 5 residential files and 5 community counseling files. All five community counseling files met this criteria. Four Secret Shopper calls were made to the agency and 2 screenings were completed. Of those screenings only 1 was entered into NETMIS in 72 hours.	Exception: All five residential files did not have documentation verifying the screening for eligibility had been logged into NetMIS within 72 hours. Additionally, only one of two Secret Shopper calls that resulted in a NetMIS screening was not entered into NetMIS within 72 hours.
Youth and parents/guardians receive the following in writing: a. Available service options b. Rights and responsibilities of youth and parents/guardians	X					All 10 records reviewed had parent/guardians and youth's acknowledgement of receipt of rights & responsibilities along with services being provided.	
The following is also available to the youth and parents/guardians: a. Possible actions occurring through involvement with CINS/FINS services (case staffing committee, CINS petition, CINS adjudication) b. Grievance procedures	X					All ten records reviewed noted parent/guardians were provided with CINS/FINS parent brochure outlining CINS/FINS services. The grievance procedures are included in the intake package provided to youth/family during admission.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.02						**YES** If NO, explain here: Policy entitled Intake and Assessment Process was reviewed 12/28/20 and approved policy on 2/28/21 by Family Counseling Program Manager.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items	No Practice	Not Applicable		

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					Five residential youth records were reviewed, 2 open, 3 closed. The Needs Assessment was initiated within 72 hours in all 5 records.	
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					Five community counseling youth records were reviewed, 2 open and 3 closed. The Needs Assessment was completed within 2 to 3 face-to-face contacts in all 5 records.	
Needs Assessment is conducted by a bachelor's or master's level staff member	X					All ten Needs Assessments were conducted by a Bachelor's or Master's level staff member.	
Needs Assessment includes a supervisor's review signature upon completion	X					A supervisor's signature was present on all 10 Needs Assessments 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					Ten files were reviewed. Four files were identified with elevated risk of suicide.	
If yes, the youth was referred for an Assessment of Suicide Risk conducted by or under the direct supervision of a licensed mental health professional	X					Four applicable files identified with elevated risk of suicide were assessed by a licensed mental health professional.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.03						**YES** If NO, explain here: Policy entitled Service/Case Plans and Case Plan Reviews was reviewed 12/28/20 and approved policy on 2/28/21 by Family Counseling Program Manager.	
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					Five residential files, 2 open and 3 closed, and five community counseling files, 2 open and 3 closed were reviewed. All ten files met the criteria with case plan development within the required timeframe.	
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	X					The 10 files reviewed included all elements of the service plans required by the indicator.	

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						
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					This indicator was applicable to all 5 community counseling and 2 residential files reviewed. Reviews were conducted as required in all 7 files.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.04						**YES** If NO, explain here: Policy entitled Service Provision/CINS/FINS Services/Case Management was reviewed 12/28/20 and approved policy on 2/28/21 by Family Counseling Program Manager.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
Counselor/Case Manager is assigned	X					Five residential files, 2 open and 3 closed, and five community counseling files, 2 open and 3 closed were reviewed. Each of the 10 records reviewed showed a counselor was assigned to the youth.	
The Counselor/Case Manager completes the following as applicable: 1. Establishes referral needs and coordinates referrals to services based upon the on-going assessment of the youth's/family's problems and needs 2. Coordinates service plan implementation 3. Monitors youth's/family's progress in services 4. Provides support for families 5. Monitors out-of-home placement (if necessary) 6. Makes referrals to the case staffing to address problems and needs of the youth/family 7. Accompanies youth and 12. Provides follow-up after 60 days of exit	X					All 10 records reviewed included applicable case management services that were provided as needed and progress was monitored. Follow-ups were applicable to the 6 closed files reviewed (3 residential and 3 non-residential). All closed files indicate that the agency provides follow-ups 30 and 60 days after exit from agency.	

The program maintains written agreements with other community partners that include services provided and a comprehensive referral process	X					The agency has 8 community partnerships which include education, health, and at risk programs.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.05						**YES** If NO, explain here: Policy entitled Counseling Services was reviewed 12/28/20 and approved 2/28/21 by the Family Counseling Program Manager.	
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					Service plans and case notes maintained demonstrated all 10 youth received individual counseling services as identified during the assessment.	
Shelter Program							
Shelter programs provides individual and family counseling	X					All 5 residential youth received individual counseling services as identified during the assessment.	
Group counseling sessions held a minimum of five days per week	X					All 5 residential files reviewed and group log documentation indicate group counseling is provided at least 5 days per week.	
Group counseling sessions consist of: a. Length of at least 30 minutes b. Opportunity for youth engagement c. Clear and relevant topic (informational/developmental/ educational) d. Clear leader or facilitator	X					Documentation of group sessions for the review period demonstrated groups held included date and times of groups; length of group for at least 30 minutes; youth engagement and list of youth participants; relevant topics; and facilitator.	
Community Counseling							
Community counseling programs provide therapeutic community-based services designed to provide the intervention necessary to stabilize the family. Services are provided in the youth's home, a community location, the local provider's counseling office or virtually if written documentation is provided in the youth's file for reasons why it is in the best interest of the youth and family.	X					Documentation of therapeutic services referred or provided directly by the program was observed in the five community counseling records reviewed.	

