Florida Network for Youth and Family Services
Compliance Monitoring Report for

Family Resources - Manatee

1001 9th Avenue
Bradenton, FL 34205

Compliance Monitoring Services Provided by

FOREFRONT

EXECUTIVE SUMMARY

Forefront LLC conducted a joint Quality Improvement (QI) and Florida Network of Youth and Family Services (FNYFS) monitoring visit for Family Resources Manatee SafePlace2B for the FY 2021-2022 at its program office located at 1001 9th Avenue Bradenton, 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. Family Resources Manatee is contracted with the Florida Network of Youth and Family Services (FNYFS) to provide direct services to Children/Families in Need of Services (CINS/FINS). The services to be provided are identified in Contract Section A - Descriptions and Specifications and Section B - Delivery and Performance and are funded with General Revenue Funds effective for July 2019 through June 30, 2022.

The review was conducted by Marcia Tavares, Consultant for Forefront LLC, and Peer Reviewer(s). Agency representatives from Family Resources Manatee present for the entrance interview were Andy Coble – COO; Nicole Leslie - VP of Impact; Breanna Knuth – Director Client Success; Lawshawna Randall – Residential Supervisor; Kelli Yeazell – SNAP Supervisor; and additional program counselors/case managers included on the attendance list. The last site QI visit was conducted August 12-13, 2020.

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

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

2021-2022 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 11-17-2021-2022

Agency Name: Family Resources Manatee	**Monitor Name: Marcia Tavares, Lead Reviewer**
Contract Type : CINS/FINS	**Region/Office: 1001 9th Street, Bradenton, FL 34205**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): November 17-18, 2021**

Major Programmatic Requirements	Explain Rating: Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable	Ratings Based Upon: I = Interview O = Observation D = Documentation PTV = Submitted Prior To Visit (List Who and What)	Notes: Explain Unacceptable or Conditionally Acceptable: (Attach Supportive Documentation)
I. Administrative and Fiscal							
DJJ Quality Improvement Peer Reviewer a. Provider shall demonstrate that a minimum of two (2) staff members have been trained to be certified as DJJ QI Peer reviewers. Provider shall participate in a minimum of one (1) on-site quality assurance review of a similar type program in another judicial circuit during each 12-month period of the contract, if requested.	☐	☐	☒	☐	☐	The provider currently has four (4) certified DJJ-QI Peer Reviewers namely: Saxon Bowler, Nicole Leslie, Kelli Yeazell, and Joe Mabry. Staff have participated and/or are scheduled to participate in QI Peer Reviews during the FY.	
Additional Contracts a. Provider shall provide a listing of all current federal, state, or local government contracts, as well as other contracts entered into with for profit and not-for-profit organizations. Such listing shall identify the awarding entity and contract start & end dates. **PTV**	☐	☐	☒	☐	☐	Documentation: The agency provided a list of seven contracts in addition to the FN for FY 2021-2022. The list includes: the funder, service provided, and contract start and end dates for the following: DOH – Food; HHS-homeless shelter; HHS shelter CARES Act; YMCA; Manatee County; SCF Collegiate; and Manatee County School Board.	

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Major Programmatic Requirements	**Unacceptable**	**Conditionally Unacceptable**	**Fully Met**	**Exceeded**	**Not Applicable**		
						The program also maintains interagency agreements and Memorandums of Agreement (MOUs) with schools, mental health, and substance abuse providers. All of the agreements reviewed had current contract/agreement dates.	
Limits of Coverage a. Provider shall provide and maintain during this contract, the following minimum kinds of insurance: Worker's Compensation and Employer's liability insurance as required by Chapter 440, F.S. with a minimum of $100,000 per accident, $100,000 per person and $500,000 policy aggregate. Commercial General Liability with a limit of $500,000 per occurrence, and $1,000,000 policy aggregate. Automobile Liability Insurance shall be required and shall provide bodily injury and property damage liability covering the operation of all vehicles used in conjunction with performance of this contract, with a minimum limit for bodily injury of $250,000 per person; with a minimum limit for bodily injury of $500,000 per accident; with a minimum limit for property damage of $100,000 per accident and with a minimum limit for	☐	☐	☐	☒	☐	Documentation: General Liability through Alliance of Nonprofits for Ins. RRG, for limits of coverage $1,000,000 each $3,000,000 aggregate and medical expenses of $20,000 for any one person, effective 6/1/2021-6/1/2022. Workers Compensation through Benchmark Insurance Company with limits of $2,000,000 each and aggregate, effective 6/1/2021-6/1/2022. Automobile insurance through North American Elite Insurance Company with combined single limits of	

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medical payments or $5,000-$10,000 per person. Florida Network is listed as payee or co-payee. **PTV**						$1,000,000, effective 6/1/2021-6/1/2022. An umbrella policy through Alliance of Nonprofits for Ins. RRG, with limits of $4,000,000 each/aggregate, effective 6/1/2021-6/1/2022. Directors and Officers Liability insurance through Alliance of Nonprofits for Ins. RRG with limits of $1 million each/ $2 million aggregate, effective 6/1/2021-6/1/2022. Florida Network is listed on the Worker's Compensation certificate as certificate holder.	
External/Outside Contract Compliance a. Provider has corrective action item(s) cited by an external funding source (Fiscal or Non-Fiscal). **ON SITE**	☐	☐	☐	☐	☒	N/A – No current corrective actions cited by external funding source	
Fiscal Practice	☐	☐	☒	☐	☐	Documentation: Fiscal Policies and Procedures are contained in Section F- Financial Management of the	

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a. Agency must have employee and fiscal policy/procedures manuals that are in compliance with GAAP and provide sound internal controls. Agency maintains fiscal files that are audit ready. **PTV**						Administrative Standard Operating Manual. The procedures reviewed appear to be consistent with GAAP and provide for sound internal controls. Procedures are included for budget process, authorization levels, credit cards, donations, capital assets, petty cash, sales tax exemption, required vendor information, journal entries, investment policy, general ledger, cost allocation, internal controls, travel, and purchasing process.	
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: General ledger for current FY 2021-2022 was reviewed. The agency maintains a detailed ledger of financial activities with corresponding source documents. General ledger is structured to track all funding sources and there is a separate GL for the CINS/FINS cost centers 40 and 41 and SNAP cost center 14.	
c. Petty cash ledger system is balanced and all cash disbursements are compliant with financial policies and	☐	☐	☒	☐	☐	Observation/Documentation:	

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allowable under the contract. (Disbursements/invoices are approved & monitored by management.) –**ON SITE**						Reviewed petty cash Policy and Procedure included in the Fiscal Manual. Petty cash is maintained by the Residential Supervisor and is stored in a secured cash box. The fund is $150 and was reconciled by the Lead Reviewer during the QI review. Petty cash is reconciled at least monthly by the custodian. All receipts are submitted to finance at the main office for reimbursement as needed. Reimbursement comes in the form of a check made out to the designee who will then cash it and place money in petty cash box.	
d. Financial records and reports are current. Includes bank statements reconciled within 6 weeks of receipt. Vendor invoices past 6 months. Invoices are submitted on a monthly basis with supporting documentation. (Disbursements/invoices are approved & monitored by management). **ON SITE**	☐	☐	☒	☐	☐	Documentation: Reviewed Bank Statements and Bank Reconciliations for the period March - August 2021 for account held with SunTrust. Bank reconciliations are conducted within 6 weeks of receiving the bank statements each month and are approved by two individuals. Checks disbursed over $750 are signed by two individuals with signing	

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						authority. Invoices are submitted on a monthly basis with supporting documentation. The agency maintains individual vendor files.	
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 – No Florida Network inventory	
f. Agency submits payroll taxes and deposits (and retirement deposits as applicable), Employee IRS Form W-2 and Independent Contractors IRS Form 1099 forms prior to federal requirements. **ON SITE**	☐	☐	☒	☐	☐	Documentation: The agency provided EFTPS payment documentation for Tax periods Q2 and Q3, 2021 showing payment of payroll taxes. Payroll taxes are paid bi-weekly via electronic payment through the IRS. These reports demonstrate submission of payroll taxes and deposits biweekly, and status is indicated as “settled” for each payment.	

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	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable		
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 Budget to Actual statement for the current FY. A review of these documents was conducted. Report shows program budget and actual for the current month, YTD, as well as a comparison from last FY. Variances in budget are monitored on a regular basis and approved by management. No operating deficit was reported YTD for the shelter or counseling program.	
h. A Single Audit is performed as part of the annual audit if expenses are greater than $750,000. The agency must submit a Corrective Action Plan for findings cited in the management letter and single audit. An annual financial audit was completed within 120 days after the previous fiscal year/calendar year and that a copy was provided to the Network unless and extension has been requested and approved in writing. Copy of Audit is submitted to the FNYFS by December 31st. **Obtain from FNYFS**	☐	☐	☒	☐	☐	Documentation: Financial audit conducted for year ending June 30, 2021, and 2020 was completed by Assurance Dimensions CPA and Associates in a report dated September 30, 2021. A Management Letter was issued solely for the purpose of information by the auditor as there were no findings cited or question costs. A copy of the audit is on file with the Reviewer.	

