# Florida Network for Youth and Family Services
# Compliance Monitoring Report for


**CCYS**
**2407 Roberts Avenue**
**Tallahassee, Florida 32310**

**Compliance Monitoring Services Provided by**

FOREFRONT

## EXECUTIVE SUMMARY

Forefront LLC conducted a joint Quality Improvement (QI) and Florida Network of Youth and Family Services (FNYFS) monitoring for CCYS for the FY 2021-2022 for its program office located at 2407 Roberts Avenue, Tallahassee, Florida. Forefront LLC (Forefront) is an independent compliance monitoring firm that is contracted by the FNYFS to perform onsite program reviews to assess the agency's adherence to fiscal, programmatic and overall contract requirements. CCYS is contracted with the Florida Network of Youth and Family Services (FNYFS) to provide direct services to Children/Families in Need of Services (CINS/FINS). The services to be provided are identified in Contract Section A - Descriptions and Specifications and Section B - Delivery and Performance and are funded with General Revenue Funds effective for July 2021 through June 30, 2022.

The review was conducted by Marcia Tavares, Consultant for Forefront LLC, and Peer Reviewer(s). Agency representatives from CCYS present for the entrance interview were Gwynn Virostek, CEO; Gina Dozier, COO; Lanekia Bennett, HR Coordinator; Regina Flowers, Shelter Manager; Alecia Hassler, Clinical Director; and Greg Farmer, SNAP Coordinator. The last onsite QI visit was conducted October 28 - 29, 2020.

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

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

# 2021-2022 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
## Report Number: CM 09-15-2021-2022

| | |
|---|---|
| **Agency Name: Capital City Youth Services** | **Monitor Name: Marcia Tavares, Lead Reviewer** |
| **Contract Type : CINS/FINS** | **Region/Office: 2407 Roberts Ave., Tallahassee, FL** |
| **Service Description: Comprehensive Onsite Compliance Monitoring** | **Site Visit Date(s): September 8-9, 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**<br>a. Provider shall demonstrate that a minimum of two (2) staff members have been trained to be certified as DJJ QI Peer reviewers. Provider shall participate in a minimum of one (1) on-site quality assurance review of a similar type program in another judicial circuit during each 12-month period of the contract, if requested. | ☐ | ☐ | ☒ | ☐ | ☐ | Interview:<br>The program currently has two staff members certified as DJJ QI Peer reviewers: Gina Dozier and Alecia Hassler. | **No recommendation or Corrective Action.** |
| **Additional Contracts**<br>a. Provider shall provide a listing of all current federal, state, or local government contracts, as well as other contracts entered into with for profit and not-for-profit organizations. Such listing shall identify the awarding entity and contract start & end dates. **PTV** | ☐ | ☐ | ☒ | ☐ | ☐ | Documentation:<br>A list of nine contracts for FY 2021-2022 was provided by the provider. The list includes the funder, amount, service provided, and duration/term. The program also has twenty-eight formal interagency agreements with community partners including local schools, mental health facilities, and sheriff's department. The agency also has a list of 29 collaborations and linkages with other agencies in the area to provide different specialized services to the youth served. | **No recommendation or Corrective Action.** |

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|---|---|---|---|---|---|---|---|
| | Unacceptable | Conditionally Unacceptable | Fully Met | Exceeded | Not Applicable | | |
| **Limits of Coverage**<br>a. Provider shall provide and maintain during this contract, the following minimum kinds of insurance: Worker's Compensation and Employer's liability insurance as required by Chapter 440, F.S. with a minimum of $100,000 per accident, $100,000 per person and $500,000 policy aggregate. Commercial General Liability with a limit of $500,000 per occurrence, and $1,000,000 policy aggregate. Automobile Liability Insurance shall be required and shall provide bodily injury and property damage liability covering the operation of all vehicles used in conjunction with performance of this contract, with a minimum limit for bodily injury of $250,000 per person; with a minimum limit for bodily injury of $500,000 per accident; with a minimum limit for property damage of $100,000 per accident and with a minimum limit for medical payments or $5,000-$10,000 per person. Florida Network is listed as payee or co-payee. **PTV** | ☐ | ☐ | ☒ | ☐ | ☐ | Documentation:<br>The provider's general liability, workers compensation, and automobile insurance policies all meet the required minimums per the limits of coverage and are in effect for the current FY 2021-2022.<br><br>Commercial general liability is provided by Philadelphia Indemnity Insurance Company with limits of coverage of $1,000,000 each and $3,000,000 aggregate, effective 07/01/2021-07/01/2022.<br><br>Automobile insurance through Philadelphia Insurance Company for combined single limit of $1,000,000 for agency vehicles effective for 7/1/21-7/1/22.<br><br>Workers Compensation insurance provided through Markel Insurance Company with limits of $500,000 each/aggregate, effective 1/12/21-1/12/22. | **No recommendation or Corrective Action.** |

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| | | | | | | | |
| | Explain Rating | | | | | | |
| **Major Programmatic Requirements** | Unacceptable | Conditionally Unacceptable | Fully Met | Exceeded | Not Applicable | **Ratings Based Upon:**<br>**I = Interview**<br>**O = Observation**<br>**D = Documentation**<br>**PTV = Submitted Prior To Visit**<br>**(List Who and What)** | **Notes**<br>**Explain Unacceptable or Conditionally Acceptable:**<br>**(Attach Supportive Documentation)** |
| | | | | | | The Florida Network is listed on the certificate as a certificate holder. | |
| **External/Outside Contract Compliance**<br>a. Provider has corrective action item(s) cited by an external funding source (Fiscal or Non-Fiscal). **ON SITE** | ☐ | ☐ | ☐ | ☐ | ☒ | **N/A –**<br>During the Entrance Conference, the provider indicated that there are no outstanding corrective action item(s) cited by an external funding source. | **No recommendation or Corrective Action.** |
| **Fiscal Practice**<br>a. Agency must have employee and fiscal policy/procedures manuals that are in compliance with GAAP and provide sound internal controls. Agency maintains fiscal files that are audit ready. **PTV** | ☐ | ☐ | ☒ | ☐ | ☐ | Documentation:<br>Fiscal Policies and Procedures are contained in the agency's Accounting Policy and Procedures Manual. The procedures, last updated 12/12/2018, were reviewed and appear to be consistent with GAAP and provide for limited internal controls. Procedures are included for general ledger, cost accounting, payroll, petty cash, computer backup, and other relevant financial processes.<br><br>Per memo dated 8/31/2021, the CEO indicated CCYS made the decision effective April 2021 to engage Harvard and Associates, an accounting firm in Tallahassee, to perform all accounting duties in lieu of hiring a fulltime CFO. | **No recommendation or Corrective Action.** |

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| Major Programmatic Requirements | Unacceptable | Conditionally Unacceptable | Fully Met | Exceeded | Not Applicable | | |
| | | | | | | The decision was approved by the management team and Board of Directors Executive Committee. | |
| b. Agency maintains a general ledger and the corresponding source documents. General ledger must be set up to track the activity of the grant separately (standard account numbers / separate funds for each revenue source, etc.). **PTV** | ☐ | ☐ | ☒ | ☐ | ☐ | Documentation: Detailed General Ledger for the period 1/1/21-08/31/2021. The Agency maintains a detailed general ledger that is structured to track all funding sources as well as activities for the CINS/FINS program separately. | **No recommendation or Corrective Action.** |
| c. Petty cash ledger system is balanced and all cash disbursements are compliant with financial policies and allowable under the contract. (Disbursements/invoices are approved & monitored by management.) –**ON SITE** | ☐ | ☐ | ☒ | ☐ | ☐ | Observation/Documentation: No change in practice was reported for the agency since the last onsite program review in October 2020. The Petty Cash fund does not exceed the established minimum. Petty cash is stored in a secure locked location in the Administration building. The agency produced past documentation of monthly petty cash reconciliations. Petty cash is reconciled on a consistent basis (monthly/quarterly) by designated staff and reviewed by the supervisor. Disbursements and invoices are approved by the Program Supervisor as required. | **No recommendation or Corrective Action.** |
| d. Financial records and reports are current. Includes bank statements reconciled within 6 weeks of receipt. Vendor | ☐ | ☐ | ☒ | ☐ | ☐ | Documentation: | **No recommendation or Corrective Action.** |

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| invoices past 6 months. Invoices are submitted on a monthly basis with supporting documentation. (Disbursements/invoices are approved & monitored by management). **ON SITE** | | | | | | Reviewed Bank Statements and Bank Reconciliations for the past six (6) months February 2021 – July 2021 for its operating bank account with Capital City Bank. The bank reconciliations were conducted more than 6 weeks past the end of the preceding month between February and April 2021; however, since May 2021, after contracting with the accounting firm, they were all conducted within 3 weeks for the activities and bank statements for the preceding month.<br><br>Checks disbursed are also signed by two (2) parties. Invoices are submitted on a monthly basis with supporting documentation. The agency maintains individual vendor files which are kept in secure file cabinet in the Chief Financial Officer's office. | |
| e. Agency maintains inventory in accordance with a written policy and FNYFS contractual requirements. If over $1,000 inventory has DJJ Property Inventory Number/Tag. In the event the provider has purchased computer equipment an Informational Resources Request (IRR) been submitted to DJJ. **PTV/ON SITE** | ☐ | ☐ | ☐ | ☐ | ☒ | N/A – The agency has not purchased any items with FNYFS monies since the last time on-site. | **No recommendation or Corrective Action.** |

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| f. Agency submits payroll taxes and deposits (and retirement deposits as applicable), Employee IRS Form W-2 and Independent Contractors IRS Form 1099 forms prior to federal requirements. **ON SITE** | ☐ | ☐ | ☒ | ☐ | ☐ | Documentation: Provider submitted evidence of its electronic EFTPS submission and documentation of filings of the 941 Tax Payments as submitted and required for the last six (6) months (February 2021 – August 2021). | **No recommendation or Corrective Action.** |
| g. Budget to actual reports prepared and reviewed by appropriate management. Variance from the budget are investigated and explained. **PTV/ON SITE** | ☐ | ☐ | ☒ | ☐ | ☐ | Documentation: Agency provided a Budget Report including the current fiscal year to date information. The report tracks all budget categories by annual budget and remaining balance separately. Variances are identified for CINS/FINS and FN programs. The program budget is reviewed and approved by the agency's Pres/CEO and Board. | **No recommendation or Corrective Action.** |
| h. A Single Audit is performed as part of the annual audit if expenses are greater than $500,000. The agency must submit a Corrective Action Plan for findings cited in the management letter and single audit. An annual financial audit was completed within 120 days after the previous fiscal year/calendar year and that a copy was provided to the Network unless and extension has been requested and approved in writing. Copy of Audit is submitted to the FNYFS by December 31st. **Obtain from FNYFS** | ☐ | ☐ | ☒ | ☐ | ☐ | Documentation: Financial audit was completed on March 17, 2021 for the Year ended June 30, 2020 by James Moore CPA and Consultants. Due to the COVID-19 pandemic, the audit was completed 5 months later than the 120-day timeframe. A copy of the audit was submitted directly to the Reviewer and the Florida Network of Youth and Family Services. A separate | **No recommendation or Corrective Action.** |

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| | | | | | | Management Letter requiring a Corrective Action Plan was not issued by the auditor. | |
| i. Agency maintains confidentiality policy with written policies and procedures to ensure the security and privacy of all employee and client data. Personal information is not easily accessible. Agency maintains a backup system in case of accidental loss of financial information. Security procedures are in place to protect laptops. Obsolete documents are shredded and computer hard drives are wiped prior to discarding. **ON SITE** | ☐ | ☐ | ☒ | ☐ | ☐ | Documentation:<br>The agency provided multiple Policies and Procedures. The policies have been applied consistently across the required areas that includes client confidentiality, record retention, data security and service interruptions, risk management data backup systems; information security; document and computer hardware destruction; security system; data storage. | **No recommendation or Corrective Action.** |