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					Coordination of services was observed in all 10 files reviewed.	
Maintain individual case files on all youth and adhere to all laws regarding confidentiality	X					An individual youth record is maintained for each of the 10 youth files reviewed.	
Case notes maintained for all counseling services provided and documents youth's progress	X					Progress notes are maintained in all ten records reviewed.	
On-going internal process that ensures clinical reviews of case records and staff performance	X					The supervisor and clinical director reviewed and signed off on assessments as well as the review of files to demonstrate ongoing internal process of case reviews.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.06						**YES** If NO, explain here: Policy entitled Case Staffing Committee was reviewed 12/28/20 and approved 2/28/21 by the Family Counseling Program Manager.	
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			The case staffing was initiated by the counselor in all three closed case staffing files reviewed.	
The youth, family and case staffing committee are contacted within a minimum of five working days a. Notification to youth/family no less than 5 working days prior to staffing b. Notification to committee no less than 5 working days prior to staffing	X					Notification was sent via email to the committee and youth/family more than 5 days prior to the case staffing for each youth.	
Case Staffing Committee							
Must include: a. DJJ rep. or CINS/FINS provider b. Local school district representative	X					All files indicate that a local school district representative and DJJ representative or CINS/FINS provider attended the case staffing.	
Other members may include: a. State Attorney's Office b. Others requested by youth/ family						All 3 files included a mental health representative and other person(s) requested by youth/family.	

c. Substance abuse representative d. Law enforcement representative e. DCF representative f. Mental health representative	X						
The program has an established case staffing committee, and has regular communication with committee members	X					The established committee members include representatives from the youth's school district, DJJ, and program staff. Email communication is sent to the committee in advance of scheduled meetings.	
The program has an internal procedure for the case staffing process, including a schedule for committee meetings	X					Case staffings are held on the 3rd Friday of each month to maximize participation.	
As a result of the Case Staffing							
The youth and family are provided a new or revised plan for services	X					Revised service plans for three applicable youth were completed in the three records reviewed.	
Written report is provided to the parent/guardian within 7 days of the case staffing meeting, outlining recommendations and reasons behind the recommendations	X					The parent/guardian is provided a report of the committee recommendations at the end of the case staffing meeting.	
If applicable, the program works with the circuit court for judicial intervention for the youth/family			X			This was not applicable for the 3 files reviewed.	
Case Manager/Counselor completes a review summary prior to the court hearing			X			This was not applicable for the 3 files reviewed.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.07						**YES** If NO, explain here: Policy entitled Security of Case records was reviewed 12/28/20 and approved 2/28/21 by the Family Counseling Program Manager.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
All records are clearly marked 'confidential'.	X					All 10 records reviewed, 5 residential (2 open, 3 closed) and 5 community counseling (2 open and 3 closed) were marked confidential.	
All records are kept in a secure room or locked in a file cabinet that is marked "confidential"	X					Residential records were kept in a locked file cabinet behind a locked door. Community counseling records were located in a locked file cabinet behind a locked door.	
When in transport, all records are locked in an opaque container marked "confidential"	X					Two locked containers marked confidential are used to transport youth records offsite.	

All records are maintained in a neat and orderly manner so that staff can quickly and easily access information	X					All ten files reviewed were observed to be organized and maintained in a neat order with cover pages for each section of the file.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.08						**YES** If NO, explain here: Policy entitled SOGIE was last reviewed 12/30/2020 and approved by the shelter program manager.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Use of youth's preferred name/ pronoun: a. Youth are addressed according to their preferred name and gender pronouns b. Youth's preferred name and gender pronouns are used in logbook and on all outward-facing documents and census boards		X				The program had two applicable residential records that were reviewed for the QI period. Two youth records reviewed showed pronouns and preferred names were used on clinical documents but not other documentation in the youth record. Preferred pronouns were used across all documents.	Exception: Preferred names were not consistently used on contact notes as well as other forms in the two youth files reviewed.
Youth in need of specialized support is referred to qualified resources (as applicable)			X			No specialized services were identified as needed in the two records reviewed.	
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					Room assignment for the two files were consistent with the youth's preference.	
Youth is provided hygiene products, undergarments and clothing that affirms their gender identity or gender expression			X			Neither of the two youth requested gender specific hygiene or clothing items during their stay.	
The agency has signage and brochures/publication placed in common areas indicating that all youth are welcome regardless of sexual orientation, gender identity, and gender expression	X					During onsite tour, signage was observed to be posted throughout the facility in common areas. Published materials providing information and education for SOGIE youth is accessible throughout the facility.	
						YES If NO, explain here:	