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	Explain Rating						
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i. Agency maintains confidentiality policy with written policies and procedures to ensure the security and privacy of all employee and client data. Personal information is not easily accessible. Agency maintains a backup system in case of accidental loss of financial information. Security procedures are in place to protect laptops. Obsolete documents are shredded and computer hard drives are wiped prior to discarding. **ON SITE**	☐	☐	☒	☐	☐	Documentation: Policies and procedures for Program 5.00 - Confidentiality/Release of Information; Program 3.00 – Case Records; Technology 9.00 - System Backup, and Technology 5.00 - System Monitoring were reviewed. Policies were last approved November 2021 and are located in the Administrative Standard Operating Manual throughout various sections of the manual. A daily back-up is performed on all information saved on various servers throughout the agency. The Residential Supervisor reported no direct care employee has a program laptop.	

CONCLUSION

Family Resources Manatee 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) 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, t**he overall compliance rate for this contract monitoring visit is 100%.** There are no corrective actions cited or recommendations made as a result of the contract monitoring visit. Overall, the provider is performing satisfactorily in meeting the fiscal and administrative terms of its contract. In addition, the majority of indicators reviewed were carried out in a manner which meets the standard as described in the report findings.

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

Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Family Resources - Manatee
CINS/FINS Program

November 17-18, 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	Satisfactory
3.05 Behavior Management Strategies	Satisfactory
3.06 Staffing and Youth Supervision	Satisfactory
3.07 Special Populations	Satisfactory

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

Standard 4: Mental Health/Health Services

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

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

Overall Rating Summary

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

Rating Definitions

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

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

Reviewers

Members

Marcia Tavares - Lead Reviewer Consultant-Forefront LLC/Florida Network of Youth and Family Services
Christine Calvert Joyner – Regional Monitor, Department of Juvenile Justice
Teresa Clove – THAISE Educational Tours
Allyson Fairchild – Safe Children Coalition
Samuel Laguerre – Lutheran Services Florida Southwest

Methodology

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

Persons Interviewed

	Chief Executive Officer	X	Case Manager		Nurse – Full time
	Chief Financial Officer	X	Counselor Non-Licensed		Nurse – Part time
	Chief Operating Officer		Advocate	1	# Case Managers
	Executive Director	X	Direct – Care Full time	2	# Program Supervisors
X	Program Director		Direct – Part time		# Food Service Personnel
	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	11	# Personnel /Volunteer Records
X	Contract Monitoring Reports	X	Medical and Mental Health Alerts	6	# Training Records
	Contract Scope of Services	X	Precautionary Observation Logs	21	# Youth Records (Closed)
X	Egress Plans	X	Program Schedules	7	# Youth Records (Open)
X	Fire Inspection Report	X	List of Supplemental Contracts		# Other: ___
X	Exposure Control Plan	X	Vehicle Inspection Reports		

Observations During Review

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

Comments

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

Monitoring Purpose:

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

Strengths and Innovative Approaches

Family Resources Inc. is sub-contracted with the Florida Network of Youth and Family Services (Florida Network) to provide temporary residential and non-residential services to youth and families through the Children In Need of Services/Families In Need of Services (CINS/FINS) program. The central office is located in Pinellas Park, Florida and CINS/FINS SafePlace2B shelters are located in Clearwater, St. Petersburg, and Bradenton, Florida. Family Resources serves both male and female youth between the ages of ten to seventeen years that are locked out, runaway, ungovernable and/or truant, homeless, abuse, neglected, or at-risk. The program is also contracted to provide services for Staff Secure Shelter and is a provider for youth referred through the Juvenile Justice Court System for domestic violence, probation respite, domestic minor sex trafficking, and Family/Youth Respite Aftercare Services (FYRAC). The program is designated by the National Safe Place Program as a Safe Place provider who is responsible for building a network of safe place sites in the community to provide help and access to run away and homeless youth. The agency is currently accredited by the Council of Accreditation (COA) effective through December 31, 2024.

Since the last QI review, the agency has transitioned its leadership structure to create various levels that increase quality leadership. Former Vice President position for community-based services and Vice President of residential/RHY services were changed to Chief Operating Officer and Vice President of Impact, respectively. A licensed staff was added to fill the previous VP community-based services position and Directors of Client Success are responsible for the management of the residential programs.

The COVID-19 pandemic has taken a toll on the agency's ability to fully staff the program and it is currently struggling with filling vacant positions. At the time of the QI review, there were nine (9) vacancies including two SNAP facilitators, two counselors, a registered nurse, a cook, an administrative assistant, and two part time as well as two 32-hour youth care positions.

SNAP in Schools was also directly impacted by the pandemic as the school district was operating virtually and program staff were not able to facilitate groups in schools. The program currently has a timeline for getting back in schools. On a positive note, the SNAP program was selected to pilot an adolescent SNAP group in the future.

Narrative Summary

Family Resources Manatee SafePlace2B provides both residential and non-residential CINS/FINS services for youth and their families in Bradenton, FL. The program located at 1001 9th Avenue, Bradenton, is under the leadership of a CEO, a Chief Operating Officer, Vice President of Impact, and Directors of Client Success for community and residential services. The shelter is licensed for 12 beds by the Department of Children and Families effective through May 31, 2022. At the time of the QI review, the shelter had a

census of four youth.

The overall findings for the QI review for SafePlace2B is summarized as follows:

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

Standard 2 has a total of ten indicators that relate to intervention and case management. Nine of the ten indicators were rated satisfactory with no exceptions (2.01 - 2.08 and 2.10) and indicator 2.09 was rated satisfactory with exceptions.

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

Standard 4, Mental Health and Health Services, is comprised of five indicators. Four of the five indicators were rated satisfactory with no exceptions (4.01, 4.02, 4.04, and 4.05) and one (4.03) received a satisfactory with exception rating.

Summary of Deficiencies resulting in Limited Rating:

Standard 1:
Indicator 1.04 – Limited
Two new YDS staff training records revealed one of the two YDS staff was missing 10 of 25 mandatory training required in the first 90 days and other YDS staff was missing the SOGIE/LGBTQ training. An additional training record for a first year clinical staff was reviewed and three mandatory training in the first 90 days were not completed by the staff.

CINS/FINS QUALITY IMPROVEMENT TOOL

Quality Improvement Indicators:	Satisfactory (S)	Non-compliant (E)	No Eligible Items for Review (N)	No Practice (NP)	Not Applicable (N/A)	Review Based Upon Document Source	Notes Explain any items that have any deficiencies, exceptions or are not applicable.
Standard One – Management Accountability							
1.01: Background Screening (BS) and compliance with DJJ OIG statewide procedures regarding BS of employees, contractors and volunteers							
Provider has a written policy and procedure that meets the requirement for Indicator 1.01						**YES** If NO, explain here: Policy 1.01 was last reviewed July 2021 and signed by the COO.	
Agency utilizes an employee suitability prescreening assessment with a passing rate criterion prior to an offer of hire for direct care staff working with youth or the agency has provided an explanation for staff hired with a non-passing/low score.	X					The agency completed the Berke Assessment prior to the hire dates reviewed for seven new staff. All staff received a passing rate of medium or high on the pre-screening assessment.	
Background screening completed prior to hire/start date or exemption obtained prior to working with youth (if rated ineligible) for new hires, volunteers/interns, and contractors	X					A total of seven new hire background screening files were reviewed. All seven background screenings were completed prior to hire.	
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					One of the seven new hires had a break in service less than 90 days and was in good standing with the program. The exit date was 8/14/21 and staff was re-rehired 9/16/21. The approved suitability assessment and background screening clearance is on file for the prior 10/16/19 date of hire.	
Five-year re-screening completed every 5 years from initial date of hire	X					Four eligible 5-year rescreenings were applicable for the review period. The agency's Clearinghouse roster shows the staff have active background prints that are not expired.	
Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?	X					Provider emailed the Annual Affidavit of Compliance with Level 2 Screening form for Pinellas County to DJJ BSU on 1/6/2021 prior to the deadline.	