## CONCLUSION

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

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


# Florida Network of Youth and Family Services Quality Improvement Program Report

Review of CCYS - Tallahassee
CINS/FINS Program

September 8-9, 2021

**Compliance Monitoring Services Provided by**

FOREFRONT

# CINS/FINS Rating Profile

**Standard 1: Management Accountability**

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

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

**Standard 2: Intervention and Case Management**

| | |
|---|---|
| 2.01 Screening and Intake | Satisfactory |
| 2.02 Needs Assessment | Satisfactory |
| 2.03 Case/Service Plan | Satisfactory |
| 2.04 Case Management & Service Delivery | Satisfactory |
| 2.05 Counseling Services | Satisfactory |
| 2.06 Adjudication/Petition Process | Satisfactory |
| 2.07 Youth Records | Satisfactory |
| 2.08 Sexual Orientation, Gender Identity, Gender Expression | Satisfactory |
| 2.09 Special Populations | Satisfactory |
| 2.10 Stop Now and Plan (SNAP) | 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 | Limited |
| 3.05 Behavior Management Strategies | Satisfactory |
| 3.06 Staffing and Youth Supervision | Satisfactory |
| 3.07 Special Populations | Satisfactory |

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

**Standard 4: Mental Health/Health Services**

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

Percent of indicators rated Satisfactory: 80 %
Percent of indicators rated Limited: 20 %
Percent of indicators rated Failed: 0 %

**Overall Rating Summary**

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

## Rating Definitions

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

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

## Reviewers

Members

Marcia Tavares - Lead Reviewer Consultant-Forefront LLC/Florida Network of Youth and Family Services
Warren Garrison – Regional Monitor, Department of Juvenile Justice
Duane Gross - Children's Home Society West Palm
Paivi Johnson - Florida Keys Children Shelter
Kayrinah Hunter - Lutheran Services Florida Northwest

## Methodology

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

## Persons Interviewed

| | | | | | |
|---|---|---|---|---|---|
| X | Chief Executive Officer | | Case Manager | | Nurse – Full time |
| | Chief Financial Officer | X | Counselor Non-Licensed | | Nurse – Part time |
| X | Chief Operating Officer | | Advocate | | # Case Managers |
| | Executive Director | X | Direct – Care Full time | 1 | # Program Supervisors |
| | Program Director | | Direct – Part time | | # Food Service Personnel |
| X | Program Manager | | Direct – Care On-Call | | # Healthcare Staff |
| | Program Coordinator | | Intern | | # Maintenance Personnel |
| | 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 | 4 | # Health Records |
| X | Logbooks | | Key Control Log | 4 | # MH/SA Records |
| X | Continuity of Operation Plan | X | Fire Drill Log | 19 | # Personnel /Volunteer Records |
| X | Contract Monitoring Reports | X | Medical and Mental Health Alerts | 8 | # Training Records |
| | Contract Scope of Services | X | Precautionary Observation Logs | 12 | # Youth Records (Closed) |
| X | Egress Plans | X | Program Schedules | 6 | # Youth Records (Open) |
| X | Fire Inspection Report | X | List of Supplemental Contracts | | # Other: ___ |
| | Exposure Control Plan | | Vehicle Inspection Reports | | |

## Observations During Review

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

## Comments

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

Monitoring Purpose:

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

Strengths and Innovative Approaches

OVERALL
• New CEO Gwynn Virostek was hired on 10/7/2020 following vacancy since December of 2019.
• Former CFO retired and moved to Tampa. The CFO continued to provide support while the agency searched for a replacement; however, a decision was made to outsource accounting services to a local accounting firm.
• Internal candidate Lanekia Bennett was promoted to HR Coordinator in March of 2021.
• The agency engaged Consultant Jesse Jordan for a 6-week period to assist with overall Network program improvements and campus updates.
• CCYS was one of just a few Florida Network agencies to be recognized for Quality Data Integrity in 2021.
• Management team and team focused on agency issues surrounding the untimely deaths of two employees of the agency over past two years. Specialized EMDR training was offered to all employees.
• Three events were held jointly with Board of Directors and Staff as follows: 1) Holiday Meet and Greet, 2) Holiday luncheon with staff and Board Chair and Vice Chair in attendance for White Elephant gift exchange, and 3) CCYS Staff kickball game where staff and the board members came together and played a kickball game against the Tallahassee Kickball Team. A great time was had bonding although the agency did not win the game.
• Volunteer services include a local accounting firm that helped with campus wide clean-up and Junior League along with other volunteers who helped with Thanksgiving Meal Give-Away, donating over two hundred meals prepared and served to the community through Thanksgiving Drive-Up event.
• The agency brought on 4 new board members from Outer Counties (outside Leon County).
• Campus Signage is posted to discourage inappropriate items being brought on campus.

SOMEPLACE EMERGENCY SHELTER – SPE

• Management Team worked diligently on Behavior Management practices for shelter team and youth – Conversations of Clarity.
• Promoted Internal Candidate that had been a long term YCS to Shelter Program Support Specialist.
• Junior League of Tallahassee worked with Shelter Management Team to design a new Relaxation/Calming Room. Consultant and Management Team did a lot of "facelift" projects in the SPE Shelter (painting, construction, wall art, organizing, simplifying work areas).
• All new COVID friendly furniture was purchased for Shelter for comfort and ease of cleaning. Classroom was reorganized for youth and artwork added.
• Memorials dedicated to two former employees: Naming and upgrading shelter kitchen to memorialize former shelter employee – "Manny's Café." and bought, built and planted three mobile planters to enjoy on the campus memorializing former Clinical Director Jason Ishley.
• Held fun Halloween, field day and water day events for youth to enjoy outside activities.
• Educational activities for the youth include: The Tallahassee Fire Department Fire truck presentation; Tween Cooking Class; Music Therapy (once a week); and Publix virtual cooking class.
• Youth participated in volunteer activities with Adopt-a-Road Clean up; Second Harvest Volunteering; and Meals on wheels.
• 2ND Annual Book bag Drive – Gave away over 100 packed book bags for different age groups.

FAMILY PLACE – NON-RESIDENTIAL PROGRAM

• Promoted Internal Candidate, Ashley Mollema to Clinical Director for FP.
• Current counselors: 3 in Leon County and 2 in Wakulla County. All five current counselors are in the process of licensure. Two of the counselors are Registered Mental Health Counseling Interns, one is a provisionally Certified Art Therapist, one counselor is a Registered Clinical Social Work Intern and the other Counselor is a Registered Marriage and Family Therapy Intern. Two additional counselors are in the process of background approval (one for third Wakulla position, and one for multi-county covering Gadsden and Liberty counties).
• Partnerships continue with school systems in Leon and outer counties. MOU's entered into with Liberty, Jefferson, and Gadsden Counties.
• This past summer FP counselors facilitated 6 groups with the 21st Century summer program at a local elementary school. Each of the three Leon counselors is providing school based services 1 to 2 days per week. We also re-engaged with Jefferson County and a counselor is spending 1 day a week in Jefferson County.
• Each FP counselor pursued specialized training in their area of interest (ACT, Trauma, Play Therapy, TF-CBT). As a group they attended specialized Grief Training.
• Each month every counselor present different interventions/techniques that they each use and present to the entire clinical team. This has allowed the agency to develop a clinical toolkit for anxiety, building rapport, communication and social skills, divorce & custody, abandonment, adoption, exploring feelings, coping skills, family conflict, gender identity, mindfulness, impulse control, self-esteem, and political climate.
• Purchased tablets to assist in telehealth when appropriate and needed for clients (especially helpful in current COVID climate).
• Through local CARES funding, replaced all furniture in the counseling offices with sanitization friendly couches and chairs and purchased a variety of supplies for clinical interventions (art supplies, game-based interventions, fidgets, and play therapy supplies).

SNAP
• Hired new SNAP Case Manager/Facilitator.
• SNAP Program Manager, President/CEO and HR Coordinator/SNAP Facilitator attended Statewide SNAP Lead Event.
• New SNAP Case Manager and President/CEO attended SNAP Facilitator Training.
• Completed a SNAP In Schools program deliverable – past fiscal year.

Narrative Summary

The CCYS agency provides residential and non-residential services to youth ages 6 - 17. The Some Place Else (SPE) Youth Shelter facility is located in Tallahassee. The non-residential program provides services to the following counties: Franklin, Gadsden, Jefferson, Leon, Liberty, Madison, Taylor and Wakulla. The agency provides services to special populations who meet the criteria for Staff Secure shelter; Domestic Minor Sex Trafficking (DMST); youth referred by the Juvenile Justice Court System for domestic violence, probation respite, and Family and Youth Respite Aftercare services (FYRAC); and SNAP. CCYS is not contracted to provide Intensive Case Management services. The youth census during the QI visit was seven youth, including two DV respite.

Since the last review the shelter has increased the youth care roster from 6 to 14 and as of the QI Review, was down to 12. The nurse position has remained vacant for the past two years; however, a potential candidate will be hired pending background screening results. The HR Coordinator's position was recently filled in March 2021 with an internal promotion.

The overall findings for the QI review for CCYS are summarized as follows:

Standard 1 has a total of seven indicators regarding Management Accountability. Three of the seven indicators in Standard 1 were rated satisfactory with no exceptions (1.02, 1.05, and 1.07). Indicators 1.01, 1.03 and 1.06 were rated satisfactory with exceptions and indicator 1.04 received a Limited rating.

Standard 2 has a total of ten indicators that relate to intervention and case management. Four of the ten indicators were rated satisfactory with no exceptions (2.04 and 2.06 - 2.08). The remaining six indicators were rated satisfactory with exceptions (2.01, 2.02, 2.03, 2.05, 2.09, and 2.10).

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

Standard 4 is comprised of five indicators. Three of the five indicators were rated satisfactory with no exceptions. Indicator 4.04 was rated satisfactory with exception and indicator 4.03 received a Limited rating.

Summary of Deficiencies resulting in Limited or Failed Rating:

Standard 1:

Indicator 1.04 - Limited

Two of the four first year staff did not complete the DJJ Civil Rights training within 30 days of hire as required.

CPR/First Aid for one staff expired 8/28/21

Three of the four first year staff did not complete all mandatory trainings during the first 90 or 120-day timeframe as applicable to their hire dates.

None of the three in-service staff had completed all annual trainings required.

Standard 3:

Indicator 3.04 – Limited

Program Director or designee logbook reviews that were documented did not include the dates reviewed and did not provide any corrections, recommendations and/or follow-ups for the 6 weeks of logbook entries reviewed.

Of the 6 weeks of logbook entries reviewed it was observed that not all staff indicate review of the logbook entries for the two previous shifts.

Sample of logbook entries from March 2021 - August 2021 did not show consistency of supervisors reviewing the logbook and indicating dates reviewed at the beginning of their shift as required.

Standard 4:

Indicator 4.03 – Limited

There were no monthly reviews of medication management practice conducted by staff since the last QI review. This is a similar finding noted on the last QI review that has not been addressed by the program.

