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

# Children's Home Society West Palm Beach
# Safe Harbor Shelter

3335 Forest Hills Blvd
West Palm Beach, FL 33406

**May 29-30, 2024**

**Compliance Monitoring Services Provided by**
**Monitoring Services Provided by**

## EXECUTIVE SUMMARY

Forefront LLC conducted a Quality Improvement (QI) monitoring visit on behalf of the Florida Network of Youth and Family Services (FNYFS) for Children's Home Society Safe Harbor (CHS Safe Harbor) for the FY 2023-2024 at its program office located at 3335 Forest Hills Blvd., West Palm Beach, 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. CHS West Palm Beach is contracted with the Florida Network of Youth and Family Services (FNYFS) to provide direct services to Children/Families in Need of Services (CINS/FINS). The services to be provided are identified in Contract Section A - Descriptions and Specifications and Section B - Delivery and Performance, and are funded with General Revenue Funds effective for July 2023 through June 30, 2024.

The review was conducted by Marcia Tavares, Consultant for Forefront LLC, and peers Paula Friedrich, Quality Monitor-Department of Juvenile Justice (DJJ); Philip N. Kabler J.D, CEO - CDS Family & Behavioral Health Services, Inc; Jose Ortega, Counselor - Lutheran Services Florida Miami Bridge Central; and Laura Saldana, Director of Compliance - Lutheran Services Florida Southeast. Agency representatives from CHS Safe Harbor present for the entrance interview were Lauren Fuentes, Vice President Child and Family Well Being; Sabrina Barnes, Executive Director; Vincelyn Barbier, Community Counseling Supervisor; Ray Coleman, Residential Supervisor; and Latraya Navarro, Residential Counselor. Also present via TEAMS were Lauren Zamjahn, Director of Out of Home Placement; Solange Knowles, QI Specialist; and Loni Lauer, Talent General Manager. The last onsite QI visit was conducted on December 14-15, 2022.

In general, the Reviewer found that CHS Safe Harbor is following specific contract requirements. **CHS Safe Harbor received an overall compliance rating of 100% for achieving full compliance with all 13 applicable indicators** of the CINS/FINS Monitoring Tool. There were no corrective actions or recommendations made as a result of the monitoring visit

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

# 2023-2024 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
# Report Number: CM 05-29-2023-2024

| | |
|---|---|
| **Agency Name: Children's Home Society, Safe Harbor** | **Monitor Name: Marcia Tavares, Lead Reviewer** |
| **Contract Type: CINS/FINS** | **Region/Office: 3335 Forest Hills Blvd., West Palm Beach, FL** |
| **Service Description: Comprehensive Onsite Compliance Monitoring** | **Site Visit Date(s): May 29-30, 2024** |

| Major Programmatic Requirements | Explain Rating: Unacceptable | Conditionally Unacceptable | Fully Met | Exceeded | Not Applicable | Ratings Based Upon: I = Interview; O = Observation; D = Documentation; PTV = Submitted Prior To Visit; (List Who and What) | Notes: Explain Unacceptable or Conditionally Acceptable: |
|---|---|---|---|---|---|---|---|
| **I. Administrative and Fiscal** | | | | | | | |
| **DJJ Quality Improvement Peer Reviewer**<br>a. Provider shall demonstrate that a minimum of two (2) staff members have been trained to be certified as DJJ QI Peer reviewers. Provider shall participate in a minimum of one (1) on-site quality assurance review of a similar type of program in another judicial circuit during each 12-month period of the contract, if requested. | ☐ | ☐ | ☒ | ☐ | ☐ | Documentation: As of the date of the monitoring visit, Vincelyn Barbier is the only designated peer reviewer for the West Palm Beach contract because Wanda Rivera, a former certified peer, transferred to another CHS program. However, both Ms. Barbier and Ms. Riviera participated in a QI Review during this FY. | **No recommendation or Corrective Action.** |
| **Additional Contracts**<br>a. Provider shall provide a listing of all current federal, state, or local government contracts, as well as other contracts entered into with for profit and not-for-profit organizations. Such a listing shall identify the awarding entity and contract start & end dates. **PTV** | ☐ | ☐ | ☒ | ☐ | ☐ | Documentation: A list of one additional contract for FY 2023-2024 was provided by the provider. The list includes the funding sources and contract term dates with the Department of Highways. | **No recommendation or Corrective Action.** |
| **Limits of Coverage**<br>a. Provider shall provide and maintain during this contract, the following minimum kinds of insurance: Worker's Compensation and Employer's liability insurance as required by Chapter 440, F.S. with a minimum of $100,000 per accident, $100,000 per person and $500,000 policy aggregate. Commercial General Liability | ☐ | ☐ | ☐ | ☒ | ☐ | Documentation: General Liability through Alliance of Nonprofits for Insurance, for limits of coverage $1,000,000 each $3,000,000 aggregate and medical payments for $5000, effective 7/01/23-7/01/24.<br><br>Auto Insurance through Alliance of | **No recommendation or Corrective Action.** |

# 2023-2024 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
# Report Number: CM 05-29-2023-2024

| | |
|---|---|
| **Agency Name: Children's Home Society, Safe Harbor** | **Monitor Name: Marcia Tavares, Lead Reviewer** |
| **Contract Type: CINS/FINS** | **Region/Office: 3335 Forest Hills Blvd., West Palm Beach, FL** |
| **Service Description: Comprehensive Onsite Compliance Monitoring** | **Site Visit Date(s): May 29-30, 2024** |

| **Major Programmatic Requirements** | **Explain Rating** | | | | | **Ratings Based Upon:**<br>**I = Interview**<br>**O = Observation**<br>**D = Documentation**<br>**PTV = Submitted Prior To Visit**<br>**(List Who and What)** | **Notes**<br>**Explain Unacceptable or Conditionally Acceptable:** |
|---|---|---|---|---|---|---|---|
| | **Unacceptable** | **Conditionally Unacceptable** | **Fully Met** | **Exceeded** | **Not Applicable** | | |
| 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** | | | | | | Nonprofits for Insurance, with combined single limit coverage for $1,000,000, effective 7/01/23-7/1/24.<br><br>Workers Compensation through United Wisconsin Insurance Co, with limits of $1,000,000 for each incident and $1,000,000 policy limit, effective 7/01/23-7/01/24.<br><br>Directors and Officers liability policy through Alliance of Nonprofits for Insurance, with limits of $1,000,000, per occurrence, effective 7/01/23-7/1/24.<br><br>Umbrella liability coverage through Alliance of Nonprofits for Insurance, with limits of $5,000,000, each and aggregate, effective 7/01/23-7/1/24.<br><br>The Florida Network of Youth and Family Services, Inc. is listed as certificate holder on the certificate of coverage. | |

# 2023-2024 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
# Report Number: CM 05-29-2023-2024

| | |
|---|---|
| **Agency Name: Children's Home Society, Safe Harbor** | **Monitor Name: Marcia Tavares, Lead Reviewer** |
| **Contract Type: CINS/FINS** | **Region/Office: 3335 Forest Hills Blvd., West Palm Beach, FL** |
| **Service Description: Comprehensive Onsite Compliance Monitoring** | **Site Visit Date(s): May 29-30, 2024** |

| | Explain Rating | | | | | | |
|---|---|---|---|---|---|---|---|
| **Major Programmatic Requirements** | **Unacceptable** | **Conditionally Unacceptable** | **Fully Met** | **Exceeded** | **Not Applicable** | **Ratings Based Upon:**<br>**I = Interview**<br>**O = Observation**<br>**D = Documentation**<br>**PTV = Submitted Prior To Visit**<br>**(List Who and What)** | **Notes**<br>**Explain Unacceptable or Conditionally Acceptable:** |
| **External/Outside Contract Compliance**<br>a. Provider has corrective action item(s) cited by an external funding source (Fiscal or Non-Fiscal). **ON SITE** | ☐ | ☐ | ☐ | ☐ | ☒ | Interview: During the Entrance Conference, the provider indicated that there are no outstanding corrective action item(s) cited by any external funding source. | **No recommendation or Corrective Action.** |
| **Fiscal Practice**<br>a. Agency must have employee and fiscal policy/procedures manuals that are in compliance with GAAP and provide sound internal controls. Agency maintains fiscal files that are audit ready. **PTV** | ☐ | ☐ | ☒ | ☐ | ☐ | Documentation: Fiscal Policies and Procedures are maintained in the agency's Accounting Policies and Procedures Manual. The Accounting Policies and Procedures were last reviewed on December 6, 2019, and are in progress of review effective 4/18/2024. The procedures reviewed appear to be consistent with GAAP and provide for limited internal controls. Procedures are included for accounts receivable, accounts payable, cash management, contributions, purchasing, travel, and payroll. Fiscal files are maintained in the agency's corporate office. | **No recommendation or Corrective Action.** |
| 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 | ☐ | ☐ | ☒ | ☐ | ☐ | Documentation: General Ledger for July 1, 2023 – April 2024. The agency maintains a detailed general ledger that is | **No recommendation or Corrective Action.** |

# 2023-2024 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
# Report Number: CM 05-29-2023-2024

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| **Contract Type: CINS/FINS** | **Region/Office: 3335 Forest Hills Blvd., West Palm Beach, FL** |
| **Service Description: Comprehensive Onsite Compliance Monitoring** | **Site Visit Date(s): May 29-30, 2024** |

| **Major Programmatic Requirements** | **Explain Rating** | | | | | **Ratings Based Upon:**<br>**I = Interview**<br>**O = Observation**<br>**D = Documentation**<br>**PTV = Submitted Prior To Visit**<br>**(List Who and What)** | **Notes**<br>**Explain Unacceptable or Conditionally Acceptable:** |
|---|---|---|---|---|---|---|---|
| | **Unacceptable** | **Conditionally Unacceptable** | **Fully Met** | **Exceeded** | **Not Applicable** | | |
| (standard account numbers / separate funds for each revenue source, etc.). **PTV** | | | | | | structured to track all funding sources and there is a separate GL for the Safe Harbor shelter and CINS/FINS community counseling program. | |
| c. Petty cash ledger system is balanced and all cash disbursements are compliant with financial policies and allowable under the contract. (Disbursements/invoices are approved & monitored by management.) –**ON SITE** | ☐ | ☐ | ☒ | ☐ | ☐ | Observation/Documentation: No change in practice was reported for the agency since the last onsite program review. Policies and procedures are maintained in the Fiscal Manual under the Cash Management section.<br><br>Interview and Documentation:<br>The residential manager/supervisor is the custodian of the petty cash fund. The fund which does not exceed $500 is utilized for purchases under $50 unless approval is granted by Management. Petty cash is stored in a locked box in the custodian's office. The fund is reconciled as needed and submitted to the Executive Administrative Assistant/Human Resources for refunding. Disbursements and invoices are approved by the residential manager. | **No recommendation or Corrective Action.** |