Provider has a written policy and procedure that meets the requirement for Indicator 2.09						Policy entitled Special Populations that applies to Staff Secure, DMST, DV, PR, and ICM, and policy entitled Family/Youth Respite Aftercare Services (FYRAC) were last reviewed 12/30/2020 and approved by the shelter program manager.	
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**					Agency Policy – Special Populations	
Program only accept youth that meet legal requirements of F.S. 984 for being formally court ordered in to Staff Secure Services			**X**			The provider has not served any youth meeting the criteria for staff secure since the last QI review.	
Staff Assigned: a. One staff secure bed and assigned staff supervision to one staff secure youth at any given time b. Program assign specific staff during each shift to monitor location/ movement of staff secure youth c. Agency clearly documents the specific staff person assigned to the staff secure youth in the logbook or any other means on each shift			**X**			The provider has not served any youth meeting the criteria for staff secure since the last QI review.	
Agency provides a written report for any court proceedings regarding the youth's progress			**X**			The provider has not served any youth meeting the criteria for staff secure since the last QI review.	

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

Agency has evidence that staff assigned to DMST youth under this provision are to enhance the regular services available through direct engagement in positive activities designed to encourage the youth to remain in shelter			X			No eligible youth served.	
All other services provided to DMST youth are consistent with all other general CINS/FINS program requirements			X			No eligible youth served.	
Domestic Violence							
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? **(If no, select rating "No eligible items for review")**	**YES**						
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Youth admitted to DV Respite placement have a pending DV charge and have evidence of being screened by JAC/Detention, but do not meet criteria for secure detention	**X**					A total of three records, one open and two closed, were reviewed. A JAC referral was present in all 3 files showing JAC screening for each youth.	
Data entry into NetMIS and JJIS within (3) business days of intake and discharge		**X**				NetMIS youth listings report and JJIS prevention module data for each youth was reviewed.	Exception: JJIS information revealed discharge data entry exceeded the 72 hour required timeframe for 1 of the three DV youth records reviewed.
Youth in program do not have length of stay in DV Respite placement that exceeds 21 days. If more than 21 days, documentation exists in youth file of transition to CINS/FINS or Probation Respite placement, if applicable.	**X**					One of the three DV youth exceeded 21 days in the DV program. Transition to CINS/FINS was documented in the youth record.	

Case plan in file reflects goals focusing aggression management, family coping skills, or other intervention design to reduce reoccurrence of violence in the home	X					Case plans in the three youth records reflect goals for reducing violence and coping skills.	
All other services provided to Domestic Violence Respite youth are consistent with all other general CINS/FINS program requirements	X					Case notes demonstrate all three youth received shelter services consistent with CINS/FINS program requirements.	
Probation Respite							
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? **(If no, select rating "No eligible items for review")**	YES						
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
All probation respite referrals are submitted to the Florida Network.	X					Reviewed three (3) closed probation respite records. Evidence of Florida Network approvals were emailed to the program and were present in all three files reviewed.	
Probation Respite Referral come from DJJ Probation and are all youth referred on probation regardless of adjudication status	X					Reviewed three (3) closed cases in which the Probation Respite Referral came from DJJ Probation and youth were referred on probation regardless of adjudication status.	
Data entry into NetMIS and JJIS within (3) business days of intake and discharge	X					Data entry into NetMIS and JJIS for the three youth records met the timeframe required.	
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			None of the three youth's length of stay was no more than fourteen (14) to thirty (30) days.	
All case management and counseling needs have been considered and addressed	X					All three records had documentation to support case management and counseling needs were considered and addressed.	
All other services provided to Probation Respite youth are consistent with all other general CINS/FINS program requirements	X					All services provided to Probation Respite youth were consistent with general 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")**					**N/A**	Orange County Youth and Family is not contracted to provide Intensive Case Management services.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Youth receiving services was court ordered					**X**	Orange County Youth and Family is not contracted to provide Intensive Case Management services.	
Services for youth and family include: a. Two (2) direct contacts per month b. Two (2) collateral contacts per week c. Direct and collateral contacts not obtained must have documentation to support attempts made to obtain them. All reasonable attempts (at minimum of three) must be made to reach all contacts (direct and collateral) and documented in the case file and NetMIS.					**X**	Orange County Youth and Family is not contracted to provide Intensive Case Management services.	
Assessments include: a. A Child Behavior Checklist (CBCL) is completed within 14 days of intake and at discharge (if applicable) b. An approved self-report assessment that was completed at intake c. An approved self-report assessment that was completed every 90 days following intake and at discharge (if applicable)					**X**	Orange County Youth and Family is not contracted to provide Intensive Case Management services.	
Case plan demonstrates a strength-based, trauma-informed focus					**X**	Orange County Youth and Family is not contracted to provide Intensive Case Management services.	

