Florida Network for Youth and Family Services
Compliance Monitoring Report for

BOYS TOWN

975 Oklahoma Street
Oviedo, FL 32765

January 17-18, 2024

Compliance Monitoring Services Provided by

FOREFRONT

EXECUTIVE SUMMARY

Forefront LLC conducted a Quality Improvement (QI) monitoring visit on behalf of the Florida Network of Youth and Family Services (FNYFS) for Boys Town for the FY 2023-2024 at its program office located at 975 Oklahoma Street, Oviedo, 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. Boys Town 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 from July 2023 through June 30, 2024.

The review was conducted by Marcia Tavares, Consultant for Forefront LLC and Peer Reviewers. Agency representatives from Boys Town present for the entrance interview were: Arlene Bartusiak, Sr. Director of Program Operations; Rochelle Davis, Program Support Services Coordinator; Carmen Rodriguez, Business Manager; Al McCray, Program Director (I&A); N'Kayah Kersey, Program Director (IHFS); Devonte Johnson, Residential Supervisor; Mari Tufts Valdez, In-Home Consultant; and Administrative Assistants Davine Hardy and Arlene Smith. The last onsite QI visit was conducted April 12-13, 2023.

In general, the Reviewer found that Boys Town is in compliance with specific contract requirements. **Boys Town received an overall compliance rating of 92% for achieving full compliance with 11 of 12 applicable indicators** of the CINS/FINS Monitoring Tool. One corrective action was cited 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

2023-2024 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 01-17-2023-2024

Agency Name: Boys Town	**Monitor Name: Marcia Tavares, Lead Reviewer**
Contract Type : CINS/FINS	**Region/Office: 975 Oklahoma Street, Oviedo, FL**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): January 17-18, 2024**

	Explain Rating						
Major Programmatic Requirements	**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:**
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 of program in another judicial circuit during each 12-month period of the contract, if requested.	☐	☐	☒	☐	☐	Interview: The provider currently has two (2) certified DJJ-QI Peer Reviewers: Rochelle Davis and Al McCray. Both staff have participated in a QI Peer Review during the current FY.	
Additional Contracts a. Provider shall provide a listing of all current federal, state, or local government contracts, as well as other contracts entered into with for profit and not-for-profit organizations. Such a listing shall identify the awarding entity and contract start & end dates. **PTV**	☐	☐	☒	☐	☐	Documentation: The agency maintains a list of 21 additional contracts for FY 2023-2024. The list includes: the contract type, contract title, funder name, contract amount, start and end date, and status. The program also maintains interagency agreements and Memorandums of Agreement (MOUs) with schools, mental health, and substance abuse providers. All of the agreements reviewed during the QI visit had current contract/agreement dates.	
Limits of Coverage	☐	☐	☒	☐	☐	Documentation: Certificate of Insurance. General Liability through Philadelphia Indemnity Insurance	

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a. Provider shall provide and maintain during this contract, the following minimum kinds of insurance: Worker's Compensation and Employer's liability insurance as required by Chapter 440, F.S. with a minimum of $100,000 per accident, $100,000 per person and $500,000 policy aggregate. Commercial General Liability with a limit of $500,000 per occurrence, and $1,000,000 policy aggregate. Automobile Liability Insurance shall be required and shall provide bodily injury and property damage liability covering the operation of all vehicles used in conjunction with performance of this contract, with a minimum limit for bodily injury of $250,000 per person; with a minimum limit for bodily injury of $500,000 per accident; with a minimum limit for property damage of $100,000 per accident and with a minimum limit for medical payments or $5,000-$10,000 per person. Florida Network is listed as payee or co-payee. **PTV**						Company, for limits of coverage $1,000,000 each $3,000,000 aggregate, and medical expense for $20,000, effective 10/01/2023 – 10/01/2024. Automobile insurance through Philadelphia Indemnity Insurance company for combined limits of liability/property damage for $1,000,000. Policy effective date 10/01/2023 – 10/01/2024. Workers Compensation through Sentry Casualty Company with limits of $1,000,000 each/aggregate, effective 12/31/2023 – 12/31/2024 Florida Network is listed as certificate holder.	
External/Outside Contract Compliance	☐	☐	☐	☐	☒	During the Entrance Conference, the provider indicated that there are no outstanding corrective action item(s) cited by an external funding source.	

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a. Provider has corrective action item(s) cited by an external funding source (Fiscal or Non-Fiscal). **ON SITE**							
Fiscal Practice a. Agency must have employee and fiscal policy/procedures manuals that are in compliance with GAAP and provide sound internal controls. Agency maintains fiscal files that are audit ready. **PTV**	☐	☐	☒	☐	☐	Documentation: The agency maintains Accounting Policies and Procedures in place for: fiscal management, cash, petty cash, support, program service fees, revenue, and receivables, expenses for program and supporting services and accounts payable, payroll and related liabilities, governmental financial assistance programs, property and equipment, debt and other liabilities. The procedures reviewed appear to be consistent with GAAP and provide for sound internal controls and revision numbers are indicated for each procedure.	
b. Agency maintains a general ledger and the corresponding source documents. A 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: The financial officer provided a detailed General Ledger Boys Town Central Florida, for the period January 1 – November 30, 2023. Agency maintains a detailed general ledger that is structured to track all funding sources as well as activities for the CINS/FINS program. Although centralized, the agency is allocating cost per each program from other funding sources separately. The GL uses a chart of accounts	

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						and each entry includes at a minimum, the type of transaction, date, cost center, and amount.	
c. Petty cash ledger system is balanced and all cash disbursements are compliant with financial policies and allowable under the contract. (Disbursements/invoices are approved & monitored by management.) –**ON SITE**	☐	☐	☒	☐	☐	Boys Town has fiscal procedures for petty cash. Petty cash is stored in a locked box in the program director's office. All receipts are submitted for accounting and requesting reimbursement as needed and the fund is reconciled. Reimbursement comes in the form of a check made out to the Program Director who will then cash it and place money in petty cash box. The fund does not exceed $150. In addition to petty cash, Supervisors have purchasing cards.	
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**	☒	☐	☐	☐	☐	Bank Statements were reviewed for the period June-December 2023 for two accounts held with JP Morgan Chase Bank, a customer depository account and a controlled disbursement account. Since the last QI review, Boys Town changed to JP Morgan Chase and no longer have local bank accounts; everything is centralized under Father Flanagan Boys Home. Bank reconciliations were only prepared at Year End for 2023 due to the system change but for 2024 are being done monthly. Consequently, the only bank reconciliation during the review period was the one conducted as of 12/31/2023.	**Corrective Action: 1)** The agency must conduct monthly reconciliations of bank statements in a timely manner, within 6 weeks of receipt of bank statements. Signatures/dates of individuals completing and approving the reconciliations must be documented.

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						Invoices from vendors are sent directly to Accounts Payable, centralized in Omaha, and or to the Central Florida site via mail or email. If sent to the site, they are rerouted to Corporate AP. If there is a Purchase Order (PO) set up, AP will pay and allocate per the PO. If not, they will send the invoice to the site to obtain proper coding and when received AP will process the payments. All approvals for invoices and expense reports are done through Workday. Payments are processed daily through settlement runs and include payments via ACH and checks for the entire organization so may include payments for Corporate or any of the Affiliate sites.	
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) has been submitted to DJJ. **PTV/ON SITE**	☐	☐	☐	☐	☒	No new equipment has been purchased with FN funds in the past year.	
f. Agency submits payroll taxes and deposits (and retirement deposits as applicable), Employee IRS Form W-2 and	☐	☐	☒	☐	☐	Documentation: Salaries are paid through Payroll account which is also centralized. Taxes, benefits, and expenses are paid	

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Independent Contractors IRS Form 1099 forms prior to federal requirements. **ON SITE**						through the Control Account which only displays transactions in summary not detail. In addition, since these are centralized, there is no way to identify from the statement which affiliate/entity the transactions are associated with. Agency provided evidence of payroll taxes being paid to the IRS documented on centralized monthly statements of accounts (June – December 2023) from ADP who is contracted for tax and payroll services.	
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 year-to-date report as of November 30, 2023 for accounts 81270 (IHFS) and 81240 (I&A). The report shows Actual, Budget, Over/Under, Annual Budget, and Balance Remaining. A review of these documents was conducted. Report shows program budget and variances with YTD net surplus. Variances in budget are monitored on a regular basis and are discussed with the Board.	
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	☐	☐	☒	☐	☐	Documentation: Financial audit conducted for year ending December 31, 2022 was completed by KPMG LLP. A separate Management Letter requiring a Corrective Action Plan was not issued by the auditor as there were no findings and questioned costs.	

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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. **Can obtain from FNYFS**							
i. Agency maintains confidentiality policy with written policies and procedures to ensure the security and privacy of all employee and client data. Personal information is not easily accessible. Agency maintains a backup system in case of accidental loss of financial information. Security procedures are in place to protect laptops. Obsolete documents are shredded and computer hard drives are wiped prior to discarding. **ON SITE**	☐	☐	☒	☐	☐	Documentation: Review of the following policies and procedures: Privacy and Confidentiality (Revision 49), Information Security Program (Revision 37), Retention, Storage, Destruction (Revision 11), Information Security (Revision 30), and Safeguarding Protected Health Information (Revision 24).	
j. Agency provided evidence that every direct care staff employee, as of October 1, 2023, is being paid at least $19.00 per hour. This also includes funding for additional staff as approved by the Department. **ON SITE**	☐	☐	☒	☐	☐	Documentation: The program provided a salary list for all direct care staff showing staff's name, position title, FTE, hourly rate, cost center, hire date and position start date. Per the salary list, all direct care staff employee, as of October 1, 2023, is being paid at least $19.00 per hour.	

CONCLUSION

Boys Town has met the requirements for the CINS/FINS contract as a result of full compliance with all 11 of 12 applicable indicators of the Administrative and Fiscal Contract Monitoring Tool. Two of the 14 indicators were not applicable because 1) the provider does not have any corrective actions cited by an external funding source, and 2) no new inventory was purchased with FN funds. Consequently, **the overall compliance rate for this contract monitoring visit is 92%.** There is one corrective action cited 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, all of indicators reviewed were carried out in a manner which meets the standard described in the report findings.

Summary of Corrective Action(s)

Corrective Action: 1)
The agency must conduct monthly reconciliations of bank statements in a timely manner, within 6 weeks of receipt of bank statements. Signatures/dates of individuals completing and approving the reconciliations must be documented.

The provider must submit a corrective action plan to address the corrective action (1) 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 Boys Town – Oviedo, Florida
CINS/FINS Program

January 17-18, 2024

Compliance Monitoring Services Provided by

FOREFRONT

CINS/FINS Rating Profile

Standard 1: Management Accountability

1.01 Background Screening of Employees/Volunteers	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	Limited

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

Standard 2: Intervention and Case Management

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

Percent of Indicators rated Satisfactory: 88.89 %
Percent of Indicators rated Limited: 11.11 %
Percent of Indicators rated Failed: 0 %

Standard 3: Shelter Care & Special Populations

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

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

Standard 4: Mental Health/Health Services

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

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

Overall Rating Summary

Percent of indicators rated Satisfactory: 82.14 %
Percent of indicators rated Limited: 17.86 %
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
Teresa Andersen – Regional Monitor, Department of Juvenile Justice
Shelley Gress – Youth and Family Alternatives - George Harris
Jessy Kingman – Tampa Housing Authority
Kristi Walsh – Childrens Home Society Fort Pierce

Methodology

This review was conducted in accordance with FDJJ-2000 (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 July 1, 2023).

Persons Interviewed

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

Documents Reviewed

	Accreditation Reports	X	Table of Organization		Visitation Logs
X	Affidavit of Good Moral Character	X	Fire Prevention Plan	X	Youth Handbook
X	CCC Reports	X	Grievance Process/Records	5	# Health Records
X	Logbooks		Key Control Log	3	# MH/SA Records
	Continuity of Operation Plan	X	Fire Drill Log	12	# Personnel /Volunteer Records
X	Contract Monitoring Reports	X	Medical and Mental Health Alerts	8	# Training Records
	Contract Scope of Services	X	Precautionary Observation Logs	9	# Youth Records (Closed)
X	Egress Plans	X	Program Schedules	4	# Youth Records (Open)
X	Fire Inspection Report	X	List of Supplemental Contracts		# Other: ___
	Exposure Control Plan		Vehicle Inspection Reports		

Observations During Review

	Intake	X	Posting of Abuse Hotline	X	Staff Supervision of Youth
X	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	X	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

Surveys

8	# of Youth	16	# of Direct Staff		# of Other		

Comments

A Quality Improvement Program Review was conducted for FY 2023-2024.

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/or community counseling services.

Strengths and Innovative Approaches

Boys Town of Central Florida (Boys Town) is located in Oviedo, Florida. The program is an affiliate of its national non-profit agency Father Flanagan's Boys Home with headquarters located in the Village of Boys Town, Omaha, Nebraska. Boys Town Central Florida provides a variety of services from its main campus as well as in the surrounding community. Services include intervention and assessment (I&A); treatment family homes; in-home family services (IHFS); a national hotline; free online resources; Common Sense Parenting; a comprehensive behavioral health clinic (located in Winter Park); and behavioral assessments. Community support services enable children and parents to tap into a wide variety of resources from agency experts or through direct specialized services. The Boys Town National Hotline® (800-448-3000) is a free resource and counseling service that assists youth and parents 24/7, year-round, and nationwide. Boys Town Press® produces books, audio products, DVDs, display materials and other resources to assist children, parents, caregivers, educators, and other professionals. YourLifeYourVoice.org is a special website that enables and encourages teens to share their problems and concerns in positive ways and provides access to immediate help in a crisis. Funding through CINS/FINS allows the agency to serve both male and female youth up to seventeen years old that are locked out, runaway, ungovernable and/or truant, homeless, abused, neglected, or at-risk. The agency also provides specialized services to youth who meet the criteria for Staff Secure shelter, Domestic Minor Sex Trafficking, and youth referred by the Juvenile Justice Court System for domestic violence, probation respite, and Family/Youth Respite Aftercare Services (FYRAC). The youth census during the Quality Improvement (QI) visit was nine CINS/FINS and 3 DCF (Department of Children & Families) youth. Boys Town is currently accredited by the Council of Accreditation (COA) and was recently re-accredited through December 31, 2026.