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| **Contract Type: CINS/FINS** | **Region/Office: 3335 Forest Hills Blvd., West Palm Beach, FL** |
| **Service Description: Comprehensive Onsite Compliance Monitoring** | **Site Visit Date(s): May 29-30, 2024** |

| **Major Programmatic Requirements** | **Explain Rating** | | | | | **Ratings Based Upon:**<br>**I = Interview**<br>**O = Observation**<br>**D = Documentation**<br>**PTV = Submitted Prior To Visit**<br>**(List Who and What)** | **Notes**<br>**Explain Unacceptable or Conditionally Acceptable:** |
|---|---|---|---|---|---|---|---|
| | **Unacceptable** | **Conditionally Unacceptable** | **Fully Met** | **Exceeded** | **Not Applicable** | | |
| d. Financial records and reports are current. Includes bank statements reconciled within 6 weeks of receipt. Vendor invoices past 6 months. Invoices are submitted on a monthly basis with supporting documentation. (Disbursements/invoices are approved & monitored by management). **ON SITE** | ☐ | ☐ | ☒ | ☐ | ☐ | Documentation: Reviewed Reconciliation Statements and corresponding general ledger entries for accounts payable and payroll accounts held with Fifth Third Bank for the period October 2023-March 2024. Bank reconciliations are processed by the finance department in the corporate office. Successful bank reconciliations were conducted timely, and all reconciliation worksheets prepared by the accounting analyst were reviewed by the accounting manager. | **No recommendation or Corrective Action.** |
| e. Agency maintains inventory in accordance with a written policy and FNYFS contractual requirements. If over $1,000 inventory has DJJ Property Inventory Number/Tag. In the event the provider has purchased computer equipment an Informational Resources Request (IRR) has been submitted to DJJ. **PTV/ON SITE** | ☐ | ☐ | ☒ | ☐ | ☐ | Documentation: Agency maintains an inventory list of equipment for the CINS/FINS programs reflecting purchase dates from 2011. No new purchases were made for the review period with Florida Network funds. | **No recommendation or Corrective Action.** |
| f. Agency submits payroll taxes and deposits (and retirement deposits as applicable), Employee IRS Form W-2 and<br>Independent Contractors IRS Form 1099 forms prior to federal requirements. **ON SITE** | ☐ | ☐ | ☒ | ☐ | ☐ | Documentation: CHS contracts with Paylocity for payroll services. Monthly bank statements reviewed for the period November 2023-April 2024 showing biweekly Paylocity corporate payroll tax payments made for CHS. | **No recommendation or Corrective Action.** |

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| **Contract Type: CINS/FINS** | **Region/Office: 3335 Forest Hills Blvd., West Palm Beach, FL** |
| **Service Description: Comprehensive Onsite Compliance Monitoring** | **Site Visit Date(s): May 29-30, 2024** |

| **Major Programmatic Requirements** | **Explain Rating** | | | | | **Ratings Based Upon:**<br>**I = Interview**<br>**O = Observation**<br>**D = Documentation**<br>**PTV = Submitted Prior To Visit**<br>**(List Who and What)** | **Notes**<br>**Explain Unacceptable or Conditionally Acceptable:** |
|---|---|---|---|---|---|---|---|
| | **Unacceptable** | **Conditionally Unacceptable** | **Fully Met** | **Exceeded** | **Not Applicable** | | |
| g. Budget to actual reports prepared and reviewed by appropriate management. Variance from the budget are investigated and explained. **PTV/ON SITE** | ☐ | ☐ | ☒ | ☐ | ☐ | Documentation: Budget to Actual report for July 1, 2023-March 2024 for the CINS/FINS Program was reviewed. The report captures the monthly variance, year-to-date, and annual budget. A net deficit was observed for the shelter program and surplus for community counseling per the report. The provider has a monthly process for reviewing and explaining variances. | **No recommendation or Corrective Action.** |
| h. A Single Audit is performed as part of the annual audit if expenses are greater than $750,000. The agency must submit a Corrective Action Plan for findings cited in the management letter and single audit. An annual financial audit was completed within 120 days after the previous fiscal year/calendar year and that a copy was provided to the Network unless and extension has been requested and approved in writing. Copy of Audit is submitted to the FNYFS by December 31st. **Can obtain from FNYFS** | ☐ | ☐ | ☒ | ☐ | ☐ | Documentation: The provider submitted a copy of the Financial audit conducted for year ending June 30, 2023 and 2022 for the review. The audit was completed by RSM US, LLP and was dated December 15, 2023. No management letter or deficiency control letter was issued. | **No recommendation or Corrective Action.** |

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| **Contract Type: CINS/FINS** | **Region/Office: 3335 Forest Hills Blvd., West Palm Beach, FL** |
| **Service Description: Comprehensive Onsite Compliance Monitoring** | **Site Visit Date(s): May 29-30, 2024** |

| | Explain Rating | | | | | | |
|---|---|---|---|---|---|---|---|
| **Major Programmatic Requirements** | **Unacceptable** | **Conditionally Unacceptable** | **Fully Met** | **Exceeded** | **Not Applicable** | **Ratings Based Upon:**<br>**I = Interview**<br>**O = Observation**<br>**D = Documentation**<br>**PTV = Submitted Prior To Visit**<br>**(List Who and What)** | **Notes**<br>**Explain Unacceptable or Conditionally Acceptable:** |
| 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: Documents reviewed included policy and procedures regarding the following: CHS1017/Confidentiality and Access to Client Information and Records; CHS1032/Board Member Confidentiality; CHS5100/Cyber Security and Awareness Training Practice; CHS5002/Password Utilization; CHS5004/Equipment and Property Assignment Policy; CHS5105/Business Continuity and Disaster Recovery Plan; CHS5007/Electronic Document Retention Practice; and Accounting Manual/Record Retention Policy. | **No recommendation or Corrective Action.** |
| 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: A salary list of all CINS/FINS staff was provided, effective 8/30/2023, showing position title, annual salary, and pay rate. All direct care staff was observed to be paid at least $19 per hour. | **No recommendation or Corrective Action.** |

## CONCLUSION

CHS Safe Harbor has met the requirements for the CINS/FINS contract as a result of full compliance with 13 applicable indicators of the Administrative and Fiscal Contract Monitoring Tool. One of the 14 indicators was not applicable because the program indicated there are no outstanding corrective action item(s) cited by any external funding source. Consequently, **the overall compliance rate for this contract monitoring visit is 100%.** There are no corrective actions or recommendations 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, the majority of indicators reviewed were carried out in a manner which meets the standard described in the report findings.

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


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

Review of Children's Home Society Safe Harbor, West Palm Beach
Residential Program

May 29-30, 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 | Limited |
| 1.04 Training Requirements | Satisfactory |
| 1.05 Analyzing and Reporting Information | Satisfactory |
| 1.06 Client Transportation | Satisfactory |
| 1.07 Outreach Services | Satisfactory |

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

Standard 2: Intervention and Case Management

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

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

Standard 3: Shelter Care & Special Populations

| | |
|---|---|
| 3.01 Shelter Environment | Satisfactory |
| 3.02 Program Orientation | Satisfactory |
| 3.03 Youth Room Assignment | Satisfactory |
| 3.04 Log Books | Satisfactory |
| 3.05 Behavior Management Strategies | Satisfactory |
| 3.06 Staffing and Youth Supervision | Limited |
| 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 | Satisfactory |
| 4.04 Medical/Mental Health Alert Process | Limited |
| 4.05 Episodic/Emergency Care | Satisfactory |

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

**Overall Rating Summary**

**Percent of indicators rated Satisfactory: 89.29 %**

**Percent of indicators rated Limited: 10.71 %**

**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
Paula Friedrich – Regional Monitor, Department of Juvenile Justice
Philip N. Kabler, J.D - CDS Family & Behavioral Health Services, Inc.
Jose Ortega – Lutheran Services Florida Miami Bridge Central
Laura Saldana – Lutheran Services Florida Southeast

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

## Documents Reviewed

| | | | | | |
|---|---|---|---|---|---|
| | Accreditation Reports | X | Table of Organization | | Visitation Logs |
| X | Affidavit of Good Moral Character | X | Fire Prevention Plan | X | Youth Handbook |
| X | CCC Reports | X | Grievance Process/Records | 5 | # Health Records |
| X | Logbooks | | Key Control Log | 5 | # MH/SA Records |
| | Continuity of Operation Plan | X | Fire Drill Log | 9 | # Personnel /Volunteer Records |
| X | Contract Monitoring Reports | X | Medical and Mental Health Alerts | 8 | # Training Records |
| | Contract Scope of Services | X | Precautionary Observation Logs | 15 | # Youth Records (Closed) |
| X | Egress Plans | X | Program Schedules | 5 | # Youth Records (Open) |
| X | Fire Inspection Report | X | List of Supplemental Contracts | | # Other: ___ |
| | Exposure Control Plan | X | Vehicle Inspection Reports | | |

## Observations During Review

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

## Surveys

| | | | | | | |
|---|---|---|---|---|---|---|
| 5 | # of Youth | 7 | # 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**

Children's Home Society Safe Harbor (CHS Safe Harbor) is a non-profit community-based corporation contracted with the Florida Network of Youth and Family Services (Florida Network) to operate Children in Need of Services/Families in Need of Services (CINS/FINS) in South Palm Beach County. The program is located at 3335 Forest Hills Boulevard in West Palm Beach, Florida. CINS/FINS funding allows the agency to provide residential, community counseling, and case management services in West Palm Beach and the surrounding areas. Safe Harbor is licensed for 20 beds and the program's license was renewed by the Department of Children and Families (DCF) and is valid until 2/23/2025. 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 following programmatic updates were provided by the agency:**

***Staffing***

Over the last couple of years, CHS has been strategic in providing vertical alignment with its programs. This allows CHS to leverage expertise in other areas of the state to best provide services for each of its programs. Staff members have peers across the state who are doing the same work to maximize the quality of work CHS is providing in each region and county. CHS staff have already seen that, because of this implementation, staff are able to spend more time with children and families and realize successes quicker. In the summer of 2023, the agency finalized the last stage of alignment and all programs statewide have made this shift. As a result, the agency has seen an increase in subject matter expertise, sharing of this knowledge, and best practice to improve the work being done with the children and families served. As it relates to Safe Harbor, program operations are now being overseen by the Director of Out of Home Care Programs. This Director reports to the VP of Child and Family Wellbeing who then reports to the Chief Program and Clinical Officer. Outside of alignment, its two shelter programs (Safe Harbor and WaveCREST) are now being overseen by Duane Gross, Residential Program Manager. This has allowed for more seamless sharing of ideas, expertise, resources, and best practices, resulting in further strengthening of both programs. Safe Harbor shelter is also overseen at the supervisory level by Ray Coleman who was recently promoted to residential supervisor.

***Facility***

During the onsite visit, the building was observed to be undergoing construction of the entrance and lobby area which when completed will improve security and allow guests/visitors to be hosted in the lobby with no access to the staff offices or residential quarters. Since the last onsite visit, the CINS/FINS residential wing was completely renovated and boasts new floors throughout, an updated kitchen complete with new and modern appliances, new beds and furniture, new lighting fixtures, and freshly painted walls.

***Funding/Finance***

The development team continues to seek monetary donations through various businesses and local donors to provide group activities for youth, holiday gifts, dinners, and various fun outings. New funding received includes: Jack & Jill that provided Safe Harbor with a new Counseling/Calming Room; the Unitarian Fellowship Church of Boca Raton $1000); Army of the Lord Church – provided food, hygiene items, towels, and games for the youth in June 2023; and Jennifer Mazyck-Brown and her son Trey provided new game room items for Safe Harbor.

***Major Challenges***

The agency reported it is unable to meet the full needs of the community. The DJJ Circuit Advisory Board, school district of Palm Beach County and DJJ Chief Sterling continue to advocate on the agency's behalf to secure funding to cover the staffing needed to fill beds in one of its unoccupied residential wings.

**Narrative Summary**

CHS Safe Harbor is under the leadership of a management team that consists of a Director of Out of Home Placement, and Residential Director, a Residential Supervisor. Day-to-day activities in the youth shelter are managed by the Residential Manager and Supervisor who oversees one residential counselor, and six fulltime and three part time youth care staff. The community counseling program is managed by a Community Counseling Supervisor and community counseling services are provided by four case managers, one of whom is responsible for Safe Place and Outreach. The program reported one vacancy for its nurse position that was vacated in February 2024. At the time of the onsite visit, the shelter youth census was six youth.

**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 with Exception**.
Indicator 1.02 Provision of an Abuse Free Environment was rated **Satisfactory with Exception**.
Indicator 1.03 Incident Reporting was rated **Limited.**
Indicator 1.04 Training Requirements was rated **Satisfactory with Exception**.
Indicator 1.05 Analyzing and Reporting Information was rated **Satisfactory**.
Indicator 1.06 Client Transportation was rated **Satisfactory with Exception**.
Indicator 1.07 Outreach Services was rated **Satisfactory**.