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

b. Individual Sessions are with the youth and family and focus to engage, identify strengths and needs of each member that help to improve family functioning			X				
Group Sessions: a. Focus on the same issues as individual/family sessions with the overall goal of strengthening relationships and prevention domestic violence b. Shall be no more than eight (8) youth at one (1) time and shall be for a minimum of sixty (60) minutes per session			X			No eligible youth served.	
Youth and family participate in services for thirteen (13) sessions or ninety (90) consecutive days of services, or there is evidence in the youth's file that an extension is granted by DJJ circuit Probation staff			X			No eligible youth served.	
2.10: STOP NOW AND PLAN (SNAP)							
Provider has a written policy and procedure that meets the requirement for Indicator 2.10						**YES** If NO, explain here: Policy entitled SNAP was reviewed 12/28/20 and approved 2/28/21 by the Family Counseling Program Manager.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
SNAP Clinical Groups							
Youth are screened to determine eligibility of services	X					Four applicable SNAP youth records (1 closed and 3 open) were reviewed. All four records contained both the NetMIS and SNAP Brief Intake screening forms.	
Needs assessment is completed at initial intake, or within two face-to-face sessions	X					Needs Assessments were completed at intake in all four records.	
SNAP Assessments						Pre-CBCLs, pre-TOPSE, and pre-PAT were	

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.						completed at intake for all 4 youth records. The post-assessments were not completed in 1 closed youth record because the family withdrew from services and were not applicable to remaining three records as the cases were open. TRF was completed in one applicable record but not applicable with the other three records because school was not in session.	
SNAP discharge report summary	X					One closed youth record did not include a discharge report because the family withdrew from services.	
SNAP Boys/SNAP Girls **Parent** Group Evaluation Form			X			Not applicable to three open cases or voluntary withdrawal record.	
SNAP Boys/SNAP Girls **Child** Group Evaluation Form			X			Not applicable to three open cases or voluntary withdrawal record.	
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					During the review period, one class ending 5/18/2021 was conducted in the school. All total of 13 sessions was completed.	
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				Nineteen students of the class participated in the group sessions facilitated by the SNAP provider with the teacher present.	Exception: Duration of group session could not be determined because the documentation was missing duration of session and/or end time.

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					Weekly attendance sheets were completed for all thirteen sessions conducted.	
"Class Goal" sheet	X					Goal sheet is documented and completed.	
Measure of Classroom Environment (MoCE) (Pre and Post) is used to identify baseline and treatment outcomes of reported classroom dynamics.	X					MoCE was completed and documented.	
Pre and Post Evaluations	X					Pre- and post evaluations were observed to be completed for the students and teacher.	
One SNAP® Fidelity Adherence Checklist completed per classroom in a 13 – week SNAP in Schools group and uploaded to Dropbox	X					Evidence of completion of the SNAP Fidelity Adherence was observed.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.01						**YES** If NO, explain here: Policies entitled Shelter Environment, Key Control, Vehicle Security and Inspections, Flammable, Poisonous, and Toxic Control, Licensure Requirements, Fire Drills, and Daily Schedule were approved 12/30/2020 and signed by the shelter program manager.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Facility Inspection	X					An onsite tour of the facility was conducted during the QI review. The facility inspection noted no deficiencies. All required inspections, licenses, and postings were present. The program was free from insects; the grounds were landscaped and well	

Additional Facility Inspection Narrative (if applicable)	maintained; bathrooms and showers were clean and functional; no evidence of graffiti on walls, doors and windows, and the lighting was adequate; the exterior was free from debris and hazards; the dumpsters were covered. The youth's rooms were clean, decorated nicely, and free from contraband and any hazardous objects. The youth had their own beds with clean and decorative linens, pillows and blankets. Any items not permitted in the program were locked up in the staff office/Control center. The washer and dryer were clean, operational and the lint collector was clean. All chemicals were listed, approved for use, stored securely in the staff office/control center and listed on the Material Safety Data Sheets (MSDS) that were maintained weekly. The location of the MSDS log was in the staff office/Control center. All doors to the facility are secured and keys are needed by staff to enter. The shelter has a video doorbell that is linked to the phones so staff can see and speak to the person at the front entrance prior to letting them into the lobby, which provided another layer of security. Staff and company vehicles were locked and secured. The shelter had a detailed map and egress plan of the facility located throughout the building. The Grievance box was easily accessed and located in the youth activity room and the grievance forms were located in the main activity room and on both the male and female dorms. The numbers to the abuse hotline, DJJ incident reporting, general client rules and the poison control hotline were posted throughout the program.						
Fire and Safety Health Hazards	**X**					Date of fire inspection(s) reviewed: 10/14/2020 and 07/01/2021	
Additional Fire and Safety Health Hazards Narrative (if applicable)	Fire inspections were conducted on 10/14/2020 and 7/1/2021. Both inspections noted "no violations". Fire equipment inspected and serviced on 8/25/2021. Residential Group Care Inspection dated 11/3/2020 reports "No Violation Comments Available".						
Youth Engagement							
a. Youth are engaged in meaningful, structured activities (e.g., education, recreation, counseling services, life and social skill training) seven days a week during awake hours. Idle time is minimal. b. At least one hour of physical activity is provided daily. c. Youth are provided the opportunity to participate in a variety of faith-based activities. Non-punitive structured activities are offered to youth who do not choose to participate in faith-based activities.	**X**					The daily schedule was posted and accessible to both staff and youth. It was observed that the shelter provides structured activities 7 days a week during waking hours with minimal idle time. The daily schedule was clearly posted throughout the shelter for the youth to see. The schedule includes shelter activities such as recreation, counseling services, and life and social skills groups. Youth receive one hour of recreation posted on the program schedule. The shelter provides the opportunity for the youth to participate in a variety of faith-based activities and non-punitive activities for youth who do not choose to participate in faith-based activities. The daily schedule also provides time for youth to complete homework, access to books for reading and youth are allowed	