The following programmatic updates were provided by the agency:

Staffing

Leadership staff across all programs have remained consistent with only a few changes since the last onsite review. There is a change in the Sr. Director of Operations position with Alice Bartusiak who started in August 2023. Ms. Bartusiak brings over 20 years of Boys Town Experience to the program. Prior In-Home employee, N'Kayah Kersey, rejoined the Boys Town team as an in home consultant in March 2022. She became a Supervisor at I&A in April 2023 and was promoted as IHFS Supervisor in June 2023. Two supervisors resigned from their positions in 2023: Eilina Suarez and Alyssa Bailey. Lead staff Devonte Johnson and Naida Joseph were promoted as supervisors of I&A in 2023. The program's nurse position was vacant for over one year and a nurse was hired in September 2023.

Program

The program has achieved several successes in the past year as follows:

- 94% intakes entered within 3 days
- 98% youth receive a 30 day follow up
- 97% of youth attend school daily upon discharge
- 100% of shelter youth have a Nirvana post assessment report.
- 73.4% Filled bed days (7/1/23 to 12/31/23)
- 69.8% Community Counseling Admits (7/1/23 to 12/31/23)
- 94% of data entry was completed within 72 hours (7/1/21 to 12/31/21)
- Served a total of 899 youth for 2023 at Central Florida; 458 youth admitted and 446 youth discharged.
- Served a total of 332 participants in Common Sense Parenting.
- Served a total of 99 youth at Intervention and Assessment.
- Served a total of 102 youth within In Home Services.
- Served a total of 331 participants in our Outpatient Behavioral Clinic.
- Served a total of 35 youth in our Family Home Program.
- A Work Life Balance Committee was created and the agency has continued with the Employee Recognition Committee.
- The Annual Tree Lighting Ceremony was a success - the biggest event to date with a Kids Zone Sponsor and positive community support.

Facility

The program invested in new furniture for the shelter in 2023. Additional improvement across the campus includes repainting the shelter interior walls, posting new posters, new room design, addition of better lighting to the campus (main walkways), painted the administrative building and Quest home, landscaping improvements with mulch and flowers at the I&A site, new basketball court installed with new hoop, and a new dishwasher at I&A.

Funding/ Finance

Development raised a total of $404,804 in Central Florida. All direct care staff in the I&A and IHFS program received a raise in 2023.

Governance

Board of directors diversity of gender increased to 40% female representation and ethnicity increased from 0% to 22%.

Overall Board engagement has been significantly increased with more active participation of Board members.

Challenges

Staffing and recruitment continues to be a struggle with staffing in the residential program (Intervention and Assessment) programming appearing to be the biggest need.

Narrative Summary

Boys Town, located at 975 Oklahoma Street, Oviedo, FL 32765, is under the leadership of a management team that consists of an Executive Director, Senior Director of Program Operations, Program Services Support Coordinator, Clinical Support Coordinator, Clinical Support Specialist, Residential Program Director, and IHFS Director. The residential program is managed by the residential director and currently staffed by an Administrative Assistant, two youth care supervisors, nine youth care workers, and a part time nurse. The community counseling program is managed by a program director and staffed by an administrative assistant, a supervisor, and two case manager consultants. At the time of the onsite visit there was one youth care worker position, an I&A supervisor, and a Financial Officer position vacant.

The overall findings for the program QI Review are summarized as follows:

Standard 1: There are seven indicators for Standard 1. Indicator 1.01 Background Screening of Employees/Volunteers was rated **Satisfactory,** Indicator 1.02 Provision of an Abuse Free Environment was rated **Satisfactory with Exception**, Indicator 1.03 Incident Reporting was rated **Satisfactory with Exception**, Indicator 1.04 Training Requirements was rated **Limited**, Indicator 1.05 Analyzing and Reporting Information was rated **Satisfactory with Exception**, Indicator 1.06 Client Transportation was rated **Satisfactory**, and Indicator 1.07 Outreach Services was rated **Limited.**

Standard 2: There are nine indicators for Standard 2. Indicator 2.01 Screening and Intake was rated **Satisfactory,** Indicator 2.02 Needs Assessment was rated **Satisfactory with Exception**, Indicator 2.03 Case/Service Plan was rated **Satisfactory with Exception**, Indicator 2.04 Case Management and Service Delivery was rated **Satisfactory with Exception**, Indicator 2.05 Counseling Services was rated **Limited**, Indicator 2.06 Adjudication/Petition Process was rated **Satisfactory**, Indicator 2.07 Youth Records was rated **Satisfactory**, Indicator 2.08 Specialized Additional Program Services was rated **Satisfactory with Exception**, and Indicator 2.09 Stop Now and Plan (SNAP) was rated **Not Applicable**.

Standard 3: There are seven indicators for Standard 3. Indicator 3.01 Shelter Environment was rated **Satisfactory with Exception**, Indicator 3.02 Program Orientation was rated **Satisfactory**, Indicator 3.03 Youth Room Assignment was rated **Satisfactory**, Indicator 3.04 Log Books was rated **Limited**, Indicator 3.05 Behavior Management Strategies was rated **Satisfactory**, Indicator 3.06 Staffing and Youth Supervision was rated **Satisfactory with Exception**, and Indicator 3.07 Video Surveillance System was rated **Satisfactory with Exception**.

Standard 4: There are five indicators for Standard 4. Indicator 4.01 Healthcare Admission Screening was rated **Satisfactory,** Indicator 4.02 was rated **Satisfactory with Exception**, Indicator 4.03 was rated **Limited**, Indicator 4.04 Medical/Mental Health Alert Process was rated **Satisfactory**, and 4.05 Episodic/Emergency Care was rated **Satisfactory with Exception**.

Summary of Deficiencies resulting in Limited or Failed Rating (If Applicable):

Standard 1:
Indicator 1.04 - Limited
One of the four new hired staff did not complete DOJ Civil Rights and Federal Funds within the required time frame from hire.

The four new hire staff training records reviewed showed none of the four completed all mandatory training during the first 90 days of hire. Staff #1 (DOH 5/1/2023) was late completing six trainings: CPR/First Aid, medication distribution, and SkillPro child abuse, trauma response, and suicide prevention training. Staff #2 (DOH 5/15/2023) was late completing four trainings: CINS/FINS core, Florida Network suicide prevention, universal precaution, and medication distribution. Staff #3 (DOH 7/31/2023) was late completing two trainings; medication distribution and Pyxis. Staff #4 (DOH 8/9/23) did not complete the Florida Network Suicide Prevention training.

Three of the four in-service staff did not complete the required 40 annual hours of training. It also appears all four did not complete the required annual Florida Network Suicide Prevention training.

Currently, there isn't an effective system in place to monitor and communicate individual training compliance while transitioning over to the national online tracking system.

Indicator 1.07 - Limited
There is no evidence program staff attended any Circuit Advisory Board meetings held between July 2023 and January 25, 2024.

Standard 2:
Indicator 2.05 - Limited
Case notes are not being maintained for counseling and/or other services provided to residential youth. The program has a page in the file for chronological notes but none of the forms were completed in any of the five youth records reviewed.

Standard 3:

Indicator 3.04 - Limited

Of the entries reviewed, there are multiple entries that are left without a time for the date of the incident, or does not have a signature or initial at the end. The Florida Network policy states that staff must sign their full name at the end of the entry, however up until September 2023 the staff are only initialing.

The approved void procedure has not been followed - the correct format is a single line cross through, the word void next to it with the staff initials and date the cross through occurred. Some void entries have multiple cross through, some have void written across the word, and none of them reviewed have initials or dates.

Of the random weeks in the past six months reviewed, only one supervisory review was noted. It provided recommendations for log book entries, but did not contain a date range of what was reviewed.

All staff on shift are not signing both log books showing a review occurred in both logbooks, including dates reviewed up to their last shift worked.

There is no documentation that the program manager/supervisor or counselors are reviewing the logbook at the beginning of their shifts. Starting in November with the promotion of the facilities new supervisor, it is seen that they were reviewing each shift; however, prior to that the facility supervisors were not documenting daily logbook reviews.

Standard 4:

Indicator 4.03- Limited

In the month of October 2023, for the medication Adderall, seven morning doses were given and five were given early. For Oxcarbazepine, 13 morning doses were given and 10 were provided early. In September 2023, for the medication Cyproheptadine, two morning doses were given and both were given early. For the medication Oxcarbazepine, 18 morning doses were given and 13 were given early.

None of the three controlled medication distribution logs reviewed showed shift-to-shift counts verified by a witness as of November 2023. There were no weekly inventories for non-controlled or OTC medications printed after 9/10/23.

There are no monthly reviews of Pyxis Reports documented for the annual review period.

CINS/FINS QUALITY IMPROVEMENT TOOL

Quality Improvement Indicators and Results: Please select the appropriate outcome for each indicator for each item within the indicator.	**Summary/Narrative Findings:** The narrative write-up is a thorough summary of each assigned QI indicator worksheet, explain how you came to your finding(s).	**Deficiencies/Exceptions:** Please add additional detailed explanations for any items that have any deficiencies or exceptions.

Standard One – Management Accountability

1.01: Background Screening of Employees, Contractors and Volunteers		**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 1.01	**YES**	
	If NO, explain here:	
	The provider has the required policy and procedures, Intervention and Assessment (IAP) 1.01-1, Background Checks and Re-screenings, approved December 27, 2023 by the Executive Director (ED).	

Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*

Total number of New Hire Employee/Intern/Volunteer Files: 9 new hires files, 2 intern/volunteer files
Total number of 5 Year Re-screen Employee Files: 1 re-screen file
Staff Position(s) Interviewed *(No Staff Names)* **: Business Manager**
Type of Documentation(s) Reviewed: Staff roster, Department of Juvenile Justice Background Screening results, Hiring Manager Interview (HMI) Pre-Employment assessment tool, E-Verify, Annual Affidavit of Compliance with Level 2 Screening Standards

All positions providing direct services to youth has successfully passed pre-employment suitability assessment on the initial attempt.	**Compliance**	Boys Town uses the Hiring Manager Interview (HMI) pre-assessment tool, implemented October 9, 2019, to determine eligibility rating for employment. An eligible pass rate for youth care worker is a minimum of 26, and 24 for In-Home Consultant. The tool was utilized to screen five applicable direct care new hires, all of whom received passing scores. Four additional new hires (a nurse, director of program operations, and two development staff) did not complete the HMI upon hire because three of the positions do not provide direct services to youth and the nurse is a licensed professional.	
For any applicant that did not pass the initial suitability assessment, there was evidence that the applicant retook the assessment and passed within five (5) business days of the initial attempt, not exceeding three (3) attempts within thirty (30) days.	**No eligible items for review**	All five applicable staff who completed the HMI received passing scores.	

Agency has evidence for employees who have had a break in service for 18 months or more, and/or when the agency had a change or update in the suitability assessment tool used was different from the employee's original assessment, that a new suitability assessment and background screening was completed as required.	**No eligible items for review**	None of the new staff were prior agency employees.	
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. *(Employees who have had a break in service and are in good standing may be reemployed with the same agency without background screening if the break is less than 90 days.)*	**Compliance**	Background screenings for all nine new hires were initiated prior to hire/start dates with eligibility documented on the DJJ background screening results. There were no exemptions required. Similarly, background screenings for two interns utilized during the review period were completed prior to their start dates.	
Five-year re-screening is completed every 5 years from last screening or prior to retained fingerprints expiration date.	**Compliance**	The program had one staff who met the criteria for 5-year re-screening. The staff was re-screened on time and had valid retained prints in the clearinghouse.	
Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?	**Compliance**	The program had a signed and notarized Annual Affidavit of Compliance with Level 2 Screening Standards that was completed, notarized, and faxed on January 3, 2023 to the Background Screening Unit, prior to the January 31st deadline.	
Proof of E-Verify for all new employees obtained from the Department of Homeland Security	**Compliance**	Proof of E-Verify work authorizations is maintained in all nine new hire files. The agency uses Workday software that offers a comprehensive solution to manage payroll, benefits, HR and employee data. Background screening data is incorporated into Workday and I-9 authorization is linked to E-verify. Each employee record had documentation referenced by an E-verify case number to support employment is authorized.	
Additional Comments: **There are no additional comments for this indicator.**			
1.02: Provision of an Abuse Free Environment			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 1.02		**NO** If NO, explain here: Policy 1.03-3 Child Abuse /Neglect Reporting does not include protocols for documenting abuse calls. The provider has multiple policies and procedures that meet the requirement of the indicator as follows: 1.02 - 1 Client Contact and Communication; 1.02-2 Social Media (Employee Handbook); 1.02-3 Ethical and Professional Conduct Booklet; 1.02-4 Standards of Conduct for Staff; 1.02-5 Grievance; and 1.03-3 Child Abuse /Neglect Reporting. The policies were approved December 27, 2023 by the ED.	

Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Staff Position(s) Interviewed (No Staff Names): Shelter Director, Business Manager **Type of Documentation(s) Reviewed: personnel policy and procedures manual, client handbook, client grievance file** **Describe any Observations: abuse hotline postings, grievance box, grievance forms**			
Agency has a code of conduct of policy and there is evidence that staff are aware of agency's code of conduct.	**Compliance**	Upon hire, program staff receive a welcome letter including a copy of the Boys Town Code of Conduct that outlines expected behavior. This practice was confirmed during interview with the Business Manager and review of welcome letter.	
The agency has a process in place for reporting and documenting child abuse hotline calls.	**Compliance**	Employees are required to report all known or suspected cases of abuse and/or neglect and youth have unimpeded access to self-report. Training records support four new staff completed the required Child Abuse training. Abuse calls are logged in 1) the Boys Town (BT) National Database (electronic format) which allows to staff and leadership to pull reports using various filters, 2) Incident Excel sheet, and 3) in the CCC Binder. A copy of each abuse call is placed in the corresponding youth's record.	
Youth were informed of the Abuse and Contact Number	**Compliance**	At intake, youth are informed of their rights and responsibilities and receive a resident handbook that informs them about the abuse hotline and grievance procedures. The abuse hotline number was observed to be posted in both the boy's and girl's dorm areas clearly and is easily accessible by staff and youth.	
Grievance			
Grievances are maintained on file at minimum for 1 year.	**Compliance**	The shelter manager maintains a record of grievances for a minimum of one year. A total eight grievances were reported during the review period.	
There are formal grievance procedures for youth, including grievance forms, and a locked box which are easily accessible to youth in a common area.	**Compliance**	Youth are informed of the grievance procedures during orientation and a copy of the procedures is included in the resident handbook. Staff documents reviewing the grievance procedures with youth on the orientation checklist. A locked grievance box is located on a wall adjacent to the dining room. Grievance forms were not located next to the grievance box but were accessible to youth on each dorm wing.	
There is evidence that grievance boxes are checked by management or a designated supervisor at least daily as evidenced in the program logbook.	**Exception**	The CEO, shelter manager, and Intake and Compliance Specialist are the only staff with access to the grievance box. Per interview with the shelter manager, the grievance box is checked on a regular basis; however, there is no written evidence of grievance box checks in the logbook as required.	There is no evidence to support grievance box is checked Monday-Friday as required as the checks are not noted anywhere during the review period.

All grievances are resolved within 72 hours and documented by program director/supervisor or escalated to higher leadership if grievance involves them directly.	**Compliance**	Eight grievances reported by youth during the review period were reviewed. All of the grievances were responded to within 72 hours. All were resolved at either the informal level or supervisory level with the youth. The supervisor also followed up with program staff when necessary to address the issue completely.	
1.03: Incident Reporting			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 1.03		**YES** If NO, explain here: The provider has the required policy and procedures, 1.03-1 Incident Reporting and Risk Management Reporting, approved December 27, 2023 by the ED.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Staff Position(s) Interviewed (No Staff Names): Program Support Services Coordinator, Shelter Director **Type of Documentation(s) Reviewed: DJJ CCC reports, Boys town CCC Reports and BT database report printouts of incidents** **Describe any Observations: CCC number posted in facility**			
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	**Exception**	Of the 11 CCC calls made in the past 6 months, 10 were called in within the 2 hours required.	One CCC incident was called in late over the 2 hours required.
The program completes follow-up communication tasks/special instructions as required by the CCC	**Compliance**	The DJJ CCC reports confirm the follow-up of the agency when additional information or tasks were requested.	
Agency internal incidents are documented on incident reporting forms and all CCC reportable incidents were consistently reported to CCC as required.	**Compliance**	Incidents are logged in the BT National Database (electronic format) which allows to staff and leadership to pull reports using various filters; on an incident excel sheet; and in the CCC Binder.	
Incidents are documented in the program logs and on incident reporting forms	**Compliance**	The agency uses an electronic log (National Database) for CCC incidents recording.	
All incident reports are reviewed and signed by program supervisors/ directors	**Exception**	There were 11 incidents for the last 6 months and eight have evidence of being reviewed and signed by Supervisor/Director.	Of the 11 CCC incident reports, three do not have signatures indicating they were reviewed by a Supervisor/Director.
1.04: Training Requirements (*Staff receives training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions*)			**Limited**
Provider has a written policy and procedure that meets the requirement for Indicator 1.04		**YES** If NO, explain here: The provider has the required policy and procedures, 1.04-1 Training Requirements, approved 12/27/2023 by the ED.	

Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of New Hire Staff Files: 4 **Total number of Annual In-Service Staff Files: 4** **Annual Training Plan Timeframe** (*Program timeframe for annual trainings*)**: The program follows the calendar year for trainings.** **Staff Position(s) Interviewed** *(No Staff Names)* **: Program Support Services Coordinator (PSSC)** **Type of Documentation(s) Reviewed: Training files/electronic records**			
First Year Direct Care Staff			
All direct care staff have completed new hire pre-service training requirements for safety and supervision as required.	**Compliance**	Of the 4 new hire staff, one of the four files completed all pre-service training requirements. Three of the four files had one or more trainings that were completed outside the 90 day time frame required but none of the staff worked independently on any shift.	
All staff completed the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days from date of hire.	**Exception**	Three of the four new hired staff completed the DOJ Civil Rights and Federal Funds training within the 30 days required from hire.	One of the four new hired staff did not complete DOJ Civil Rights and Federal Funds within the required time frame from hire.
All direct care CINS/FINS staff (full time, part time, or on-call) demonstrated a minimum of 80 hours of training or more for the first full year of employment.	**Compliance**	All four new hired staff completed the required 80 hours of required training during the first year of employment.	
All staff receives all mandatory training during the first 90 days of employment from date of hire.	**Exception**	Of the four new hire, no staff received all mandatory training during the first 90 days from the date of hire. One staff completed five trainings outside the 90 day time frame, and the other three new hire staff had one to four trainings outside of the required time frame.	The four new hire staff training records reviewed showed none of the four completed all mandatory training during the first 90 days of hire. Staff #1 (DOH 5/1/2023) was late completing six trainings: CPR/First Aid, medication distribution, and SkillPro child abuse, trauma response, and suicide prevention training. Staff #2 (DOH 5/15/2023) was late completing four trainings: CINS/FINS core, Florida Network suicide prevention, universal precaution, and medication distribution. Staff #3 (DOH 7/31/2023) was late completing two trainings; medication distribution and Pyxis. Staff #4 (DOH 8/9/23) did not complete the Florida Network Suicide Prevention training.
Staff Required to Complete Data Entry for NIRVANA or access the Florida Department of Juvenile Justice Information System (JJIS)			
Any designated staff that is responsible for entering NIRVANA or ensuring accurate and complete data entry in the Florida Department of Juvenile Justice Information System (JJIS) have completed all of the required trainings.	**Compliance**	The one applicable new hire was trained in NIRVANA prior to administration and data entry of the tool.	

Documentation of instructor led FL Statute 984 CINS Petition Training by a local DJJ Attorney. *Effective for staff hired after 7/1/23*	**No eligible items for review**	One applicable staff has time to complete the required training by June of 2024.	
Non-licensed Mental Health Clinical Shelter Staff (within first year of employment)			
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).	**No eligible items for review**	The program has not hired any new non-licensed mental health clinical staff person during the review period.	
In-Service Direct Care Staff			
Direct care staff completes 24 hours of mandatory refresher Florida Network, SkillPro, and job-related training annually *(40 hours if the program has a DCF child caring license).*	**Exception**	Of the four annual staff training records reviewed, one had the required 40 hours of training with the other three having hours ranging from 28-33 hours. It also appears all four did not complete the required annual Florida Network Suicide Prevention training.	Three of the four in-service staff did not complete the required 40 annual hours of training. It also appears all four did not complete the required annual Florida Network Suicide Prevention training.
Required Training Documentation			
The agency has a training plan that includes all of the required training topics including the pre-service and in-service.	**Compliance**	The program has a training plan that lists all of the required training topics required for both pre-service and in-service.	
The agency has a designated staff member responsible to manage all employee's individual training files and completes routine tracking and reviews of staff files to ensure compliance.	**Exception**	It is the responsibility of the employee to make sure they meet their annual training requirements. The Program Support Services Coordinator (PSSC) monitors overall compliance and would inform supervisors and employees of upcoming required trainings via the Mandatory Tracking System via email; however, the agency is in the process of transitioning to a National Online tracking system for all training. Throughout the transitioning process, notifications have been delayed or not been sent out to staff with trainings that are coming due.	Currently, there isn't an effective system in place to monitor and communicate individual training compliance while transitioning over to the national online tracking system.
The program maintains an individual training file or employee file AND a FLN Training Log (or similar document that includes all requirements) for each staff, which includes an annual employee training hours tracking form and related documentation, such as electronic record/transcript, training certificates, sign-in sheets, and agendas for each training attended.	**Compliance**	The program maintains electronic training records and each staff has an online training file that includes the trainings and hours, uploaded certificates, sign-in sheets and/or verification of the training via a training transcript.	
Additional Comments: **There are no additional comments for this indicator.**			

1.05 - Analyzing and Reporting Information			Satisfactory with Exception
Provider has a written policy and procedure that meets the requirement for Indicator 1.05		**YES** If NO, explain here: The provider has the required policy and procedure, 1.05-1 Data Collection (approved 12/26/23) as well as Boys Town CINS/FINS Quality Assurance Plan -CFL (revision 14), approved by the ED.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Staff Position(s) Interviewed *(No Staff Names)* **: Program Support Services Coordinator (PSSC)** **Type of Documentation(s) Reviewed: Quality Assurance Plan, peer record reviews, FY 2023 Balanced Scoreboard, quarterly utilization reports, behavioral index report, critical success factors, QMC meeting minutes, board of director meeting minutes, program committee/staff meeting agendas/minutes, and End of month (EOM) NetMIS data reports and emails.**			
Case record review reports demonstrate reviews are conducted quarterly, at a minimum	**Compliance**	Youth and Family Records Review and Service Review committee conducts peer record reviews for the residential and community counseling CINS/FINS programs separately on a quarterly basis and documented on a youth record review tool. Peer record reviews were conducted for residential and community counseling case record reviews for the 2nd (April-July) and 3rd quarter (August-October) of 2023. The 4th quarter was also completed but not yet compiled on the report tool.	
The program conducts reviews of incidents, accidents, and grievances quarterly, at a minimum	**Exception**	Incidents and accidents are entered into the national database and are reviewed daily by Program Audit and Quality and Sr. Program Director. The Senior Program Director discusses incidents with program leaders during meetings. A behavioral index report provided during the audit shows the program monitors trends monthly related to behavioral issues such as lethality, aggression, sexual, avoidance, school, problem behaviors, and substance abuse. Per PSSC, grievances are discussed in program meetings; however, no evidence was provided to support the program conducts reviews of incidents, accidents, and grievances quarterly.	There is no evidence to support the program conducts a review of incidents, accidents, and grievances on a quarterly basis to identify trends and implement corrective actions based on negative findings.
The program conducts an annual review of customer satisfaction data	**Compliance**	Consumer Satisfaction Surveys are completed a variety of ways: directly by CINS/FINS youth upon discharge; coordinated by the Compliance Specialist once per month with active youth in the residential programs; and by the Home Campus in Nebraska. Survey results are compiled monthly for the shelter and non-residential clients separately. Areas of concerns are identified and followed up with the program managers. Evidence of discussion of the 2022 annual survey results at the 2/27/2023 QMC meetings is documented.	

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.	**Compliance**	Outcomes data for the program is monitored in a variety of ways and were observed to be included on the agency's monthly Scorecard, quarterly utilization reports, and monthly review of critical success factors. Program outcomes are included on the monthly Quality Management Committee (QMC) meeting agenda and are discussed accordingly. A copy of the 2023 Balanced Scorecard was reviewed that addresses specific areas, comparing current results with actual planned/expected and change in outcome as compared to the prior two years.	
The program has a process in place to review and improve accuracy of data entry & collection	**Compliance**	End of month (EOM) NetMIS data is reviewed on a monthly basis by the program directors who correspond mainly via email to communicate areas of performance met/ deficient. Email documentation and EOM reports were reviewed demonstrating a process is in place. Discrepancies and deficiencies are communicated verbally to the program directors during QMC and CINS meetings.	
There is documentation that findings are regularly reviewed by management and communicated to staff and stakeholders.	**Compliance**	Evidence was provided to support findings are communicated regularly at various program and committee meetings including Quality Management Committee, Safety and Health Committee, and Program Support meetings. Program monthly staff meeting minutes supported review of findings from aggregated data being discussed with detailed action plans of any needed areas of improvements or changes needed from analysis.	
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.	**Compliance**	All internal and external audits are reviewed quarterly during the Board of Directors meetings. Documentation of board meeting minutes show audit/compliance is discussed at each meeting to address contracts that were reviewed and overall performance.	
There is evidence that strengths and weaknesses are identified, improvements are implemented or modified, and staff are informed and involved throughout the process.	**Compliance**	QMC meetings were conducted quarterly during the review period at which time data trends are reviewed and plans for improvement are developed with program directors. Strengths and weaknesses are identified, improvements are implemented or modified, and staff are informed and involved throughout the process.	
Additional Comments: **There are no additional comments for this indicator.**			
1.06: Client Transportation			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 1.06		**YES** If NO, explain here: The provider has the required policy and procedures, 1.06-1 Vehicle Maintenance, Use and Transportation of Youth that was approved 12/27/23 by the ED.	

Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*

Dates or Timeframe Reviewed: July-December 2023
Staff Position(s) Interviewed *(No Staff Names)* **: Shelter Manager**
Type of Documentation(s) Reviewed: Van transportation logs
Describe any Observations: 125 single transport entries were observed

Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	**Compliance**	Boys Town has approved agency drivers to drive in agency or approved private vehicle. Approved drivers are verified by human resources to have valid driver's license.	
Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	**Compliance**	All agency drivers were documented with proof of valid drivers' licenses that were presented, supporting they met the agency's criteria of having a valid Florida's drivers license. Approved drivers are covered under the agency's auto insurance coverage held with Philadelphia Indemnity Insurance Company effective through 10/1/2024.	
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	**Compliance**	The agency has a transportation policy that outlines transportation of clients and the preferred transportation with adequate coverage. The policy also indicate procedures when a 3rd party is not present in the vehicle, including approval and documentation.	
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	**Compliance**	The program supervisor notes approval in the event that a 3rd party cannot be obtained for transport, taking into consideration the client's history, evaluation and recent behavior. Notation is made on the transportation log.	
The 3rd party is an approved volunteer, intern, agency staff, or other youth	**Compliance**	In the event a 3rd party is used, the 3rd party was observed to be documented on the transportation log as an agency staff or other youth.	
The agency demonstrated evidence via logbook or other written verification that supervisor approval was obtained prior to all single youth transports.	**Exception**	The program conducted 125 single transports during the review period. Evidence of supervisor's approval was documented on the transportation log prior to transport for 121 transportation events.	There were four of the 125 single transports that did not have supervisory approval prior to transport on the following dates: 9/22/2023, 12/1/2023, 1/8/2024, 1/9/2024.
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.	**Compliance**	The agency has two vans that have two separate transportation logs. Each log notes the names/ initials of the driver and 2nd party, the date & time of the trip, mileage, number of passengers and purpose of travel along with the destination.	

Additional Comments: **There are no additional comments for this indicator.**

1.07 - Outreach Services			Limited
Provider has a written policy and procedure that meets the requirement for Indicator 1.07		**YES** If NO, explain here: The provider has the required policy and procedures, 1.07-1 Interagency Agreements and Outreach Services, approved 12/27/23 by the ED.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Staff Position(s) Interviewed *(No Staff Names)* **: In Home Services Program Supervisor; Program Support Services Coordinator** **Type of Documentation(s) Reviewed: Netmis log of Outreach Activities, Notice of Upcoming Event; Email between Executive Director and Chief JPO for the Circuit and over 40 Interagency Agreements/ Memorandums of Understanding** **Describe any Observations: Electronic communications observed**			
The program has a lead staff member designated to participate in local DJJ board, Circuit and Council meetings with evidence that includes minutes of the event or other verification of staff participation.	**Exception**	The program has not attended any Circuit Advisory Board meetings in the last year. Program representative has participated in the Seminole County Alliance meeting and Children's Cabinet meeting which includes Chief DJJ. Just recently the Executive Director has had communication with the Chief Probation Officer from the Circuit inquiring about date/ times/ location of DJJ Circuit Advisory Board (CAB) meetings to have a representative present moving forward. Per the DJJ CAB meeting website, the Circuit 18 advisory board met in January, April, July and October 2023 and January 25, 2024.	There is no evidence program staff attended any Circuit Advisory Board meetings held between July 2023 and January 25, 2024.
The program maintains written agreements with other community partners which include services provided and a comprehensive referral process.	**Compliance**	The program maintains over 40 Interagency Agreements/ MOU with community partners which include services provided and a comprehensive referral process.	
The program will maintain documentation of outreach activities and enter into NetMIS the title, date, duration (hours), zip code, location description, estimated number of people reached, modality, target audience and topic.	**Compliance**	The program maintained documentation of a variety of outreach activities that the agency participated in, through emails and flyers. These activities were entered into NetMIS with the title, date, duration, zip code, location description, estimated number of people reached, the modality, target audience and topic.	
The program has designated staff that conducts outreach which is defined in their job description.	**Compliance**	Staff responsible for conducting outreach are listed on the outreach log, including the program managers and counseling staff.	
Additional Comments: **There are no additional comments for this indicator.**			

2.01 - Screening and Intake			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 2.01		**YES** If NO, explain here: The provider has the required policy and procedures, 2.01 Screening and Intake approved 12/27/2023 by the ED.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open (Residential & Community) Files: 3 **Total number of Closed (Residential & Community) Files: 7** **Staff Position(s) Interviewed** *(No Staff Names)* **: Community Counseling staff** **Type of Documentation(s) Reviewed: Case files/youth records**			
Shelter youth: Eligibility screening is completed immediately for all shelter placement inquiries.	**Compliance**	All five residential files reviewed demonstrated eligibility screening is completed immediately for all shelter placement inquiries.	
Community counseling: Eligibility screening is completed within 3 business days of referral by a trained staff using the Florida Network screening form.	**Compliance**	All five community counseling files reviewed demonstrated eligibility screening is completed within three business days of referral by a trained staff using the Florida Network screening form.	
There is evidence all referrals for service is screened for eligibility and is logged in NetMIS within 72 hours of screening completion.	**Compliance**	All ten records reviewed demonstrated evidence all referrals for service is screened for eligibility and is logged in NetMIS within 72 hours of screening completion.	
Youth and parents/guardians receive the following in writing: a. Available service options b. Rights and responsibilities of youth and parents/guardians	**Compliance**	All ten files reviewed demonstrated youth and parents/guardians receive the available service options and rights and responsibilities of youth and parents/guardians in writing during intake.	
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	**Compliance**	All ten files demonstrated the program provided the CINS/FINS parent brochure and grievance procedures during intake. An acknowledgement of review of this information is included in each youth record.	
During intake, all youth were screened for suicidality and assessed as required if needed.	**Compliance**	During intake, all youth were screened for suicide risk and assessed as required if needed.	
Additional Comments: **There are no additional comments for this indicator.**			

2.02 - Needs Assessment			Satisfactory with Exception
Provider has a written policy and procedure that meets the requirement for Indicator 2.02		**YES**	
		If NO, explain here:	
		The provider has the required policy and procedures, 2.02 Needs Assessment, approved 12/27/2023 by the ED.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open (Residential & Community) Files: 3 **Total number of Closed (Residential & Community) Files: 7** **Type of Documentation(s) Reviewed: Case files**			
Shelter Youth: NIRVANA is initiated within 72 hours of admission	**Compliance**	All five residential youth had a NIRVANA initiated within 72 hours of admission.	
Non-Residential youth: NIRVANA is initiated at intake and completed within 2 to 3 face-to-face contacts after the initial intake **OR** updated, if most recent assessment is over 6 months old	**Exception**	Four of the community counseling youth had NIRVANA assessments initiated and completed timely.	One case file had a late NIRVANA assessment completed one month after intake.
Supervisor signatures is documented for all completed NIRVANA assessments and/or the chronological note and/or interview guide that is located in the youths' file.	**Exception**	Nine of the files observed had supervisor signatures on the NIRVANA assessments.	One case file had a supervisor's signature missing from the NIRVANA assessment.
(Shelter Only) NIRVANA Self-Assessment (NSR) is completed within 24 hours of youth being admitted into shelter. If unable to complete, there must be documentation in NetMIS and the youth's file explaining the barriers to completion.	**Compliance**	All five residential files reviewed demonstrated NIRVANA Self-Assessment was completed within 24 hours of youth being admitted into shelter.	
A NIRVANA Post-Assessment is completed at discharge for all youth who have a length of stay that is greater than 30 days.	**Compliance**	Five applicable files reviewed demonstrated a NIRVANA Post-Assessment was completed at discharge.	
A NIRVANA Re-Assessment is completed every 90 days excluding files for youth receiving SNAP services.	**Compliance**	NIRVANA re-assessment was completed in one applicable file.	
All files include the interview guide and/or printed NIRVANA.	**Compliance**	All ten files reviewed included a printed NIRVANA.	
Additional Comments: **There are no additional comments for this indicator.**			

2.03 - Case/Service Plan			Satisfactory with Exception
Provider has a written policy and procedure that meets the requirement for Indicator 2.03		**YES** If NO, explain here: The provider has the required policy and procedures, 2.03 Case Plan, approved by the ED on 12/27/2023.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open (Residential & Community) Files: 3 **Total number of Closed (Residential & Community) Files: 7** **Staff Position(s) Interviewed** *(No Staff Names)* **: Community Counseling Staff** **Type of Documentation(s) Reviewed: Case files**			
The case/service plan is developed on a local provider-approved form or through NETMIS and is based on information gathered during the initial screening, intake, and NIRVANA.	**Compliance**	All case plans were developed on a local provider approved form and are based on information gathered during the initial screening, intake, and NIRVANA.	
Case/Service plan is developed within 7 working days of NIRVANA	**Compliance**	Nine of the files observed had a case plan developed within 7 working days of NIRVANA. One of the community counseling files with intake 9/22/2023 had the case plan developed 10/06/2023, prior to completion of the NIRVANA.	
Case plan/service plan includes: 1. Individualized and prioritized need(s) and goal(s) identified by the NIRVANA 2. Service type, frequency, location 3. Person(s) responsible 4. Target date(s) for completion and Actual completion date(s) 5. Signature of youth, parent/ guardian, counselor, and supervisor 6. Date the plan was initiated	**Exception**	Eight of the files observed had a case plan that included individualized and prioritized need(s) and goal(s) identified by the NIRVANA, service type, frequency, location, person(s) responsible, target date(s) for completion, signatures of youth, parent/guardian, counselor, and supervisor, and date the plan was initiated.	One case plan is missing signature of parent/guardian, youth, and counselor. A second case plan is missing signature of parent/guardian. None of the case plans observed had completion dates indicated on the plans.
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	**Compliance**	Three applicable Case/ Service plans were reviewed for progress and revised by counselor and parent every 30 days for the first three months.	
Additional Comments: **There are no additional comments for this indicator.**			

2.04 - Case Management and Service Delivery			Satisfactory with Exception
Provider has a written policy and procedure that meets the requirement for Indicator 2.04		**YES** If NO, explain here: The provider has the required policy and procedures, 2.04 Case Management and Delivery Services, approved by the ED on 12/27/2023.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open (Residential & Community) Files: 3 **Total number of Closed (Residential & Community) Files: 7** **Staff Position(s) Interviewed** *(No Staff Names)* **: Program Support Services Coordinator, Administrative Assistant, community counseling staff** **Type of Documentation(s) Reviewed: Case files**			
Counselor/Case Manager is assigned	**Compliance**	Counselor/case manager is assigned to each case reviewed.	
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. Monitoring of progress for court ordered youth in shelter 6. Makes referrals to the case staffing to address problems and needs of the youth/family 7. Accompanies youth and parent/guardian to court hearings and related appointments 8. Refers the youth/family for additional services when appropriate 9. Provides case monitoring and reviews court orders 10. Provides case termination notes 11. Provides follow-up after 30 days of exit 12. Provides follow-up after 60 days of exit	**Exception**	The Counselor/Case Manager completes the following as applicable: Establishes referral needs and coordinates referrals to services based upon the on-going assessment of the youth's/family's problems and needs; coordinates service plan implementation; monitors youth's/family's progress in services; provides support for families; monitoring of progress for court ordered youth in shelter; refers the youth/family for additional services when appropriate; provides case monitoring and reviews court orders; provides case termination notes; provides follow-up after 30 days of exit for four observed youth; and provides follow-up after 60 days of exit for three observed youth.	One youth was missing a 30 and 60 day follow up. A second youth was missing a 60 day follow up.
The program maintains written agreements with other community partners that include services provided and a comprehensive referral process	**Compliance**	Program maintains written agreements with community partners including services provided.	
Additional Comments: **There are no additional comments for this indicator.**			

2.05 - Counseling Services			Limited
Provider has a written policy and procedure that meets the requirement for Indicator 2.05		**YES** If NO, explain here: The provider has the required policy and procedures, 2.05 Counseling Services, approved by the ED on 12/27/2023.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open (Residential & Community) Files: 3 **Total number of Closed (Residential & Community) Files: 7** **Staff Position(s) Interviewed** *(No Staff Names)* **: Program Support Services Coordinator** **Type of Documentation(s) Reviewed: Case files**			
Shelter Program			
Shelter programs provides individual and family counseling	**Compliance**	Program provides individual and family counseling.	
Group counseling sessions held a minimum of five days per week	**Compliance**	The program conducts group sessions five times per week and maintains documentation of the groups.	
Groups are conducted by staff, youth, or guests and group counseling sessions consist of : 1. A clear leader or facilitator 2.Relevant topic - educational/informational or developmental 3. Opportunity for youth to participate 4. 30 minutes or longer	**Compliance**	Groups are conducted by staff with youth attending. Groups have a clear facilitator, relevant topics, opportunities for youth to participate, and are 30 minutes long.	
Documentation of groups must include date and time, a list of participants, length of time, and topic.	**Compliance**	Documentation of groups include date, time, participates, length of time, and topics.	
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.	**Compliance**	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.	
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	**Compliance**	All of the files reviewed reflected coordination between presenting problem(s), psychosocial assessment, case/service plans, case/service plan reviews, case management, and follow-up when applicable.	