Standard 2: There are nine indicators for Standard 2.
Indicator 2.01 Screening and Intake was rated **Satisfactory with Exception**.
Indicator 2.02 Needs Assessment was rated **Satisfactory**.
Indicator 2.03 Case/Service Plan was rated **Satisfactory**.
Indicator 2.04 Case Management and Service Delivery was rated **Satisfactory**.
Indicator 2.05 Counseling Services was rated **Satisfactory**.
Indicator 2.06 Adjudication/Petition Process was rated **Satisfactory**.
Indicator 2.07 Youth Records was rated **Satisfactory with Exception**.
Indicator 2.08 Specialized Additional Program Services was rated **Satisfactory.**
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 **Satisfactory with Exception.**
Indicator 3.05 Behavior Management Strategies was rated **Satisfactory.**
Indicator 3.06 Staffing and Youth Supervision was rated **Limited.**
Indicator 3.07 Video Surveillance System was rated **Satisfactory.**

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

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

**Standard 1:**

**Indicator 1.03 - Limited**

Seven incidents occurred during the review period. Two of the seven incidents were not reported to CCC (1/28/24 - medical emergency, and 2/19/24 - Baker Act). EMS responded to the program for youth having "heart problems" and completed EKG. There was no documentation of the incident being reported to the CCC in the incident report database and no call to CCC was noted in the logbook, as required. The program was informed to report the two incidents to CCC immediately.

One of the five incidents reported to CCC (incident date 3/21/24) was not reported within the 2-hour timeframe.

Upon review, four of the five CCC incidents entered into Eco Online were not flagged in the system as reported to CCC and include the relevant reporting information.

**Standard 3:**

**Indicator 3.06 - Limited**

April 30, 2024 - Bed Checks were completed between 14 to 16 minutes, and one bed check had a 30 minute lapse in between checks. Bed check times are different, off by two minutes per logbook entry vs camera. Camera system time is 10 minutes behind current time.

May 4, 2024- Bed check times are different, off by two minutes per logbook entry vs camera. Two bed checks were between completed late, 20 to 22 minutes.

May 8, 2024 - Bed check times are different, off by two minutes per logbook entry vs camera. Bed check between 5:32am to 6:02am missing activity on camera.

May 12, 2024 was not able to be review due to camera problem (jumps from 12:43am to 5:38am ).

May 24, 2024- Bed checks are different two minutes per logbook entry vs camera. Bed checks between 14 to 16 minutes in between. One bed check had a 30 minute lapse in between checks.

**Standard 4:**

**Indicator 4.04**

Three of five youth were not appropriately placed on the program's alert system. The program's policy requires for those youth with medical/ mental health needs to have a medical/ mental health alert sticker placed on the outside of the client's record; however, the active records did not have any indication of alerts on the outside of the records. Neither of the two forms used to document alerts include youth on medication as an alert status.

Reviewed documentation indicated one youth scored for suicide risk and was placed on precautionary observation but was not identified on the General Alert sheet in his record as a suicide risk, which then differed from alert forms in the medical section of the youth records which did identify suicide risk as an active alert. The General Alert form in another youth's record did not notate an alert for runaway behavior while the alert forms in the medical section of the record did. One youth was prescribed three psychotropic medications at the time of admission; however, there was no alert for the youth being on medication or for medication side effects.

The Alert Board on Day 1 of the review did not indicate one youth's allergy to penicillin and amoxicillin, although this was noted on the Alert Form in the youth's individual healthcare record. None of the five other youth in the shelter on Day 2, all of whom were identified on the room assignment board as having open alerts, were listed on the Alert Board.

| CINS/FINS QUALITY IMPROVEMENT TOOL | | |
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| **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, explaining how finding(s) are determined. | **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 with Exception** |
| **Provider has a written policy and procedure that meets the requirement for Indicator 1.01** | **NO** | |
| | If NO, explain here: Policy CHS/7101 does not address the retaking of the suitability assessment if an applicant does not pass the assessment and is considered for hire. | |
| | The provider has a policy and procedures CHS/7101 - Background Screening of Employees/ Volunteers, Annual Affidavit of Compliance with Good Moral Character & Annual Abuse Registry Clearance that was approved 2/17/2024 by the Director of Out of Home Programs (DOHP). | |
| **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: 6 new hire staff and 1 Intern**<br>**Total number of 5 Year Re-screen Employee Files: 2 rescreened staff**<br>**Staff Position(s) Interviewed** *(No Staff Names)*: **Talent General Manager, DOHP**<br>**Type of Documentation(s) Reviewed: Staff roster, Department of Juvenile Justice Background Screening results, Berke Pre-employment Assessment, E-Verify, Annual Affidavit of Compliance with Level 2 Screening Standards, Email sent to BSU for confirmation of receipt of Annual Affidavit.** | | |
| All positions providing direct services to youth has successfully passed pre-employment suitability assessment on the initial attempt. | **Exception** | A total of six new staff were hired since the last onsite QI review. All six staff met the criteria for a pre-screening assessment. The agency uses the Berke Assessment and completed the screening prior to hire for all six staff. Five of the six staff received passing scores of medium or high on the assessment. | One new staff, hired 12/28/2022, scored low on the Berke Assessment but did not have any documentation to support reason for hire despite a low suitability score. |
| 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** | The one staff who did not pass the suitability assessment was hired December 2022, prior to the July 2023 effective date of this requirement. | |
| 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 hires were prior employees. | |

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| Background screening completed prior to hire/start date (or exemption obtained prior to working with youth if rated ineligible) for new hires, volunteers/interns, and contractors. *( 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 the six new hires and one applicable intern were completed prior to hire/start dates with eligibility documented on the DJJ background screening results. There were no exemptions required. | |
| Five-year re-screening is completed every 5 years from the date of the last screening or prior to retained fingerprints expiration date. | **Compliance** | The program had two employees who met the criteria for re-screening during the review period. Both staff were rescreened prior to the retained fingerprints expiration date. | |
| 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 emailed its Annual Affidavit of Compliance with Level 2 Screening Standards to the Background Screening Unit on January 16, 2024, prior to the January 31st deadline. | |
| Proof of E-Verify for all new employees obtained from the Department of Homeland Security | **Compliance** | Proof of employment authorization from the Department of Homeland Security was obtained through E-Verify and maintained on file for the six new hires. | |

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

| **1.02: Provision of an Abuse Free Environment** | | **Satisfactory with Exception** |
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| **Provider has a written policy and procedure that meets the requirement for Indicator 1.02** | **YES** | |
| | If NO, explain here: | |
| | The provider has the required policy and procedures CHS/7102 - Providing an Abuse Free Environment, that was approved 2/17/2024 by the DOHP. | |

**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): Residential Supervisor**
**Type of Documentation(s) Reviewed: CHS Employee Handbook, code of conduct, client handbook, client grievance file, logbook, Eco Online incident report**
**Describe any Observations: abuse hotline postings, grievance box, grievance forms**

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| Agency has a code of conduct of policy and there is evidence that staff are aware of agency's code of conduct. | **Compliance** | The program has a code of conduct that prohibits the use of physical abuse, profanity, threats or intimidation. All new employees (full, part-time and relief) will have access to the electronic CHS Employee Handbook at the time of hire and will sign an acknowledgement to abide by all policies. Staff will comply with all rules of conduct as described in the CHS Employee Handbook. This includes clear prohibitions against using physical abuse, intimidation of any kind, profanity, threats, and/or excessive use of force. Youth are not deprived of basic needs, such as food, clothing, shelter, medical care and security. | |
| The agency has a process in place for reporting and documenting child abuse hotline calls. | **Compliance** | The program has a process in place for reporting and documenting any child abuse hotline calls. In addition to receipt of the employee handbook and acknowledgement of the information, staff are required to report allegations directly to the abuse hotline, document it on the agency's incident report form, and enter the incident into the agency's online database called Eco Online, formerly Airs Web. A review of the database report shows eight non-institutional calls to the abuse hotline during the review period. | |
| Youth were informed of the Abuse and Contact Number | **Compliance** | Youth are informed of the abuse hotline and telephone number during orientation and are required to initial receipt of the information on the orientation checklist and information in the youth handbook. This was verified in the five residential youth records reviewed. There are also many postings throughout the shelter with information regarding the Florida Abuse Hotline. | |
| **Grievance** | | | |
| The program must have an accessible and responsive grievance process for youth to provide feedback and address complaints. Program director/ supervisor will have access to and manage grievances unless it is towards themselves. | **Compliance** | The program provides an accessible, as well as responsive grievance process for youth to provide feedback and address complaints. The direct care workers do not handle the complaint/grievance documents, only the supervisor. | |
| <u>Shelter only:</u><br>Grievances are maintained on file at minimum for 1 year. | **Compliance** | The program maintains copies of all grievances reported in a file exceeding one year. | |

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| Shelter only:<br>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 and are required to initial receipt of the information on the orientation checklist and information in the youth handbook. The locked grievance box and grievance forms are available to youth in the dormitory hallway. During the review period the program provided copies of eight grievances reported by youth during the review period. | |
| Shelter only:<br>There is evidence that grievance boxes are checked by management or a designated supervisor at least daily as evidenced in the program logbook. | **Exception** | Grievance box checks were reviewed for the following random 2-week periods: December 18-22, 2023, and January 8-12, February 19-23, March 4-8, April 22-26, and May 13-17, 2024 for a total of 30 days. Grievance box checks were observed for only 17 of the 30 days. | Thirteen (13) of the 30 days reviewed did not document checks of the grievance box in the logbook by the shelter manager or supervisor as required. The days missing evidence of grievance box checks are as follows: 12/19/23, 12/21/23, 12/22/23, 1/8/24, 1/10-1/12/24, 2/19/24, 2/23/24, 3/5/24, 3/7/24, 4/24/24, and 4/26/24. |
| Shelter only:<br>All grievances are resolved within 72 hours and documented by program director/supervisor or escalated to higher leadership if grievance involves them directly. | **Compliance** | All eight grievances reported were reviewed by the shelter manager or supervisor and resolved within 72 hours. The manager/supervisor writes a statement of how the grievance is resolved on the grievance form, then signs and dates the form. An incident report is also generated and is reviewed by the shelter manager and DOHP. | |
| **1.03: Incident Reporting** | | | **Limited** |
| **Provider has a written policy and procedure that meets the requirement for Indicator 1.03** | | **YES**<br>If NO, explain here:<br>The provider has the required policy and procedures CHS/7103 - Incident Reporting, that was approved 2/17/2024 by the Director of Out of Home Programs (DOHP). | |

**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)* **: Quality Management Specialist, Residential Supervisor**
**Type of Documentation(s) Reviewed: Program log books, and Eco Online internal incident reports for the past six months.**
**Describe any Observations: Postings of CCC telephone number**

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| 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** | The program documents all incidents, both reportable and non-reportable, in the electronic Eco Online system. The program had a total of seven reportable incidents that occurred during the review period. Five of the seven reportable incidents were reported to the CCC; four of the five were reported within two hours, as required. The program uses an online system, Eco Online, to enter and maintain incident reports. | Seven incidents occurred during the review period. Two of the seven incidents were not reported to CCC (1/28/24 - medical emergency, and 2/19/24 - Baker Act). EMS responded to the program for youth having "heart problems" and completed EKG. There was no documentation of the incident being reported to the CCC in the incident report database and no call to CCC was noted in the logbook, as required. The program was informed to report the two incidents to CCC immediately.<br><br>One of the five incidents reported to CCC (incident date 3/21/24) was not reported within the 2-hour timeframe. |
| The program completes follow-up communication tasks/special instructions as required by the CCC | **Compliance** | All five CCC reports reviewed demonstrated follow-up communication tasks/ special instructions were completed by the program. | |
| Agency internal incidents are documented on incident reporting forms and all CCC reportable incidents were consistently reported to CCC as required. | **Exception** | Incident reports are documented electronically in the agency's online system which is an incident management and incident tracking software that simplifies incident reporting, investigations, and corrective action within a single, secure platform. All five incidents reviewed were recorded in the online system; however, incident reporting status was not found to be accurately entered in the system. | Upon review, four of the five CCC incidents entered into Eco Online were not flagged in the system as reported to CCC to include the relevant reporting information. |
| Incidents are documented in the program logs and on incident reporting forms | **Compliance** | All five CCC reports reviewed were documented in the program logbook. | |
| All incident reports are reviewed and signed by program supervisors/ directors | **Compliance** | All five incident reports recorded in Eco Online showed electronic documentation of supervisor's reviews. | |
| **1.04: Training Requirements** (*Staff receives training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions*) | | | **Satisfactory with Exception** |
| **Provider has a written policy and procedure that meets the requirement for Indicator 1.04** | | **YES**<br>If NO, explain here:<br>The provider has a policy and procedures CHS/7104- Training Requirements that was approved 2/17/2024 by the DOHP. | |