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.						quiet time to read.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.02						**YES** If NO, explain here: Policy entitled Orientation was reviewed 12/30/2020 and policy for Intake and Assessment Process was reviewed 12/28/2020. Both are approved by the shelter Program Manager.	
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**					Four client files were reviewed, 2 open and 2 closed. All 4 files indicated the youth received an orientation and a handbook within 24 hours of intake.	
Orientation includes the following: a. Youth is given a list of contraband items b. Disciplinary action is explained c. Dress code explained d. Review of access to medical and mental health services e. Procedures for visitation, mail and telephone f. Grievance procedure g. Disaster preparedness instructions h. Physical layout of the facility i. Sleeping room assignment and introductions	**X**					All 4 files indicated that all requirements of the orientation process were met. Each youth record includes an orientation checklist that consists of all items required to be completed during orientation.	

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					All requirements were met for the indicator. Copies of the orientation checklist completed during intake is maintained in each youth record reviewed. The checklist is signed by the youth and staff conducting orientation.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.03						**YES** If NO, explain here: Policy entitled Classification and Room Assignment was reviewed 12/30/2020 and policy for Alert Procedures was reviewed 12/28/2020. Both were signed and approved by the shelter Program Manager.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
A process is in place that includes an initial classification of the youths, to include:							
a. Review of available information about the youth's history, status and exposure to trauma b. Initial collateral contacts, c. Initial interactions with and observations or the youth d. Separation of younger youth from older youth, e. Separation of violent youth from non-violent youth f. Identification of youth susceptible to victimization g. Presence of medical, mental or physical disabilities h. Suicide risk i. Sexual aggression and predatory behavior j. Sexual orientation gender identity/ expression	X					Four client files were reviewed, 2 open and 2 closed. All of the requirements of the indicator were verified in the four files as observed on the CINS/FINS Intake form completed for each youth.	

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					Of the 4 files, 3 were observed to include the youth alerts in all required areas. One closed file was missing the color-coded alert stickers on the front of the file but the alerts were nonetheless documented in the file. Per program manager, the stickers are sometimes dislodged when the files are archived in storage.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.04						**YES** If NO, explain here: Policy entitled Logbooks was reviewed 12/20/2020 and approved by the shelter Program Manager.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Log book entries that could impact the security and safety of the youth and/or program are highlighted	X					Logbook entries were reviewed for the following weeks of the review period: Week 1 - April; Week 3 - May; Week 4 - June; Week 1 - July; Week 2 - August; and Week 3 - September. All documented incidents were observed to be highlighted in the random weekly samples reviewed.	
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					Six months of the logbook were reviewed. All entries reviewed were observed to include the date and time of the incident or activity, the staff involved, information related to the entry, and the staff's signature. Not all entries were observed to include the name of the resident(s) when referring to youth transition within the facility. However, names are always documented whenever youth leaves campus.	
Recording errors are struck through with a single line. The staff person must initial and date the correction. The use of whiteout and erasures is prohibited.	X					Errors were observed to be struck through and initialed.	

The program director or designee reviews the facility logbook(s) every week and makes a note chronologically in the logbook indicating the dates reviewed and if any correction, recommendations and follow-up are required and sign/date the entry	X					It was observed that the Program Manager reviewed the logbook and that the timeframe was indicated.	
All staff review the logbook of the previous two shifts and makes an entry signed and dated into the logbook indicating the dates reviewed	X					In the samples reviewed, it was observed that staff signed and indicated a review of the logbook had been conducted to include a minimum of two shifts.	
At the beginning of their shift, oncoming supervisor and shelter counselor reviews the logbook of all shifts since their last log entry and makes a signed and dated entry and into log book indicating the dates reviewed.	X					In the samples reviewed, it was observed that staff, supervisors, and counselors indicated a review of the logbook had been conducted and signed their entries.	
Logbook entries include: a. Supervision and resident counts b. Visitation and home visits	X					Youth counts are documented by the program but not in the logbook. The counts are conducted a minimum of three times a day on the Shift Change Form. Documentation of visitations was noted in the logbook.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.05						**YES** If NO, explain here: Policy entitled Behavior Management System was last reviewed on 12/30/2019; policy titled Crisis and Behavioral Intervention was last reviewed on 12/28/2020. Both were approved by the shelter Program Manager.	
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					BMS is detailed in the client handbook and is provided during orientation.	
Behavior Management Strategies MUST include:						The shelter utilizes a Behavioral Management strategy that is based on positive reinforcement and	

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					logical consequences. All youth files reviewed documented that youth are oriented to the behavioral management system during orientation/intake process and provided a youth handbook that further outlines the system. The shelter provides a wide variety of incentives for the youth and uses appropriate interventions to teach the youth new behaviors and to help youth to understand natural consequences.	
Program's Use of the BMS							
All staff are trained in the theory and practice of administering BMS rewards and consequences	X					Staff receive training during orientation. Training files for three new hires were reviewed and supported practice.	