# 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<br>Document Source | Notes<br>Explain any items that have any deficiencies, exceptions or are not applicable. |
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| **Standard One – Management Accountability** | | | | | | | |
| **1.01: Background Screening (BS) and compliance with DJJ OIG statewide procedures regarding BS of employees, contractors and volunteers** | | | | | | | |
| **Provider has a written policy and procedure that meets the requirement for Indicator 1.01** | | | | | | **NO**<br>**If NO, explain here:**<br>Upon initial review, Background Screening policy did not include information on pre-employment suitability assessment regarding decision to hire staff who scored Low. The program submitted a revised P&P effective September 2021 during the QI review.<br>The provider has a policy in place titled Background Screening that was last approved August 31, 2021 by the Chief Executive Officer. | |
| Agency utilizes an employee suitability prescreening assessment with a passing rate criterion prior to an offer of hire for direct care staff working with youth or the agency has provided an explanation for staff hired with a non-passing/low score. | | **X** | | | | A total of nine new staff (8 CINS/FINS and 1 SNAP) were hired since the last onsite QI review. All nine staff met the criteria for a pre-screening assessment. The agency uses the Berke Assessment and completed the screening prior to hire for eight of the nine staff. | Exception:<br>Berke Assessment was not completed for one SNAP staff (MT). A second staff scored low (TS) on the Berke Assessment although an explanation was provided in the file as to reason for hire after a second interview was conducted, there is no indication of interviewer/individual making hiring decision. |

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| 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 | | | | | All nine staff hired were background screened prior to hire. In addition, there were a total of three interns utilized since the last QI review. All three interns had a background screening completed prior to their start date. | |
| Agency has evidence for employees who have had a break in service and who are in good standing and reemployed with the same agency without an additional suitability assessment or background screening if the break is less than 90 days. | | | X | | | None of the nine staff hired had a break in service with the agency. | |
| Five-year re-screening completed every 5 years from initial date of hire | | X | | | | There were seven staff (3 CINS/FINS and 4 SNAP) due for a five-year rescreening during the review period; six of the seven re-screenings were completed within the required time frame. | Exception:<br>One of seven 5-yr rescreening was not completed on time and background prints in the clearinghouse expired; a new background screening was required. |
| 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 completed and notarized the Annual Affidavit of Compliance with Level 2 Screenings on January 28, 2021; however, DJJ Background screening (BSU) did not have any record of receipt prior to January 31st deadline. The agency's email shows it was submitted to DJJ BSU on February 10, 2021. | Exception:<br>Annual Affidavit of Compliance with Level 2 Screenings was not received by DJJ BSU until February 10, 2021, after the January 31st deadline. |
| Proof of E-Verify for all new employees obtained from the Department of Homeland Security | X | | | | | Documentation of approval of E-Verify work eligibility was provided for all nine 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**<br>**If NO, explain here:**<br>The provider has several policies titled Behavior Management, Abuse Reporting, Client Grievance, Supervision of Client, and Staff Responsibilities; all were approved 8/31/2021. | |
| Rating Criteria | Satisfactory | Non-compliant | No Eligible Items for Review | No Practice | Not Applicable | | |

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| **Abuse Free Environment** | | | | | | | |
| Agency has a code of conduct of policy and there is evidence that staff are aware of agency's code of conduct. | X | | | | | Policy on Abuse Reporting was last reviewed August 2021. All staff are required to sign a code of conduct, upon hire. These forms are kept in the employee's personnel file. | |
| Child Abuse Registry telephone number is visible to youth and posted common areas of the facility | X | | | | | Child Abuse telephone number was observed posted in the dayroom during the on-site tour of the facility. | |
| Youth were informed of the Abuse and Contact Number (see youth survey results) | X | | | | | All four residential files reviewed documented the youth were informed of the Abuse Hotline number during orientation. All three youth surveyed indicated knowledge of the abuse hotline and location of the abuse hotline number in the facility. | |
| Management takes immediate action to address any incidents of threats or abuse | | | X | | | No incidents of abuse or threats were identified and/or reported during the review period needing management action. | |
| **Grievance Process** | | | | | | | |
| Agency has a formal grievance process | X | | | | | Policy on Client Grievances last reviewed in August 2021. | |
| Locked box accessible to only management and available to youth in a common area | X | | | | | During the on-site tour, it was observed that the program has an accessible grievance box that is locked and located in the dayroom. | |
| Direct care does not handle the complaint/grievance unless assistance is asked for by the youth. Program director/supervisor will have access to and manage grievances unless it is towards themselves. | X | | | | | The program reported one grievance filed during the QI review period; the grievance was resolved and signed by the residential supervisor. | |
| 72-hour resolution requirement by management. If this does NOT occur within the 72 hour period, there is sufficient documentation explaining the cause for the delay in resolution. | | X | | | | There was one grievance reviewed during the reporting period. The residential supervisor resolved the grievance within 72 hours. However, a "test" grievance was deposited in the box by a Forefront Team member on 9/10/21 and was retrieved by the Residential Supervisor (RS) five days later on 9/15/21. As instructed, the RS acknowledged receipt of the "test" grievance via email to the Lead Reviewer. | Exception: Grievance box does not appear to be checked daily as the "test" grievance was not retrieved by the program until five days after it was deposited in the grievance box. |
| **1.03: Incident Reporting** | | | | | | | |
| **Provider has a written policy and procedure that meets the requirement for Indicator 1.03** | | | | | | **YES** | |

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| | | | | | | The provider has a policy in place titled Incident Reporting that was last approved August 31, 2021 by the Chief Executive Officer. | |
| Rating Criteria | Satisfactory | Non-compliant | No Eligible Items for Review | No Practice | Not Applicable | | |
| During the past 6 months, the program notified the Department's CCC (Central Communication Center) no later than two hours after any reportable incident occurred or within two hours of the program learning of the incident | | X | | | | Total of twelve CCC reports were reported during this review period by DJJ CCC. Seven of the twelve were non-COVID incidents and five of the twelve were to notify CCC of COVID testing and/or results. Five of the seven non-COVID CCC reports were reported during the 2-hour timeframe required. | Exception:<br>Two of the seven non-COVID related CCC reports filed were not reported within the required 2 hours. |
| The program completes follow-up communication tasks/special instructions as required by the CCC | X | | | | | All CCC incidents that required followed up were completed. | |
| Incidents are documented in the program logs and on incident reporting forms | | X | | | | Three of the seven CCC incidents were documented in the logbook; however, two of the incidents were not documented in the logbook (4/24 and 7/5) and 2 out of the 7 could not be verified as staff was unable to locate these (5/10 and 8/5). | Exception:<br>Two out of seven incidents were not documented in the program logbook (4/24/21 and 7/5/21). Two other incidents documented by DJJ CCC (5/10/21 and 8/5/21) were missing from the provider's CCC file as staff was unable to locate these reports. |
| All incident reports are reviewed and signed by program supervisors/directors | X | | | | | All incidents reviewed were signed by the program supervisor or by the COO. | |
| **1.04: Training Requirements (Staff receives training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions)** | | | | | | | |
| **Provider has a written policy and procedure that meets the requirement for Indicator 1.04** | | | | | | **YES**<br>**If NO, explain here:**<br>The provider has a policy in place titled Training that was last approved August 31, 2021 by the Chief Executive Officer. | |

| Rating Criteria | Satisfactory | Non-compliant | No Eligible Items for Review | No Practice | Not Applicable | | |
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| **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 five first year training records reviewed for four CINS/FINS staff and one SNAP staff. Two of the four applicable CINS/FINS staff completed USDOJ Civil Rights training within 30 days of hire. | Limited Exception:<br>Two of the four first year staff did not complete the DJJ Civil Rights training within 30 days of hire as required. |

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| All staff receives all mandatory training during the first 90 days of employment from date of hire. | | **X** | | | | Two of the four first year 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. Two of the staff completed an excess of 80 training hours required annually and the remaining two new staff were on target for completing the required 80 hours.<br><br>Only one of the four first year staff completed all mandatory trainings required during the first 90 or 120-day timeframe as applicable to their hire dates. The two staff hired in 2020 are nearing the end of their first year and have time remaining to complete the annual Fire Safety and LGBTQ training. | Limited Exception:<br>Three of the four first year staff did not complete all mandatory trainings during the first 90 or 120-day timeframe as applicable to their hire dates as follows:<br>Staff #1: DOH 10/21/20<br>Two of the mandatory 120-day trainings due by 2/21/21 were not completed (CINS/FINS Core and SSMHSA) and one (Behavior Management) was completed past the 120-day timeframe.<br><br>Staff #2: DOH 1/16/21<br>Only 5 of 24 trainings required in the first 90 days were completed on time. Nineteen of the 24 mandatory trainings were not completed during the required 90-day timeframe as of the review. Ten of the 19 were completed late/past the 90-day timeframe and 9 had not yet been completed (Orientation, SSMHSA, SkillPro Suicide Prevention 1&2 and Human Trafficking). |

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| Additional all staff receives all mandatory training during the first 90 days of employment from date of hire narrative | | | | | | | Upon notification, staff completed 5 trainings on 9/9/21 during the QI review (Child abuse, Info Security, EEO, PREA, and Sex Harassment).<br><br>Staff #3: DOH 5/14/21 Only 13 of 24 mandatory trainings were completed in the first 90 days as required. The remaining 11 mandatory trainings are overdue and were not yet completed.<br><br>Additionally, the CPR/First Aid certificate for one staff expired on 8/28/21. |
| **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 had one applicable non-licensed shelter staff who was hired on 8.10.21 and has completed 3 of the requirements to date. | |
| 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 to date were completed and signed by the Licensed Mental Health Counselor. | |
| **In-Service Direct Care Staff** | | | | | | | |

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| 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 in-service employee training files were reviewed and all three had completed over 40 hours of training. However, all three staff did not complete all required annual FN or DJJ SkillPro trainings. | Limited Exception:<br>None of the three in-service staff had completed all annual trainings required.<br>• All three staff did not complete 3 annual DJJ SkillPro trainings (Suicide Prevention 1&2 and Child Abuse)<br>• Two staff did not complete MAB required every two years<br>• Two staff did not complete Fire Safety required every two years<br>• Two staff did not complete Human Trafficking required annually<br>• One staff did not complete PREA and Sexual Harassment required annually. |
| **Required Training Documentation** | | | | | | | |
| The program maintains an individual training file for each staff, which includes an annual employee training hours tracking form and related documentation, such as certificates, sign-in sheets, and agendas for each training attended. | X | | | | | In all training files there was a spreadsheet with all trainings, date completed, and hours. Also, training files included training certificates and training worksheets. | |
| **Provider has a written policy and procedure that meets the requirement for Indicator 1.05** | | | | | | **YES**<br>**If NO, explain here:**<br>Provider has a policy in place titled Analyzing and Reporting Information that was last approved in August 2021 by the CEO. | |
| Rating Criteria | Satisfactory | Non-compliant | No Eligible Items for Review | No Practice | Not Applicable | | |

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| Case record review reports demonstrate reviews are conducted quarterly, at a minimum | X | | | | | Case record reviews were reviewed for the 2nd and 3rd quarters of the FY 2020-2021. Quarter 4 was not yet completed and was scheduled for the week of September. | |
| The program conducts reviews of incidents, accidents, and grievances quarterly, at a minimum | X | | | | | The program collects and reviews incidents and accident data on an Internal Incident Summary Report monthly reviewed for March - July 2021. Grievances are reviewed monthly on the Grievance Data report FY 20-21. | |
| The program conducts an annual review of customer satisfaction data | X | | | | | Customer satisfaction data is reviewed quarterly. January thru March and April thru June 2021 were reviewed in addition to monthly climate surveys regarding youth's experience at the shelter. | |
| The program conducts an annual review of outcome data and (if applicable) there is evidence of annual reconciliation that occurs through communication from the Florida Network via email or phone call when corrections are needed and the information is corrected and submitted within the requested timeframes. | X | | | | | Outcome data from the FNYFS is reviewed at management and staff meetings. Meeting agendas for March, June, and July meetings were reviewed.<br><br>The last annual reconciliation for FY2019-2020 was submitted by the COO to DJJ and the FN in May 2021 evidenced by email sent May 5, 2021. | |
| 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 | | | | | Program managers send the COO their personal logs which is compare to the NetMIS reports, checking for same number of intake, discharges, name spelling, and intake and discharge dates. Once those are reconciled, the COO runs a report of youth served for the month in prevention web. The prevention web report is then checked against the NetMIS report to verify names, intake and exit dates to verify that the data is accurate in NetMIS (management section) to “lock” the data before generating the monthly invoice. Once done, the invoices are printed signed and submitted to the Network by the 4th working day of the month for the prior month’s service provision. | |
| The Florida Network conducts monthly reconciliation by comparing NetMIS data to JJIS data. Agency has evidence that they have reconciled any differences noted. | X | | | | | NetMIS data reports are sent monthly by email to the COO, Clinical Director, and Shelter Support Specialist from the CEO for review. The COO is the designated data administrator. A thread of emails between the COO and the FN regarding monthly data reconciliation for April-July 2021 was provided. | |