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| **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**<br>**Total number of Annual In-Service Staff Files: 4**<br>**Total number of Non-Licensed Mental Health Clinical Shelter Staff Files: 0**<br>**Annual Training Plan Timeframe** (*Program timeframe for annual trainings* )**: 1/1/23 - 12/31/23**<br>**Staff Position(s) Interviewed** *(No Staff Names)* **: Residential Supervisor**<br>**Type of Documentation(s) Reviewed: Staff training notebooks**<br>**Describe any Observations: Substantially complete training notebooks, with requests for a limited number of documents not included** | | | |
| **First Year Direct Care Staff** | | | |
| All direct care staff have completed new hire pre-service training requirements for safety and supervision as required. | **Compliance** | Four first year direct care staff files were reviewed for new hire pre-service training requirements for safety and supervision as required, utilizing training logs, certificates, Relias transcripts, Bridge transcripts, and SkillPro transcripts as sources. All four new hire pre-service training requirements were reviewed, and it was verified that all pre-service training requirements were completed. | |
| All staff completed the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days from date of hire. | **Exception** | Training records reviewed evidenced three of the four direct care staff completed the required Civil Rights training within the 30 day timeframe. | One of four first year direct care staff competed the United States Department of Justice (DOJ) Civil Rights & Federal Funds training beyond 30 dates from hire (hired 9/18/23, completed 10/27/23). |
| 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** | Each staff Training log was examined and found to include a minimum of 80 hours of training or more for the first full year of employment | |
| All staff receives all mandatory training during the first 90 days of employment from date of hire. | **Compliance** | All four new hires training records included training documentation to support all mandatory trainings were completed within 90 days of employment. | |
| **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** | One applicable staff member responsible for entering NIRVANA completed the required trainings prior to completing a NIRVANA assessment. | |
| **Staff Participating in Case Staffing & CINS Petitions (within first year of employment)** | | | |
| 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 community counseling new hire staff member still has time remaining to complete the required training. | |

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| **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 a non-licensed mental health clinical staff 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).* | **Compliance** | Four in-service staff training records were reviewed. All four required in-service trainings were completed by the agency's annual calendar training year. | |
| **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** | Each staff training notebook included a CINS/FINS Program Training Plan detailing Staff Development and Training, Introduction and General Orientation of the Organization (4 hours), Pre-service Child Caring Agency Training/Introduction and General Orientation to CINS/FINS (40 hours), First year required and recommended training topics to be completed in first 90 days in DJJ SkillPro, Training to be completed in first 120 days of hire, additional CINS/FINS Training, Total 40 hours annually. and Supervisors are required a minimum of six hours a year of Supervisory training. | |
| 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. | **Compliance** | The agency's residential manager manages all staff training for the program and a training file is maintained for each staff. | |
| 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 an individual training file or employee file with a training log, which tracks annual employee training hours, certificates of completion, sign-in sheets, and transcripts. Reviewer observed the training plans were not signed or dated by two of the three new hire residential staff and one new community counseling staff. | |
| ***Additional Comments:*** **There are no additional comments for this indicator.** | | | |

| 1.05 - Analyzing and Reporting Information | | | Satisfactory |
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| **Provider has a written policy and procedure that meets the requirement for Indicator 1.05** | | **YES**<br>If NO, explain here:<br>The provider has the required policy and procedures CHS/7105-Reporting and Analyzing Data/Information, that was approved 2/17/2024 by the Director of Out of Home Programs (DOHP). | |
| **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): Quality Management Specialist**<br>**Type of Documentation(s) Reviewed: Compliance and Quality Record Review Aggregation Tool, Quality Council Meeting - Quarterly, Quarterly Program Performance Meeting, Flash Report - Monthly, Quarterly Executive Director Report, Monthly Matrix, Quarterly Board Report, Program Performance Report (PPR), and Client Satisfaction Survey Email.** | | | |
| Case record review reports demonstrate reviews are conducted quarterly, at a minimum | **Compliance** | Record reviews were conducted for both the shelter and community counseling programs quarterly during the current fiscal year (FY). During the past two quarters of the FY, the shelter completed a total of 12 record reviews and community counseling completed 15 record reviews. Record reviews are documented on the Compliance and Quality Record Review Aggregation tool which includes 53 indicators relevant to CINS/FINS youth record requirements. A quality team member meets with program staff weekly or at staff meetings to review deficiencies and create a plan of action. Action plans are tracked on the shared drive and reported through quality meetings with leadership. | |
| The program conducts reviews of incidents, accidents, and grievances quarterly, at a minimum | **Compliance** | Incidents and accidents are entered in real time into the agency's Eco Online electronic system. All staff has access to enter incidents in lieu of using a report form. The system tracks the types of incidents, status of reviews, and generates reports. Consumer grievances are submitted to program supervisors and entered into Eco Online. A review of the Eco Online report for the review period demonstrates the program collects detailed information for incidents, accidents, and grievances and communicate findings at monthly staff meetings. | |

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| The program conducts an annual review of customer satisfaction data | **Compliance** | Consumer surveys are collected by program staff as well as electronically submitted through the agency's website. Surveys are monitored by quality management staff who generate reports to be reviewed at monthly program meetings, and quarterly quality council meetings. Evidence of consumer survey results is reported on quarterly program performance review (PPR) reports. | |
| The program demonstrates a monthly review of the statewide End-of-Month ("EOM") report generated by the Florida Network Office. This includes monthly data, fiscal year to date data, benchmarks for residential and community counseling, screening data, report card measures, follow-up reporting measures. | **Compliance** | EOM reports are emailed to the Program Director and disseminated to the management team. Data from the EOM report is reviewed at the monthly staff meetings. Monthly staff meeting agendas and minutes for the review period validates program review of the EOM reports on a regular basis with staff. | |
| The program has a process in place to review and improve accuracy of data entry & collection | **Compliance** | The agency has a robust quality management process and data collection system in place to monitor, analyze, and communicate information to the Board of Directors, local management team. Data collected is maintained on a dashboard accessible to the QM team and findings are regularly reported and reviewed with staff and stakeholders. | |
| There is documentation that findings are regularly reviewed by management and communicated to staff and stakeholders. | **Compliance** | The provider's quality management team has monthly and quarterly reporting timeframes to analyze data with reporting requirements to leadership, management, and staff. Evidence of quarterly quality council meetings, executive leadership meetings, and staff meeting minutes support regular communication to stakeholders. | |
| There is evidence the program demonstrates that program performance is routinely reviewed with the Board of Directors. 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 final QI reports that include a limited or failed score are submitted electronically or by mail to the providers' executive committee. Two board meetings held on 9/8/23 and 12/1/23 during the FY were reviewed. The agenda includes an item for Risk and Audit information so that program performance is reviewed with the board of directors. | |

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| There is evidence that strengths and weaknesses are identified, improvements are implemented or modified, and staff are informed and involved throughout the process. | **Compliance** | The agency has a Senior Director of Quality and Compliance who leads a quality management team in the development, implementation, documentation, evaluation, and promotion of continuous improvement practices and systems. The Quality Management team is responsible for oversight at the local level. Processes are in place and established in the agency's PQI plan to collect data and identify areas needing improvement. Should negative trends be observed, a corrective action will be implemented as a priority issue to be addressed and is monitored by the compliance staff as well as the program's management team. | |
| ***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** | | **NO**<br>If NO, explain here:<br>The providers transportation policy does not address check-ins when there is a single transport event.<br>The provider has a policy and procedures CHS/7106- Client transportation, that was approved 2/17/2024 by the DOHP. | |
| **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: 1/1/24 - 5/23/24**<br>**Staff Position(s) Interviewed** *(No Staff Names)* **: Residential Supervisor**<br>**Type of Documentation(s) Reviewed: Approved drivers list, Log Books, 2023-2024 Transportation Records (notebook)** | | | |
| Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle | **Compliance** | The approved list of agency staff drivers was provided and reviewed. The agency maintains a list of 14 staff authorized to drive agency vehicles. | |
| Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy | **Compliance** | All approved drivers' licenses were examined (including for expiration dates) against the approved staff driver list and were found to be valid. Per the residential manager, all 14 staff members are approved by administration and are covered under the agency's insurance policy to drive agency vehicles. | |
| 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** | Provider's policy states youth will be transported with 3rd party presence when at all possible. This 3rd party may be another direct care staff, volunteer, intern, clinical or administrative staff or other youth. | |

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| 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 agency's policy provides provision in the event a 3rd party cannot be obtained. The provision includes supervisory consideration of the client's history, evaluation and recent behavior prior to authorizing single transport. | |
| The 3rd party is an approved volunteer, intern, agency staff, or other youth | **Compliance** | Agency staff or other youth serve as 3rd parties. | |
| The agency demonstrated evidence via logbook or other written verification that supervisor approval was obtained prior to all single youth transports. | **Exception** | A sample of 24 single client transports during the review period was reviewed. Ten were related to use of the Nissan/2016 NV 3500 minivan and 15 related to use of the Ford/2023 minivan. Clear evidence of supervisor's approval, prior to transport, was documented in the program logbook for 21 of the 24 transportation events reviewed. Another two single transports documented the supervisor's approval as late entries (2/2/24 single transport at 8:25am, late entry at 11am and 4/18/24 single transport at 8am, late entry at 4:30pm). | Supervisor's approval for single transport on 4/24/24 at 11:48am was not noted in the logbook by staff. |
| 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** | Both vehicles' Transportation Logs record: Date, Travel Performed (From-To), Reason for Travel, Starting # of Clients, Client Initial(s), Mileage (Gas Purchase), Time of Exist, Time of Return, Start Mileage, End Mileage, Total Mileage, Ending # of Clients, Clients Initial(s), Staff Initials. The Ford Transportation Log includes an additional column marked "A Supervisor Initial". | |
| ***Additional Comments:*** **There are no additional comments for this indicator.** | | | |
| **1.07 - Outreach Services** | | | **Satisfactory** |
| **Provider has a written policy and procedure that meets the requirement for Indicator 1.07** | | **YES**<br>If NO, explain here:<br>The provider has the required policy and procedures CHS/7107-Outreach and Interagency Agreements, that was approved 2/17/2024 by the DOHP. | |
| **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.* | | | |

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| **Staff Position(s) Interviewed (No Staff Names): Residential Counselor**<br>**Type of Documentation(s) Reviewed: DJJ CAB Meeting Minutes, CINS/FINS Outreach forms, NetMIS Outreach List Report** | | | |
| 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. | **Compliance** | The Program Manager is the lead staff member designated to participate in local DJJ Board, Circuit and Council meetings, with position description supporting role. Minutes of November 2023 - April 2024, 15th Circuit Advisory Board meetings demonstrated attendance to all of the meetings held. | |
| The program maintains written agreements with other community partners which include services provided and a comprehensive referral process. | **Compliance** | Two written agreements were identified with the Palm Beach School Board. The program reported it is pursuing additional agreements with DJJ, the School District, Urban League, and South Behavioral Health (local managing entity). | |
| 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's NetMIS outreach list report was examined, and showed event/program title, dates, duration (hours), zip code, location description, estimated number of people reached, modality, target audience, and topic. The program maintains CINS/FINS Outreach outline forms which showed counselor name, and month/year, name/title of contact person, address, zip code, location, contact mail/telephone, and signature. | |
| The program has designated staff that conducts outreach which is defined in their job description. | **Compliance** | The position description of the lead staff (Program Manager) was reviewed, and the outreach lead function was identified on the job description. | |
| ***Additional Comments:*** **There are no additional comments for this indicator.** | | | |
| **2.01 - Screening and Intake** | | | **Satisfactory with Exception** |
| **Provider has a written policy and procedure that meets the requirement for Indicator 2.01** | | **YES**<br>If NO, explain here:<br>The provider has the required policy and procedures CHS/7201, Screening Eligibility for Services and Intake Assessment, that was approved 2/17/2024 by the DOHP. | |
| **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: 2 open residential, 2 open community counseling**<br>**Total number of Closed (Residential & Community) Files: 3 closed residential, 3 closed community counseling**<br>**Staff Position(s) Interviewed (No Staff Names): Residential Counselor and Community Counseling Supervisor**<br>**Type of Documentation(s) Reviewed: youth records** | | | |
| **Shelter youth:** Eligibility screening form is completed immediately for all shelter placement inquiries. | **Compliance** | All five shelter cases reviewed had the eligibility screening form completed within the time frame allowed. | |