Proof of E-Verify for all new employees obtained from the Department of Homeland Security	X					All seven new hires had E-Verify work authorization on file.	
1.02: Provision of an abuse free environment to ensure safety and abuse free environment for youth in care							
Provider has a written policy and procedure that meets the requirement for Indicator 1.02						**YES** If NO, explain here: Policy 1.02 was last reviewed July 2021 and signed by the COO.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Abuse Free Environment							
Agency has a code of conduct of policy and there is evidence that staff are aware of agency's code of conduct.	X					The code of conduct is in the agency's handbook and is covered with all new staff during the initial orientation.	
Child Abuse Registry telephone number is visible to youth and posted common areas of the facility	X					The agency had the Child Abuse Registry telephone numbers posted in the common areas as reviewed and observed during tour.	
Youth were informed of the Abuse and Contact Number (see youth survey results)	X					Youth are informed of the abuse policy during intake; abuse number is located in the youth handout and review with youth is noted in the client case file.	
Management takes immediate action to address any incidents of threats or abuse			X			The agency has a policy and procedure noted to address incidents of abuse or threat. There were no incidents of abuse or threats during this audit period.	
Grievance Process							
Agency has a formal grievance process	X					The agency has a grievance process and there were three grievances reported by youth. They were resolved within the time frame and were reviewed and signed by the client, staff person and supervisor.	
Locked box accessible to only management and available to youth in a common area	X					The grievance box is locked and only the program manager has access to the keys. The box is located in the common area so the youth and staff has access to make a grievance complaint.	

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 policy and procedures indicates that the management handles grievances reported. It was noted on the three grievance reports that the manager/supervisor reviewed and signed off on them.	
72-hour resolution requirement by management. If this does NOT occur within the 72 hour period, there is sufficient documentation explaining the cause for the delay in resolution.	X					All three grievance reports were resolved within 72 hours by the management.	
1.03: Incident Reporting							
Provider has a written policy and procedure that meets the requirement for Indicator 1.03						**YES** If NO, explain here: Policy 1.03 was last reviewed July 2021 and signed by the COO.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
During the past 6 months, the program notified the Department's CCC (Central Communication Center) no later than two hours after any reportable incident occurred or within two hours of the program learning of the incident	X					During the past 6 months a total of twelve reportable incidents were reported to the Department's Central Communication Center (CCC). All twelve incidents were reported to the CCC within 2 hours and were documented on the form and confirmed by the CCC incident reports.	
The program completes follow-up communication tasks/special instructions as required by the CCC	X					The review of the Department's CCC reports indicates that the program completed follow-up communications as required by the CCC.	
Incidents are documented in the program logs and on incident reporting forms	X					The agency documented the incident reports in their log book and on the incident reporting form.	
All incident reports are reviewed and signed by program supervisors/directors	X					All incident reports during this reporting period were reviewed and signed by the supervisor.	
1.04: Training Requirements (Staff receives training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions)							
Provider has a written policy and procedure that meets the requirement for Indicator 1.04						**NO**	

						If NO, explain here: Policy 1.04 was last reviewed July 2021 and was signed by the COO.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
First Year Direct Care Staff							
All staff completed the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days from date of hire. *(Staff hired before January 1st were required to complete no later than December 31, 2020)*	X					Training files for three new employees hired during this reporting period was reviewed. All three staff completed the DOJ Civil Rights & Federal Funds training within 30 days of hire.	
All staff receives all mandatory training during the first 90 days of employment from date of hire.		X				There were 3 first year staff training records reviewed. Mandatory training topics required were not completed during the 90-day required time frame for all three staff.	Limited Exception: Two new YDS staff training records revealed one of the two YDS staff was missing 10 of 25 mandatory training required in the first 90 days and other YDS staff was missing the SOGIE LGBTQ training. One first year clinical staff did not complete three mandatory trainings in the first 90 days.
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					One non licensed mental health clinical staff was reviewed during this reporting period. The staff completed the Assessment of Suicide Risk training within the time frame.	
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					One non licensed mental health clinical shelter staff was reviewed during this reporting period. The staff completed the Suicide Risk training within the time frame.	
In-Service Direct Care Staff							

Direct care staff completes 24 hours of mandatory refresher Florida Network, SkillPro, and job-related training annually *(40 hours if the program has a DCF child caring license).*		X				Two of three staff completed the required 40 hours and mandatory annual refresher trainings.	Limited Exception: One of the three in-service staff did not complete the required Suicide Prevention training required annually and Fire Safety training required every two years.
Required Training Documentation							
The program maintains an individual training file for each staff, which includes an annual employee training hours tracking form and related documentation, such as certificates, sign-in sheets, and agendas for each training attended.	X					All staff maintained annual individual training files that included certificates, sign in sheets and date of trainings.	
Provider has a written policy and procedure that meets the requirement for Indicator 1.05						**YES** If NO, explain here: Policy 1.05 was last reviewed July 2021 and signed by the COO.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
Case record review reports demonstrate reviews are conducted quarterly, at a minimum		X				Peer record reviews were conducted for the last quarter of FY 2020-2021, in May 2021 for Family Counseling and June 2021 for shelter. A total of 7 files were reviewed for each program. There is no evidence of peer record reviews for CINS/FINS since that time. There were peer record reviews submitted for June, August, and October for the SNAP Program.	Exception: Peer record reviews were not completed quarterly as required for the current fiscal year 2021-2022.
The program conducts reviews of incidents, accidents, and grievances quarterly, at a minimum	X					Incidents, accidents, and grievance data is collected and reviewed quarterly by the Risk Management Committee. Trend data was included in quarterly reports reviewed for March, June, and September 2021. This information was also included on the CQI annual report for FY 20-21.	

The program conducts an annual review of customer satisfaction data	X					Customer satisfaction data is collected and reviewed quarterly by the Impact Committee. The last impact committee meeting was held 9/23/21 and most recent annual review was conducted for the FY 20-21.	
The program conducts an annual review of outcome data and (if applicable) there is evidence of annual reconciliation that occurs through communication from the Florida Network via email or phone call when corrections are needed and the information is corrected and submitted within the requested timeframes.	X					Program outcomes data are reviewed at monthly staff meetings as well as Directors and Supervisors meetings that includes a review of contract benchmarks, data integrity, CQI, outreach, and client satisfaction. Quarterly Impact Management Committee meetings are also held to review/discuss the quarterly reports. Director's and Supervisor's meetings were held July 19th, August 2nd, September 13th, October 18th, and November 8, 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					Monthly NetMIS data received from the Florida Network is emailed to management staff and reviewed at a minimum monthly at the Directors and Supervisor meetings.	
The Florida Network conducts monthly reconciliation by comparing NetMIS data to JJIS data. Agency has evidence that they have reconciled any differences noted.	X					Annual data reconciliation was submitted to the Florida Network via email on 8/20/21 for FY 2019-2020. The program held monthly data meetings May-September 2021 to review and address NetMIS and JJIS data entry, data certification, and LLOS reports. Monthly certification and LLOS report emails sent to the Florida Network's Program Information Manager demonstrate program reconciles any data differences noted in the reports.	
The program has a process in place to review and improve accuracy of data entry & collection	X					Monthly data meetings are held to review and discuss NetMIS and JJIS data collection, accuracy, and data reconciliation. Meetings minutes supported this practice monthly between May and September 2021.	
There is documentation that findings are regularly reviewed by management and communicated to staff and stakeholders.	X					Reviews are conducted regularly at CQI Analysis, Risk Management, Impact Committee, and Supervisors meetings. Staff meetings are held monthly to communicate critical findings.	

There is evidence the program demonstrates that critical performance data reports are shared with the Board of Directors frequently. All final reports that include a Limited or Failed score is submitted electronically or by mail to the providers Executive Committee on the Board of Directors.	X					Board meeting minutes from 9/30/21 was reviewed. The minutes included data reported on percentage of bed days being low and the report card was provided to the Board. No QI reports were conducted prior to the meeting to report to the Board.	
There is evidence that strengths and weaknesses are identified, improvements are implemented or modified, and staff are informed and involved throughout the process.	X					Monthly supervisors, team/staff minutes were reviewed for the review period and were found to document discussion of QI activities, reports, and areas identified as needing improvements resulting from analysis of data collected.	
Provider has a written policy and procedure that meets the requirement for Indicator 1.06						**YES** If NO, explain here: Policy 1.06 was last reviewed July 2021 and was signed by the COO.	
Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	X					The agency provided a list of twelve approved drivers.	
Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	X					All approved drivers have valid driver's license and are covered under the company's insurance policy.	
Agency's Transportation policy prohibit transporting a client without maintaining at least one other passenger in the vehicle during the trip and include exceptions in the event that a 3rd party is NOT present in the vehicle while transporting	X					The program's policy for Client Transportation prohibited transporting a youth alone and includes exceptions in the event a 3rd party is not present in the vehicle. The policy states the supervisor must be contacted and approve the transportation if a 3rd person can not be present. There was evidence on the shelter log as well as the transportation log that the supervisor approved the transport.	
In the event that a 3rd party cannot be obtained for transport, the agency's supervisor or managerial personnel consider the clients' history, evaluation, and recent behavior	X					There was evidence on the log sheet and transportation log that the supervisor considered the clients' history and overall behavior.	
The 3rd party an approved volunteer, intern, agency staff, or other youth	X					The agency policy list a volunteer, intern, agency staff or other youth as an approved 3rd party.	