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| The program has a process in place to review and improve accuracy of data entry & collection | X | | | | | NetMIS data reports from the FNYFS are sent monthly to the Clinical Director and Shelter Support Specialist for reconciliation. They then notify the CEO corrections that have been made. | |
| There is documentation that findings are regularly reviewed by management and communicated to staff and stakeholders. | X | | | | | There was documentation through emails and staff meeting minutes that findings are communicated to 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 | | | | | Reviewed monthly Board meeting minutes for March-May 2021 that includes program participants (CEO and COO) and shows a discussion of program performance, licensing, and audit updates. | |
| There is evidence that strengths and weaknesses are identified, improvements are implemented or modified, and staff are informed and involved throughout the process. | | | X | | | If applicable, the meeting agenda includes a discussion of corrective actions, person(s) responsible, deadline, and progress. However, no active corrective action were observed to be in place during the review period. | |
| **Provider has a written policy and procedure that meets the requirement for Indicator 1.06** | | | | | | **NO**<br>**If NO, explain here:**<br>In reviewing the agency's transportation policy, it does not specify if clients' history, evaluation and recent behavior are considered prior to single transport.<br>Provider has a policy in place titled Transportation and Vehicles that was last approved in August 2021 by the Chief Executive Officer. | |
| Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle | X | | | | | The agency maintains a list of 42 staff approved to drive clients generated by the agency's insurance company. | |
| Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy | X | | | | | All driving records are submitted to the insurer for approval on agency's insurance. A list of drivers added to the Hub International insurance correspondence from insurer listed approved drivers. | |

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| 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 | | | | | Reviewed current policy on Transportation and Vehicles. | |
| 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 Vehicle Logs for March 1st - September 1, 2021. There were thirteen single client transports during the period with documentation of supervisory approval prior to the single transport of youth. | |
| The 3rd party an approved volunteer, intern, agency staff, or other youth | X | | | | | Van Logs were reviewed from March 2021 to 9/1/2021. Staff and/or youth were present in all non-single transports. | |
| 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 | | | | Van Logs were reviewed from March 2021 to 9/1/2021. | Exception:<br>Purpose of travel is not included on the logs. |
| **Provider has a written policy and procedure that meets the requirement for Indicator 1.07** | | | | | | **NO**<br><br>**If NO, explain here:**<br>Current policy does not include the following verbiage: 1) designation of a staff member to participate in the local DJJ board and council meetings; and to verify participation by providing: minutes to meetings; verification of attendance at DJJ Board and Council meetings; support and accommodation for representative to participate in assigned meetings; maintaining a log of outreach activity to include the target audience, date, outreach modality, duration of encounter, estimated number of people reached, and date; and designated personnel to conduct outreach, defined in the job description. Additionally, the policy does not address the agency's comprehensive referral process.<br><br>Provider has a policy in place titled Outreach that includes the agency's annual Outreach Plan. The policy was approved August 2021 by the CEO. | |
| Rating Criteria | Satisfactory | Non-compliant | No Eligible Items for Review | No Practice | Not Applicable | | |

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| 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 | | | | | Agency staff participates in Circuit 2 advisory board which takes place 4 times/year. Four Circuit 2 Advisory board meeting agendas and minutes provided to show participation by the agency's CEO; however these are not listed in the log of outreach activity. | |
| 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 | | | | | Agency has evidence of outreach events by providing NetMIS outreach report which includes title of event, date of event, number of youth and adults in event, purpose of event, and what area event took place in the community. Report was provided from March – August 2021 and including outreach events at local schools, churches, local organizations, and community events. | |
| The program maintains written agreements with other community partners which include services provided and a comprehensive referral process. | X | | | | | Agency has twenty-eight formal interagency agreements with community partners including local schools, mental health facilities, and sheriff's department. The agency also has a list of 29 collaborations and linkages with other agencies in the area to provide different specialized services to the youth served. | |
| **Provider has a written policy and procedure that meets the requirement for Indicator 2.01** | | | | | | **YES**<br>**If NO, explain here:**<br>Provider has a policy in place titled Screening and Intake that was last approved in August 2021 by the Chief Executive Officer. | |
| Rating Criteria | **Satisfactory** | **Non-compliant** | **No Eligible Items for Review** | **No Practice** | **Not Applicable** | | |

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| **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 | | | | All five residential records reviewed (3 closed and 2 open) had screenings completed immediately upon referral of the youth. Two of the five records were open/recent intakes, applicable to the indicator effective August 2021.<br><br>Three Secret Shopper calls were made to the agency between September 3-10, 2021. All calls resulted in an immediate screening. One call did not obtain acceptance within 30 minutes but the agency staff called back the same day. The other 2 calls resulted in a call back after the screening was complete.<br>2 of the screenings completed were entered into NETMIS within 72 hours. | Exception:<br>One of the three Secret Shopper calls made to the agency did not result in an immediate acceptance or within 30 minutes from the initial inquiry. |
| **Community counseling:** Eligibility screening is completed within 3 business days of referral by a trained staff using the NetMIS form | | | X | | | All 5 community counseling records reviewed (3 closed and 2 open) had intake dates prior to the indicator's effective date (August 2021); consequently, there were no eligible items to review from the randomly selected sample. | |
| There is evidence all referrals for service is screened for eligibility and is logged in NetMIS within 72 hours of screening completion. | | X | | | | Two of the five records were open/recent intakes, applicable to the indicator effective August 2021. The two applicable screenings were completed and entered into NetMIS within 72 hours of screening completion.<br><br>Three Secret Shopper calls were made to the agency between September 3-10, 2021. All three calls resulted in an immediate screening; however, only two of the three screenings were entered into Netmis within 72 hours as required. | Exception:<br>All three Secret Shopper calls made to the agency resulted in an immediate screening: however, one of the three screenings was not entered into NetMIS within 72 hours as required. |
| Youth and parents/guardians receive the following in writing:<br><br>a. Available service options<br><br>b. Rights and responsibilities of youth and parents/guardians | X | | | | | All 10 records reviewed had parent/guardians' signature and youths' signature reviewing rights & responsibilities along with services being provided. | |
| The following is also available to the youth and parents/guardians: | | | | | | All ten records reviewed noted parent/guardians were provided with CINS/FINS parent brochure outlining CINS/FINS services. The grievance procedures are | |

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| a. Possible actions occurring through involvement with CINS/FINS services (case staffing committee, CINS petition, CINS adjudication)<br><br>b. Grievance procedures | X | | | | | 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**<br>**If NO, explain here:**<br>Provider has a policy in place titled Assessment and Service Plan Development that was last approved in August 2021 by the Chief Executive Officer. | |
| Rating Criteria | Satisfactory | Non-compliant | No Eligible Items for Review | No Practice | Not Applicable | | |
| **Completion of Needs Assessment** | | | | | | | |
| Shelter Youth: Needs Assessment initiated within 72 hours of admission | X | | | | | The Needs Assessment was initiated within 72 hours in all five residential records reviewed. | |
| Non-Residential youth: Needs Assessment is done within 2 to 3 face-to-face contacts after the initial intake **OR** updated, if most recent assessment is over 6 months old | X | | | | | All five community counseling records had completed needs assessments done within 2-3 face to face contacts after initial intake. | |
| Needs Assessment is conducted by a bachelor's or master's level staff member | X | | | | | All ten charts reviewed listed YFC (Youth Family Counselor) after counselors' name for their credentials. Credentials indicating bachelor or master's level counselors were not documented next to the name/signatures of staff in the youth records, however it was confirmed the counselors were bachelor or master level staff members. | |
| Needs Assessment includes a supervisor's review signature upon completion | X | | | | | All ten records included the supervisor's signature upon review. | |
| **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 | | | | | One residential youth (open) and one community counseling youth (closed) was identified as a risk for suicide during the needs assessment. | |
| If yes, the youth was referred for an Assessment of Suicide Risk conducted by or under the direct supervision of a licensed mental health professional | X | | | | | The two youth has an Assessment of Suicide Risk conducted by a licensed mental health professional. | |
| **Provider has a written policy and procedure that meets the requirement for Indicator 2.02** | | | | | | **YES**<br>**If NO, explain here:** | |

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| **Provider has a written policy and procedure that meets the requirement for Indicator 2.03** | | | | | | Provider has a policy in place titled Assessment and Service Plan Development that was last approved in August 2021 by the Chief Executive Officer. | |
| Rating Criteria | Satisfactory | Non-compliant | No Eligible Items for Review | No Practice | Not Applicable | | |
| Case/Service plan is developed within 7 working days of Needs Assessment | X | | | | | Nine of the ten records reviewed had case plans developed within seven days of the needs assessments. One record was a recent residential intake and had time to develop and implement the service plan. | |
| **Case plan service Plan includes:**<br>1. Individualized and prioritized need(s) and goal(s) identified by the Needs Assessment<br>2. Service type, frequency, location<br>3. Person(s) responsible<br>4. Target date(s) for completion and Actual completion date(s)<br>5. Signature of youth, parent/ guardian, counselor, and supervisor<br>6. Date the plan was initiated | | X | | | | Nine applicable case plans reviewed included service type, frequency, location, the persons responsible for each goal listed, target dates and date the plan was initiated. Only one (closed) of three applicable community counseling records had completed target date. Three of five community counseling records had obtained parent's signatures and two were missing parent's signature, (1 closed but attempted and 1 open attempted with "LVM" listed) for signature. Two of the 4 applicable residential charts had parent's signatures via phone contact; however, attempts were made and documented to obtain parental signatures in the other two residential charts. | Exception:<br>Three closed residential charts had "ongoing" for actual completion dates. Two closed community counseling charts did not list actual completion dates. |
| Case/service plans are reviewed for progress/revised by counselor and parent (if available) every 30 days for the first three months and every 6 months after | | X | | | | All closed residential charts reviewed were discharged before 30 days. One community counseling record demonstrated reviews every 30 days before discharge. | Exception:<br>Four of five community counseling records did not have timely service plan reviews. The 30-day service plan review was late in one of the four records and three records had late 60-day reviews. |
| **Provider has a written policy and procedure that meets the requirement for Indicator 2.04** | | | | | | **YES**<br>**If NO, explain here:**<br>Provider has a policy in place titled Service Modalities and Interventions that was last approved in August 2021 by the Chief Executive Officer. | |
| Rating Criteria | Satisfactory | Non-compliant | No Eligible Items | No Practice | Not Applicable | | |

| Rating Criteria | Satisfactory | Non-compliant | for Review | No Practice | Not Applicable | | |
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| Counselor/Case Manager is assigned | X | | | | | Each of the ten records reviewed showed a counselor was assigned to the youth. | |
| The Counselor/Case Manager completes the following as applicable:<br>1. Establishes referral needs and coordinates referrals to services based upon the on-going assessment of the youth's/family's problems and needs<br>2. Coordinates service plan implementation<br>3. Monitors youth's/family's progress in services<br>4. Provides support for families<br>5. Monitors out-of-home placement (if necessary)<br>6. Makes referrals to the case staffing to address problems and needs of the youth/family<br>7. Accompanies youth and parent/guardian to court hearings and related appointments<br>8. Refers the youth/family for additional services when appropriate<br>9. Provides case monitoring and reviews court orders<br>10. Provides case termination notes<br>11. Provides follow-up after 30 days of exit<br>12. Provides follow-up after 60 days of exit | X | | | | | All 10 records reviewed had referral needs addressed and services put into place. All 10 reviewed records included chronological and/or progress notes to document youth's progress and provided support to the family.<br><br>Nine applicable records had goals and objectives to implement service plans.<br><br>All five residential charts documented youth's out-of-home placements. None of the charts reviewed were applicable for referrals to the case staffings.<br><br>One of the 10 youth (DV respite) was accompanied by CCYS for court hearing.<br><br>One open residential record provided documentation and care coordination with court hearing appointment.<br><br>All discharged records (6) presented recommendations and referrals for additional services and had completed discharge summaries and case termination notes.<br><br>Two applicable residential and three community counseling records had completed 30 day follow-ups. Two applicable residential and two community counseling records had completed 60 day follow-ups as required. | |
| The program maintains written agreements with other community partners that include services provided and a comprehensive referral process | X | | | | | Agency has twenty-eight formal interagency agreements with community partners including local schools, mental health facilities, and sheriff's department. The agency also has a list of 29 collaborations and linkages with other agencies in the area to provide different specialized services to the youth served. | |
| | | | | | | **YES** | |
| | | | | | | **If NO, explain here:** | |