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| **Community counseling:** Eligibility screening form is completed within 3 business days of referral by a trained staff using the Florida Network screening form. | **Exception** | Three of five community counseling cases reviewed, had the eligibility screening forms completed by a trained staff within the three business days. | Two community counseling records reviewed did not demonstrate completion of eligibility screening within three business days of the referral. For one youth, the referral was received on 1/18/24, but eligibility screening was done on 2/6/24. A second youth's referral was 12/01/23 but date of screening eligibility was done on 4/3/24. |
| There is evidence all referrals for service is screened for eligibility and is logged in NetMIS within 72 hours of screening completion. | **Compliance** | All 10 cases reviewed had referrals for service screened for eligibility and were logged in NetMIS within 72 hours of screening completion. | |
| Youth and parents/guardians receive the following in writing:<br>a. Available service options<br>b. Rights and responsibilities of youth and parents/guardians | **Compliance** | All 10 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. | |
| The following is also available to the youth and parents/guardians:<br>a. Possible actions occurring through involvement with CINS/FINS services (case staffing committee, CINS petition, CINS adjudication)<br>b. Grievance procedures | **Compliance** | All 10 files reviewed, also shown that the families were informed of the CINS/FINS services, and grievance procedures. | |
| During intake, all youth were screened for suicidality and correctly assessed as required if needed. | **Compliance** | All 10 files reviewed were screened for suicidality. Six of the 10 youth answered "yes" to at least one of the five suicide screening questions, indicating a suicide risk. Four of the six youth records (residential youth) demonstrated an assessment of suicide risk was completed.<br>Two community counseling youth, with intake dates 3/27/2024 and 4/10/2024, were screened as suicide risk; however, no assessment of suicide risk appeared to be completed and there were no case notes explaining what steps were taken to ensure the client's safety. Upon further review, an additional reviewer was able to locate the missing assessments. | |
| ***Additional Comments:*** **There are no additional comments for this indicator.** | | | |
| **2.02 - Needs Assessment** | | | **Satisfactory** |
| **Provider has a written policy and procedure that meets the requirement for Indicator 2.02** | | **YES**<br>If NO, explain here:<br>The provider has the required policy and procedure, CHS/7202 Needs Assessment, that was approved 2/17/2024 by the DOHP. | |

**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: 2 open residential, 2 open community counseling**
**Total number of Closed (Residential & Community) Files: 3 closed residential, 3 closed community counseling**
**Staff Position(s) Interviewed (No Staff Names): Residential Counselor and Community Counseling Supervisor**
**Type of Documentation(s) Reviewed: youth records**

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| Shelter Youth: NIRVANA is initiated within 72 hours of admission | **Compliance** | All five residential records reviewed demonstrated NIRVANA was 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 | **Compliance** | All five community counseling files reviewed demonstrated NIRVANA was initiated at intake and completed within two to three face-to-face contacts after the initial 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. | **Compliance** | The supervisor signed all the NIRVANA assessments for both residential and community counseling services. | |
| (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** | The five shelter files reviewed had all self-assessments completed within 24 hours of the youth being admitted into the 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** | Four applicable youth files, with length of stay greater than 30 days, included NIRVANA post assessments that were completed and documented in the files. | |
| A NIRVANA Re-Assessment is completed every 90 days excluding files for youth receiving SNAP services. | **Compliance** | Two applicable files reviewed completed the NIRVANA 90-day re-assessment. | |

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| All files include the interview guide and/or printed NIRVANA. | **Compliance** | All 10 files included the interview guide and printed NIRVANA for all youth | |
| ***Additional Comments:*** **There are no additional comments for this indicator.** | | | |
| **2.03 - Case/Service Plan** | | | **Satisfactory** |
| **Provider has a written policy and procedure that meets the requirement for Indicator 2.03** | | **YES**<br>If NO, explain here:<br>The provider has the required policy and procedure, CHS/7203 Case Plans Implementation, Review, and Revision, that was approved 2/17/2024 by the DOHP. | |
| **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: 2 open residential, 2 open community counseling**<br>**Total number of Closed (Residential & Community) Files: 3 closed residential, 3 closed community counseling**<br>**Staff Position(s) Interviewed (No Staff Names): Residential Counselor and Community Counseling Supervisor**<br>**Type of Documentation(s) Reviewed: youth records** | | | |
| 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 10 files reviewed had the case/service plan developed based on information from the screening, intake, and the nirvana. | |
| Case/Service plan is developed within 7 working days of NIRVANA | **Compliance** | The case and service plans were created immediately in all 10 files | |
| **Case plan/service plan includes:**<br>1. Individualized and prioritized need(s) and goal(s) identified by the NIRVANA<br>2. Service type, frequency, location<br>3. Person(s) responsible<br>4. Target date(s) for completion and actual completion date(s)<br>5. Signature of youth, parent/guardian, counselor, and supervisor<br>6. Date the plan was initiated | **Compliance** | All 10 files reviewed, had the individualized and prioritized needs and goals, service type, frequency, location, signature of both parents, youth and counselor. | |
| 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** | All applicable case plans were observed to be reviewed for progress and revised by the 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 |
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| **Provider has a written policy and procedure that meets the requirement for Indicator 2.04** | | **YES**<br>If NO, explain here:<br>The provider has the required policy and procedure, CHS/7204 Case Management Services - Family Involvement, that was approved 2/17/2024 by the DOHP. | |
| **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: 2 open residential, 2 open community counseling**<br>**Total number of Closed (Residential & Community) Files: 3 closed residential, 3 closed community counseling**<br>**Staff Position(s) Interviewed (No Staff Names): Residential Counselor and Community Counseling Supervisor**<br>**Type of Documentation(s) Reviewed: youth records** | | | |
| Counselor/Case Manager is assigned | **Compliance** | In all 10 cases a counselor/case manager was assigned to work with the youth and family from the beginning to termination. | |
| The Counselor/Case Manager completes the following as applicable:<br>1. Establishes referral needs and coordinates referrals to services based upon the on-going assessment of the youth's/family's problems and needs<br>2. Coordinates service plan implementation<br>3. Monitors youth's/family's progress in services<br>4. Provides support for families<br>5. Monitoring progress of court ordered youth in shelter<br>6. Makes referrals to the case staffing to address problems and needs of the youth/family<br>7. Accompanies youth and parent/guardian to court hearings and related appointments<br>8. Refers the youth/family for additional services when appropriate<br>9. Provides case monitoring and reviews court orders<br>10. Provides case termination notes<br>11. Provides follow-up after 30 days post discharge<br>12. Provides follow-up after 60 days post discharge | **Compliance** | All ten records reviewed demonstrated coordination of service plan implementation based on the youth's/family's problems and needs. It was also evident the case worker monitored youth's/family's progress in services, provided support for families when needed, and referred the youth/family for additional services when appropriate. None of the ten files reviewed were referred for case staffing; however, staff monitored progress and accompanied one domestic violence youth to court. Case termination notes were present in the six closed files. Thirty and 60 day follow ups were completed timely in all applicable files. | |
| The program maintains written agreements with other community partners that include services provided and a comprehensive referral process | **Compliance** | If applicable, referrals were made for youth and/family to local community agencies. The program maintains agreements with a variety of community partners that include services provided and a comprehensive referral process. | |
| ***Additional Comments:*** **There are no additional comments for this indicator.** | | | |

| 2.05 - Counseling Services | | | Satisfactory |
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| **Provider has a written policy and procedure that meets the requirement for Indicator 2.05** | | **YES**<br>If NO, explain here:<br>The provider has the required policy and procedure, CHS/7205 Counseling Services, that was approved 2/17/2024 by the DOHP. | |
| **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: 2 open residential, 2 open community counseling**<br>**Total number of Closed (Residential & Community) Files: 3 closed residential, 3 closed community counseling**<br>**Staff Position(s) Interviewed (No Staff Names): Residential Counselor and Community Counseling Supervisor**<br>**Type of Documentation(s) Reviewed: youth records** | | | |
| **Shelter Program** | | | |
| Shelter programs provides individual and family counseling | **Compliance** | Residential youth received individual and family counseling as evidenced by the clinical notes in the five residential youth records reviewed. | |
| Group counseling sessions held a minimum of five days per week | **Compliance** | All five shelter files reviewed had group sessions five times a week. | |
| Groups are conducted by staff, youth, or guests and group counseling sessions consist of :<br>1. A clear leader or facilitator<br>2.Relevant topic - educational/informational or developmental<br>3. Opportunity for youth to participate<br>4. 30 minutes or longer | **Compliance** | Each of the group counseling sessions reviewed included documentation of a clear leader or facilitator, relevant topic, opportunity for youth to participate, completed worksheets which are kept in the youth files, and per the residential manager, all groups are held 30 minutes or longer. | |
| Documentation of groups must include date and time, a list of participants, length of time, and topic. | **Compliance** | Group sessions are documented on a group form that documented date and time, list of youth participating, and topic. | |
| **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** | The five files reviewed for community counseling showed clear goals on how counselor will help stabilize the family. No client required virtual services. | |

| Counseling Services | | | |
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| There is evidence the program completes review of all case files for coordination between presenting problem(s), psychosocial assessment, case/service plan, case/service plan reviews, case management, and follow-up. | **Compliance** | In all 10 files there is evidence the program completes review of all case files for coordination between presenting problem(s), psychosocial assessment, case/service plan, case/service plan reviews, case management, and follow up | |
| Maintain individual case files on all youth and adhere to all laws regarding confidentiality. | **Compliance** | Each file reviewed had an individual case file which followed the law regarding confidentiality. | |
| Case notes maintained for all counseling services provided and documents youth's progress. | **Compliance** | All the files maintained case notes in a chronological order. | |
| On-going internal process that ensures clinical reviews of case records and staff performance. | **Compliance** | All files had an in-house audit to ensure clinical reviews of the case records, youth involvement, and staff performance. | |
| When an intake is conducted through virtual means, consent is confirmed by the counselor, documented in the file, and reviewed with the supervisor during supervision/case review. There is written documentation provided in the youths file for reasons why virtual sessions are in the best interest of the youth and family. | **No eligible items for review** | None of the intakes for the records reviewed were conducted through virtual means. | |
| ***Additional Comments:*** **There are no additional comments for this indicator.** | | | |

| **2.06 - Adjudication/Petition Process** | | **Satisfactory** |
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| **Provider has a written policy and procedure that meets the requirement for Indicator 2.06** | **YES**<br>If NO, explain here:<br>The provider has the required policy and procedure, CHS/7206 Case Staffing Committee - CINS Petition, Adjudication Process, that was approved 2/17/2024 by the DOHP. | |

**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 closed community counseling records**
**Staff Position(s) Interviewed (No Staff Names): Community Counseling Supervisor**
**Type of Documentation(s) Reviewed: youth records**

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| Must include:<br>a. DJJ rep. or CINS/FINS provider<br>b. Local school district representative | **Compliance** | Three applicable case records were reviewed for case staffing that was held during the review period. Documentation in the file indicated a DJJ representative, CINS/FINS provider, and local school district representative was present at the staffing. | |