Maintain individual case files on all youth and adhere to all laws regarding confidentiality	**Compliance**	All of the youth records were maintained in individual case files with adherence to all laws regarding confidentiality	
Case notes maintained for all counseling services provided and documents youth's progress	**Exception**	All non-residential clients had case notes; however, there are no individual chronological case notes being documented for meetings with the residential clients. There are monthly progress notes on the case plans but no notes to document services provided to the youth. All five residential files chronological notes pages did not have notes.	Case notes are not being maintained for counseling and/or other services provided to the residential youth. The program has a page in the file for chronological notes but none of the forms were completed in any of the five youth records reviewed.
On-going internal process that ensures clinical reviews of case records and staff performance	**Compliance**	Programs completes reviews of employees and does scheduled quarterly reviews of 20% of the opened files during that quarter.	
Additional Comments: **There are no additional comments for this indicator.**			
2.06 - Adjudication/Petition Process			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.06		**YES** If NO, explain here: The provider has the required policy and procedures, 2.06 Adjudication/Petition Process, approved 12/27/2023 by ED.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open (Residential & Community) Files: 0 **Total number of Closed (Residential & Community) Files: 0** **Staff Position(s) Interviewed** *(No Staff Names)* **: Program Support Services Coordinator** **Type of Documentation(s) Reviewed: Policy and Procedure Manual**			
Must include: a. DJJ rep. or CINS/FINS provider b. Local school district representative	**Compliance**	Per interview with the PSSC, there were no adjudication/petitions filed or case staffing held during the review period. The agency's policy and procedure was reviewed to determine compliance. If requested, at a minimum, the program's case staffing committee is comprised of a DJJ representative or CINS/FINS provider and a local school district representative.	
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	**Compliance**	Per the program's policy and procedure, other members of the committee may include: State Attorney's Office; others requested by youth/ family; substance abuse representative; law enforcement representative; DCF representative; and mental health representative.	

The program has an established case staffing committee, and has regular communication with committee members	**Compliance**	There were no families to schedule for case staffing during the review period. A monthly board room at Seminole County Public School is pre-scheduled for potential cases. The Case Staffing committee is contacted for any requests.	
The program has an internal procedure for the case staffing process, including a schedule for committee meetings	**Compliance**	Program has an internal procedure in their policy and procedure manual for the case staffing process.	
The youth and family are provided a new or revised plan for services	**No eligible items for review**	No case staffings were held since the last QI review.	
Written report is provided to the parent/guardian within 7 days of the case staffing meeting, outlining recommendations and reasons behind the recommendations	**No eligible items for review**	No case staffings were held since the last QI review.	
If applicable, the program works with the circuit court for judicial intervention for the youth/family	**No eligible items for review**	No case staffings were held since the last QI review.	
Case Manager/Counselor completes a review summary prior to the court hearing	**No eligible items for review**	No case staffings were held since the last QI review.	
Additional Comments: **There are no additional comments for this indicator.**			
2.07 - Youth Records			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.07		**YES** If NO, explain here: The provider has the required policy and procedures, 2.07 Youth Records, approved 12/27/2023 by Executive Director	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Staff Position(s) Interviewed *(No Staff Names)* **: Program Support Services Coordinator.** **Type of Documentation(s) Reviewed: Case files, file cabinet, transportation container.** **Describe any Observations: Case files, transportation container, and file cabinet were labeled confidential, opaque, and secured.**			
All records are clearly marked 'confidential'.	**Compliance**	All records reviewed were clearly marked "confidential".	
All records are kept in a secure room or locked in a file cabinet that is marked "confidential"	**Compliance**	All records are kept in a secure room and locked in a file cabinet.	
When in transport, all records are locked in an opaque container marked "confidential"	**Compliance**	While in transport, all records are locked in an opaque container marked "confidential".	
All records are maintained in a neat and orderly manner so that staff can quickly and easily access information	**Compliance**	All records are maintained in a neat and orderly manner with file sections and cover sheets so staff can easily access information.	
Additional Comments: **There are no additional comments for this indicator.**			

2.08 - Specialized Additional Program Services			Satisfactory with Exception
Provider has a written policy and procedure that meets the requirement for Indicator 2.08		**YES** If NO, explain here: The provider has the required policy and procedures, 2.08-1 Staff Secure and Special Populations, approved 12/26/2023 by the ED.	
Staff Secure			
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Staff Position(s) Interviewed (No Staff Names): PSSC			
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 eligible items for review**	Boys Town has not served any youth who meet the criteria for Staff Secure services 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	**No eligible items for review**		
Program only accept youth that meet legal requirements of F.S. 984 for being formally court ordered in to Staff Secure Services	**No eligible items for review**		
Staff Assigned: a. One staff secure bed and assigned staff supervision to one staff secure youth at any given time b. Program assign specific staff during each shift to monitor location/ movement of staff secure youth c. Agency clearly documents the specific staff person assigned to the staff secure youth in the logbook or any other means on each shift	**No eligible items for review**		
Agency provides a written report for any court proceedings regarding the youth's progress	**No eligible items for review**		
Domestic Minor Sex Trafficking (DMST)			
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Staff Position(s) Interviewed (No Staff Names): PSSC			
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 eligible items for review**	Boys Town has not served any youth who meet the criteria for Domestic Minor Sex Trafficking (DMST) services since the last QI review.	

Agency has evidence that the FNYFS was contacted for approval prior to admission for all Domestic Minor Sex Trafficking (DMST) placements.	**No eligible items for 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.	**No eligible items for review**		
Services provided to these youth specifically designated services designed to serve DMST youth	**No eligible items for 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?	**No eligible items for review**		
Length of Stay: a. Youth in program do not have length of stay in DMST placement that exceeds seven (7) days b. Agency has approval for stays and support beyond seven (7) days for DMST placements that are obtained on a case-by-case basis? (If applicable.)	**No eligible items for review**		
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	**No eligible items for review**		
All other services provided to DMST youth are consistent with all other general CINS/FINS program requirements	**No eligible items for review**		
Domestic Violence			
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: 1 open DV Respite file **Total number of Closed Files: 2 closed DV Respite files** **Type of Documentation(s) Reviewed: Case files**			
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**	A total of three residential DV youth records were reviewed, two closed and one open.	
Youth admitted to DV Respite placement have evidence in the file of a pending DV charge	**Compliance**	All three records reviewed have face sheets in their files with documentation to show the three youth have pending DV charge and were referred to the shelter for DV respite.	
Data entry into NetMIS within (3) business days of intake and discharge	**Exception**	Two youth records were reviewed in NetMIS and data entry was verified to be completed within three business days of intake and discharge.	Discharge data entry for one DV youth exceeded three business days discharge was 9/28 and data entry in NetMIS is 10/5/23.

Youth length of stay in DV Respite placement does not exceed 21 days. If more than 21 days, documentation exists in youth file of transition to CINS/FINS or Probation Respite placement, if applicable.	**Exception**	One of the three youth had a placement in DV Respite for less than 21 days.	Two DV youth were transferred to CINS/FINS. Although the dates were noted on the file folder, there was no documentation in the file of transition to CINS/FINS.
Case plan in file reflects goals for aggression management, family coping skills, or other intervention designed to reduce propensity for violence in the home	**Compliance**	The case plans for all three youth reflected goals for anger management and family coping skills.	
All other services provided to Domestic Violence Respite youth are consistent with all other general CINS/FINS program requirements	**Compliance**	All three files reviewed demonstrated youth participated in services consistent with other general CINS/FINS population while in care.	
Probation Respite			
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: 0 **Total number of Closed Files: 3 closed probation respite files** **Type of Documentation(s) Reviewed: Case files**			
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**	A total of three closed residential probation respite youth records were reviewed.	
All probation respite referrals are submitted to the Florida Network.	**Compliance**	All three files reviewed contained an email showing approval was granted by the Florida Network.	
All Probation Respite Referral come from DJJ Probation and there is evidence that the youth is on Probation regardless of adjudication status.	**Compliance**	All three records reviewed have face sheets in their files or email from the probation officer showing referral of youth.	
Data entry into NetMIS and JJIS within (3) business days of intake and discharge	**Compliance**	All three youth records were reviewed in NetMIS and data entry was verified to be completed within three business days of intake and discharge.	
Length of stay is no more than fourteen (14) to thirty (30) days. Any placement beyond thirty (30) days contains evidence in the file that the JPO was contacted in writing to request the need of an extension no later than the 25th day the youth was admitted into the program.	**Exception**	Two of the three youth had a placement in probation respite for less than 30 days.	One Probation Respite youth exceeded 30 days in program; approval from CPO was not included in the youth's record.
All case management and counseling needs have been considered and addressed	**Compliance**	The case plans for all three youth reflected appropriate goals and counseling services were provided to address the needs of the youth/family.	
All other services provided to Probation Respite youth are consistent with all other general CINS/FINS program requirements	**Compliance**	All three files reviewed demonstrated youth participated in services consistent with other general CINS/FINS population while in care.	

Intensive Case Management (ICM)			
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Staff Position(s) Interviewed (No Staff Names): PSSC			
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")	**Not Applicable**	Boys Town does not have a contract to provide ICM services.	
Youth receiving services were deemed chronically truant and/or runaway and require more intensive and lengthy services. The youth was determined to be eligible because they have gone through petition and/or case staffing and was in need of case management services.	**Not Applicable**		
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.	**Not Applicable**		
Assessments include a. NIRVANA at intake b. NIRVANA Re-Assessment every 90 days c. Post NIRVANA at discharge as aligned with timeframe requirements	**Not Applicable**		
Service/case plan demonstrates a strength-based, trauma-informed focus	**Not Applicable**		
For any virtual services provided, there is written documentation in the youths' file as to why virtual contact is in the best interest of the youth and family	**Not Applicable**		
Family and Youth Respite Aftercare Services (FYRAC)			
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Staff Position(s) Interviewed (No Staff Names): PSSC			
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 eligible items for review**	The program has not served any youth who met the criteria for FYRAC in the last six months or since the last onsite QI review.	
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.	**No eligible items for review**		

Agency has evidence that all FYRAC referrals have documented approval from the Florida Network office	**No eligible items for review**		
Intake and initial assessment sessions meets the following criteria: a. Services shall be documented through the signature of the youth and his/her parent/guardian as well as orientation to the program which is kept in the youths file. b. The initial assessment shall be face-to-face, in person or through virtual means, to include a gathering of all family history and demographic information, as well as the development of the service plan. c. For youth on probation, a copy of the youths Community Assessment Tool (CAT) to assist with development of the family service plan.	**No eligible items for review**		
Life Management Sessions meets the following criteria: a. Sessions are face-to-face, sixty (60) minutes in length and focus on strengthening the family unit b. Services are highly supportive, individualized, and flexible and require a "whole family" approach to dealing with the problems affecting the youth and family.	**No eligible items for review**		
Individual Sessions: a. The program conducted sessions with the youth and family to focus on work to engage the parties and identify strengths and needs of each member that help to improve family functioning. b. Issues to be covered through each session include but are not limited to: Identifying emotional triggers; body cues; healthy coping strategies through individual, group and family counseling; understanding the cycle of violence and the physical and emotional symptoms of anger; developing safety plans; and educating families on the legal process and rights	**No eligible items for review**		
Group Sessions: a. Focus on the same issues as individual/family sessions with application to youth pulling on similar experiences with other group members with the overall goal of strengthening relationships and prevention of 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	**No eligible items for review**		
There is evidence of completed 30 and/or 60 day follow-ups and is documented in NetMIS following case discharge.	**No eligible items for review**		
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	**No eligible items for review**		

Any service that is offered virtually, is documented in the youth's file why it was in the youth and families best interest.	**No eligible items for review**		
All data entry in NetMIS is completed within 3 business days as required.	**No eligible items for review**		
Additional Comments: **There are no additional comments for this indicator.**			
2.09- Stop Now and Plan (SNAP)			**Not Applicable**
Provider has a written policy and procedure that meets the requirement for Indicator 2.09		**N/A** If NO, explain here: Boys Town is not contracted to provide SNAP services	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Staff Position(s) Interviewed (No Staff Names): PSSC			
SNAP Clinical Groups Under 12			
Youth are screened to determine eligibility of services.	**Not Applicable**	Boys Town is not contracted to provide SNAP services.	
The NIRVANA was completed at initial intake, or within two sessions.	**Not Applicable**		
There is evidence of the completed Child Behavior Checklist (CBCL) by the caregiver (pre and post) and is located within the file.	**Not Applicable**		
There is evidence of the completed Teacher Report Form (TRF) is completed by the teacher (pre and post) and is located within the file.	**Not Applicable**		
SNAP Clinical Groups Under 12 - Discharge			
There is evidence of the completed SNAP Discharge Report located within the file for any discharged youth.	**Not Applicable**		
There is evidence of the completed SNAP Discharge Report located within the file for any discharged youth.	**Not Applicable**		
There is evidence of the SNAP Boys/SNAP Girls Child Group Evaluation Form located in the file.	**Not Applicable**		
There is evidence of the SNAP Boys/SNAP Girls Parent Group Evaluation Form located in the file.	**Not Applicable**		
SNAP Clinical Groups for Youth 12-17			
Youth are screened to determine eligibility of services.	**Not Applicable**		
The Consent to Treatment and Participation in Research Form is completed and located within the file.	**Not Applicable**		
The NIRVANA was completed at initial intake, or within two sessions.	**Not Applicable**		
There is evidence of the completed 'How I Think Questionnaire' (HIT) form located within the file or evidence of at least three (3) documented attempts in the youths' file to obtain this information.	**Not Applicable**		

There is evidence of the completed Social Skills Improvement System (SSIS) Student form located within the file or evidence of at least three (3) documented attempts in the youths' file to obtain this information.	**Not Applicable**		
There is evidence of the completed Social Skills Improvement System (SSIS) Teacher/Adult form located within the file or evidence of at least three (3) documented attempts in the youths' file to obtain this information.	**Not Applicable**		
SNAP for Schools & Communities			
The program demonstrated all of the required weekly attendance sheets that included youth names and/or identifying numbers completed with the teacher and trained SNAP Facilitator signatures. (*This must include a total of 13 attendance sheets for a full cycle*)	**Not Applicable**		
The program maintained evidence of a completed "Class Goal" Document for the class reviewed.	**Not Applicable**		
The program maintained evidence of both pre AND post Measure of Classroom Environment (MoCE) completed documents for the class reviewed.	**Not Applicable**		
The program maintained evidence of completed pre and post evaluation documents for the class reviewed.	**Not Applicable**		
There is evidence of the fidelity adherence checklist maintained in the file for each class reviewed.	**Not Applicable**		
Additional Comments: **There are no additional comments for this indicator.**			
3.01 - Shelter Environment			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 3.01		**YES** If NO, explain here: The provider has multiple policies that cover the different aspects of this indicator: 3.01-1 Shelter Services; 3.02-3 Youth Hygiene; 3.01-5 Recreational and Cultural Enrichment Activities; 3.01-7 Fire and Emergency Drills; 3.01-14 Chemicals, Flammable, Poisonous, & Toxic Control; and 3.01-15 Fire Prevention Program. All of the policies were approved by the ED as of 12/26/23.	

Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*

Staff Position(s) Interviewed *(No Staff Names)* **: Program director, PSSC**
Type of Documentation(s) Reviewed: Weekly and perpetual chemical inventory, MSDS, Fire Drills, Emergency Drills, County Fire Inspection, Fire equipment inspection, Department of Health Inspections, activity and program schedule.
Describe any Observations: Tour of facility, postings, inspection of agency vehicle, chemical storage

Facility Inspection: a. Furnishings are in good repair. b. The program is free of insect infestation. c. Bathrooms and shower areas are clean and functional, free of foul odors, leaks, dust, and mildew and in good working order. d. There is no graffiti on walls, doors, or windows. e. Lighting is adequate for tasks performed there. f. Exterior areas are free of debris; grounds are free of hazards. g. Dumpster and garbage can(s) are covered. h. All doors are secure, in and out access is limited to staff members and key control is in compliance. i. Detailed map and egress plans of the facility, general client rules, grievance forms, abuse hotline information, DJJ Incident Reporting Number and other related notices are posted. j. Interior areas (bedrooms, bathrooms, common areas) do not contain contraband and are free from hazardous unauthorized metal/foreign objects.	**Compliance**	The furniture appears to be in good order, and most appear to be brand new. There is no evidence of an infest infestation on property. The bathrooms and showers were very clean and tidy. There is no evidence of graffiti in the building, as the shelter recently had a paint job completed. The lighting throughout the entire shelter is appropriate. There were no visible hazards around the shelter. There is one sidewalk near the administration building that is uneven - however it is properly labelled with warning paint. The dumpster and garbage cans are covered appropriately with lids. The facility requires badge entry and key entry to all areas of the shelter. There are facility maps located in multiple common areas of the shelter for viewing behind plexiglass to prevent damage, and the client rules and abuse hotline information, and DJJ incident reporting number are posted in each dorm on the wall as well. The grievance forms are located in each wing of the building. There was no noticed contraband or hazardous material in any of the dorm rooms, common areas or bathrooms.	
Facility Inspection: a. All agency and staff vehicles are locked. b. Agency vehicles are equipped with major safety equipment including first aid kit, (all items in the first aid kit are current and do not have expired items; all expired items should be replaced regularly), fire extinguisher, flashlight, glass breaker and, seat belt cutter.	**Compliance**	All vehicles checked during the tour were locked. The facility has two operational vehicles. There is a 2015 Ford Transit van which has a valid tag and title and has appropriate safety equipment and required keys to access. The vehicle is inspected by a supervisor monthly, and all repairs are sent to the maintenance shop. The second vehicle is a 2016 Nissan Van, which is currently in the shop as of 12/15/2023. The vehicle is inspected monthly. The vehicle is expected to return to the building tomorrow, to be able to be inspected.	

Facility Inspection: All chemicals are listed, approved for use, inventoried weekly and perpetually, stored securely and Material Safety Data Sheets (MSDS) are maintained on each item (minimum 1 time per week or per agency policy). A perpetual inventory will be the primary means of maintaining a current and real-time inventory. The weekly inventory will be conducted weekly at a minimum to ensure that a perpetual inventory is being maintained consistently and accurately. If more than one location is used to store chemicals, there is an inventory wherever chemicals are stored that is current and well maintained unless previously approved by the Network.	**Exception**	There are two locations that the chemicals are kept, next to the pantry in the kitchen (in its own utility closet), and in the staff office at the front of the building. The utility closet remains locked at all times, and the chemicals are kept organized with a specific spot that is labelled clearly. There is a matching MSDS sheet for all chemicals. The approved chemical list was minimized to the bare necessities, and they are only allowed to keep 2 of each chemical on hand at any time per their in house supervision. The program manager mostly maintains the weekly inventory, while the staff maintain the perpetual inventory. Both inventories are kept with their respective chemicals in the two locations they are kept. The secondary location of chemicals is in the main staff office. Generally the youth do not have access to the staff office as it requires badge access, however there are instances the staff allow the youth to enter for virtual appointments, etc. The staff office has a cabinet that is unsecured that has Lysol Disinfectant Spray, Febreze air freshener, Clorox disinfecting wipes and hand sanitizer.	Chemicals stored in staff office are inventoried; however, the room is sometimes accessed by youth and the storage cabinet is not secured with a lock.
Facility Inspection: Washer/dryer are operational & general area/lint collectors are clean. Agency has a current DCF Child Care License which is displayed in the facility. Each youth has own individual bed with clean covered mattress, pillow, sufficient linens and blanket. Youth have a safe, lockable place to keep personal belongings, if requested.	**Compliance**	The facility has two washer and dryer units, one for each gender wing. They were both in operation at the time of the audit. One lint trap was clean, the other lint trap was dirty only due to the drying finishing its load as the reviewer was checking. The current DCF license is hanging on the wall in the staff office at the front of the building. DCF license is issued by Department of Children and Families for 18 beds effective through 12/04/2024. Each bed was seen made up with linen and pillows. There were 12 youth in the facility at the time of the visit, and each youth has their own assigned bed. The youth are able to request a storage bin to keep their belongings safe; the bin is kept on a high shelf in the staff office which remains locked. Youth are occasionally in the staff office, however staff do not allow the youth to access the bins themselves.	
Additional Facility Inspection Narrative (if applicable)			

Fire and Safety Health Hazards: a. Annual facility fire inspection was conducted, and the facility is in compliance with local fire marshal and fire safety code within jurisdiction. b. Agency completes a minimum of 1 fire drill on each shift monthly (within 2 minutes or less). c. Completes 1 mock emergency drill per shift per quarter. d. All annual fire safety equipment inspections are valid and up to date (extinguishers, sprinklers, alarm system and kitchen overhead hood, including fire extinguishers in all vehicles).	**Exception**	The most recent annual fire inspection was completed on 12/12/2023. During the inspection three minor violations were found, however the facility was able to make amends prior to the departure of the inspector - allowing the facility to comply across the board. The facility has conducted fire drills for all shifts during the review period. The facility's monitoring system for fire drills was changed in October, and the new system format did not print in a way that allowed the reviewer to see the start and end time of the drill, preventing confirmation of all drills since October took less than 2 minutes to complete. A report from IT was provided that shows the duration of drills auto populated from time inputs. The times for the current reports revealed evacuation times less that 2 minutes. Five mock drills were completed for the last quarter of 2023; with assistance from IT to obtain drills that occurred prior to their system change in October, it was determined a quarterly mock drill is missing for the first shift in December. The last one was conducted in October. The sprinkler system was inspected on 12/5/2023, and was found to be operational and have no concerns. The fire extinguishers were inspected on 3/13/2023, all were found to be in compliance. The alarm system was inspected on 12/20/2023, and no issues were noted. There are no records at this time of the kitchen overhead hood being inspected, more information will be requested from the facility.	A quarterly mock drill is missing for the first shift in December. The last one was conducted in October.
Fire and Safety Health Hazards: a. Agency has a current Satisfactory Residential Group Care inspection report from the Department of Health. b. Agency has a current Satisfactory Food Service inspection report from the Department of Health and food menus are posted, current and signed by Licensed Dietician annually. c. All cold food is properly stored, marked and labeled and dry storage/pantry area is clean and food is properly stored. d. Refrigerators/Freezers are clean and maintained at required temperatures and all small and medium sized appliances are operable and clean for use as needed.	**Exception**	The most recent food service inspection occurred on 10/11/2023, and no violations were noted. The most recent menu was approved by a licensed dietician on 1/7/2024, and are posted in the kitchen. The refrigerator temperature was found to be 38 degrees Fahrenheit. One of the freezers (labeled 1) is 18 degrees Fahrenheit which is out of preferred temperature, and the second freezer had two different thermometers, one was -8, and the other -10 degrees Fahrenheit (which is in the preferred range).The fridges are clean and well organized.	One of the freezers (labeled 1) is 18 degrees Fahrenheit which is out of preferred temperature.
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. 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.	**Compliance**	There is a very clear activity schedule that is posted across the facility for youth, visitors and staff to refer to. The schedule is posted in both dorm rooms and in the dining area. The schedule covers vacation periods and school periods, and grants time for homework, religious activities, and educational groups.	
Additional Comments: **There are no additional comments for this indicator.**			
3.02 - Program Orientation			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 3.02		**YES** If NO, explain here: The provider has the required policy and procedures titled Program Orientation (there is no listed policy number), that was approved 12/27/2023 by the ED.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: 1 open file **Total number of Closed Files: 2 closed files** **Type of Documentation(s) Reviewed: Orientation checklist and Fire Drill and Emergency Evacuation Procedure/Personal Articles/Orientation Procedures**			
Youth received a comprehensive orientation and handbook provided within 24 hours	**Compliance**	All three youth files have a checklist indicating the youth received a comprehensive orientation within 24 hours.	
Orientation includes the following: a. Youth is given a list of contraband items b. Disciplinary action is explained c. Dress code explained 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	**Compliance**	All files have a checklist with the youth's signature indicating the youth received a comprehensive orientation explaining the disciplinary action, program rules, grievance procedure and emergency procedures, the contraband policy, suicide prevention, tour, room assignment and how to contact the abuse hotline.	

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	**Compliance**	The youth in all files reviewed signed that all required items were discussed with them prior to the conclusion of their intake process.	
Additional Comments: **There are no additional comments for this indicator.**			
3.03 - Youth Room Assignment			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 3.03		**YES** If NO, explain here: The provider has multiple policies that cover the different aspects of this indicator: 3.02-2 Classification, last reviewed 12/17/2023 and 3.03-1 Classification, last reviewed 10/17/2023. The policies were approved 12/27/2023 by the ED.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: 1 open files **Total number of Closed Files: 2 closed files** **Staff Position(s) Interviewed** *(No Staff Names)* **: Program director** **Type of Documentation(s) Reviewed: Suicide Probability Scale, Screening Form, Alert Board**			
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. Acute health symptoms requiring quarantine or isolation	**Compliance**	The youth's initial interactions are documented thoroughly in the logbook, and the facility speaks with parents and other known community partners that referred the youth regarding the youths behaviors. Upon arrival to the facility a health screening and very detailed assessment is completed (Suicide Probability Scale) with the youth to help identify any special needs. The only people that can determine room assignment are supervisors or the program director to ensure all considerations are taken into place. All files show documentation of staff gathering information of the youth's history and exposure to trauma, age, and gender, history of violence, disability, physical size and gang affiliation. All files show documentation of the youth's sexual behavior, sexual orientation, suicide risk and if isolation is necessary.	

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	**Compliance**	All files show documentation of noted alerts, collateral contacts and the youth's initial interactions and observations.	
Additional Comments: **There are no additional comments for this indicator.**			
3.04 - Log Books			**Limited**
Provider has a written policy and procedure that meets the requirement for Indicator 3.04		**YES** If NO, explain here: The provider has the required policy and procedures, 3.04-1 Log Books, approved 12/27/2023 by the ED.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Dates or Timeframe Reviewed: Two weeks out of every month between July to January was reviewed in the boys and girls log book. **Staff Position(s) Interviewed** *(No Staff Names)* **:** **Type of Documentation(s) Reviewed:** **Describe any Observations:**			
Log book entries that could impact the security and safety of the youth and/or program are highlighted	**Compliance**	The staff highlighted every major incident that occurred in the shelter, including runaways, hospitalizations, sight and sounds, and physical altercations. The log book is very brief in summary of each incident, and does not include enough details to explain entirely what occurred.	
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	**Exception**	All entries are brief, legible, and include dates and times of incidences as well as all parties involved. The staff have initialed at the end of each entry throughout the six months reviewed.	Of the entries reviewed, there are multiple entries that are left without a time for the date of the incident, or does not have a signature or initial at the end. The Florida Network policy states that staff must sign their full name at the end of the entry, however, up until September 2023 the staff are only initialing.
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.	**Exception**	There was not a clear void procedure noted as each void entry observed was different.	The approved void procedure has not been followed - the correct format is a single line cross through, the word void next to it with the staff initials and date the cross through occurred. Some void entries have multiple cross through, some have void written across the word, and none of them reviewed have initials or dates.