| **Provider has a written policy and procedure that meets the requirement for Indicator 2.05** | | | | | | Provider has a policy in place titled Service Modalities and Interventions that was last approved in August 2021 by the Chief Executive Officer. | |
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| 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/or case notes maintained demonstrated all ten youth received individual counseling services as identified during the assessment process. | |
| **Shelter Program** | | | | | | | |
| Shelter programs provides individual and family counseling | X | | | | | All five residential records demonstrated individual counseling/family counseling was provided. | |
| Group counseling sessions held a minimum of five days per week | X | | | | | All five residential records documented client's participation in group sessions. A review of group logs during the period March-August 2021 supported the program is providing groups at least five times per week. | |
| Group counseling sessions consist of:<br>a. Length of at least 30 minutes<br>b. Opportunity for youth engagement<br>c. Clear and relevant topic (informational/developmental/ educational)<br>d. Clear leader or facilitator | X | | | | | Group logs for March-August 2021 were reviewed. Indicators for group sessions were complete. Groups were documented on an activity log that contained other activities including social skills activity and group activity that occurred during that day with specific time period for each. The activity also included a check mark for youth who participated, group topic, 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 | | | | | All five community counseling records reviewed documented therapeutic services were provided that met youth and family's needs. | |
| **Counseling Services** | | | | | | | |

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| 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 | | | | | The nine applicable records reviewed had completed service plans. Other documentation (needs assessment, case plans reviews, chrono notes, etc.) coincide with youth's presenting issue. | |
| Maintain individual case files on all youth and adhere to all laws regarding confidentiality | X | | | | | Individual youth record was maintained for all ten youth files reviewed, marked confidential and securely maintained. | |
| Case notes maintained for all counseling services provided and documents youth's progress | X | | | | | All ten youth records included case notes that documented services provided including counseling. | |
| On-going internal process that ensures clinical reviews of case records and staff performance | | X | | | | All five residential records included staffings listed on the chronological sheets. | Exception:<br>The five community counseling records reviewed did not include clinical reviews of case records and staff performances. |
| **Provider has a written policy and procedure that meets the requirement for Indicator 2.06** | | | | | | **YES**<br>**If NO, explain here:**<br>Provider has a policy in place titled CINS/FINS Case Staffing Committee that was last reviewed in August 2021 by the Chief Executive Officer. | |
| Rating Criteria | Satisfactory | Non-compliant | No Eligible Items for Review | No Practice | Not Applicable | | |
| **Case Staffing Initiation and Notifications** | | | | | | | |
| If parent/guardian initiates, staffing is held within 7 days | | | X | | | The program has not had any case staffings since the last on-site Quality Improvement review. | |
| The youth, family and case staffing committee are contacted within a minimum of five working days<br>a. Notification to youth/family no less than 5 working days prior to staffing<br>b. Notification to committee no less than 5 working days prior to staffing | | | X | | | The program has not had any case staffings since the last on-site Quality Improvement review. | |
| **Case Staffing Committee** | | | | | | | |
| **Must include:**<br>a. DJJ rep. or CINS/FINS provider<br>b. Local school district representative | | | X | | | No case staffings held. | |
| **Other members may include:** | | | | | | No case staffings held. | |

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| a. State Attorney's Office<br>b. Others requested by youth/ family<br>c. Substance abuse representative<br>d. Law enforcement representative<br>e. DCF representative<br>f. Mental health representative | | | X | | | | |
| The program has an established case staffing committee, and has regular communication with committee members | X | | | | | The program has an established case staffing committee with regular communication when staffing is requested. | |
| The program has an internal procedure for the case staffing process, including a schedule for committee meetings | X | | | | | Procedure is documented in agency policy titled CINS/FINS Case Staffing Committee. | |
| **As a result of the Case Staffing** | | | | | | | |
| The youth and family are provided a new or revised plan for services | | | X | | | No case staffings held. | |
| Written report is provided to the parent/guardian within 7 days of the case staffing meeting, outlining recommendations and reasons behind the recommendations | | | X | | | No case staffings held. | |
| If applicable, the program works with the circuit court for judicial intervention for the youth/family | | | X | | | No case staffings held. | |
| Case Manager/Counselor completes a review summary prior to the court hearing | | | X | | | No case staffings held. | |
| **Provider has a written policy and procedure that meets the requirement for Indicator 2.07** | | | | | | **YES**<br>**If NO, explain here:**<br>The provider has multiple policies in place titled Confidentiality of Client Information, File Organization, and Staff Access to Case Records. All of the policies were last approved in August 2021 by the Chief Executive Officer. | |
| Rating Criteria | Satisfactory | Non-compliant | No Eligible Items for Review | No Practice | Not Applicable | | |
| All records are clearly marked 'confidential'. | X | | | | | All charts observed during the tour were marked confidential. | |
| All records are kept in a secure room or locked in a file cabinet that is marked "confidential" | X | | | | | All records were kept in a file cabinet that was marked confidential. File cabinet was located in locked room with sign identifying file room for authorized staff and with confidential label. | |

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| When in transport, all records are locked in an opaque container marked "confidential" | X | | | | | Youth files when transported are locked in an opaque container also marked confidential. | |
| All records are maintained in a neat and orderly manner so that staff can quickly and easily access information | X | | | | | All records were kept in a file cabinet in alphabetical order. Files were neatly stored. | |
| **Provider has a written policy and procedure that meets the requirement for Indicator 2.08** | | | | | | **YES**<br>**If NO, explain here:**<br>Provider has multiple policies in place titled Sexual Orientation, Gender identity, Gender Expression; Client Rights; Room Assignment; and Access and Eligibility Criteria that were last reviewed in August 2021 by the Chief Executive Officer. | |
| **Rating Criteria** | **Satisfactory** | **Non-compliant** | **No Eligible Items for Review** | **No Practice** | **Not Applicable** | | |
| **Use of youth's preferred name/ pronoun:**<br>a. Youth are addressed according to their preferred name and gender pronouns<br>b. Youth's preferred name and gender pronouns are used in logbook and on all outward-facing documents and census boards | X | | | | | Since the last on-site Quality Improvement review, the program served one applicable youth who met the criteria for this indicator. Documentation in the youth's records, logbook, and forward facing documents included the use of youth's preferred pronoun and name. | |
| Youth in need of specialized support is referred to qualified resources (as applicable) | | | X | | | Youth did not require specialized support during their shelter stay. | |
| Youth preference is considered and documented for room assignment and youth is not roomed in isolation due to sexual orientation, gender identity, or gender expression | X | | | | | The youth's preference for room assignment was honored by the program and youth was not roomed in isolation. | |
| Youth is provided hygiene products, undergarments and clothing that affirms their gender identity or gender expression | | | X | | | The youth's record did not indicate youth requested items to affirm their gender identity. | |
| The agency has signage and brochures/publication placed in common areas indicating that all youth are welcome regardless of sexual orientation, gender identity, and gender expression | X | | | | | SOGIE signage is located on glass door in lobby, all common areas, and doors of dorm rooms. | |
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| Provider has a written policy and procedure that meets the requirement for Indicator 2.09 | | | | | | If NO, explain here: | |
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| | | | | | | The provider has two policies in place to address the requirements of this indicator, CINS Staff Secure and Special Populations. Policies were approved in August 2021 by the Chief Executive Officer. | |
| **Rating Criteria** | **Satisfactory** | **Non-compliant** | **No Eligible Items for Review** | **No Practice** | **Not Applicable** | | |
| **Staff Secure** | | | | | | | |
| Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? **(If no, select rating "No eligible items for review")** | | | **NO** | | | | |
| **Staff Secure policy and procedure outlines the following:**<br>a. In-depth orientation on admission<br>b. Assessment and service planning<br>c. Enhanced supervision and security with emphasis on control and appropriate level of physical intervention<br>d. Parental involvement<br>e. Collaborative aftercare | **X** | | | | | Reviewed policy titled CINS Staff Secure. | |
| Program only accept youth that meet legal requirements of F.S. 984 for being formally court ordered in to Staff Secure Services | | | **X** | | | No eligible youth served. | |
| **Staff Assigned:**<br>a. One staff secure bed and assigned staff supervision to one staff secure youth at any given time<br>b. Program assign specific staff during each shift to monitor location/ movement of staff secure youth<br>c. Agency clearly documents the specific staff person assigned to the staff secure youth in the logbook or any other means on each shift | | | **X** | | | No eligible youth served. | |

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| Agency provides a written report for any court proceedings regarding the youth's progress | | | X | | | No eligible youth served. | |
| **Domestic Minor Sex Trafficking (DMST)** | | | | | | | |
| Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? **(If no, select rating "No eligible items for review")** | | | **NO** | | | | |
| **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:<br>a. Youth in program do not have length of stay in DMST placement that exceeds seven (7) days<br>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. | |

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| 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** | | | | | Two open and one closed Domestic Violence (DV) youth record was reviewed. All three youth were screened and referred by JAC. | |
| Data entry into NetMIS and JJIS within (3) business days of intake and discharge | | **X** | | | | One of the three DV youth records reviewed was entered into NetMIS within 3 business days of intake and exit as required. JJIS data entry lag occurred in 1 applicable discharge entry. | Exception: NetMIS intake data entry lags were observed in two of three DV records reviewed and discharge lag in one of three records. JJIS data entry lag occurred in 1 applicable discharged record. |

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| Youth in program do not have length of stay in DV Respite placement that exceeds 21 days. If more than 21 days, documentation exists in youth file of transition to CINS/FINS or Probation Respite placement, if applicable. | X | | | | | None of the three youth's length of stay in the DV program exceeded 21 days. | |
| 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 | | | | | Three closed probation respite youth records were reviewed. Approvals by the Florida Network were obtained for each youth as evidenced by approval emails. | |
| Probation Respite Referral come from DJJ Probation and are all youth referred on probation regardless of adjudication status | | X | | | | A DJJ Face sheet was present in all two of the three records showing probation status of the youth and referral to the agency. | Exception:<br>Proof of DJJ referral was not documented for one of three probation respite youth. |

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| Data entry into NetMIS and JJIS within (3) business days of intake and discharge | | **X** | | | | Intake data was entered into NetMIS 1 day late for all three probation respite youth and discharge data in both NetMIS and JJIS was within 72 hours as required for one of the 3 youth. | Exception: NetMIS intake data entry lags were observed in all three probation respite records reviewed and discharge lag in two of three records. JJIS data entry lag occurred in one of three applicable discharged record. |
| Length of stay is no more than fourteen (14) to thirty (30) days? (Placement beyond thirty (30) days requires the approval of the JPO and/or CPO) | **X** | | | | | Probation respite length of stay did not exceed 30 days for any of the three youth records reviewed. | |
| All case management and counseling needs have been considered and addressed | **X** | | | | | Case plans in the three youth records reflect goals for reducing violence and coping skills. | |
| All other services provided to Probation Respite youth are consistent with all other general CINS/FINS program requirements | **X** | | | | | Case notes demonstrate all three youth received shelter services consistent with CINS/FINS program requirements. | |
| **Intensive Case Management (ICM)** | | | | | | | |
| Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? **(If no, select rating "No eligible items for review")** | | | | | **N/A** | CCYS is not contracted to provide ICM services. | |
| **Rating Criteria** | **Satisfactory** | **Non-compliant** | **No Eligible Items for Review** | **No Practice** | **Not Applicable** | | |
| Youth receiving services was court ordered | | | | | **X** | CCYS is not contracted to provide ICM services. | |