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| Other members may include:<br>a. State Attorney's Office<br>b. Others requested by youth/ family<br>c. Substance abuse representative<br>d. Law enforcement representative<br>e. DCF representative<br>f. Mental health representative | **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. No additional members were requested to be present for the staffing reviewed. | |
| The program has an established case staffing committee, and has regular communication with committee members | **Compliance** | The program has an established case staffing committee in the event the youth/family is not in agreement with services or treatment; the youth/family will not participate in the services selected; or the program receives a written request from a parent/guardian or any other member of the committee. | |
| The program has an internal procedure for the case staffing process, including a schedule for committee meetings | **Compliance** | The case staffing meetings will be held if requested, including emergency case staffing. Members of the committee are notified via email when a case staffing is scheduled to be convened. | |
| The youth and family are provided a new or revised plan for services | **Compliance** | As a result of the case staffing, documentation supported the youth and family were provided a revised case plan. | |
| Written report is provided to the parent/guardian within 7 days of the case staffing meeting, outlining recommendations and reasons behind the recommendations | **Compliance** | Written report was provided to the parent or guardian immediately after the case staffing, outlining the reasons behind the recommendations of the committee. | |
| If applicable, the program works with the circuit court for judicial intervention for the youth/family | **No eligible items for review** | Court intervention was not required for the case staffed. | |
| Case Manager/Counselor completes a review summary prior to the court hearing | **No eligible items for review** | Court intervention was not required for the case staffed. | |
| ***Additional Comments:*** **There are no additional comments for this indicator.** | | | |
| **2.07 - Youth Records** | | | **Satisfactory with Exception** |
| **Provider has a written policy and procedure that meets the requirement for Indicator 2.07** | | **YES**<br>If NO, explain here:<br>The provider has the required policy and procedure, CHS/7207 Youth Records and Case Management Services, that was approved 2/17/2024 by the DOHP. | |
| **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)* **: Residential Counselor and Community Counseling Supervisor**<br>**Type of Documentation(s) Reviewed: thirteen youth records**<br>**Describe any Observations: File storage cabinets, youth case files** | | | |

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| All records are clearly marked 'confidential'. | **Exception** | Nine of the 10 files reviewed were marked confidential on the exterior of the file folder. | One open residential youth case file binder did not have the youth's name recorded on the file and was not marked confidential. |
| All records are kept in a secure room or locked in a file cabinet that is marked "confidential" | **Compliance** | All youth records were observed to be kept in a secure room and locked in a file cabinet that is marked "confidential". | |
| When in transport, all records are locked in an opaque container marked "confidential" | **Compliance** | The program has a container that is used to transport records off site. The storage container is marked confidentiality and equipped with a lock. Program laptops are encrypted and password protected for confidentiality and safety. | |
| All records are maintained in a neat and orderly manner so that staff can quickly and easily access information | **Exception** | All files had a cover page for each section of the case file but during the review, the order of the documents in the sections did not always follow the order listed on the cover page. | Two of the reviewers experienced difficulties finding some of the case record documents in the same order while reviewing the files. |
| ***Additional Comments:*** **There are no additional comments for this indicator.** | | | |
| **2.08 - Specialized Additional Program Services** | | | **Satisfactory** |
| **Provider has a written policy and procedure that meets the requirement for Indicator 2.08** | | **YES**<br>If NO, explain here:<br>The provider has the required policy and procedure, CHS/7211 Specialized Additional Program Services, that was approved 2/17/2024 by the DOHP. | |
| **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)* **: Residential Program Supervisor** | | | |
| Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted?<br>**(If no, select rating "No eligible items for review")** | **No eligible items for review** | CHS Safe Harbor has not served any youth who met the criteria for Staff Secure services since the last QI review. | |
| Staff Secure policy and procedure outlines the following:<br>a. In-depth orientation on admission<br>b. Assessment and service planning<br>c. Enhanced supervision and security with emphasis on control and appropriate level of physical intervention<br>d. Parental involvement<br>e. Collaborative aftercare | **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** | | |

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| Staff Assigned:<br>a. One staff secure bed and assigned staff supervision to one staff secure youth at any given time<br>b. Program assign specific staff during each shift to monitor location/ movement of staff secure youth<br>c. Agency clearly documents the specific staff person assigned to the staff secure youth in the logbook or any other means on each shift | **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)* **: Residential Program Supervisor** | | | |
| Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted?<br>(If no, select rating "No eligible items for review") | **No eligible items for review** | The provider has not served any youth who met 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:<br>a. Youth in program do not have length of stay in DMST placement that exceeds seven (7) days<br>b. Agency has approval for stays and support beyond seven (7) days for DMST placements that are obtained on a case-by-case basis? (If applicable.) | **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** | | |

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| 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 Closed Files: 3 closed DV Respite youth records**<br>**Staff Position(s) Interviewed (No Staff Names): Shelter Counselor**<br>**Type of Documentation(s) Reviewed: Youth records, NetMIS** | | | |
| Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted?<br>(If no, select rating "No eligible items for review") | **Yes** | A total of three closed residential DV youth records were reviewed. | |
| Youth admitted to DV Respite placement have evidence in the file of a pending DV charge | **Compliance** | All three records reviewed have documentation in the files to show the three youth have pending DV charges and were referred by DJJ to the shelter for DV respite services. | |
| Data entry into NetMIS within (3) business days of intake and discharge | **Compliance** | The three youth records were reviewed in NetMIS and data entry was verified to be completed within three business days of intake and discharge. | |
| 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. | **Compliance** | None of the three youth had a placement in DV Respite for more than 21 days. | |
| 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 the 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 Closed Files: 1 closed probation respite youth record**<br>**Staff Position(s) Interviewed (No Staff Names): Shelter Counselor**<br>**Type of Documentation(s) Reviewed: Youth record, NetMIS** | | | |
| Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted?<br>(If no, select rating "No eligible items for review") | **Yes** | One probation respite youth was served during the review period. | |

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| All probation respite referrals are submitted to the Florida Network. | **Compliance** | Documentation of email approval from the Florida Network was present in the case file. | |
| All Probation Respite Referral come from DJJ Probation and there is evidence that the youth is on Probation regardless of adjudication status. | **Compliance** | The referral information and court document in the youth's record supported the youth is on probation and a probation officer referred the youth to the shelter for probation respite services. | |
| Data entry into NetMIS and JJIS within (3) business days of intake and discharge | **Compliance** | NetMIS data reviewed verified the youth's intake and discharge were entered 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. | **Compliance** | The youth's length of stay exceeded 30 days; however, there is documentation in the youth's record showing the request for the extension was made by the JPO. | |
| All case management and counseling needs have been considered and addressed | **Compliance** | The case plan for the youth reflected goals that addressed the youth's behavior and skills needed to effect improved family relationship and coping skills. | |
| All other services provided to Probation Respite youth are consistent with all other general CINS/FINS program requirements | **Compliance** | Services provided to the youth demonstrate participation in program services that are 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)* **: Residential Program Supervisor**

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| Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted?<br>(If no, select rating "No eligible items for review") | **Not Applicable** | CHS Safe Harbor 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:<br>a. Two (2) direct contacts per month<br>b. Two (2) collateral contacts per week<br>c. Direct and collateral contacts not obtained must have documentation to support attempts made to obtain them. All reasonable attempts (at minimum of three) must be made to reach all contacts (direct and collateral) and documented in the case file and NetMIS. | **Not Applicable** | | |

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| Assessments include<br>a. NIRVANA at intake<br>b. NIRVANA Re-Assessment every 90 days<br>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)* **: Residential Program Supervisor** | | | |
| Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted?<br>(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 6 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:<br>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.<br>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.<br>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:<br>a. Sessions are face-to-face, sixty (60) minutes in length and focus on strengthening the family unit<br>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** | | |

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| Individual Sessions:<br>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.<br>b. Issues to be covered through each session include but are not limited to:<br>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:<br>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.<br>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** | | |

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| 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**<br>If NO, explain here:<br>CHS Safe Harbor 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)* **: Residential Program Supervisor**

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| **SNAP Clinical Groups Under 12** | | | |
| Youth are screened to determine eligibility of services. | **Not Applicable** | CHS Safe Harbor 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** | | |
| There is evidence of the completed TOPSE is completed by the caregiver (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** | CHS Safe Harbor is not contracted to provide SNAP services. | |
| 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** | CHS Safe Harbor is not contracted to provide SNAP services. | |
| 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** | | |

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| 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** | CHS Safe Harbor is not contracted to provide SNAP services. | |
| 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**<br>If NO, explain here:<br>The program has the required policy and procedures CHS/7301 Shelter Environment, approved on 4/29/2024 by the DOHP. | |

**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: Residential Supervisor**
**Type of Documentation(s) Reviewed: Weekly and perpetual chemical inventory, MSDS, Fire Drills, Emergency Drills, Palm Beach 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**

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| **Facility Inspection:**<br>a. Furnishings are in good repair.<br>b. The program is free of insect infestation.<br>c. Bathrooms and shower areas are clean and functional, free of foul odors, leaks, dust, and mildew and in good working order.<br>d. There is no graffiti on walls, doors, or windows.<br>e. Lighting is adequate for tasks performed there.<br>f. Exterior areas are free of debris; grounds are free of hazards.<br>g. Dumpster and garbage can(s) are covered.<br>h. All doors are secure, in and out access is limited to staff members and key control is in compliance.<br>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.<br>j. Interior areas (bedrooms, bathrooms, common areas) do not contain contraband and are free from hazardous unauthorized metal/foreign objects. | **Exception** | Touring of the facility was very welcoming and inviting as Safe Harbor completed full renovations of the shelter during the past year. As you come in the common area, it is clean, furniture is in good condition and youth have adequate space to gather. Lighting in the common area makes the area bigger and inviting. No graffiti was found on the walls, doors or windows. All doors are secure and access is limited for the youth. Each youth's bedroom is personalized for the youth and the dormitory is separated by girls on one end of the hallway and the boys on the opposite end. Each room has a clean bathroom that was found to be in good working condition with no visible leaks detected. Outside dumpsters are covered and no rodents were seen in the immediate area. Most areas were free of debris. Adjacent to the staff desk, a mounted board contains posted information for youth such as egress plan of the facility, general client rules, abuse hotline information, DJJ Incident Reporting Number and other related notices are posted. Egress maps are found in all common areas and hallways. A grievance box is mounted next to the information board with grievance forms.<br><br>Contraband according to the agency's policy was found in three of the eight bedrooms toured. Items included body spray, Q-tips, witch hazel, mouthwash, and a blow dryer. | During the tour of the facility, reviewer observed an unsecured ladder by the small building next to the dumpster. Construction is being done on the building that houses Safe Harbor Shelter and per the Residential Manager, the Construction Crew was using the ladder on the property.<br><br>A cleaning mop and bucket were also observed outside the facility door. |
| **Facility Inspection:**<br>a. All agency and staff vehicles are locked.<br>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. | **Exception** | The program has two vans that are used to transport youth. Each van is has updated safety equipment in the front area of the vehicle. First Aid kit, fire extinguisher, flashlight, glass breaker and seat belt cutter are all easy to access in case of an emergency. Each youth has room to sit and seats have individual seatbelts. | A walk through the parking lot found five out of 18 vehicles were not locked including a Toyota Corolla, a Nissan Sentra, in addition to the three vehicles from the contractors working on the building. |