There is a protocol for providing feedback and evaluation of staff regarding their use of BMS rewards and consequences	X					Supervisor's staff meetings include a discussion of the use of the behavior management system as well as positive and negative consequences for youth.	
Supervisors are trained to monitor the use of rewards and consequences by their staff	X					Both the shelter program manager and supervisor have received BMS training and monitoring of its use of rewards and consequences.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.06						**YES** If NO, explain here: Policies entitled Safety, Health, and Welfare of Clients; Work Schedule and OT; and Staff Coverage and Ratios were reviewed 12/30/2020 and approved by the shelter Program Manager.	
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					Staff schedules for the past six months, youth census documentation, as well as camera review shows this requirement is met.	
All shifts must always provide a minimum of two staff present	X					Practice was supported by staff schedules and review of video surveillance.	
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 listed on the program roster maintain eligible background screenings and training is conducted for new staff during onboarding prior to working with youth.	
The staff schedule is provided to staff or posted in a place visible to staff	X					The staff schedule is in a folder in the office and accessible to staff.	
There is a holdover or overtime rotation roster which includes the telephone numbers of staff who may be accessed when additional coverage is needed	X					Staff roster is also located in the office and available to staff.	

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				Five dates of video surveillance and documented bed checks were reviewed as follows: 9/22/2021 - 12am-2am; 9/26/2021 - 2am-4am; 10/2/2021 - 4am - 6am; 10/8/2021 - 1am-3am; and 10/11/2021 - 3am-5am. The program manager stated the bed check entry on 10/8/2021 at 1:57am was written over, and was possibly changed from 1:45am to 1:55am. A written statement from the staff confirmed the time was 1:55 am; however, this was difficult to ascertain on the bed check entry and the 15-minute interval was exceeded.	Limited Exception: On 10/8/2021, a bed check appeared to be logged on the Resident Accountability Checklist by staff at 1:45 a.m. On video, however, it shows that bed check was conducted at 1:57 a.m. There was also a check logged by same staff at 2:30 a.m. but video shows that check was completed at 2:36 a.m. Note, the camera system time is off by two minutes and is consequently two minutes later in comparison to real time. In addition to the discrepancy observed between documented bed checks and video recording mentioned above, fifteen minute bed checks did not occur consistently on three of the five randomly selected overnight shifts as follows: on 9/21/21-9/22/21, eight bed checks exceeded 15-minute intervals; 10/10/21-10/11/21,
Additional Exception Notes	eleven bed checks exceeded 15-minute intervals; and on 10/7/21-10/8/21, eight bed checks exceeded 15-minute intervals.						
						YES	

Provider has a written policy and procedure that meets the requirement for Indicator 3.07						If NO, explain here: Policy entitled Safety, Health, and Welfare of Clients was reviewed 12/30/2020 and signed by the shelter program manager.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Surveillance System							
The agency, at a minimum, shall demonstrate: a. A written notice that is conspicuously posted on the premises for the purpose of security b. System can capture and retain video photographic images which must be stored for a minimum of 30 days c. System can record date, time, and location; maintain resolution that enables facial recognition d. Back-up capabilities consist of cameras' ability to operate during a power outage e. Have cameras placed in interior and exterior general locations of the shelter where youth and staff congregate and where visitors enter and exit. Cameras are never placed in bathrooms or sleeping quarters. f. All cameras are visible	X					A tour of the facility was conducted. Cameras were placed in required areas and visible. A back-up generator is in place in the event of a power outage. The shelter has a video surveillance system in operation 24 hours a day, 7 days a week. During the shelter tour it was observed that a written notice was posted on the premises that there was video surveillance for the purpose of security. Cameras were observed in the interior, exterior and general locations of the shelter where youth and staff congregate as well as where visitors enter and exit. All cameras were visible, and no cameras are in the bathrooms or sleeping quarters. The video system can capture and retain video photographic images for a minimum 30 days. The shelter's video system can record the date, time, and location and maintain a resolution that enables facial recognition. The video system can operate during a power outage as well.	
A list of designated personnel who can access the video surveillance system is maintained (includes off-site capability per personnel)?	X					The shelter has a list of designated supervisors who can access the video surveillance system.	
Supervisory review of video is conducted a minimum of once every 14 days and timeframes reviewed are noted in the logbook.						Video reviews were conducted on the following dates: 4/16, 4/23, 5/21, 5/28, 6/11, 6/26, 7/16, 7/30, 8/23, 8/30, 9/9, 9/17, 10/1. Timeframes were noted and overnight shifts were reviewed.	Exception: Several of the supervisory reviews were outside of the 14 day time