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| **Services for youth and family include:**<br>a. Two (2) direct contacts per month<br>b. Two (2) collateral contacts per week<br>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** | | |
| **Assessments include:**<br>a. A Child Behavior Checklist (CBCL) is completed within 14 days of intake and at discharge (if applicable)<br>b. An approved self-report assessment that was completed at intake<br>c. An approved self-report assessment that was completed every 90 days following intake and at discharge (if applicable) | | | | | **X** | | |
| Case plan demonstrates a strength-based, trauma-informed focus | | | | | **X** | | |
| 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** | | |
| **Family and Youth Respite Aftercare Services (FYRAC)– Non-residential Only** | | | | | | | |

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| Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? **(If no, select rating "No eligible items for review")** | **YES** | | | | | | |
| **Rating Criteria** | **Satisfactory** | **Non-compliant** | **No Eligible Items for Review** | **No Practice** | **Not Applicable** | | |
| Youth is referred by DJJ for a domestic violence arrest on a household member, and/or the youth is on probation regardless of adjudication status and at risk of violating | **X** | | | | | Two youth records were reviewed (1 open and 1 closed). Both youth were referred by DJJ for domestic violence arrest. | |
| Agency has evidence that all FYRAC referrals have documented approval from the Florida Network office | **X** | | | | | Approvals by the Florida Network were obtained for each youth as evidenced by approval emails. | |
| Intake and initial assessment sessions meets the following criteria:<br>a. Face-to-face gathering of family history and demographic information<br>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** | | | | A review of the service plans for the two youth shows they were not developed during the intake session as required. | Exception:<br>Intake session did not include development of service plan in the two FYRAC records reviewed. |
| Life Management Sessions meets the following criteria:<br>a. Sessions are face-to-face, sixty (60) minutes in length and focus on strengthening the family unit<br>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** | | | | | One applicable youth record documents the required life management and individual sessions. The other record was a new intake and FYRAC services had not yet begun. | |
| Group Sessions:<br>a. Focus on the same issues as individual/family sessions with the overall goal of strengthening relationships and prevention domestic violence | | | **X** | | | No group sessions were provided to the two FYRAC youth. | |

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| b. Shall be no more than eight (8) youth at one (1) time and shall be for a minimum of sixty (60) minutes per session | | | | | | | |
| Youth and family participate in services for thirteen (13) sessions or ninety (90) consecutive days of services, or there is evidence in the youth's file that an extension is granted by DJJ circuit Probation staff | | X | | | | Applicable to one of the two youth. | Exception:<br>One applicable FYRAC youth did not receive 13 sessions required; only 6 sessions were provided during youth's stay in the program. |
| **2.10: STOP NOW AND PLAN (SNAP)** | | | | | | | |
| **Provider has a written policy and procedure that meets the requirement for Indicator 2.10** | | | | | | **YES**<br>**If NO, explain here:**<br>Provider has a policy in place titled Stop Now and Plan (SNAP) and SNAP in Schools that was last approved August 2021. | |
| **Rating Criteria** | **Satisfactory** | **Non-compliant** | **No Eligible Items for Review** | **No Practice** | **Not Applicable** | | |
| **SNAP Clinical Groups** | | | | | | | |
| Youth are screened to determine eligibility of services | X | | | | | There were three files reviewed, one open and two closed. All three files had NetMIS Screening form and SNAP Brief Intake Screening form. | |
| Needs assessment is completed at initial intake, or within two face-to-face sessions | X | | | | | Needs Assessment was completed at intake in all three records reviewed. | |
| SNAP Assessments<br>a. Child Behavior Checklist (CBCL) is completed by the caregiver (pre & post)<br>b. Teacher Report Form (TRF) completed by the teacher (pre & post)<br>c. Tool for Parenting Self Efficacy (TOPSE) completed by the caregiver (pre & post)<br>d. Prevention Assessment Tool (PAT) (pre & post) | | X | | | | A pre-CBCL was completed in all three files and post-CBCL in two applicable records; one of the youth withdrew from the program.<br><br>None of the two applicable records included a TRF and attempts to obtain them were not documented in the file.<br><br>Pre- and post-TOPSE were completed in two applicable youth records.<br><br>Pre-PAT assessment was completed at intake in all 3 records and post-PAT in one of two applicable | Exceptions:<br>Two of three youth records did not include TRF and no attempts to obtain the forms were documented<br>• The Consent Form and Pre-TOPSE was not completed during intake for 1 youth.<br>• The Post-TOPSE and Post-PAT forms were not completed at discharge |

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| There must be at least three (3) documented attempts in the youths' file to obtain all pre-assessment (listed above) information. | | | | | | records. | for one youth. |
| SNAP discharge report summary | X | | | | | The two closed files had a SNAP discharge report summary. | |
| SNAP Boys/SNAP Girls **Parent** Group Evaluation Form | X | | | | | The two closed files had Parent Group Evaluation Forms completed. | |
| SNAP Boys/SNAP Girls **Child** Group Evaluation Form | X | | | | | The two closed files had Child Group Evaluation Forms completed. | |
| **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 | | | The program completed one SNAP in Schools cycle within the school setting during the review period. | |
| 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 | | | | | The program was provided to a 5th grade class and was facilitated for 45 minutes by a trained SNAP facilitator and teacher. The classroom consisted of children less than 11 years of age with a starting group of eleven students. | |
| Weekly attendance sheet with youth names and/or identifying number completed with signatures of teacher and facilitator(s) (For a total of 13 attendance sheets) | X | | | | | All 13 weekly attendance sheets were present with youth names and teacher and facilitator signatures. | |
| "Class Goal" sheet | X | | | | | "Class Shoot for Your Goal" sheet was completed. | |
| Measure of Classroom Environment (MoCE) (Pre and Post) is used to identify baseline and treatment outcomes of reported classroom dynamics. | X | | | | | MOCE was completed. | |
| Pre and Post Evaluations | X | | | | | Pre and post evaluations were present for all youth and the teacher. | |

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| One SNAP® Fidelity Adherence Checklist completed per classroom in a 13 – week SNAP in Schools group and uploaded to Dropbox | X | | | | | There was one Fidelity Adherence Checklist completed. | |
| **Provider has a written policy and procedure that meets the requirement for Indicator 3.01** | | | | | | **YES**<br>**If NO, explain here:**<br>Provider has a policy in place titled Shelter Environment that was last approved in August 2021 by the Chief Executive Officer. | |
| **Rating Criteria** | **Satisfactory** | **Non-compliant** | **No Eligible Items for Review** | **No Practice** | **Not Applicable** | | |
| **Facility Inspection** | | X | | | | During onsite tour of the facility on September 10, 2021, the furnishing were observed to be in good repair. Some of the common areas reflect newly purchased couches, chairs, and decor. Grounds are landscaped, free of debris/hazards, and extremely well maintained. There is a vast area for outdoor activities, basketball court, gazebo, etc. No graffiti could be seen on walls, doors or windows. The program recently painted client dorm doors with chalkboard paint and they are provided chalk to write positively on the doors. No pens or pencils are allowed in client rooms. Dumpster and garbage cans were covered. Doors are secure with key access required. Egress plans were posted in several locations along with grievance forms, abuse hotline number, SOGIE signage, and DJJ Incident Reporting numbers. Agency vehicles were locked. Interior areas did not contain contraband and were free of hazardous items. Chemicals were stored behind locks and inventories and MSDS were maintained. The washers and dryers were operational and clean of lint. Interior areas did not contain contraband and were free of hazardous items. MSDS and Chemicals are kept loosely in a locked Cleaning Closet. | Exceptions:<br>During the onsite tour, the following items needing repair were observed:<br>1) Some lighting fixtures in the laundry room, kitchen and Dayroom are not operational, and were not turning on at all or flickering.<br>2) The reviewer detected a consistent leak in one of the bathroom showers. The leak was originating from the showerhead into the corner of the shower floor, creating a consistently wet area that should be repaired as soon as possible. |

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| **Additional Facility Inspection Notes** | Chemical Inventory Binder is kept at Staff Station and inventory is conducted at a minimum of once per week. The last inventory count was completed on 9/7/21. The washers and dryers were operational and clean of lint. Key fobs are utilized by all staff to enter facility. Once inside, facility keys are kept in the staff station. Team members exchange their personal keys for facility keys, and then change back at the end of their shifts. The DCF Child Care License is displayed in the Main Lobby. Effective Date: April 2, 2021, and good thru April 1, 2022. Each client is provided a small locker to keep personal belongings and appropriate hygiene products. A locked drawer/safe is kept in the staff station that holds clients items such as wallet, jewelry, money, etc. | |

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| **Fire and Safety Health Hazards** | | **X** | | | | Tallahassee Fire Department completed annual inspection on 12/07/20 - Noted: Compliance Met.<br>Kitchen overhead hood inspection: 6/30/2021<br>5 Extinguishers (3 Facility & 2 Vans) inspection: 6/30/21"<br>□<br>The satisfactory Food Service Inspection Report from the DOH is combined with the Group Care Report and inspection date is 3/4/21.<br><br>Food Menus approved and signed by Licensed Dietician. However, there is no date documented to determine if done annually but provider submits meal plans annually to DOE for National School Lunch Program and they are approved.<br><br>Kitchen Refrigerator: 36 degrees - Kitchen Freezer: 15 degrees<br>Freezer #2 (Laundry Room) - 10 degrees<br>Freezer #3 (Laundry Room) - 10 degrees<br><br>At least one fire drill was completed monthly on each shift since March 2021. Mock Emergency Drills are completed once per month for a random shift. Consequently, 1st and 2nd shifts are being done at a minimum of once per quarter but not the 3rd shift. | Exceptions:<br>The third shift is out of compliance for completing mock emergency drills once per quarter and has only done one in the last 6 months. |
| **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.<br>b. At least one hour of physical activity is provided daily.<br>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** | | | | | Observed daily schedule posted in the facility during on-site tour. The daily schedule reveals that youth are engaged in meaningful, structured activities seven days a week. The schedule also provides for at least one hour of physical activity. Youth are given the opportunity to participate in faith-based activities with non-punitive activities offered for those who choose not to participate in those activities. Youth are given the time and opportunity to do homework and read. Youth have access to a variety of books to read. | |

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| 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.<br>e. Daily programming schedule is publicly posted and accessible to both staff and youth. | | | | | | | |
| **Provider has a written policy and procedure that meets the requirement for Indicator 3.02** | | | | | | **YES**<br>**If NO, explain here:**<br>Provider has a policy in place titled Program Orientation that was last approved in August 2021 by the Chief Executive Officer. | |
| **Rating Criteria** | **Satisfactory** | **Non-compliant** | **No Eligible Items for Review** | **No Practice** | **Not Applicable** | | |
| Youth received a comprehensive orientation and handbook provided within 24 hours | **X** | | | | | Four residential files (2 open and 2 closed) were reviewed. Orientation checklists were observed in all four files and were completed on the day of admission. | |
| **Orientation includes the following:**<br>a. Youth is given a list of contraband items<br>b. Disciplinary action is explained<br>c. Dress code explained<br>d. Review of access to medical and mental health services<br>e. Procedures for visitation, mail and telephone<br>f. Grievance procedure<br>g. Disaster preparedness instructions<br>h. Physical layout of the facility<br>i. Sleeping room assignment and introductions | **X** | | | | | An Orientation checklist was completed in all four files and covered all required elements of the indicator. | |