There is documentation of use of vehicle that notes name or initials of driver, date and time, mileage, number of passengers, purpose of travel and location.	X					The agency transportation log list the name or initials of the driver, date and time, mileage, number of passengers, purpose of travel and location.	
Provider has a written policy and procedure that meets the requirement for Indicator 1.07						**YES** If NO, explain here: Policy 1.07 was last reviewed July 2021 and was signed by the COO.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
The program has a lead staff member designated to participate in local DJJ board and council meetings with evidence that includes minutes of the event or other verification of staff participation	X					Designated staff participated in the Manatee Juvenile Justice Council Meeting on 10/10/21. The staff took a Zoom picture of herself attending the meeting as proof of attending and provided the agenda for the meeting.	
Outreach and prevention services are provided by designated staff and include increasing community awareness, offering informational and educational CINS/FINS services to youth and families.	X					The program documented a total of 57 outreach activities during the review period. The activities included the name of the event, date, number of youth attending, number of adults attending, zip code of the events and purpose of the event.	
The program maintains written agreements with other community partners which include services provided and a comprehensive referral process.	X					The agency has MOUs with several community providers to ensure a comprehensive referral process between the agencies including education, court, delinquency diversion, substance abuse, mental health, law enforcement, medical, and specialized services.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.01						**YES** If NO, explain here: Policy 2.01 was last reviewed September 2021 and signed by the COO.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		

Shelter youth: Eligibility screening is completed immediately for all shelter placement inquiries. If staff on duty cannot complete the screening, an on-call supervisor is contacted and eligibility is determined within 30 minutes from initial inquiry.	X					Five (5) applicable residential case files were reviewed for three (3) closed and two (2) open files. Screenings were all completed in a timely manner as outlined by policies and procedures.	
Community counseling: Eligibility screening is completed within 3 business days of referral by a trained staff using the NetMIS form	X					Five (5) community counseling youth case files were reviewed for three (3) open and two (2) closed youth. All five screenings were completed.	
There is evidence all referrals for service is screened for eligibility and is logged in NetMIS within 72 hours of screening completion.		X				Screenings for all ten (10) files reviewed were entered into NetMIS within 72 hours of completion. Five Secret Shopper calls were made to the agency and two screenings were completed. One of the screenings was entered into NetMIS in 72 hours. One screening was provided a response of acceptance into the program within 30 minutes of the call being made.	Exception: Two of the five Secret Shopper calls did not result in completion of a screening.
Youth and parents/guardians receive the following in writing: a. Available service options b. Rights and responsibilities of youth and parents/guardians	X					All ten files reviewed supported service options and rights and responsibilities were provided to youth and parent/guardians in writing.	
The following is also available to the youth and parents/guardians: a. Possible actions occurring through involvement with CINS/FINS services (case staffing committee, CINS petition, CINS adjudication) b. Grievance procedures	X					Information was documented and provided in the ten files reviewed.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.02						**YES** If NO, explain here: Policy 2.02 was last reviewed September 2021 and signed by the COO.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
Completion of Needs Assessment							

Shelter Youth: Needs Assessment initiated within 72 hours of admission	X					The needs assessments reviewed in the five files were initiated in a timely fashion as outlined by the requirement.	
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					Two of the five files had needs assessments completed within the 2 to 3 face-to-face contacts. Three of the five files were not applicable as the youth were on a waiting list.	
Needs Assessment is conducted by a bachelor's or master's level staff member	X					The applicable seven files reviewed had a needs assessment initiated by a bachelor's or master's level staff member.	
Needs Assessment includes a supervisor's review signature upon completion	X					All seven applicable needs assessments were signed by a supervisor.	
Suicide Risk as a Result of the Needs Assessment							
Youth was identified with an elevated risk of suicide as a result of the Needs Assessment	X					Four of the ten youth were identified with an elevated risk of suicide as a result of 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					An Assessment of Suicide Risk was conducted by or under the supervision of a licensed mental health professional for all four applicable youth.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.03						**YES** If NO, explain here: Policy 2.03 was last reviewed September 2021 and signed by the COO.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
Case/Service plan is developed within 7 working days of Needs Assessment	X					Verified in all seven applicable files reviewed. Three files reviewed are on a waiting list and did not have a service plan initiated due to being waitlisted.	
Case plan service Plan includes: 1. Individualized and prioritized need(s) and goal(s) identified by the Needs Assessment 2. Service type, frequency, location 3. Person(s) responsible 4. Target date(s) for completion and Actual completion date(s) 5. Signature of youth, parent/ guardian, counselor, and supervisor	X					The case plans documented within seven of the ten files were completed in full. All necessary components were documented. All signatures for service plans reviewed were available.	

6. Date the plan was initiated							
Case/service plans are reviewed for progress/revised by counselor and parent (if available) every 30 days for the first three months and every 6 months after	X					Three files out of ten did not have a documented service plan. Relevant indicators cannot be assessed at this time. Of the seven files, no exceptions were noted.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.04						**YES** If NO, explain here: Policy 2.04 was last reviewed September 2021 and signed by the COO.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
Counselor/Case Manager is assigned	X					All seven applicable files were assigned a counselor/case manager. Three files reviewed do not have a counselor/case manager presently due to being waitlisted.	
The Counselor/Case Manager completes the following as applicable: 1. Establishes referral needs and coordinates referrals to services based upon the on-going assessment of the youth's/family's problems and needs 2. Coordinates service plan implementation 3. Monitors youth's/family's progress in services 4. Provides support for families 5. Monitors out-of-home placement (if necessary) 6. Makes referrals to the case staffing to address problems and needs of the youth/family 7. Accompanies youth and parent/guardian to court hearings and related appointments 8. Refers the youth/family for additional services when appropriate	X					As applicable to the seven files reviewed, the documentation reflects comprehensive services to the youth/families.	

9. Provides case monitoring and reviews court orders 10. Provides case termination notes 11. Provides follow-up after 30 days of exit 12. Provides follow-up after 60 days of exit							
The program maintains written agreements with other community partners that include services provided and a comprehensive referral process	X					MOUs with 19 community agencies are on file that list the services provided and a comprehensive referral process between the agencies.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.05						**YES** If NO, explain here: Policy 2.05 was last reviewed September 2021 and signed by the COO.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
Youth and families receive counseling services, in accordance with the youth's case/service plan, to address needs identified during the assessment process	X					Service plans and case notes maintained demonstrated all seven applicable youth received individual counseling services as identified during the assessment.	
Shelter Program							
Shelter programs provides individual and family counseling	X					Documentation and progress notes depict ongoing individual and group services.	
Group counseling sessions held a minimum of five days per week	X					Group notes display ongoing and consistent services.	
Group counseling sessions consist of: a. Length of at least 30 minutes b. Opportunity for youth engagement c. Clear and relevant topic (informational/developmental/ educational) d. Clear leader or facilitator	X					Group notes were detailed and offered insight into relevancy, youth's participation, length, and facilitation.	
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					Verified in two applicable community counseling records reviewed.	
Counseling Services							
Reflect all case files for coordination between presenting problem(s), psychosocial assessment, case/service plan, case/service plan reviews, case management, and follow-up	X					Coordination of services was observed in all seven applicable files reviewed.	
Maintain individual case files on all youth and adhere to all laws regarding confidentiality	X					Confidentiality is maintained based on completed file review. Individual youth record is maintained for all 10 youth files reviewed.	
Case notes maintained for all counseling services provided and documents youth's progress	X					Progress notes are defined and provide information on the youth's progress.	
On-going internal process that ensures clinical reviews of case records and staff performance	X					The supervisor and clinical director reviewed and signed off on review of files to document their case review.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.06						**YES** If NO, explain here: Policy 2.06 was last reviewed September 2021 and signed by the COO.	
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
Case Staffing Initiation and Notifications							
If parent/guardian initiates, staffing is held within 7 days	X					Three applicable case staffing youth records were reviewed for the QI period. The case staffing was requested by school staff in the two records and youth's parent in one record.	
The youth, family and case staffing committee are contacted within a minimum of five working days a. Notification to youth/family no less than 5 working days prior to staffing	X					Notification was sent via email to the committee and youth/family more than 5 days prior to the case staffing for each youth.	

b. Notification to committee no less than 5 working days prior to staffing							
Case Staffing Committee							
Must include: a. DJJ rep. or CINS/FINS provider b. Local school district representative	**X**					Participation by DJJ/CINS and school staff was documented in the three files reviewed.	
Other members may include: a. State Attorney's Office b. Others requested by youth/ family c. Substance abuse representative d. Law enforcement representative e. DCF representative f. Mental health representative	**X**					Other staff represented and accounted for based on evidence provided in the three files reviewed included mental health representative and others requested by youth/family.	
The program has an established case staffing committee, and has regular communication with committee members	**X**					Case staffing committees and representatives have been appropriately accounted for within the files reviewed.	
The program has an internal procedure for the case staffing process, including a schedule for committee meetings	**X**					The program's procedure is outlined in policy 2.06.	
As a result of the Case Staffing							
The youth and family are provided a new or revised plan for services	**X**					Revised service plans were provided for all three youth.	
Written report is provided to the parent/guardian within 7 days of the case staffing meeting, outlining recommendations and reasons behind the recommendations	**X**					All written reports include appropriate and necessary information based on the three files reviewed and parent/guardian is provided a report of the committee recommendations at the end of the case staffing meeting.	
If applicable, the program works with the circuit court for judicial intervention for the youth/family	**X**					One of the three youth records reviewed was applicable for judicial intervention for the youth/family and judicial intervention was documented.	
Case Manager/Counselor completes a review summary prior to the court hearing	**X**					Review summary was present in applicable youth record.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.07						**YES** If NO, explain here: Policy 2.07 was last reviewed September 2021 and signed by the COO.	

Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
All records are clearly marked 'confidential'.	X					All ten youth records reviewed were stamped confidential.	
All records are kept in a secure room or locked in a file cabinet that is marked "confidential"	X					During the facility tour, files were observed to be stored in locked file cabinets marked confidential.	
When in transport, all records are locked in an opaque container marked "confidential"	X					Files that are transported are kept within confidential boxes with locks upon transport by relevant staff.	
All records are maintained in a neat and orderly manner so that staff can quickly and easily access information	X					Files are organized and kept in a neat manner based on observations upon file review.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.08						**YES** If NO, explain here: Policy 2.08 was last reviewed September 2021 and signed by the COO.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Use of youth's preferred name/ pronoun: a. Youth are addressed according to their preferred name and gender pronouns b. Youth's preferred name and gender pronouns are used in logbook and on all outward-facing documents and census boards			X			Since the last QI visit the program has not served any youth who meets the criteria for this indicator. However, policies and procedures are established to meet the requirements.	
Youth in need of specialized support is referred to qualified resources (as applicable)			X			N/A	
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			N/A	
Youth is provided hygiene products, undergarments and clothing that affirms their gender identity or gender expression			X			N/A	

The agency has signage and brochures/publication placed in common areas indicating that all youth are welcome regardless of sexual orientation, gender identity, and gender expression	X					During onsite tour, signage was observed to be posted throughout the facility in common areas. Published materials providing information and education for SOGIE youth are accessible on a table in the building lobby and youth lounge.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.09						**YES** If NO, explain here: Policy 2.09 (Specialized Additional Program Services) and 2.10 (FYRAC) was last reviewed September 2021 and signed by the COO.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Staff Secure							
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? **(If no, select rating "No eligible items for review")**			**NO**			The provider has not served any youth meeting the criteria for staff secure since the last QI review.	
Staff Secure policy and procedure outlines the following: a. In-depth orientation on admission b. Assessment and service planning c. Enhanced supervision and security with emphasis on control and appropriate level of physical intervention d. Parental involvement e. Collaborative aftercare	X					Policy 2.09 addresses the requirement of the indicator.	
Program only accept youth that meet legal requirements of F.S. 984 for being formally court ordered in to Staff Secure Services			X			No applicable records to review.	
Staff Assigned: a. One staff secure bed and assigned staff supervision to one staff secure youth at any given time b. Program assign specific staff during each shift to monitor location/ movement of staff secure youth			X			No applicable records to review.	

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

b. Agency has approval for stays and support beyond seven (7) days for DMST placements that are obtained on a case-by-case basis? (If applicable.)			X				
Agency has evidence that staff assigned to DMST youth under this provision are to enhance the regular services available through direct engagement in positive activities designed to encourage the youth to remain in shelter			X				
All other services provided to DMST youth are consistent with all other general CINS/FINS program requirements			X				
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")**							
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					Three closed DV youth records were reviewed. A DJJ Face sheet was present in all 3 files showing JAC screening and pending DV charge for each youth.	
Data entry into NetMIS and JJIS within (3) business days of intake and discharge	X					NetMIS youth listings report and JJIS prevention module log for each youth showed timely entry for intake and discharge.	
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 DV youth exceeded 21 days in the DV program.	

Case plan in file reflects goals focusing aggression management, family coping skills, or other intervention design to reduce reoccurrence of violence in the home			X			All three youth were in care for less than 72 hours; two went AWOL and one was discharged by the parent/guardian.	
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 during their length of stay.	
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				Florida Network approval was found for one of two youth records reviewed.	Exception: One of two probation youth record reviewed did not have proof of Florida Network approval.
Probation Respite Referral come from DJJ Probation and are all youth referred on probation regardless of adjudication status	X					Two applicable probation respite records were reviewed for youth served during the review period. A DJJ Face sheet was present in each file showing probation status. The reason for the referral and/or referral from the JPO was not in writing in the two files reviewed, though verbal referrals were made by the JPO accordingly.	
Data entry into NetMIS and JJIS within (3) business days of intake and discharge	X					NetMIS youth listings report and JJIS youth placement history verified timely data entry for two youth records reviewed.	
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					Length of stay did not exceed required timeframe for two records reviewed.	
All case management and counseling needs have been considered and addressed	X					Service plans and case notes demonstrate identified needs were addressed in case management and counseling services.	

All other services provided to Probation Respite youth are consistent with all other general CINS/FINS program requirements	X					Case notes demonstrate 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**	Family Resources Manatee is not contracted to provide Intensive Case Management services.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Youth receiving services was court ordered					**X**	N/A	
Services for youth and family include: a. Two (2) direct contacts per month b. Two (2) collateral contacts per week c. Direct and collateral contacts not obtained must have documentation to support attempts made to obtain them. All reasonable attempts (at minimum of three) must be made to reach all contacts (direct and collateral) and documented in the case file and NetMIS.					**X**	N/A	
Assessments include: a. A Child Behavior Checklist (CBCL) is completed within 14 days of intake and at discharge (if applicable) b. An approved self-report assessment that was completed at intake c. An approved self-report assessment that was completed every 90 days following intake and at discharge (if applicable)					**X**	N/A	
Case plan demonstrates a strength-based, trauma-informed focus					**X**	N/A	

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	N/A	
Family and Youth Respite Aftercare Services (FYRAC)– Non-residential Only							
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? **(If no, select rating "No eligible items for review")**	**YES**						
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Youth is referred by DJJ for a domestic violence arrest on a household member, and/or the youth is on probation regardless of adjudication status and at risk of violating	X					Three applicable closed youth records reviewed for the QI period were referred for domestic violence on a household member.	
Agency has evidence that all FYRAC referrals have documented approval from the Florida Network office		X				Florida Network approval was found in writing in 2 of three records reviewed.	Exception: Florida Network FYRAC approval was not found in the file for one of the three records reviewed.
Intake and initial assessment sessions meets the following criteria: a. Face-to-face gathering of family history and demographic information b. Includes development of the service plan and is documented through signature of the youth and his/her parent/guardian as well as orientation to the program	X					The intake was noted as Zoom sessions in two of the three records due to Pandemic but face-to-face for one record. A face-to-face was completed in the 3rd youth record reviewed.	
Life Management Sessions meets the following criteria:						Each of the three youth records reviewed demonstrated the program provided individual	Exception: Documentation provided

a. Sessions are face-to-face, sixty (60) minutes in length and focus on strengthening the family unit b. Individual Sessions are with the youth and family and focus to engage, identify strengths and needs of each member that help to improve family functioning		X				sessions with the youth and/or family during service delivery; however, the majority of sessions were not conducted for at least 60 minutes as required.	did not support Life Management Sessions were held at least 60 minutes as follows: one youth's service log does not have start and end times to determine duration of at least 60 minutes. A second youth completed 12 sessions but only 1 of the 12 sessions was held for at least 60 minutes. Only 1 of the 13 sessions was held for at least 60 minutes in the third youth's record.
Group Sessions: a. Focus on the same issues as individual/family sessions with the overall goal of strengthening relationships and prevention domestic violence b. Shall be no more than eight (8) youth at one (1) time and shall be for a minimum of sixty (60) minutes per session					X	The provider offers only individual life management sessions for FYRAC youth and not group sessions.	
Youth and family participate in services for thirteen (13) sessions or ninety (90) consecutive days of services, or there is evidence in the youth's file that an extension is granted by DJJ circuit Probation staff	X					Two applicable records showed all 13 sessions were completed for one youth and a second youth completed 12 sessions but did not show for 4 additional sessions that were scheduled.	
2.10: STOP NOW AND PLAN (SNAP)							
Provider has a written policy and procedure that meets the requirement for Indicator 2.10						**YES** If NO, explain here:	