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	**Exception**	There were very limited instances of the program director reviewing the logbook, and when they were found they did not include the dates of information being reviewed. Prior to the start of their newest supervisor, there was no other supervisory documentation showing that the log book was reviewed; however, starting in November there were daily reviews of the log book by the new supervisor. The supervisors reviews did not include the dates they were reviewing, however, he did leave detailed notes on corrections and recommendations for the staff to make. The supervisor also only initialed his entries.	Of the random weeks in the past six months reviewed, only one supervisory review was noted. It provided recommendations for log book entries, but did not contain a date range of what was reviewed.
All staff review the logbook of the previous two shifts and makes an entry signed and dated into the logbook indicating the dates reviewed	**Exception**	There is a male and female logbook for the shelter; however, only one staff on each shift documents that they reviewed the logbook up to their last shift worked. The staff review entries did not start containing dates of review until September 2023. All prior entries had no dates. There is not a clear format being used for the reviewing of the prior entries.	All staff on shift are not signing both log books showing a review occurred in both logbooks, including dates reviewed up to their last shift worked.
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.	**Exception**	Of the months reviewed, only one supervisory review was noted. It provided recommendations for log book entries, but did not contain a date range of what was reviewed.	There is no documentation that the program manager/supervisor or counselors are reviewing the logbook at the beginning of their shifts. Starting in November with the promotion of the facilities new supervisor, it is seen that they were reviewing each shift; however, prior to that the facility supervisors were not documenting daily logbook reviews.
Logbook entries include: a. Supervision and resident counts b. Visitation and home visits	**Compliance**	The logbook documents headcounts every 30 minutes on the shift, and clearly labels when youth are off property.	
Additional Comments: **There are no additional comments for this indicator.**			
3.05 - Behavior Management Strategies			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 3.05		**YES** If NO, explain here: The provider has the required policy and procedures, 3.05-1 Behavioral Redirection and Safety Holds, approved 12/27/2023 by the ED.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Staff Position(s) Interviewed *(No Staff Names)* **: Shelter Program Director** **Type of Documentation(s) Reviewed: Log Books**			

The program has a detailed written description of the BMS and it is explained during program orientation	**Compliance**	The program includes a written description of the Behavior Management system and reviews it with youth during orientation to the program.	
Behavior Management Strategies must include:			
a.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	**Compliance**	The program utilizes the Point Card Short Term Client Report to provide a visual of the application of the Behavior Management System (BMS) by each staff and the effectiveness of the interactions including the positive corrections. The written description of the BMS strategies has a wide variety of positive incentives, appropriate interventions used to teach youth new behaviors and help youth understand natural consequences for their action, and behavioral interventions. The agency's BMS includes consequences for violations that's logical and consistent. The agency uses a variety of rewards/incentives.	
Program's use of the BMS			
All staff are trained in the theory and practice of administering BMS rewards and consequences	**Compliance**	The program trains all staff in the Boy's Town Model of Behavior Management and the system of using awards and consequences as part of the teaching process.	
There is a protocol for providing feedback and evaluation of staff regarding their use of BMS rewards and consequences	**Compliance**	Supervisors provide feedback and evaluation of staff regarding their use of positive and negative consequences and reviews feedback at staff meetings.	
Supervisors are trained to monitor the use of rewards and consequences by their staff	**Compliance**	Staff and supervisory staff engage in the following trainings: motivational system overview and point card mechanics; motivational system practice; observing and describing behaviors; principles of behaviors; and non-crisis intervention.	
Additional Comments: **There are no additional comments for this indicator.**			

3.06 - Staffing and Youth Supervision			Satisfactory with Exception
Provider has a written policy and procedure that meets the requirement for Indicator 3.06		**YES** If NO, explain here: The provider has the required policy and procedures, 3.06-1 Security, Youth Counts and Staffing Ratio, approved 12/28/2023 by the ED.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Dates or Timeframe Reviewed: All staff schedules were reviewed for the last 6 months. **Type of Documentation(s) Reviewed: Staff Schedules** **Describe any Observations: Unsupervised youth in Dream Room**			
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	**Compliance**	Schedules for staff were reviewed between July 2023 and January 2024. There are three overlapping shifts to cover a 24 hour period. In January there was a lot of staff turnover, and there appeared to be issues with staffing for the month. Management and counseling staff needed to step in to fill in the coverage gaps, which is not seen on the schedule; however , it is documented in the logbook for those days. There are currently 4 vacancies within the shelter, which is causing other staff to step in. If staff is unable to make their shift, it is the supervisor's responsibility to cover the empty spots in the schedule.	
All shifts must always provide a minimum of two direct care staff present that have met the minimum training requirements	**Compliance**	All shifts had a minimum of two staff scheduled, with months between September to December having 3 staff on almost every shift. All staff scheduled on shift have completed the minimum training requirements.	
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	**Compliance**	The program policy requires all staff to have completed the required HR background checks and training to be in ratio to be around youth. None of the new staff worked independently with you until they have completed the minimum training requirements.	
The staff schedule is provided to staff or posted in a place visible to staff	**Compliance**	The staff schedule is located on the wall in the staff office at the front of the shelter.	
There is a holdover or overtime rotation roster which includes the telephone numbers of staff who may be accessed when additional coverage is needed	**Compliance**	The staff contact list is kept inside the Administrative/Supervisor office to avoid youth or visitors obtaining staff information in the general area. It was explained during the review that the staff have a group chat to be able to speak to each other, so all staff have access to each others numbers.	

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	**Exception**	The shelter wings are T-shaped and connected to the dining room which is in the center. The boys dorm is on the right of the shelter and the girls dorm is on the left, and the dorm wings are separated from each other. The facility utilizes log book records for 30 minute walks, a separate nighttime bed check walk log for the 15 minute logs, as well as a badge scanner at the end of the hall that documents the end of the walk. The staff complete 12 minute walks instead of 15 minutes, which provides an extra walk per hour, adding to better supervision of the youth. Bed Check Dates/Times Selected: December 24th, 12am-2am; December 29th, 2am-4am; January 3rd, 4am-6am; January 8th, 1am-3am; and January 13th, 3am-5am. All 15-minute bed checks and walks were completed appropriately.	It was observed on the second day of the review, a male youth was found unattended in the Dream Room with the door only cracked an inch, while staff was sitting in the staff office across the hall.

Additional Comments: There are no additional comments for this indicator.

3.07 - Video Surveillance System		**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 3.07	**YES** If NO, explain here: The provider has the required policy and procedures, Program Video Monitoring (there is not a listed policy number) and Video Monitoring – CFL/I&A , approved 12/27/2023 by the ED.	

Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*

Dates or Timeframe Reviewed: December 2023-January 2024
Staff Position(s) Interviewed *(No Staff Names)* **: shelter manager, program support services coordinator, and senior director of program operations.**
Type of Documentation(s) Reviewed: nightly bed check log, camera footage, camera signage
Describe any Observations: the camera system has loading difficulty, causing issues with reviewing footage. The organization is supposed to be gaining a new way to access the recorded images sometime this week to make retrieving easier.

Surveillance System			
The agency, at a minimum, shall demonstrate: a. A written notice that is conspicuously posted on the premises for the purpose of security b. System can capture and retain video photographic images which must be stored for a minimum of 30 days c. System can record date, time, and location; maintain resolution that enables facial recognition d. Back-up capabilities consist of cameras' ability to operate during a power outage e. Have cameras placed in interior and exterior general locations of the shelter where youth and staff congregate and where visitors enter and exit. Cameras are never placed in bathrooms or sleeping quarters. f. All cameras are visible	**Exception**	There are signs acknowledging cameras are recording at all times near every exit door. There are nine internal cameras, and two external cameras on the shelter itself as well as a camera at the recreation area, but there are none in view of the parking lot. There are no cameras located in bedrooms or bathrooms, only in common spaces including hallways. Camera footage is maintained for 30 days, and is accessible using the company share point drive. The system records date and time information and is clear enough to see facial features. The cameras are not on a battery backup system and is set to operate for a few minutes if power is lost. The site does have generators for use during power outages. All generators are tested annually prior to hurricane season.	There was an instance during a recent hurricane that caused the shelter to lose power for a few hours of the day. During that period it was noted the cameras became inoperable due to loss of power and were not connected to the generator for alternate source of power.

A list of designated personnel who can access the video surveillance system is maintained (includes off-site capability per personnel)?	**Compliance**	The only staff that have access to the cameras are the shelter director, senior director of program operations, and the executive director who have the capability to review the cameras and have to log in through a SharePoint system granted by IT. The formal list is maintained by the national office. All access is managed by that office.	
Supervisory review of video is conducted a minimum of once every 14 days and timeframes reviewed are noted in the logbook.	**Compliance**	The shelter manager has a separate log book dedicated for camera reviews. The log book displayed that he was completing camera checks a minimum of twice a week - with most weeks being 5 times a week. There is not a standard written process for how any issues are documented to staff, however they address any concerns they have verbally. The walks are also double checked with a badge scanner showing the walks were completed.	
The reviews assess the activities of the facility and include a review of random sample of overnight shifts	**Compliance**	The cameras are reviewed throughout different times of the day including overnights and weekends.	
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	**Compliance**	The footage time stamps are requested through the organization's IT department, and the footage is dropped directly into the CCC drop box.	
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	**Compliance**	There has only been one documented incident of loss of camera coverage due to a hurricane causing an extended loss of power. The camera's became operational again before the end of a 24 hour period. There was no formal request to IT for repairs to the camera's as the cameras became operational when the power returned. If requested, video footage time stamps are requested through the organization's IT department, and the footage is dropped directly into the CCC drop box.	
Additional Comments: **There are no additional comments for this indicator.**			
4.01 - Healthcare Admission Screening			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 4.01		**YES**	
		If NO, explain here:	
		The provider has multiple policies and procedures to meet the requirement of the indicator: 4.01-1 - Physical Health Screening & 4.01- 2 Mental Health Services/Referrals. Both were approved 12/27/2023 by the ED.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			

Total number of Open Files: 1
Total number of Closed Files: 4
Staff Position(s) Interviewed *(No Staff Names)* **: Registered nurse, program director**
Type of Documentation(s) Reviewed: Youth records
Describe any Observations: An observation of the program's medical unit was observed. It was organized and locked and secured, making it inaccessible to youth.

Preliminary Healthcare Screening			
Screening includes : a. Current medications b. Existing (acute and chronic) medical conditions c. Allergies d. Recent injuries or illnesses e. Presence of pain or other physical distress f. Observation for evidence of illness, injury, physical distress, difficulty moving, etc. g. Observation for presence of scars, tattoos, or other skin markings h. Acute health symptoms requiring quarantine or isolation	**Compliance**	A total of five youth records were reviewed, four closed and one open. A review of all five records confirmed Boys Town completes a primary healthcare screening within twenty-fours of the youth's admission. The required healthcare screening observations for each were documented when applicable. Four of the five youth were applicable for a chronic medical condition. The one youth who was applicable was listed on the program's chronic condition log. All medical referrals are located on a daily log.	
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.)	**Compliance**	A review of one applicable youth, with a chronic medical condition, confirmed the youth was receiving proper medical care for the chronic condition.	
When needed, the parent is involved with the coordination and scheduling of follow-up medical appointments	**Compliance**	There was documentation of parent contact for follow-up appointments when needed.	
All medical referrals are documented on a daily log.	**Compliance**	All medical appointment were documented on a daily log.	
The program has a thorough referral process and a mechanism for necessary follow-up medical care as required and/or needed	**Compliance**	The program has procedures to include a thorough referral process and a mechanism for necessary follow-up for medical care for youth admitted with chronic medical conditions.	
Additional Comments: **There are no additional comments for this indicator.**			
4.02 - Suicide Prevention			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 4.02		**YES** If NO, explain here: The provider has the required policy and procedures, 4.02-1 - At Risk Screening & Assessment, approved 12/27/23 by the ED.	

Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*

Total number of Closed (Residential & Community) Files: 3 Residential and 3 Community **Staff Position(s) Interviewed** *(No Staff Names)* **: Program director** **Type of Documentation(s) Reviewed: Youth records**			
Suicide Risk Screening and Approval (*Residential and Community Counseling*)			
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.	**Compliance**	Six total youth records were reviewed for three residential and three community counseling youth. The suicide risk screening occurred during the initial intake and screening process for all six youth. The suicide screening results were reviewed and signed by the supervisor and documented in each of the youth's case records.	
The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	**Compliance**	The program's suicide risk assessment was not changed since the last QI review and has been approved by the Florida Network of Youth and Family Services.	
Supervision of Youth with Suicide Risk *(Shelter Only)*			
Youth are placed on the appropriate level of supervision based on the results of the suicide risk assessment.	**Compliance**	Three youth records were reviewed for residential youth. Each of the three youth were placed on the appropriate level of supervision based on the results of the suicide risk assessment.	
Staff person assigned to monitor youth maintained one-to-one supervision or constant supervision and documented his/her observations of the youth's behavior at 30 minute or less intervals	**Compliance**	The staff assigned to monitor the three residential youth reviewed maintained one-to-one supervision or constant supervision and documented his/her observations of the youth's behavior at 30 minute or less intervals.	
Documentation includes the time of day, behavioral observations, any warning signs observed, and the observers' initials and was maintained in either an observation log or in the shelter daily log.	**Compliance**	The documentation for all three youth included the time of day, behavioral observations, any warning signs observed, and the observers' initials. Each of the three youth's information was maintained in either an observation log or in the shelter daily log.	
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	**Exception**	One of the three youth records contained the follow up Risk Assessment prior to being stepped down from one-to-one to standard supervision.	The youth records did not contain the Risk Assessment for two of the three youth who required a follow up Risk Assessment prior to being stepped down from one-to-one to standard supervision.
There was evidence that documentation was reviewed by supervisory staff each shift. If program uses an observation log, completed logs are maintained in the youth's file.	**Compliance**	Each of the three youth records confirmed documentation was reviewed by supervisory staff on each shift. The completed observation logs were maintained in all three youth records.	
Youth with Suicide Risk *(Community Counseling Only)*			
Youth identified for suicide risk during intake was immediately assessed by a licensed professional or non-licensed professional (under the direct supervision of a licensed mental health professional) and the parents and supervisor were both notified of the results.	**Compliance**	Each of the three community counseling youth identified for suicide risk during intake and was immediately assessed by a licensed professional and the parents and supervisor were both notified of the results.	