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| **Facility Inspection:**<br><br>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).<br><br>A perpetual inventory will be the primary means of maintaining a current and real-time inventory.<br><br>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. | **Compliance** | A chemical inventory was conducted and found that all MSDS sheets were available and Reviewed noticed that even if the program is no longer using the items, MSDS sheets are still available in case the item is restocked. All chemical are secure in a locked closet and program maintains a perpetual inventory available for staff to update with more frequent use of chemicals as needed. | |
| **Facility Inspection:**<br><br>Washer/dryer are operational & general area/lint collectors are clean.<br>Agency has a current DCF Child Care License which is displayed in the facility.<br>Each youth has own individual bed with clean covered mattress, pillow, sufficient linens and blanket.<br>Youth have a safe, lockable place to keep personal belongings, if requested. | **Compliance** | Laundry room equipment is in excellent condition and all dryers had clean filters. Current Department of Children and Families license effective February 24, 2024 was display at the facility. Each youth has his/her own bed with linen and pillow for each bed. Also, a dresser is available for each youth to store personal clothing. | |
| **Additional Facility Inspection Narrative (if applicable)** | **Facilities looks great and well organized. Everything is very colorful and inviting.** | | |
| **Fire and Safety Health Hazards:**<br>a. Annual facility fire inspection was conducted, and the facility is in compliance with local fire marshal and fire safety code within jurisdiction.<br>b. Agency completes a minimum of 1 fire drill on each shift monthly (within 2 minutes or less).<br>c. Completes 1 mock emergency drill per shift per quarter.<br>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). | **Compliance** | Annual Fire Inspection was conducted on March 12, 2024. Fire Drills are completed for each shift monthly with the last Fire Drill on May 10, 2024. All fire drills had evacuations under two minutes and in some occasion even less. All Fire extinguishers were observed to be inspected on December 13, 2023 and are valid for one year. Kitchen overhead hood was cleaned February 16, 2024 and is maintained in a clean condition. | |

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| **Fire and Safety Health Hazards:**<br>a. Agency has a current Satisfactory Residential Group Care inspection report from the Department of Health.<br>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.<br>c. All cold food is properly stored, marked and labeled and dry storage/pantry area is clean and food is properly stored.<br>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. | **Compliance** | Agency has the Department of Health satisfactory Residential Group Care Inspection dated March 7, 2024 on display in the kitchen area. The food menu also on display is the kitchen area as well and is approved by a licensed dietician on September 14,2023. All cold food is properly stored with a fridge temperature of 37 degrees and freezer temperature of -10 degrees Fahrenheit. Refrigerator and freezer was clean. A pantry with all dry items is clean and organized. Knives were properly store in a lock box inside the pantry. | |
| **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.<br>b. At least one hour of physical activity is provided daily.<br>c. Youth are provided the opportunity to participate in a variety of faith-based activities. Non-punitive structured activities are offered to youth who do not choose to participate in faith-based activities.<br>d. Daily programming includes opportunities for youth to complete homework and access a variety of age appropriate, program approved books for reading. Youth are allowed quiet time to read.<br>e. Daily programming schedule is publicly posted and accessible to both staff and youth. | **Compliance** | The activity schedule provided shows the program keeps youth active throughout the week and weekends providing groups and outdoor activities as well as time for homework and reading. At least one hour for outdoor activities is on the schedule. Youth have the opportunity to participate in faith-based activities. The activity schedule gives a time frame for activities to follow and allows the youth to have an input on their activities. | |
| ***Additional Comments:*** **There are no additional comments for this indicator.** | | | |

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| **3.02 - Program Orientation** | | **Satisfactory** |
| **Provider has a written policy and procedure that meets the requirement for Indicator 3.02** | **YES**<br>If NO, explain here:<br>The program has the required policy and procedures CHS/7302 Program Orientation, approved 4/29/2024 by the DOHP. | |

**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.*

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| **Total number of Open Files: 2 open residential files**<br>**Total number of Closed Files: 3 closed residential files**<br>**Staff Position(s) Interviewed** *(No Staff Names)* **: Residential supervisor, Residential Counselor**<br>**Type of Documentation(s) Reviewed: Intake Forms in five youth files** | | | |
| Youth received a comprehensive orientation and handbook provided within 24 hours | **Compliance** | All five residential files reviewed included an orientation checklist showing orientation was completed on the intake date. Youth all signed an acknowledgement of receipt of the resident handbook. | |
| Orientation includes the following:<br>a. Youth is given a list of contraband items<br>b. Disciplinary action is explained<br>c. Dress code explained<br>d. Review of access to medical and mental health services<br>e. Procedures for visitation, mail and telephone<br>f. Grievance procedure<br>g. Disaster preparedness instructions<br>h. Physical layout of the facility<br>i. Sleeping room assignment and introductions<br>j. Suicide prevention- alerting staff of feelings or awareness of others having suicidal thoughts | **Compliance** | In the five files reviewed, the orientation process for shelter services consisted of a completion of the checklist which list the orientation information each client was informed about during the intake. Staff and client initialed acknowledging that that youth was given a list of contraband items which are not allowed in program, disciplinary action is explained, dress code explained, review of access to medical and mental health services, procedures for visitation, information regarding mail and telephone usage, grievance procedure, tour of facility, bed assignment, and disaster preparedness instructions. | |
| 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** | Program has a checklist with all topics for orientation, including date of orientation and signatures of youth and staff involved. | |
| ***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**<br>If NO, explain here:<br>The program has the required policy and procedures CHS/7303 Youth Room Assignment - Classification, that was approved 4/29/2024 by the DOHP. | |
| **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.* | | | |

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| **Total number of Open Files: 2 open residential files**<br>**Total number of Closed Files: 3 closed residential files**<br>**Staff Position(s) Interviewed** *(No Staff Names)* **: Residential supervisor, Residential Counselor**<br>**Type of Documentation(s) Reviewed: Intake forms in five youth files** | | | |
| **A process is in place that includes an initial classification of the youths, to include:** | | | |
| a. Review of available information about the youth's history, status and exposure to trauma<br>b. Initial collateral contacts,<br>c. Initial interactions with and observations or the youth<br>d. Separation of younger youth from older youth,<br>e. Separation of violent youth from non-violent youth<br>f. Identification of youth susceptible to victimization<br>g. Presence of medical, mental or physical disabilities<br>h. Suicide risk<br>i. Sexual aggression and predatory behavior<br>j. Acute health symptoms requiring quarantine or isolation | **Compliance** | The youth room assignment was written on the CINS/FINS intake screening form that includes information gathered during the intake process to determine room assignment. The program takes into consideration the demographic information of a youth such as the age, trauma experiences, general alerts, triggers of a youth, and if a youth is susceptible to being victimized. | |
| 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** | The program has a general alert form completed at intake which lists youth special needs and risks such as risk of suicide, mental health, substance abuse, physical health or security risk factors. Alerts are also well noted in the logbooks by staff for each youth. | |
| ***Additional Comments:*** **There are no additional comments for this indicator.** | | | |
| **3.04 - Log Books** | | | **Satisfactory with Exception** |
| **Provider has a written policy and procedure that meets the requirement for Indicator 3.04** | | **YES**<br>If NO, explain here:<br>The program has the required policy and procedures CHS/7304 Logbooks - Electronic Logbook, approved 4/29/2024 by the DOHP. | |
| **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: Log book was reviewed for two consecutive weeks each month, 11/1/2023 to 4/30/2024 total of six, 2-week periods**<br>**Staff Position(s) Interviewed** *(No Staff Names)* **: Residential supervisor**<br>**Type of Documentation(s) Reviewed: Observed two randomly selected consecutive weeks four of the past six months**<br>**Describe any Observations: Program uses manual logbook** | | | |
| Log book entries that could impact the security and safety of the youth and/or program are highlighted | **Compliance** | Logbook entries reviewed highlighted critical incidents and important issues which could impact security and safety of the youth and/or program. | |

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| All entries are brief, legibly written in ink and include:<br>• Date and time of the incident, event or activity<br>• Names of youth and staff involved<br>• Brief statement providing pertinent information<br>• Name and signature of person making the entry | **Compliance** | Staff entries were brief and legibly written in ink and included date and time of incident, event or activity, names of youth and staff involved, brief statement providing pertinent information, and name/signature of person making entries in the logbook. Some entries were written in a different color ink to highlight importance of note. | |
| 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. | **Compliance** | Staff takes great care entering information in the logbook. No whiteout was found during the review of the logbooks provided. | |
| 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** | Observation from the review of supervisor's logbook reviews during 11/1/2023 to 4/30/2024 show all required supervisory reviews were completed for the weeks reviewed. The supervisor's reviews were written in red ink; however, the logbook dates reviewed by the supervisor were not specified as required. | Supervisor's review of the logbook on the following entry dates did not document the dates in the logbook that were reviewed: November 6,7,9; December 12, 18, 20, 24, 27, 31; January 15, 16, 17, 18, 23, 25; February 20, 21, 22, 26,28, 29; March 17, 19, 20, 21, 26, 27, 29; and April 17, 18, 22, 23, 25. |
| All staff review the logbook of the previous two shifts and makes an entry signed and dated into the logbook indicating the dates reviewed | **Compliance** | Shelter staff reviewed log books and wrote review of two previous shifts. Program staff also uses codes when documenting in log book, i.e., SI- means sign in, SO-means sign out, K-means Keys, PC-means phone call, etc. | |
| 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. | **Compliance** | Logbook shows evidence of both supervisor and shelter counselor review of shifts since their last shift worked. Each entry is well notated. | |
| Logbook entries include:<br>a. Supervision and resident counts<br>b. Visitation and home visits | **Compliance** | Staff entries include head counts, stating keys are placed in locked box, overall impressions on shift, signing in and out, house meetings, visitation/home visits, and indicating when critical incidents happen with highlights. | |
| ***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**<br>If NO, explain here:<br>Indicate policy number, authorized signee, date(s) of last review/revision/approval: 7305, Behavior Management Strategies/Interventions, Director of Out of Home Programs, 4/24/24 | |

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| **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.* | | | |
| **The Resident Handbook was read in-full. The Handbook consists of 33 topics including: Safe Harbor Shelter Goals; Hands Off Facility; Guaranteed Privilege; Will You Be Able to Have Visitors?; What If You Begin to Feel Confused or Out of Control?; Do You Attend School or Work?; What is Counseling About?; What is Group Counseling Like?; What is Confidentiality?; Who Are All These People Working Here?; What is the Grievance Party?; Youth Rights; Behavior Management Policy; Behavior Points; Dress Code; Rights and Responsibilities; Daily Schedule (Sample); What is Safe Place?**<br>**The full Handbook is posted in the facility**<br>**An interview with a Youth Care Worker on-duty was conducted regarding implementation of the behavior management policy** | | | |
| The program has a detailed written description of the BMS and it is explained during program orientation | **Compliance** | The behavior management program is reviewed during new resident orientation and was confirmed by the interviewed Youth Care Worker. | |
| **Behavior Management Strategies must include:** | | | |
| a. BMS is designed to teach youth new behaviors and help youth understand the natural consequences for their actions<br>b. Behavioral interventions are applied immediately, with certainty, and reflect the severity of the behavior<br>c. BMS uses a wide variety of awards/incentives to encourage participation and completion of the program<br>d. Appropriate consequences and sanctions are used by the program and consequences for behavior are logical and designed to promote skill-building for the youth<br>e. Counseling, verbal intervention and de-escalation techniques are used prior to physical intervention (Only techniques approved by the Florida Network and DJJ are used if physical intervention is required)<br>f. Only staff discipline youth. Group discipline is not imposed<br>g. Room restriction is not used as part of the system or for youth who are physically and/or emotionally out of control<br>h. Youth should never be denied basic rights such as meals, clothing, sleep, services, exercise, or correspondence privileges | **Compliance** | The program's BMS, its implementation, and consequences is addressed in the Handbook. The Youth Care Worker interviewed confirmed that behavioral interventions are applied immediately, with certainly, and reflect the severity of the behavior. The Handbook explains the extensive variety of rewards and incentives to encourage participation and completion of the program. The philosophy and logic, and coordinating skill-building goal, is explained in the Handbook; implementation of this goal was confirmed by the interviewed Youth Care Worker. The Handbook explains that counseling, verbal intervention, and de-escalation are used prior to physical intervention; implementation of these limits was confirmed by the interviewed Youth Care Worker. The Handbook explains that only staff discipline residents, and group discipline is not imposed; implementation of these limits was confirmed by the interviewed Youth Care Worker. The Handbook explains that room restriction is not used as a part of the behavior management system or for youth who are physically or emotionally out-of-control. The Handbook explains that youth should not be denied basic rights (means, clothing, sleep, services, exercise, correspondence privileges). Page 11 of Policy 7305 should consistently use Director of Out of Home Programs instead of Director of Program Operations/DPO. | |
| **Program's use of the BMS** | | | |
| All staff are trained in the theory and practice of administering BMS rewards and consequences | **Compliance** | The interviewed Youth Care Worker confirmed all staff are trained in the theory and practice of administering behavior management system rewards and consequences. Training records for four new staff supported this practice. | |