						Policy 2.11 was last reviewed September 2021 and signed by the COO.	
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					Three applicable SNAP youth records were reviewed for two open and one closed file. Screenings were completed for all three youth.	
Needs assessment is completed at initial intake, or within two face-to-face sessions	X					Verified in all three records reviewed.	
SNAP Assessments a. Child Behavior Checklist (CBCL) is completed by the caregiver (pre & post) b. Teacher Report Form (TRF) completed by the teacher (pre & post) c. Tool for Parenting Self Efficacy (TOPSE) completed by the caregiver (pre & post) d. Prevention Assessment Tool (PAT) (pre & post) There must be at least three (3) documented attempts in the youths' file to obtain all pre-assessment (listed above) information.						Pre-CBCLs were completed at intake in the youth records and post-CBCLs in all 3 closed youth records. Pre and post TRF were completed by the teacher during school periods. TOPSE and PAT assessments were also completed at intake and at applicable discharges.	
SNAP discharge report summary	X					Completed in 1 applicable closed youth record.	
SNAP Boys/SNAP Girls **Parent** Group Evaluation Form	X					Observed on SNAP Evaluation records.	
SNAP Boys/SNAP Girls **Child** Group Evaluation Form	X					Observed on SNAP Evaluation records.	
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			No SNAP in school session was completed since the last QI review due to the COVID-19 pandemic and schools operating virtually.	
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			No applicable practice during review period.	
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			No applicable practice during review period.	
"Class Goal" sheet			X			No applicable practice during review period.	
Measure of Classroom Environment (MoCE) (Pre and Post) is used to identify baseline and treatment outcomes of reported classroom dynamics.			X			No applicable practice during review period.	
Pre and Post Evaluations			X			No applicable practice during review period.	
One SNAP® Fidelity Adherence Checklist completed per classroom in a 13 – week SNAP in Schools group and uploaded to Dropbox			X			No applicable practice during review period.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.01						**YES** If NO, explain here: Policy 3.01 was last reviewed September 2021 and signed by the COO.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		

Facility Inspection		X				A tour of the facility was conducted with the Residential Shelter Manager. The tour of the facility included: facility lobby, all common/living areas, youth bedrooms, bathrooms, kitchen, laundry room, staff offices, and the exterior of the building.	Exceptions: • Two emergency lights were not working when checked. One is in the foyer and the other is above the youth care station. • Lint collectors for dryers were not cleaned and loose items were found behind the washer/dryer in the laundry room. • Kitchen Refrigerator temperature reading was 50 degrees Fahrenheit, above the recommended range (36-41 degrees). • Overflow drainage under the kitchen sink has visible dirt and debris. • Blinds have cords in the bedrooms; potential hazard involved. • Eggs were observed on the middle shelf of refrigerator and should be stored on the bottom shelf to avoid cross-contamination of food, as per Department of Health requirement.

Additional Facility Inspection Narrative (if applicable)	The tour of the facility revealed that the furnishings were in good repair. Beds were neatly made in all rooms and each bedroom had a different mural theme painted on the walls creating a home-like and inviting atmosphere. There were no visible indication of insects or pests and the agency uses a regular exterminator to spray the facility. All bathrooms were clean with no observable foul smell and were operational. Walls were free from graffiti. There were no observed hazards (other than corded blinds) on the ground during the tour. Egress plans, maps, client rules, hotline information, SOGIE signage etc. were posted throughout the shelter in conspicuous places. Chemicals were kept in a locked cabinet and were labeled accordingly. All doors are secure throughout the shelter though some were opened for the tour and in and out access was limited to staff who exercised key control. On the exterior, no visible debris was observed and garbage cans were covered.						
Fire and Safety Health Hazards		**X**				The shelter is licensed as a Child Caring Agency for 12 beds under the current DCF license effective as of June 1, 2021. COA Certificate-Accreditation is valid through 12/31/2024. DOH Group Care/Food Inspection completed a satisfactory inspection on 01/28/2021. The Annual fire inspection was conducted on 12/16/2020. Fire drills for the past 6 months indicate the agency has completed a minimum of one fire drill per month within 2 minutes on all shifts. Episodic emergency drills were observed on all shifts for the past 2 quarters; however, none was completed for 3rd shift.	Exception: Episodic emergency drills were not observed for the past 2 quarters for 3rd shift.
Additional Fire and Safety Health Hazards Narrative (if applicable)							
Youth Engagement							
a. Youth are engaged in meaningful, structured activities (e.g., education, recreation, counseling services, life and social skill training) seven days a week during awake hours. Idle time is minimal. b. At least one hour of physical activity is provided daily. c. Youth are provided the opportunity to participate in a variety of faith-based activities. Non-punitive structured activities are offered to youth who do not choose to participate in faith-based activities.	**X**					As observed during the virtual and onsite tour, the activity schedule was posted as well as the daily schedule and are accessible to both staff and youth with numerous activities daily including faith based opportunities.	

d. Daily programming includes opportunities for youth to complete homework and access a variety of age appropriate, program approved books for reading. Youth are allowed quiet time to read. e. Daily programming schedule is publicly posted and accessible to both staff and youth.							
Provider has a written policy and procedure that meets the requirement for Indicator 3.02						**YES** If NO, explain here: Policy 3.02 was last reviewed September 2021 and signed by the COO.	
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**					Orientation checklist was observed in all 4 residential records reviewed (2 open, 2 closed).	
Orientation includes the following: a. Youth is given a list of contraband items b. Disciplinary action is explained c. Dress code explained d. Review of access to medical and mental health services e. Procedures for visitation, mail and telephone f. Grievance procedure g. Disaster preparedness instructions h. Physical layout of the facility i. Sleeping room assignment and introductions j. Suicide prevention- alerting staff of feelings or awareness of others having suicidal thoughts	**X**					Verified in 2 open, 2 closed residential records. Orientation checklists included all requirements of the indicator and proof of review with youth was demonstrated by youth and staff initials.	

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 was observed in 2 open and 2 closed residential records. All the orientation checklists were signed by the youth and staff upon shelter entry.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.03						**YES** If NO, explain here: Policy 3.03 was last reviewed September 2021 and signed by the COO.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
A process is in place that includes an initial classification of the youths, to include:							
a. Review of available information about the youth's history, status and exposure to trauma b. Initial collateral contacts, c. Initial interactions with and observations or the youth d. Separation of younger youth from older youth, e. Separation of violent youth from non-violent youth f. Identification of youth susceptible to victimization g. Presence of medical, mental or physical disabilities h. Suicide risk i. Sexual aggression and predatory behavior j. Sexual orientation gender identity/ expression k. Acute health symptoms requiring quarantine or isolation	X					Verified on the CINS/FINS Intake form for 2 open and 2 closed residential records. The program used a list of items required by the indicator to determine room assignment and/or level of supervision needed.	

An alert is immediately entered into the program's alert system when a youth is admitted with special needs and risks such as risk of suicide, mental health, substance abuse, physical health or security risk factors	X					Alerts for the youth are marked with colored dots on the front of the 4 files reviewed and colored dots on the youth alert board in the shelter for 2 active youth reviewed. All risk factor assessment on the intake were completed.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.04						**YES** If NO, explain here: Policy 3.04 was last reviewed September 2021 and signed by the COO.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Log book entries that could impact the security and safety of the youth and/or program are highlighted	X					Randomly selected one-week samples of the program logbook for each month during the past six months were reviewed. All entries are brief and legibly written in ink. Dates reviewed are as follows: 05/01/2021-05/07/2021, 06/15/2021-06/21/2021, 07/22/2021- 07/28/2021, 08/01/2021-08/07/2021, 08/15/2021- 08/22/2021, 09/08/2021-09/14/2021, 10/15/2021-10/21/2021. The program maintains a bound paper logbook.	
All entries are brief, legibly written in ink and include: • Date and time of the incident, event or activity • Names of youth and staff involved • Brief statement providing pertinent information • Name and signature of person making the entry	X					All entries reviewed were observed to meet the requirements of the indicator. However, there is a finding that did not result in an exception because a.m. or p.m. was not consistently documented with the time; however, time of day was still distinguishable.	
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					Recording errors were struck out as required in logbook entries reviewed.	