During the intake, if the appropriate staff is unavailable, youth identified for suicide risk was immediately referred by the provider and the parent/guardian is notified of the suicide risk findings disclosed and advised that an Assessment of Suicide Risk should be completed ASAP by a licensed professional.	**Not Applicable**	All three youth were assessed immediately by appropriate provider licensed staff.	
Information on resources available in the community for further assessment was provided to the parent/guardian and is documented in the youth's file and signed by the parent/guardian OR a written follow-up notification was sent by certified mail if the parent/guardian was not present during the screening and was notified by telephone.	**Compliance**	Documentation showed information was provided to the youth and parent/guardian.	
If the parent/guardian cannot be contacted, all efforts to contact them are documented in the case file.	**Compliance**	The program staff was able to contact the youth parents and all contacts were documented in the youth's file	
When the screening was completed during school hours on school property, the appropriate school authorities were notified.	**Not Applicable**	None of the screenings were completed during school hours or on school property.	
Additional Comments: **There are no additional comments for this indicator.**			
4.03 - Medications			**Limited**
Provider has a written policy and procedure that meets the requirement for Indicator 4.03		**YES** If NO, explain here: The provider has the required policy and procedures, 4.03 Medications (Medication Verification, Storage, Access, Inventories, Medication Administration Log and Provision, approved 12/27/23 by the ED.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Files: Total 3, 2 closed and 1 open **Staff Position(s) Interviewed** *(No Staff Names)* **: Registered nurse** **Type of Documentation(s) Reviewed: Youth records** **Describe any Observations: Pyxis Med-Station**			
The agency has a Registered Nurse (RN) and/or a Licensed Practical Nurse (LPN) that is being supervised by RN and all of their credentials have been verified.	**Compliance**	The program has a registered nurse with a clear and active license.	
The agency has evidence of the following for all non-nursing shelter staff designated to assist with the self-administration of medication: a. Documentation of in-person self-administration of medication distribution training provided by a Registered Nurse b. Evidence demonstrating their competency to assist with self-administration of medication distribution c. Maintenance of their annual medication training re-certification	**Compliance**	Nine non-licensed staff are trained in administration of medication. Each staff was trained by a registered nurse.	

The agency held at least quarterly staff meetings conducted by RN and/or Shelter Manager to review and assess: a. strategies implemented to reduce medication errors shelter wide b. analyze factors that contributed to medication errors c. allow staff the opportunity to practice and role-play solutions	**Compliance**	A review of documentation confirmed the program held at least quarterly meetings conducted by the shelter manager to review and assess strategies implemented to reduce medication errors shelter wide, analyze factors that contributed to medication errors and allowed staff the opportunity to practice and role-play solutions.	
The agency has strategies implemented to ensure medications are provided within the 2-hour time frame.	**Compliance**	The program has strategies implemented to ensure medications are provided within the 2-hour time frame.	
All non-licensed staff members are clearly identified and designated on the staff schedule and shift change report/shift responsibility form for assisting with the self-administration of medications on each shift	**Compliance**	All non-licensed staff are clearly identified and designated on the staff schedule designating who is responsible for assisting with the self-administration of medications on each shift.	
The agency has clear methods of communicating which youth are on medications with the times and dosage easily discernable by all staff on each shift.	**Compliance**	The program utilized a computer program which is projected on a large screen TV, notating each youth on medication and the required time of their dosage.	
The delivery process of medications is consistent with the FNYFS Medication Management and Distribution Policy and the agency has an internal quality assurance process to include the following: a. to ensure appropriate medication management and distribution methods b. to track medication errors c. to identify systemic issues and implement mitigation strategies, as appropriate.	**Compliance**	There is a an internal quality assurance process. The program identifies medication issues and discusses medication management and errors during CINS/FINS meetings, Safety and Health Committee meeting, program staff meetings, Florida Network Medication Error meetings and Programmatic Action Plan meeting.	
Admission/Intake of Youth			
a. Upon admission, the youth and parent/guardian (if available) were interviewed by the Registered Nurse (when on-site) about the youth's current medications as part of the Medical and Mental Health Assessment screening process and/or an interview was conducted by the RN within three (3) business days if the RN was not on the premise at admission. **If the agency does not have a RN, there was a medication review conducted by a certified Leadership position.* b. Upon intake/admission, there is evidence that the on-shift certified supervisor of higher level staff did review all medication forms by the next business day.	**Compliance**	Three youth records were reviewed and each confirmed the youth and parent/guardian were interviewed by the RN about the youth's current medication on the day of admission. There was evidence the on-shift certified supervisor did review all medication forms by the next business day, for all three reviewed youth.	

Medication Storage			
a. All medications are stored in a Pyxis ES 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 Pyxis ES 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	**Compliance**	An observation was completed of the medical unit during the annual monitoring. All medication is stored in a Pyxis Cabinet and is inaccessible to youth. The medication cabinet is stored in accordance with Florida Statues. All oral medications are stored separately from injectable epi-pen and topical medication. There is a refrigerator which is only utilized for medications, as needed. The refrigerator was not secure; however, the room is secure. All narcotics and controlled medications are stored in the Pyxis Cabinet. The keys, with required labels, were observed and available to staff in the event they are needed.	
Medication Distribution			
a. Agency maintains a minimum of 2 site-specific System Managers for the Pyxis ES 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 three methods listed in the FNYFS Policies & Procedures Manual e. When nurse is on duty, medication processes are ALWAYS conducted by the nurse or when the nurse is not onsite, then the designated staff who has been trained by a licensed Registered Nurse provides the medication. f. Agency does not accept youth currently prescribed injectable medications, except for epi-pens h. Non-licensed staff have received training in the use of epinephrine auto-injectors provided by a registered nurse	**Compliance**	The program maintains a minimum of 2 site-specific System Managers for the Pyxis. There are 9 trained staff who are designated and delineated User Permissions and have access to secured medications, with limited access to controlled substances. A review of youth records confirmed a Medication Distribution Log is used for distribution of medication by non-licensed and licensed staff. The program verifies medication using one of the three methods listed in the FNYFS Policies & Procedures Manual. The program confirmed when the registered nurse is on duty, medication processes are always conducted by the nurse. When the nurse is not onsite, then the designated staff who has been trained by a licensed Registered Nurse provides the medication. According to the program, they do not accept youth currently prescribed injectable medications, except for epi-pens. Nine non-licensed staff have received training in the use of epinephrine auto-injectors provided by a registered nurse.	

The medication distribution log documentation includes: a. the time of medication administration b. evidence of youth initials that the dosage was given c. evidence of staff initials that the dosage was given	**Compliance**	A review of youth records and medication distribution log documentation confirmed the time of medication administration, youth initials that the dosage was given, and evidence of staff initials that the dosage was given.	
There is evidence that staff provide youth with medications within one hour of the scheduled time of delivery as ordered by the medication. Documentation is provided for instances this does not occur within the required timeframe.	**Exception**	There were two dates observed where staff did not provide youth with medications within one hour of the scheduled time of delivery prescribed. No documentation was provided to explain why these occurred.	In the month of October 2023, for the medication Adderall, seven morning doses were given and five were given early. For Oxcarbazepine, 13 morning doses were given and 10 were provided early. In September 2023, for the medication Cyproheptadine, two morning doses were given and both were given early. For the medication Oxcarbazepine, 18 morning doses were given and 13 were given early. The majority of early medication passes were observed to be as much as two hours prior to the time the medication was to be given.
During the review period, there were no instances where youth missed their medication due to failure to open the pyxis machine.	**Compliance**	During the review period, there were no instances or incidents related to failure to distribute medication to a youth due to the Pyxis machine not working.	
If applicable: Any staff member deemed responsible for a medication error, there was evidence that the staff member received refresher training from an RN and demonstrated competency prior to being assigned future medication administration responsibilities. There is evidence that any staff member deemed responsible for 3 errors within a 1-year time frame, had their certification suspended and was not recertified until the completion of the full **in-person** medication administration training, demonstrating competency and re-certification from an RN.	**No eligible items for review**	Effective mid-December 2023, all staff responsible for medication errors must be retrained. There were no medication errors observed since the effective date of the requirement. On 12/16/23 the program's RN conducted a medication refresher training for all staff.	

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 and inventoried weekly c. Syringes and sharps (needles, scissors, etc.) are secured, and counted and documented weekly	**Exception**	Three medication youth files were reviewed for two closed and one open youth. All three had a medication distribution log for each medication they received. The three youth had a controlled substance prescribed. November 2023 – January 2024, confirmed shift to shift counts were conducted; however, there was no witness documented on any shift-to-shift counts. Non- controlled and OTC medications were inventoried weekly July through Sept 10, 2023. Sharps are secured and inventoried weekly.	None of the three controlled medication distribution logs reviewed showed shift-to-shift counts verified by a witness as of November 2023. There were no weekly inventories for non-controlled or OTC medications printed after 9/10/23.
There are monthly reviews of the Pyxis reports to monitor medication management practice.	**Exception**	Per interview with the program director and nurse, there are no monthly review of pyxis reports for the review period.	There are no monthly reviews of Pyxis Reports documented for the annual review period.
Medication discrepancies are cleared after each shift.	**Compliance**	The program conducts daily clearing of medication discrepancies on each shift in which it occurs.	
Additional Comments: **There are no additional comments for this indicator.**			

4.04 - Medical/Mental Health Alert Process		**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 4.04	**YES** If NO, explain here: The provider has the required policy and procedures, 4.04-1 Medic Alert Process & Mental Health and Medical Follow-up, approved 12/27/23 by the ED.	

Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*

Total number of Closed Files: 3
Staff Position(s) Interviewed *(No Staff Names)* **: Program director, RN**
Type of Documentation(s) Reviewed: youth records, alert codes
Describe any Observations: alert board

Youth with a medical, mental health, or food allergy was appropriately placed on the program's alert system	**Compliance**	The program has an alert board in the shelter's front office and when applicable alerts are documented including other essential information pertaining to the youth. The board is inaccessible to youth in the shelter. A total of three closed residential files were reviewed. Each of the youth records reviewed indicated the youth had medical, mental health condition and/or food allergies and were placed in the program's alert system.	
Alert system includes precautions concerning prescribed medications, medical/mental health conditions	**Compliance**	The program's alert system includes precautions concerning the prescribed medications, medical and mental health conditions. Medical alerts are documented in the medical records. An alert board located in the intake office also documents the youth name and alert in a confidential manner. A nutritional alert form will be in the kitchen which includes a list of youth who have an allergy or other kind of nutritional alert.	
Staff are provided sufficient training, information and instructions to recognize/respond to the need for emergency care for medical/mental health problems	**Compliance**	All the staff are provided sufficient training information and instructions to recognize/respond to the need for emergency medical/mental health problems which was observed in a total of eight staff training files reviewed.	
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	**Compliance**	The program's alert system is in place to ensure information concerning youth medical condition and mental health treatment information is communicated to all staff. Each of the three residential youth record demonstrated alerts were documented in the files and communicated to staff.	
Additional Comments: **There are no additional comments for this indicator.**			
4.05 - Episodic/Emergency Care			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 4.05		**YES** If NO, explain here: The provider has the required policy and procedures, 4.05 Episodic/Emergency Care, approved 12/27/23 by the ED.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			

Total number of Closed Files: 3 **Staff Position(s) Interviewed** *(No Staff Names)* **: Program director, RN** **Type of Documentation(s) Reviewed: Youth records, episodic care log, logbooks**			
Off Site Emergency Care			
a. If off-site emergency medical or dental care was provided, an incident report was submitted for the medical or dental care b. Upon youth return, there is a verification receipt of medical clearance via discharge instructions with follow-up is present in file c. Youth's parent/guardian was notified d. A daily log is maintained for emergency care provided	**Exception**	A total of three episodic/emergency care that occurred during the past six months were reviewed. All three youth required offsite emergency care and an incident report was called in for each incident. Upon youth's return, the program was provided medical clearance via discharge instructions. These were not located in the youth's records but were retrieved and provided upon request. Parental notification was verified in two of the three cases. One of the three offsite emergencies was noted on the episodic care log.	Parent/guardian notification was not evident for one of the three episodic emergencies (10/23/23)reviewed. Two of the three offsite emergencies were not documented on the episodic care. Documentation in program logbook is not about the offsite emergency incident that occurred and transport of youth offsite, but only notes location of youth during rounds (i.e. offsite for one, hospital for another).
All staff are trained on emergency medical procedures	**Compliance**	A total of eight staff training records were reviewed. Documentation supported all the staff received training on emergency medical procedures.	
The program has a Knife-for-life and wire cutters accessible to staff in a secure location(s)	**Compliance**	First Aid kits are located in Youth Care Worker office and one in each van. Knife for life is located in Youth Care Worker office.	
Additional Comments: **There are no additional comments for this indicator.**			