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| 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 | | | | | Orientation checklist included each component of orientation that is reviewed with youth during intake. The checklist was completed in all four files and signatures of youth and staff were obtained. | |
| **Provider has a written policy and procedure that meets the requirement for Indicator 3.03** | | | | | | **YES**<br>**If NO, explain here:**<br>Provider has a policy in place titled Youth Room Assignment that was last reviewed in August 2021 by the Chief Executive Officer. | |
| **Rating Criteria** | **Satisfactory** | **Non-compliant** | **No Eligible Items for Review** | **No Practice** | **Not Applicable** | | |
| **A process is in place that includes an initial classification of the youths, to include:** | | | | | | | |
| a. Review of available information about the youth's history, status and exposure to trauma<br>b. Initial collateral contacts,<br>c. Initial interactions with and observations or the youth<br>d. Separation of younger youth from older youth,<br>e. Separation of violent youth from non-violent youth<br>f. Identification of youth susceptible to victimization<br>g. Presence of medical, mental or physical disabilities<br>h. Suicide risk<br>i. Sexual aggression and predatory behavior<br>j. Sexual orientation gender identity/ expression<br>k. Acute health symptoms requiring quarantine or isolation | X | | | | | Four residential files (2 open and 2 closed) were reviewed.<br><br>The SPE Intake and Assessment form was completed in all four files and documented all of the required components of the youth's history, status and exposure to trauma, propensity for violence, susceptibility to victimization, sexual orientation, and symptoms requiring quarantine. These factors are reviewed to identify the most appropriate room assignment for youth. | |

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| An alert is immediately entered into the program's alert system when a youth is admitted with special needs and risks such as risk of suicide, mental health, substance abuse, physical health or security risk factors | X | | | | | Reviewed the SPE Intake and Assessment form and the SPE Medication Overview form for the four residential files. Alerts for the youth were documented on these two forms and a color-coded dot corresponding with the alerts is placed on the files. | |
| **Provider has a written policy and procedure that meets the requirement for Indicator 3.04** | | | | | | **YES**<br>**If NO, explain here:**<br>Provider has a policy in place titled Log Book Requirements that was last reviewed in August 2021 by the Chief Executive Officer. | |
| **Rating Criteria** | **Satisfactory** | **Non-compliant** | **No Eligible Items for Review** | **No Practice** | **Not Applicable** | | |
| Log book entries that could impact the security and safety of the youth and/or program are highlighted | X | | | | | Logbook entries were reviewed for March 2021 (Week 1), April 2021 (Week 2), May 2021 (Week 3), June 2021 (Week 4), July 2021 (Week 1) and August 2021 (Week 2).<br><br>Entries that could impact the security and safety of the youth and/or program were observed highlighted. The program uses highlighted colors as codes to depict safety & security issues: Green-Safety, Pink-Medical, Blue-Law Enforcement & Baker Act, Yellow-Parent/Guardian Contact, Orange-Youth Behaviors. | |
| All entries are brief, legibly written in ink and include:<br>• Date and time of the incident, event or activity<br>• Names of youth and staff involved<br>• Brief statement providing pertinent information<br>• Name and signature of person making the entry | X | | | | | Reviewed entries are brief, and at times more in-depth when necessary. Most entries were legibly written, however, there were multiple entries that were not completely legible. Each entry included the date and time of the event. Most involved staff names were represented. Brief statements were provided, and included the name and signature of the person making the entry. | |
| Recording errors are struck through with a single line. The staff person must initial and date the correction. The use of whiteout and erasures is prohibited. | X | | | | | Of the six weeks of logbook entries reviewed, there was only one entry on 5/21/21 at 9:30pm (L/E) that was scribbled out, rather than struck through with a single line. It was not initialed or dated. There were no uses of whiteout or erasures observed. | |

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| The program director or designee reviews the facility logbook(s) every week and makes a note chronologically in the logbook indicating the dates reviewed and if any correction, recommendations and follow-up are required and sign/date the entry | | X | | | | Program director or designee reviews were documented at least weekly and were signed and dated. | Limited Exception: Program Director or designee logbook reviews that were documented did not include the dates reviewed and did not provide any corrections, recommendations and/or follow-ups for the 6-weeks of logbook entries reviewed. |
| 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 | | | | Sample of logbook entries reviewed from March - August 2021 lacked consistency of staff confirming review of logbook entries for two previous shifts upon the beginning of his/her shift. It was difficult to determine if/when staff were signing in or out from their shifts regularly. | Limited Exception: Of the 6-weeks of logbook entries reviewed it was observed that not all staff indicate review of the logbook entries for the two previous 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 | | | | Sample of logbook entries from March 2021 - August 2021 depict that supervisors and shelter counselor are reviewing the logbook upon beginning their shifts, but without consistency. | Limited Exception: Sample of logbook entries from March 2021 - August 2021 did not show consistency of supervisors reviewing the logbook and indicating dates reviewed at the beginning of their shift. |
| Logbook entries include:<br>a. Supervision and resident counts<br><br>b. Visitation and home visits | | X | | | | Logbook entries observed depict visitation and home visits. Youth counts were not consistent. | Limited Exception: Names and/or initials, as well as resident counts were not consistent in logbook entries. |
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| Provider has a written policy and procedure that meets the requirement for Indicator 3.05 | | | | | | Provider has a policy in place titled Behavior Management Strategies that was last approved in August 2021 by the Chief Executive Officer. | |
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| **Rating Criteria** | **Satisfactory** | **Non-compliant** | **No Eligible Items for Review** | **No Practice** | **Not Applicable** | | |
| The program has a detailed written description of the BMS, and it is explained during program orientation | X | | | | | The program's Behavior Management System (BMS) is represented in detail in the Resident Orientation Handbook and given to the youth upon admission. An Orientation Checklist was completed in all four residential files reviewed and documented a review of the BMS. In addition, all signatures of youth depict they were in receipt of this information. | |
| **Behavior Management Strategies MUST include:**<br>a. Supervisors are trained BMS is designed to teach youth new behaviors and help youth understand the natural consequences for their actions<br>b. Behavioral interventions are applied immediately, with certainty, and reflect the severity of the behavior<br>c. BMS uses a wide variety of awards/incentives to encourage participation and completion of the program<br>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<br>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) | X | | | | | The program does not use an incentive based system within its BMS. However, youth are incentivized for positive behavior through intangible rewards: onsite activities, offsite activities, cooking classes with staff, and verbal praise. "The Someplace Else" Behavior Management Policy is utilized, specifically geared towards 3 skills (Target Skills). The "Why Try" activities based on a trauma informed, evidence based curriculum designed to promote and build resiliency in youth, while also building positive and supportive relationships. These skills are taught in daily activities and during groups. The program's BMS is an individualized approach to managing youth behavior, incorporating healthy coping and social skills. | |

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| f. Only staff discipline youth. Group discipline is not imposed<br>g. Room restriction is not used as part of the system or for youth who are physically and/or emotionally out of control<br>h. Youth should never be denied basic rights such as meals, clothing, sleep, services, exercise, or correspondence privileges | | | | | | | |
| **Program's Use of the BMS** | | | | | | | |
| All staff are trained in the theory and practice of administering BMS rewards and consequences | X | | | | | Upon review of four 1st year staff training files, three staff had taken the BMS training, one staff currently had not, but the training review period is still ongoing and doesn't conclude until 9/13/21. | |
| There is a protocol for providing feedback and evaluation of staff regarding their use of BMS rewards and consequences | X | | | | | Youth feedback includes the grievance box and continual staff discussion and meetings regarding the BMS system. | |
| Supervisors are trained to monitor the use of rewards and consequences by their staff | X | | | | | Training files for four staff and on-going training was documented for three staff on the use of the BMS system (training review period is still ongoing for fourth staff member). | |
| **Provider has a written policy and procedure that meets the requirement for Indicator 3.06** | | | | | | **YES**<br>**If NO, explain here:**<br>Provider has a policy titled Supervision of Clients & Staff Responsibilities, Bed Checks that was approved in August 2021 by the CEO. | |
| **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.<br>• 1 staff to 6 youth during awake hours and community activities<br>• 1 staff to 12 youth during the sleep period | X | | | | | There were four random samples of video surveillance reviewed: August 11, 2021 (12am-2am), August 28, 2021 (4am-6am), September 3, 2021 (1am-3am), September 6, 2021 (3am-5am).<br><br>A review of the above video surveillance sample, staff schedules, and video log entries documented required staffing ratios were met for awake hours and sleeping hours. | |

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| All shifts must always provide a minimum of two staff present | X | | | | | A review of the staff schedules and logbook entries depict that there is a minimum of two staff present on each shift accordingly. | |
| Program staff included in staff-to-youth ratio includes only staff that are background screened and properly trained youth care workers, supervision staff, and treatment staff | X | | | | | Only staff who are background screened and properly trained are included on the staff schedules and shifts. | |
| The staff schedule is provided to staff or posted in a place visible to staff | X | | | | | During the virtual tour of the facility, a posted schedule was observed and visible to staff. | |
| There is a holdover or overtime rotation roster which includes the telephone numbers of staff who may be accessed when additional coverage is needed | X | | | | | The program maintains a holdover and overtime roster with staff names and numbers. Currently, the color-coded red section in the staff schedule depicts vacant shifts, and staff write in their names to cover vacant shifts. | |
| 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 | | | | | There were four random samples of video surveillance reviewed: August 11, 2021 (12am-2am), August 28, 2021 (4am-6am), September 3, 2021 (1am-3am), September 6, 2021 (3am-5am).<br><br>The random review sample reviewed depicts that staff observe the youth at least every 15 minutes during the overnight hours. | |
| **Provider has a written policy and procedure that meets the requirement for Indicator 3.07** | | | | | | **YES**<br>**If NO, explain here:**<br>Provider has a policy in place titled Alarm and Security System that was last approved in August 2021 by the Chief Executive Officer. | |
| **Rating Criteria** | **Satisfactory** | **Non-compliant** | **No Eligible Items for Review** | **No Practice** | **Not Applicable** | | |
| **Surveillance System** | | | | | | | |
| The agency, at a minimum, shall demonstrate:<br>a. A written notice that is conspicuously posted on the premises for the purpose of security | | | | | | This reviewer observed cameras and written notices during the virtual tour. The Video Surveillance System was reviewed with the assistance of the Program Manager's surveillance access from a workplace computer. The system can capture and retain video images for up to 30 days. A review of random | |

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| b. System can capture and retain video photographic images which must be stored for a minimum of 30 days<br>c. System can record date, time, and location; maintain resolution that enables facial recognition<br>d. Back-up capabilities consist of cameras' ability to operate during a power outage<br>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.<br>f. All cameras are visible | X | | | | | samples of overnight video surveillance depicted system records date, time and location and enables facial recognition. Cameras have back-up battery capabilities in case of power outage. All cameras were visible and no cameras were located in the bathrooms or sleeping quarters.<br><br>During a recent severe storm the shelter suffered a power outage and its entire electronic access and surveillance system went down. The current back-up battery did not function during the power outage. A new double battery pack back-up unit for the Surveillance System was purchased on 9/8/21. | |
| A list of designated personnel who can access the video surveillance system is maintained (includes off-site capability per personnel)? | X | | | | | Reviewed list maintained by the program of designated staff who have access to video surveillance system. | |
| Supervisory review of video is conducted a minimum of once every 14 days and timeframes reviewed are noted in the logbook.<br><br>The reviews assess the activities of the facility and include a review of random sample of overnight shifts | X | | | | | Review of video surveillance log reflects supervisory review of video from March 2021 - August 2021. Video was reviewed every fourteen days and included a random sample of overnight shifts.<br><br>Supervisory reviews of video are not noted in the program logbook. The date of the review, the date and times being reviewed, and the supervisor conducting the review are documented and kept in a separate security and surveillance binder. | |
| Grant the requesting of video recordings to yield a result within 24-72 hours from program quality improvement visits and when an investigation is pursued after an allegation of an incident | X | | | | | Reviewed policy titled Alarm and Security System which addresses the submission of video recordings within 24-72 hours of request as needed by authorized third parties. | |