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					Residential program manager and/or designee reviews the logbook every week and makes a note stating dates reviewed with signature.	
All staff review the logbook of the previous two shifts and makes an entry signed and dated into the logbook indicating the dates reviewed	X					All staff review the logbook at least the previous two shifts and include the dates they have reviewed. Some staff reviewed the logbook dating back to their last working day.	
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					Incoming supervisor and shelter counselor reviewed the logbook and entered a note stating the time and dates of the review and signed it.	
Logbook entries include: a. Supervision and resident counts b. Visitation and home visits	X					Logbook entries include a shift census on each shift with the youth name next to their room. Visitation was listed in the logbook indicating who visits the client and with whom they leave the facility.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.05						**YES** If NO, explain here: Policy 3.05 was last reviewed September 2021 and signed by the COO.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
The program has a detailed written description of the BMS, and it is explained during program orientation	X					The program uses four levels in their behavior management system whereby positive rewards are given and negative behavior results in a demotion for at least 24 hours. The behavior management description is clearly identified in the client's handbook and given to youth during orientation.	
Behavior Management Strategies MUST include:						A review of policy 3.05, youth handbook, and BMS point sheets supported the program's BMS includes	

a. Supervisors are trained BMS is designed to teach youth new behaviors and help youth understand the natural consequences for their actions b. Behavioral interventions are applied immediately, with certainty, and reflect the severity of the behavior c. BMS uses a wide variety of awards/incentives to encourage participation and completion of the program d. Appropriate consequences and sanctions are used by the program and consequences for behavior are logical and designed to promote skill-building for the youth e. Counseling, verbal intervention and de-escalation techniques are used prior to physical intervention (Only techniques approved by the Florida Network and DJJ are used if physical intervention is required) f. Only staff discipline youth. Group discipline is not imposed g. Room restriction is not used as part of the system or for youth who are physically and/or emotionally out of control h. Youth should never be denied basic rights such as meals, clothing, sleep, services, exercise, or correspondence privileges	X					all requirements of the indicator. There was no observation of group discipline, youth being deprived basic rights, or inappropriate sanctions. All six training files reviewed provided documentation of BMS training for staff.	
Program's Use of the BMS							

All staff are trained in the theory and practice of administering BMS rewards and consequences	X					Staff receive training during orientation. All staff are made aware of the theory of the behavior management system for best practice. Training was verified in the records reviewed for three new hires.	
There is a protocol for providing feedback and evaluation of staff regarding their use of BMS rewards and consequences	X					Supervisors meet with staff to discuss use of positive and negative consequences with youth and also include discussion of the BMS during staff meetings.	
Supervisors are trained to monitor the use of rewards and consequences by their staff	X					During the interview it was stated, supervisors are trained by another supervisor from another program location who is well aware of the behavior management system.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.06						**YES** If NO, explain here: Policy 3.06 was last reviewed September 2021 and signed by the COO.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
The program maintains minimum staffing ratios as required by Florida Administrative Code and contract. • 1 staff to 6 youth during awake hours and community activities • 1 staff to 12 youth during the sleep period	X					Monthly staff schedules for May 2021 - October 2021 was provided and reviewed. The program maintains a minimum staffing of 1 staff to 6 youth during awake hours and community activities, and 1 staff to 12 youth during sleeping period.	
All shifts must always provide a minimum of two staff present		X				Most shifts maintained a minimum of two staff except for 3rd shift. The program reported 2 YDS staff vacancies during the QI review.	Exception: During the 3rd shift only one staff was on shift between 09/05-09/11/2021 and 10/10-10/16/2021.
Program staff included in staff-to-youth ratio includes only staff that are background screened and properly trained youth care workers, supervision staff, and treatment staff	X					All staff listed on the staff roster are background screened and have valid screenings with the clearinghouse.	
The staff schedule is provided to staff or posted in a place visible to staff	X					Staff schedule is posted in YDS area 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					There is a holdover overtime roster for staff available for on call including contact telephone number and preferred 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					A review of the video surveillance for 4 randomly selected overnight shifts, during the 30-day period prior to the QI review, was conducted. The dates selected were: October 17th, 2am-4am; October 23rd, 4am-6am; October 27th, 1am-3am; November 1st, 3am-5am; and November 12, 12am-2am.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.07						**YES** If NO, explain here: Policy 3.07 was last reviewed September 2021 and signed by the COO.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Surveillance System							
The agency, at a minimum, shall demonstrate: a. A written notice that is conspicuously posted on the premises for the purpose of security b. System can capture and retain video photographic images which must be stored for a minimum of 30 days c. System can record date, time, and location; maintain resolution that enables facial recognition d. Back-up capabilities consist of cameras' ability to operate during a power outage e. Have cameras placed in interior and exterior general locations of the shelter where youth and staff congregate and where visitors enter and exit. Cameras are never placed in bathrooms or sleeping quarters.	X					Video surveillance review was conducted via Teams conference and interview with residential supervisor. Video surveillance dates reviewed were: 10/17/2021 - 2:00 A.M, 10/23/2021 - 11:00 P.M, 10/27/2021- 3:30 A.M, 11/01/2021- 6:30 A.M, and 11/12/2021 - 1:00 A.M. The written notice of surveillance was observed to be posted during the facility tour. It is a bright yellow sign indicating that there is 24 hour surveillance. The surveillance system can capture at least 30 days of recording and can record date, time, location, and facial recognition. None of the cameras were located in the bedrooms or bathrooms. □	

f. All cameras are visible							
A list of designated personnel who can access the video surveillance system is maintained (includes off-site capability per personnel)?	X					List of personnel designated to access the system is maintained by the program with staff name and position.	
Supervisory review of video is conducted a minimum of once every 14 days and timeframes reviewed are noted in the logbook. The reviews assess the activities of the facility and include a review of random sample of overnight shifts	X					Supervisory reviews are done every 14 days and documented in the logbook. A review of logs supported practice.	
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			Policy indicates that third party review can be made available during investigations and in conjunction with specific incidents. There were no incidents requiring requests of video recordings during the review period.	
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			No request has been made in the past year, however; the policy indicate the agency will contact the provider (Iron Shield).	
Provider has a written policy and procedure that meets the requirement for Indicator 4.01						**YES** If NO, explain here: Healthcare Admission Screening, policy 4.01, Reviewed "September 2021" by the Chief Operating Officer.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Preliminary Healthcare Screening							
Screening includes : a. Current medications b. Existing (acute and chronic) medical conditions c. Allergies d. Recent injuries or illnesses						One open and three closed records were reviewed for the completion of a healthcare screening admission. Each record documented a screening was completed on the day of admission and included a review of current medications, existing medical conditions, allergies, recent injuries, or illnesses, and/or presence of pain or other physical distress. Documentation	

e. Presence of pain or other physical distress f. Observation for evidence of illness, injury, physical distress, difficulty moving, etc. g. Observation for presence of scars, tattoos, or other skin markings h. Acute health symptoms requiring quarantine or isolation	X					included observations for evidence of illness, injury, pain, physical distress, difficulty moving, presence of scars, tattoos, skin markings, and acute health symptoms which may require quarantine or isolation. The program's nursing position has been vacant since February 2021. Each reviewed admission screening was completed by direct care staff and reviewed by a supervisor; however, due to the nurse vacancy, none were reviewed by the program nurse. Recruitment effort documentation was provided. The program was able to provide documentation to show the practice of licensed staff reviewing healthcare screening admissions prior to the nursing position vacancy.	
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 records were applicable for the youth having a chronic condition and/or requiring a referral. There were no youth with a chronic condition requiring referrals in the past six months per staff interview. Typically, youth are linked with medical care prior to admission in community, and efforts to assist and/or confirm access to treatment are discussed with the parent/guardian when applicable.	
When needed, the parent is involved with the coordination and scheduling of follow-up medical appointments			X			No applicable records.	
All medical referrals are documented on a daily log.			X			No applicable records.	
The program has a thorough referral process and a mechanism for necessary follow-up medical care as required and/or needed	X					The policy and procedures adhered to indicator requirements and the program has an interagency agreement with the local hospital for emergency care when needed.	
Provider has a written policy and procedure that meets the requirement for Indicator 4.02						**YES** If NO, explain here: Comprehensive Master Plan for Suicide Prevention and Response, policy 4.02A, Reviewed "September 2021" by the Chief Operating Officer.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible**	**No Practice**	**Not Applicable**		

Rating Criteria	Satisfactory	Non-compliant	Items for Review	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 reviewed records each documented a suicide risk screening was completed on the day of admission during the initial intake and screening process. The intake paperwork was signed and dated by the supervisor indicating a review was completed in each record.
The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	X					Each record was applicable for being placed on constant sight and sound supervision and an Assessment of Suicide Risk (ASR) was completed by the non-licensed mental health practitioner working under the direct supervision of the licensed mental health counselor (LMHC). The ASR is a Florida Network approved assessment.
Supervision of Youth with Suicide Risk						
Youth are placed on the appropriate level of supervision based on the results of the suicide risk assessment.	X					Each youth was assessed within twenty-four hours as required. All youth were placed on the appropriate level of supervision as determined by the suicide risk assessment results and supervision levels were not changed until assessments were completed.
Staff person assigned to monitor youth documented youth's behavior at 30 minute or less intervals	X					Each of the four youth records contained supervision logs maintained for the duration the youth was placed on increased supervision. Each log documented youth behaviors at fifteen-minute intervals, exceeding the thirty-minute requirement.
Supervision level was not changed/reduced until a licensed professional or a non-licensed mental health professional under the supervision of a licensed professional completed a further assessment OR Baker Act by local law enforcement	X					An Assessment of Suicide Risk (ASR) was completed by the non-licensed mental health practitioner working under the direct supervision of the licensed mental health counselor (LMHC) in each record. Two youth were stepped to standard supervision and two youth were Baker Acted due to the assessment results. Reviewed training records showed the mental health professional (MHP) completing ASR's received 20 hours of required training in suicide and crisis assessments under the direct supervision of a licensed mental health practitioner.
						YES
						If NO, explain here:

Provider has a written policy and procedure that meets the requirement for Indicator 4.03						The agency has multiple policies and procedures as follows: 1) Medications, policy 4.03; 2) Medication Management and Distribution, policy 403A; and 3) Medication Disposal, policy 4.03B. All three policies were reviewed September 2021 and signed by the Chief Operating 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) b. Pyxis machine is stored in accordance with guidelines in FS 499.0121 and policy section in Medication Management c. Oral medications are stored separately from injectable epi-pen and topical medications d. Medications requiring refrigeration are stored in a secure refrigerator that is used only for this purpose, at temperature range 2-8 degrees C or 36-46 degrees F. (If the refrigerator is not secure, the room is secure and inaccessible to youth.) e. Narcotics and controlled medications are stored in the Med Station f. Pyxis keys with the following labels are accessible to staff in the event they need to access medications if there is a Pyxis malfunction: a TOP COVER b BACK PANEL- LEFT TALL CABINET LOCK- LEFT, c BACK PANEL- RIGHT TALL CABINET LOCK- RIGHT	**X**					The program stores all medications in a Pyxis Med-Station Cabinet inaccessible to youth. The cart is stored within a locked office specifically used as the medical room. Access to the office is obtained through obtaining the office key maintained within a safe. The cart is stored in accordance with Florida Statute. The program stores oral medications in a separate drawer from topical medications and epinephrine auto injectors. Additionally, the program stores all controlled medications and narcotics within the secured Med-Station. All three emergency Pyxis keys are appropriately labeled and kept in a clear bag that is stored on top of the machine, behind the monitor. There were no youth on medications the time of the on-site tour.	

Medication Distribution							
a. Agency maintains a minimum of 2 Super Users for the Med-Station b. Only designated staff delineated in User Permissions have access to secured medications, with limited access to controlled substances (narcotics) c. A Medication Distribution Log shall be used for distribution of medication by non-licensed and licensed staff d. Agency verifies medication using one of four methods listed in the FNYFS Operations Manual e. When nurse is on duty, medication processes are conducted by the nurse f. The delivery process of medications is consistent with the FNYFS Medication Management and Distribution Policy g. Agency does not accept youth currently prescribed injectable medications, except for epi-pens h. Non-licensed staff have received training in the use of epi-pens provided by a registered nurse	X					An interview with the residential supervisor was conducted and on-site observations were completed as part of the annual compliance review. The program has three "Superusers" and six "Users" trained to assist in the administration of medications and use of the Pyxis system. The program's policy outlines youth currently prescribed injectable medications, with the exception of epinephrine auto injector, shall not be accepted. Medical training for staff is completed by a licensed registered nurse. The VP of Impact indicated the program has access to two additional nurses from other agency locations who are utilized to provide medication training to new staff in the absence of the Manatee program nurse and, at the time of the review, all staff had been trained on Medication Management by a registered Nurse. The program's medication verification process includes the completion of a medication verification form, whereby direct care staff document a call to the prescribing pharmacy to confirm medication, dosage, and ensure the prescription is current. The program's nursing position has been vacant since February 2021 and, in the absence of a nurse, a program supervisor has absorbed the responsibilities of pulling pyxis reports and coordinating pyxis training for staff as needed.	
Medication Inventory							

a. For controlled substances, a perpetual inventory with running balances is maintained as well as a shift-to shift count verified by a witness and documented b. Over-the-counter medications that are accessed regularly are inventoried weekly by maintaining a perpetual inventory c. Syringes and sharps (needles, scissors, etc.) are secured, and counted and documented weekly	X					A review of youth records and an interview with the residential supervisor and reviewed documentation confirmed the program maintains perpetual inventories with running balances and shift to shift counts for all controlled substances. The program uses a Medication Distribution Log to document all medication distributed by a non-licensed staff. A review of sharps inventories reflected the program practice is to count the number of scissors, pencil sharpeners, and razors on each shift and document the number on the "Sharps Count Sign In & Out Form." A review of the log reflected the staff do not sign-in or out scissors as outlined on the form. Staff members document the inventory, date, shift, and staff signature. The inventories for the past six months reflected when the inventory of scissors changed and no explanation was documented in October or November 2021; however, an explanation was documented in May 2021. The razor inventories were documented to be zero. An interview with program staff reported the program stopped allowing razor use at the program several months ago. The program does not store any over the counter (OTC) medications at the program.	

There are monthly reviews of medication management practice via Knowledge Portal or Pyxis Med-Station Reports.		X				Per interview with the program supervisor, monthly reviews of medication management practice was the role of the nurse. There is no documentation of monthly medication management reports from the time the nurse's position became vacant until October 2021.	Exception: The program was only able to provide documentation to support monthly Pyxis management report was run on October 1, 2021 and not monthly as required for the past six months. The program has three Super Users. Monthly review of medication management practice via Knowledge Portal or Pyxis Med-Station Reports is required.
Medication discrepancies are cleared after each shift.	X					Policy also dictates all medication discrepancies shall be corrected at the end of each shift. Reviewed documentation supported the program practice is to clear discrepancies prior to the end of each shift. A review of internal incidents and the Department's Central Communications reports reflected the program had three medication errors due to missed medication administrations since the last annual review. The program conducted retraining and applicable disciplinary action in each instance.	
Provider has a written policy and procedure that meets the requirement for Indicator 4.04						**YES** If NO, explain here: Medical and Mental Health Alert Process, policy 4.04, Reviewed "September 2021" by the Chief Operating Officer.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Youth with a medical, mental health, or food allergy was appropriately placed on the program's alert system	X					A review of four youth records reflected each was applicable for a medical, mental health, and/or food allergy alert. Each youth alert coincided with the record alerts as required.	

Alert system includes precautions concerning prescribed medications, medical/mental health conditions	X					The program's alert system includes alert details for sight and sound supervision, mental health, sharps restriction, elevated support, general medications, diet and/or allergies, medical issues, substance abuse issues, behavioral issues, domestic violence, controlled medications, and exigent youth. Additionally, the alert system is color coded.	
Staff are provided sufficient training, information and instructions to recognize/respond to the need for emergency care for medical/mental health problems	X					An interview with the residential supervisor verified the program's practice for sharing alerts. All program staff are trained upon hire on the program's alert policies. Additionally, all staff received required training on emergency response to medical and 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					A review of program logbooks and observations of the alert board verified the alert sharing process. The program places stickers indicating alerts on youth records and discusses alerts in the "shift exchange log."	
Provider has a written policy and procedure that meets the requirement for Indicator 4.05						**YES** If NO, explain here: Episodic/Emergency Care, policy 4.05, Reviewed "September 2021" by the Chief Operating Officer.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Off-site Emergency Services							
a. If off-site emergency medical or dental care was provided, an incident report was submitted for the medical or dental care b. Upon youth return, there is a verification receipt of medical clearance via discharge instructions with follow-up is present in file c. Youth's parent/guardian was notified	X					Three closed applicable records were reviewed for off-site emergency care. All three-youth received emergency medical treatment at the local emergency room. Each incident had a corresponding internal incident and a report was submitted to the Department's Central Communication Center as required. The program provided documentation to support the youth was medically cleared and receipt of discharge instructions was maintained in the record. All youth were only applicable for a follow up in the event the need persisted; however, all issues were resolved and follow up medical care was not needed. The reviewed incident reports and Episodic Care/Emergency Care Log confirmed the	

d. A daily log is maintained for emergency care provided						parent/guardian was notified of off-site care in each instance.	
All staff are trained on emergency medical procedures	X					The program's training plan includes training in recognizing medical emergencies, first-aid, cardiopulmonary resuscitation (CPR) and emergency preparedness. These trainings are provided to all program staff upon hire and annually thereafter.	
The program has a Knife-for-life and wire cutters accessible to staff in a secure location(s)	X					The program maintains a suicide response kit which includes a knife-for-life and wire cutters in a secure area inaccessible to youth.	
First aid kit/supplies are fully equipped and inventoried	X					The program maintains a first-aid inventory checklist. Documentation supported inventories are conducted weekly. The program has a main tackle box style first-aid kit and two mobile first aid kits. Kits are replenished as needed. The program maintains a large first aid kit in the medical room, two mobile first aid kits, one suicide response kit, and an AED.	