The reviews assess the activities of the facility and include a review of random sample of overnight shifts		X					frame.
Grant the requesting of video recordings to yield a result within 24-72 hours from program quality improvement visits and when an investigation is pursued after an allegation of an incident	X					The shelter has a process for third party reviews of video recordings after a request from quality improvement visits or when an investigation is pursued after an allegation of an incident.	
Camera service order/requests will be made within 24 hours of discovery of camera malfunctioning or being inoperable. All efforts made to obtain repairs are documented and maintained			X			All cameras were operational and working during the review and no recent work orders were conducted.	
Provider has a written policy and procedure that meets the requirement for Indicator 4.01						**YES** If NO, explain here: Policy entitled 4.01/Healthcare was reviewed on 12/28/20 and approved by the program manager.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Preliminary Healthcare Screening							
Screening includes : a. Current medications b. Existing (acute and chronic) medical conditions c. Allergies d. Recent injuries or illnesses e. Presence of pain or other physical distress f. Observation for evidence of illness, injury, physical distress, difficulty moving, etc. g. Observation for presence of scars, tattoos, or other skin markings		X				Policy 4.01 was reviewed on December 28, 2020 by the program manager. Policy addresses the requirements outlined in the indicator. The program has a procedure including a thorough referral process and mechanism for necessary follow-up medical care for youth admitted with chronic medical conditions. Three closed files and two open files were reviewed. Three of the five youth were on medications. One of the youth had asthma, one had a seizure condition, and none had recent injuries or illnesses, presence of pain or other physical distress at the time of admission. There was no observation of illness, injury, pain or physical distress for any of the youth reviewed. One of the five youths had scars, tattoos or	Exception: For four youth, the screening form does not have the question answered as to whether a medical follow-up is necessary; however, nurse confirmed in interview that she reviews all forms and none of the listed youth required medication follow up. Nurse's signature was on the form indicating she had reviewed the form.

h. Acute health symptoms requiring quarantine or isolation		X				other skin markings; the other youths did not. Two youths had a chronic medical condition (asthma and seizures). No youth reviewed had a head injury in the previous two weeks. None of the youth reviewed required medical follow-up. For four youth the screening form does not have the question answered as to whether a medical follow-up is necessary; however, nurse confirmed in interview that she reviews all forms and non of the listed youth required medication follow up. Nurse's signature was on the form indicating she had reviewed the form.	
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 reviewed records contained youth with a chronic condition; however, neither youth required medical follow-up due to already being followed by a physician. Additionally, one youth had asthma, but had not needed an inhaler for several years.	
When needed, the parent is involved with the coordination and scheduling of follow-up medical appointments	X					Parental follow-up for medical appointments was not-applicable for all five records reviewed.	
All medical referrals are documented on a daily log.	X					None of the records reviewed required a medical referral.	
The program has a thorough referral process and a mechanism for necessary follow-up medical care as required and/or needed	X					The nurse reviews all intake assessments and screenings and will refer for follow-up care as needed.	
Provider has a written policy and procedure that meets the requirement for Indicator 4.02						**YES** If NO, explain here: Policy 4.02-Suicide Prevention was reviewed on 12/28/20 and approved by the program manager.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Suicide Risk Screening and Approval							

Suicide risk screening occurred during the initial intake and screening process. Suicide screening results reviewed and signed by the supervisor and documented in the youth's case file.	X					Four closed records were reviewed. All four youth received a suicide risk screening during the initial intake and screening process and the results were reviewed and signed by the supervisor and documented in the youths' record. All four youth were placed on constant or one-on-one sight and sound, the appropriate level of supervision based on the results of the suicide risk assessment. In all four records, youth remained on sight and sound supervision for the duration of their shelter stay, All four youth placed on sight and sound had observation logs reflecting staff documented youths' behavior, activities, etc. at least once every fifteen minutes.	
The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	X					Assessment was approved previously by the Florida Network of Youth and Family Services and has not changed.	
Supervision of Youth with Suicide Risk							
Youth are placed on the appropriate level of supervision based on the results of the suicide risk assessment.	X					All youth were placed on the appropriate level of supervision based on the results of the suicide risk assessment.	
Staff person assigned to monitor youth documented youth's behavior at 30 minute or less intervals	X					Documentation confirmed youth were constantly monitored and youth's behavior was documented in ten to fifteen minute intervals.	
Supervision level was not changed/reduced until a licensed professional or a non-licensed mental health professional under the supervision of a licensed professional completed a further assessment OR Baker Act by local law enforcement	X					One youth's Assessment of Suicide Risk (ASR) indicated the need for youth to have a follow-up ASR completed in seventy-two hours; however, this did not occur as the program's policy is to have youth with extensive mental health history remain on sight and sound for the duration of their stay at the program, which is what occurred with this youth.	
						YES	
						If NO, explain here:	