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| 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 | | | | During a storm on 8/19/21, the shelter suffered a power outage where the current back-up battery did not function accordingly and the system was not recording between 8/11/21 and 8/27/21. On 8/19/21 it was discovered by the COO that the electronic access and Surveillance System were not functioning due to a power outage from a storm the night before. The shelter program manager confirmed in an email dated 8/20/21. Through an email thread provided by the CEO, it was revealed that on 8/26/21 the CEO contacted Lewis Digital (a website/computer/technology company) to handle the surveillance issue. On 8/27/21 a work order was submitted to Cabling Specialists Inc. (CSI), and on 8/30/21 CSI was able to come out and repair the surveillance system accordingly. In addition to the issues mentioned above, during the onsite tour one of the camera views, out of a total of 16, was not operational at the time of this onsite inspection. The reviewer detected that the global screen that displays all 16 camera views had 1 of the 16 displaying a blank screen. | Exception:<br>The agency must ensure camera service work orders are requested within 24 hours of discovery of malfunction so that all efforts can be made to repair the system promptly and all 16 cameras are working properly. |
| **Provider has a written policy and procedure that meets the requirement for Indicator 4.01** | | | | | | **YES**<br>**If NO, explain here:**<br>Provider has a policy in place titled Health Screening on Admission that was last approved in August 2021 by the Chief Executive Officer. | |
| **Rating Criteria** | **Satisfactory** | **Non-compliant** | **No Eligible Items for Review** | **No Practice** | **Not Applicable** | | |
| **Preliminary Healthcare Screening** | | | | | | | |
| **Screening includes :**<br>a. Current medications<br>b. Existing (acute and chronic) medical conditions<br>c. Allergies<br>d. Recent injuries or illnesses<br>e. Presence of pain or other physical distress | X | | | | | A total of four youth records were reviewed for this indicator. The four youth entered into the program on four separate occasions: August 26, 2021, August 28 2021, April 3, 2021, & June 6, 2021. A screening was completed for each youth on their arrival date. Each youth was screened for the following: current medications, existing medical conditions, allergies, recent injuries or illnesses, presence of pain or other physical distress, observation for evidence of illness, | |

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| f. Observation for evidence of illness, injury, physical distress, difficulty moving, etc.<br>g. Observation for presence of scars, tattoos, or other skin markings<br>h. Acute health symptoms requiring quarantine or isolation | | | | | | injury, physical distress, difficulty moving, etc., observation for presence of scars, tattoos, or other skin markings, and acute health symptoms requiring quarantine or isolation. | |
| **Referral and Follow-up** | | | | | | | |
| Youth with chronic medical conditions have a referral to ensure medical care (e.g. diabetes, pregnancy, seizure disorder, cardiac disorders, asthma, tuberculosis, hemophilia, head injuries, etc.) | | | X | | | None of the four youth records reviewed required a referral or follow. The policy addresses referrals and follow-ups. The program's screening form also has a section for follow-ups and referrals. Diabetes, pregnancies, seizure disorder, asthma, tuberculosis, hemophilia, and head injuries are examples of conditions requiring a referral or follow-ups. | |
| When needed, the parent is involved with the coordination and scheduling of follow-up medical appointments | | | X | | | None of the four youth records reviewed required a referral or follow-up needing parental notification. | |
| All medical referrals are documented on a daily log. | | | X | | | None of the four youth 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 | | | | | It is the program's practice to screen each youth upon arrival for medical condition requiring care. The program has a thorough referral process and follow-up process to address medical care as needed. | |
| **Provider has a written policy and procedure that meets the requirement for Indicator 4.02** | | | | | | **YES**<br>**If NO, explain here:**<br>Provider has a policy in place titled Suicide Prevention that was last approved in August 2021 by the Chief Executive Officer. | |
| **Rating Criteria** | **Satisfactory** | **Non-compliant** | **No Eligible Items for Review** | **No Practice** | **Not Applicable** | | |
| **Suicide Risk Screening and Approval** | | | | | | | |
| Suicide risk screening occurred during the initial intake and screening process. Suicide screening results reviewed and signed by the supervisor and documented in the youth's case file. | X | | | | | Four youth records were reviewed for this indicator. The suicide screening results were reviewed and signed by the supervisor and documented in each of the four youth's file. | |
| The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services | X | | | | | The suicide risk assessment has been approved by the Florida Network of Youth and Family Services. | |

| Supervision of Youth with Suicide Risk | | | | | | | |
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| Youth are placed on the appropriate level of supervision based on the results of the suicide risk assessment. | X | | | | | Each of the four youth records reviewed shows the youth were placed on the appropriate level of supervision. Two of the records included the assessment of suicide risk; however, the other two youth records were missing the assessment of suicide risk in the files. The files were notated to document one youth being withdrawn by the parent and other youth refusing to participate then leaving the program prior to staff completing the assessment of suicide risk. | |
| Staff person assigned to monitor youth documented youth's behavior at 30 minute or less intervals | X | | | | | For each of the four youths' records reviewed, a staff person was assigned to monitor the youths' behavior every thirty minutes or less 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 | | | | | For two applicable youth records reviewed, supervision levels were not changed until the licensed professional completed a further assessment. | |
| **Provider has a written policy and procedure that meets the requirement for Indicator 4.03** | | | | | | **YES**<br>**If NO, explain here:**<br>Provider has a policy in place titled Medication that was last approved in August 2021 by the Chief Executive Officer. | |
| **Rating Criteria** | **Satisfactory** | **Non-compliant** | **No Eligible Items for Review** | **No Practice** | **Not Applicable** | | |
| **Medication Storage** | | | | | | | |
| a. All medications are stored in a Pyxis Med-Station 4000 Medication Cabinet that is inaccessible to youth (when unaccompanied by authorized staff)<br>b. Pyxis machine is stored in accordance with guidelines in FS 499.0121 and policy section in Medication Management<br>c. Oral medications are stored separately from injectable epi-pen and topical medications | | | | | | An observation conducted during onsite tour of the facility and via FaceTime determined the following: all medication are stored in the Pyxis Med-Station; the Pyxis machine is stored in accordance with guidelines; oral medications are store separately; medication requiring refrigeration is stored appropriately with correct temperatures; narcotics and controlled medications are stored in the med station; and the Pyxis keys are located in the designated locations and are accessible to staff. | |

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| 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.)<br>e. Narcotics and controlled medications are stored in the Med Station<br>f. Pyxis keys with the following labels are accessible to staff in the event they need to access medications if there is a Pyxis malfunction: a TOP COVER b BACK PANEL- LEFT TALL CABINET LOCK- LEFT, c BACK PANEL- RIGHT TALL CABINET LOCK- RIGHT | X | | | | | | |
| **Medication Distribution** | | | | | | | |
| a. Agency maintains a minimum of 2 Super Users for the Med-Station<br>b. Only designated staff delineated in User Permissions have access to secured medications, with limited access to controlled substances (narcotics)<br>c. A Medication Distribution Log shall be used for distribution of medication by non-licensed and licensed staff<br>d. Agency verifies medication using one of four methods listed in the FNYFS Operations Manual<br>e. When nurse is on duty, medication processes are conducted by the nurse<br>f. The delivery process of medications is consistent with the FNYFS Medication Management and Distribution Policy | X | | | | | The program has designated two super users for the med station and authorized 17 staff to distribute medications. Non-licensed staff are utilized for distribution of medication utilizing a medication distribution log. The program staff verifies and distributes medication using methods approved by the FNYFS. The agency reported they do not accept injectable medication. All staff designated to use the epi-pens have been provided training by a registered nurse. The program's nurse position has been vacant for about two years due to challenges recruiting a nurse; however, per the CEO, a potential registered nurse candidate is awaiting background screening. They believe the pay being too low and competing jobs contribute to the recruitment failure. | |

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| g. Agency does not accept youth currently prescribed injectable medications, except for epi-pens<br>h. Non-licensed staff have received training in the use of epi-pens provided by a registered nurse | | | | | | | |
| **Medication Inventory** | | | | | | | |
| a. For controlled substances, a perpetual inventory with running balances is maintained as well as a shift-to shift count verified by a witness and documented<br>b. Over-the-counter medications that are accessed regularly are inventoried weekly by maintaining a perpetual inventory<br>c. Syringes and sharps (needles, scissors, etc.) are secured, and counted and documented weekly | X | | | | | Medication Oversight and Inventory Record forms reviewed documented controlled substances were inventoried perpetually and shift-to-shift verified by a witness. Over-the-counter (OTC) medication inventories were reviewed and documented OTC's are inventoried perpetually and weekly by a Super User. Weekly inventories of sharps were reviewed and found to be accurate. There were no syringes on-site. | |
| There are monthly reviews of medication management practice via Knowledge Portal or Pyxis Med-Station Reports. | | X | | | | Staff use knowledge portal to retrieve discrepancy reports; however, currently there are no monthly reviews of medication management practice via knowledge portal demonstrated by staff. When asked, staff seemed perplexed and puzzled. Staff reported they are unaware of the requirement. | Limited Exception: There were no monthly reviews of medication management practice conducted by staff since the last QI review. This is a similar finding noted on the last QI review that has not been addressed by the program. |
| Medication discrepancies are cleared after each shift. | X | | | | | Staff provided documentation in the knowledge portal of discrepancies being cleared after each shift. | |
| **Provider has a written policy and procedure that meets the requirement for Indicator 4.04** | | | | | | **YES**<br>**If NO, explain here:**<br>Provider has a policy in place titled Medical that was last approved in August 2021 by the Chief Executive Officer. | |
| **Rating Criteria** | **Satisfactory** | **Non-compliant** | **No Eligible Items for Review** | **No Practice** | **Not Applicable** | | |

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| Youth with a medical, mental health, or food allergy was appropriately placed on the program's alert system | | X | | | | Four youth records were reviewed for this indicator. Each of the four youth reviewed had appropriate medical, mental health, or food allergy alerts requiring placement in the program's alert system. Three of the youth were on sight and sound; however, one of the three youth did not have the suicide alert placed in the file. | Exception: One of 3 youth records was missing the suicide alert in the file. |
| Alert system includes precautions concerning prescribed medications, medical/mental health conditions | X | | | | | An observation of the program's alert system determined it included precautions concerning prescribed medications and medical/mental health conditions. Any critical medical, mental health, and/or other pertinent health/safety information is reported, staff must place a Hot Dot sticker on the outside of client's file and on the client's picture. | |
| Staff are provided sufficient training, information and instructions to recognize/respond to the need for emergency care for medical/mental health problems | X | | | | | Seven staff training files were reviewed. All six residential staff received training in CPR and First Aid to recognize/respond to the need for emergency care for medical/mental health problems. | |
| A medical and mental health alert system is in place that ensures information concerning a youth's medical condition, allergies, common side effects of prescribed medications, foods and medications that are contraindicated, or other pertinent mental health treatment information, is communicated to all staff | X | | | | | The program has a color dot system in place to label alerts. Alerts are identified by the color of the dot placed in the youth's file and on the outside of the file. The color system allows staff to easily recognize the alert. The dots ensure medical and mental health concerns are addressed. | |
| **Provider has a written policy and procedure that meets the requirement for Indicator 4.05** | | | | | | **YES**<br>**If NO, explain here:**<br>Provider has a policy in place titled Medical that was last approved in August 2021 by the Chief Executive Officer. | **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 | | | | | | Four youth records were reviewed for this indicator. Each of the four youth reviewed was provided off site medical or dental care. Upon return, the program staff verified receipt of medical clearance. The youth's | |

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| b. Upon youth return, there is a verification receipt of medical clearance via discharge instructions with follow-up is present in file<br>c. Youth's parent/guardian was notified<br>d. A daily log is maintained for emergency care provided | X | | | | | parent/guardian was notified, and a daily log was maintained. | |
| All staff are trained on emergency medical procedures | X | | | | | All six residential staff training records reviewed includes training in CPR and First Aid to recognize/respond to the need of emergency medical care. | |
| The program has a Knife-for-life and wire cutters accessible to staff in a secure location(s) | X | | | | | The program utilizes one Knife of life and wire cutter kit which was observed during the tour of the facility. | |
| First aid kit/supplies are fully equipped and inventoried | X | | | | | During the on-site tour first aid kits in the shelter were observed to be fully stocked and inventoried. | |