Provider has a written policy and procedure that meets the requirement for Indicator 4.03						Policy entitled Ordering and Distribution, Storage, Access, Inventory and Disposal was reviewed on December 28, 2020 and approved by the program manager addressing all of the requirements outlined in the indicator.	
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**					The program maintains six Super Users for the Med-Station (program director, nurse, and four supervisors). The program maintains the youth prescription medications, as well currently used over-the-counter medications all separated in the Pyxis Medication Station in single locked containers. The program has a locked medication refrigerator, which was currently empty and is only being used for medications; the temperature is maintained between thirty-six and forty Fahrenheit, within the required storage temperature. The program's Pyxis medication cart provides a daily inventory of medications used. When on-site, the nurse conducts medication processes. When not on-site certified staff dispense medication. The program conducts daily clearing of medication discrepancies. Monitor reviewed six months of medication discrepancies which confirmed this practice. All three emergency Pyxis keys were available and accessible to staff.	
Medication Distribution							

a. Agency maintains a minimum of 2 Super Users for the Med-Station b. Only designated staff delineated in User Permissions have access to secured medications, with limited access to controlled substances (narcotics) c. A Medication Distribution Log shall be used for distribution of medication by non-licensed and licensed staff d. Agency verifies medication using one of four methods listed in the FNYFS Operations Manual e. When nurse is on duty, medication processes are conducted by the nurse f. The delivery process of medications is consistent with the FNYFS Medication Management and Distribution Policy g. Agency does not accept youth currently prescribed injectable medications, except for epi-pens h. Non-licensed staff have received training in the use of epi-pens provided by a registered nurse	X					The program maintains six Super Users for the Med-Station (program director, nurse, and four supervisors). Additionally, there are seventeen staff who are trained in the assistance of delivery of medications. Only staff trained in the distribution of medications have access, which is limited by the Pyxis Med-Cart system. The nurse is onsite for twenty to twenty-five hours a week and will complete all medication processes when present. The delivery of medication is consistent with the FNYFS Medication Management and Distribution Policy. Training documents support all applicable staff were trained by the program's medical staff in medication distribution. The program did not have any youth in need of an EpiPen. A review of six staff training records indicated the staff received the EpiPen training, which was included in the First Aid training.	
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					Per interview with the nurse, a perpetual inventory with running balances is conducted for all controlled medications and there is a shift-to-shift count verified by a witness and documented.	

There are monthly reviews of medication management practice via Knowledge Portal or Pyxis Med-Station Reports.	X					Nurse confirmed that the program reviewed medication management reports monthly.	
Medication discrepancies are cleared after each shift.	X					Six months of discrepancy reports were reviewed to confirm the practice that discrepancies are cleared after every shift.	
Provider has a written policy and procedure that meets the requirement for Indicator 4.04						**YES** If NO, explain here: Policy 4.04-Alert Procedures was last reviewed on December 28, 2020 and approved by the program manager.	
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					Policy 4.04 was reviewed on December 28, 2020 approved by the program manager addressing the requirements outlined in the indicator.	
Alert system includes precautions concerning prescribed medications, medical/mental health conditions	X					Four youth records (two open and two closed) were reviewed. All four youths had mental health, medical or substance abuse alerts at the time of admission. They were appropriately placed on the alert system, which includes precautions concerning prescribed medications, food allergies, and medical/mental health conditions. The program has color-coded stickers on all youth's files and alert to indicate specific types of alerts.	
Staff are provided sufficient training, information and instructions to recognize/respond to the need for emergency care for medical/mental health problems	X					Six staff training records reviewed provided documentation of training in MHSA, CPR and First Aid.	
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 shelter utilizes an alert board which has color coded dots indicating what alert the youth is on, as well as using the same system for the front of the individual youth records. The shelter also informs their staff during shift change regarding each youth's medical condition, common side effects of prescribed medications, allergies, and mental health information.	Exception: One youth's chart was missing the required color coded sticker to reflect the youth's alert on their record.
						YES	

Provider has a written policy and procedure that meets the requirement for Indicator 4.05						If NO, explain here: Policy entitled 4.05 Medical and Dental Procedures (Episodic/Emergency Care) was reviewed on 12/28/20 and approved by the program manager.	Add any exceptions below:
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
Off-site Emergency Services							
a. If off-site emergency medical or dental care was provided, an incident report was submitted for the medical or dental care b. Upon youth return, there is a verification receipt of medical clearance via discharge instructions with follow-up is present in file c. Youth's parent/guardian was notified d. A daily log is maintained for emergency care provided	X					Four closed records were reviewed. In all four records youth were taken off-site requiring medical care, and the incident report was submitted. In all four incidents, parent/guardian was notified and youth was medically cleared and program was provided with discharge paperwork. All incidents were located on their episodic log. The program maintains an episodic emergency medical and dental log. Staff are trained on emergency medical procedures and Epi-Pen training.	
All staff are trained on emergency medical procedures	X					Per interview with the nurse, all staff are trained in emergency procedures and Epi-Pen annually. Nurse also stated when a youth with any special medical needs is admitted, nurse will train the staff on any relevant concerns or needs.	
The program has a Knife-for-life and wire cutters accessible to staff in a secure location(s)	X					Per interview with the nurse, the Knife-for-Life is kept in a cabinet in the medical office.	
First aid kit/supplies are fully equipped and inventoried	X					First aid kit and Knife-for-Life are kept in a cabinet in the medical office per interview with the nurse.	