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| There is a protocol for providing feedback and evaluation of staff regarding their use of BMS rewards and consequences | **Compliance** | The interviewed Youth Care Worker confirmed there is a protocol implemented for providing feedback and evaluation of staff regarding use of behavior management system rewards and consequences | |
| Supervisors are trained to monitor the use of rewards and consequences by their staff | **Compliance** | The interviewed Youth Care Worker confirmed that supervisors are trained to monitor the use of rewards and consequences by staff, and implement that training. Training documentation showed all supervisory staff are trained in the BMS to monitor the use of rewards and consequences by their staff. | |
| ***Additional Comments:*** **There are no additional comments for this indicator.** | | | |
| **3.06 - Staffing and Youth Supervision** | | | **Limited** |
| **Provider has a written policy and procedure that meets the requirement for Indicator 3.06** | | **YES**<br>If NO, explain here:<br>The program has the required policy and procedures CHS/7306 Staffing and Youth Supervision, approved on 4/29/2024 by the DOHP. | |
| **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: Logbook and staff schedules for the period November 2023-April 2024; Video Surveillance dates/times: April 30th 12am-2am; May 4th 2am-4am; May 8tht 4am-6am; May 12th 1am-3am; May 24th, 3am-5am.**<br>**Staff Position(s) Interviewed** *(No Staff Names)* **: Residential supervisor**<br>**Type of Documentation(s) Reviewed: Staff Schedules and Logbooks**<br>**Observation: Video surveillance system** | | | |
| The program maintains minimum staffing ratios as required by Florida Administrative Code and contract.<br>• 1 staff to 6 youth during awake hours and community activities<br>• 1 staff to 12 youth during the sleep period | **Compliance** | A review of staff schedules, logbook entries, and observation of staff present during the review indicated the program maintains the required staffing ratios of one staff to six youth during awake time and during sleeping hours, at least one staff to 12 youth. | |
| All shifts must always provide a minimum of two direct care staff present that have met the minimum training requirements | **Compliance** | Staff schedules for November 2023 - April 2024 showed at least two staff on all shifts. The program is licensed for twenty (20) youth and there was always two staff on schedule. All staff met the minimum training requirements to work on schedule with youth. | |
| 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** | Background screening and training records for four new and four Inservice staff demonstrate staff included on the staff schedule are trained and background screened to work on schedule with youth. | |

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| The staff schedule is provided to staff or posted in a place visible to staff | **Compliance** | The program manager develops a staff schedule on a two week basis and the schedule is posted for staff. | |
| There is a holdover or overtime rotation roster which includes the telephone numbers of staff who may be accessed when additional coverage is needed | **Compliance** | During interview with the residential supervisor it was reported the program has an On-call/Staff phone list in case coverage is needed. | |
| 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** | Bed checks were observed via the video surveillance system and compared to staff logging of bed checks in the logbook for the following dates/times: April 30th 12am-2am; May 4th 2am-4am; May 8tht 4am-6am; May 12th 1am-3am; May 24th, 3am-5am. Observations of the video surveillance system revealed a discrepancy between the system's clock and real time that fluctuated over the various dates and times reviewed. | April 30, 2024 - Bed Checks were completed between 14 to 16 minutes, and one bed check had a 30 minute lapse in between checks. Bed check times are different, off by two minutes per logbook entry vs camera. Camera system time is 10 minutes behind current time.<br><br>May 4, 2024- Bed check times are different, off by two minutes per logbook entry vs camera. Two bed checks were between completed late, 20 to 22 minutes.<br><br>May 8, 2024 - Bed check times are different, off by two minutes per logbook entry vs camera. Bed check between 5:32am to 6:02am missing activity on camera.<br><br>May 12, 2024 was not able to be review due to camera problem (jumps from 12:43am to 5:38am ).<br><br>May 24, 2024- Bed checks are different two minutes per logbook entry vs camera. Bed checks between 14 to 16 minutes in between. One bed check had a 30 minute lapse in between checks. |
| ***Additional Comments:*** **There are no additional comments for this indicator.** | | | |
| **3.07 - Video Surveillance System** | | | **Satisfactory** |
| **Provider has a written policy and procedure that meets the requirement for Indicator 3.07** | | **YES**<br>If NO, explain here:<br>The program has the required policy and procedures CHS/7307 Video Surveillance System, approved on 4/29/2024 by the DOHP. | |

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| **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: Logbook and staff schedules for the period November 2023-April 2024; Video Surveillance dates/times: April 30th 12am-2am; May 4th 2am-4am; May 8tht 4am-6am; May 12th 1am-3am; May 24th, 3am-5am.**<br>**Staff Position(s) Interviewed** *(No Staff Names)* **: Residential supervisor**<br>**Type of Documentation(s) Reviewed: Logbooks**<br>**Observation: Video surveillance system** | | | |
| **Surveillance System** | | | |
| The agency, at a minimum, shall demonstrate:<br>a. A written notice that is conspicuously posted on the premises for the purpose of security<br>b. System can capture and retain video photographic images which must be stored for a minimum of 30 days<br>c. System can record date, time, and location; maintain resolution that enables facial recognition<br>d. Back-up capabilities consist of cameras' ability to operate during a power outage<br>e. Have cameras placed in interior (e.g. intake office, counseling office, cafeteria, day room) and exterior (e.g. entrance/exit, recreation area, parking lot) general locations of the shelter where youth and staff congregate and where visitors enter and exit; to include locations where youth searches are conducted. Cameras are never placed in bathrooms or sleeping quarters.<br>f. All cameras are visible | **Compliance** | Program has "Camera in Use" sign at the entrance of the facility. Cameras record date/time and location of the cameras. No cameras are placed in bathrooms or sleeping quarters. All cameras are visible. | |
| A list of designated personnel who can access the video surveillance system is maintained (includes off-site capability per personnel)? | **Compliance** | A list of designated personnel for access to camera is located next to the camera system. | |
| Supervisory review of video is conducted a minimum of once every 14 days and timeframes reviewed are noted in the logbook. | **Compliance** | Logbook review evidenced supervisory reviews of the video is conducted by the residential supervisor at a minimum, once every 14 days. The most recent camera reviews in May were completed on May 15th, May 22nd, and May 28, 2024. | |
| The reviews assess the activities of the facility and include a review of random sample of overnight shifts | **Compliance** | Supervisory camera reviews documented in the logbook consisted of review times during activities of the facility and a random sample of overnight shifts. | |
| 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 program has a process to allow access to footage of surveillance video for third party review by downloading on a USB and sending video file link to a drop box for third party requests. | |

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| Camera service order/requests will be made within 24 hours of discovery of camera malfunctioning or being inoperable. All efforts made to obtain repairs are documented and maintained | **Compliance** | All camera request are made within 24 hours. A workorder was submitted for IT to review camera issues observed during the QI review visit. | |
| ***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**<br>If NO, explain here:<br>The program has the required policy and procedures CHS/7401 Healthcare Admission Screening, approved on 4/29/2024 by the DOHP. | |
| **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: 2 open residential files**<br>**Total number of Closed Files: 3 closed residential files**<br>**Staff Position(s) Interviewed** *(No Staff Names)* **: Residential Supervisor, Residential Counselor**<br>**Type of Documentation(s) Reviewed: A total of five youth records were reviewed, healthcare screening.** | | | |
| **Preliminary Healthcare Screening** | | | |
| Screening includes :<br>a. Current medications<br>b. Existing (acute and chronic) medical conditions<br>c. Allergies<br>d. Recent injuries or illnesses<br>e. Presence of pain or other physical distress<br>f. Observation for evidence of illness, injury, physical distress, difficulty moving, etc.<br>g. Observation for presence of scars, tattoos, or other skin markings<br>h. Acute health symptoms requiring quarantine or isolation | **Compliance** | A review of five individual youth healthcare records was conducted; two were open records and three were closed. One youth was admitted while prescribed medication and one was noted as having allergies. Reviewed documentation validated all five youth were observed for evidence of illness, injury, pain or physical distress, difficulty moving, the prescence of scars, tattoos, and other skin markings. None of the youth had any acute health symptoms requiring quarantine or isolation. | |
| **Referral and Follow-Up** | | | |
| Youth with chronic medical conditions have a referral to ensure medical care (e.g. diabetes, pregnancy, seizure disorder, cardiac disorders, asthma, tuberculosis, hemophilia, head injuries, etc.) | **No eligible items for review** | None of the five reviewed records were for a youth with any chronic condition requiring a referral to ensure medical care; however, the program has procedures which requires a process and mechanism for the referral and follow up for any necessary medical care for youth admitted with a chronic medical condition. | |

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| When needed, the parent is involved with the coordination and scheduling of follow-up medical appointments | **Compliance** | For all youth with chronic conditions, the referral process requires the parent/guardian be contacted to identify established guidelines for daily medical care and routines. If any chronic conditions are identified which indicate a need for medical follow-up, staff are to document discussion of this need with the parent/ guardian in the medical section of the youth's file. If a youth has not been treated for a condition, the intake staff will follow-up with the parent/ guardian, to have the parent schedule a medical examination as soon as possible and document communication. If needed, parent will be provided with a list of area medical facilities that provide care, taking into consideration the medical insurance information attained during intake. Youth will be transported by parent/ guardian to any scheduled medical appointments. | |
| All medical referrals are documented on a daily log. | **Compliance** | An interview with the shelter supervisor stated referrals for medical are only documented in the shelter logbook when a youth leaves the facility with a parent/guardian for medical care. | |
| The program has a thorough referral process and a mechanism for necessary follow-up medical care as required and/or needed | **Compliance** | The program maintains a policy, procedure and process for referring youth for follow-up medical care as required. If a youth has not been treated for a condition, the intake staff will follow-up with the parent/ guardian, to have the parent schedule a medical examination as soon as possible and document communication. If needed, parent will be provided with a list of area medical facilities that provide care, taking into consideration the medical insurance information attained during intake. | |
| ***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**<br>If NO, explain here:<br>The program has the required policy and procedures CHS/7402 Identification of Suicide Risk in Shelter Prevention, approved on 4/29/2024 by the DOHP. | |
| **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: 1 open residential and two open community counseling file**<br>**Total number of Closed (Residential & Community) Files:2 closed residential and one closed community counseling file**<br>**Staff Position(s) Interviewed** *(No Staff Names)* **: Residential Supervisor, Residential Counselor, Community Counseling Supervisor**<br>**Type of Documentation(s) Reviewed: youth records, Suicide screening results, Suicide Risk Assessment, Observation Logs** | | | |

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| **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** | All three reviewed residential records showed each youth was screened for suicide risk during the initial intake and screening process, and the suicide screening results were reviewed and signed by the supervisor and documented in each youth's case record. | |
| The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services | **Compliance** | Documentation verified the program's suicide risk assessment 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** | Each of the three residential youth was placed and maintained on sight-and-sound supervision until the youth was assessed by a licensed professional or a non-licensed clinician working under the direct supervision of a licensed professional within twenty-four hours of the suicide risk screening. All three youths were placed on the appropriate level of supervision based upon 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** | All three applicable youth were placed on an appropriate level of supervision based upon the results of the suicide risk assessment, and each documented the direct care staff assigned to monitor the youth documented the youth's behavior in thirty minutes 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** | Precautionary observation documentation included the time of day, behavioral observations, any warning signs observed, and the staff observers' initials. | |
| 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 | **Compliance** | Reviewed documentation confirmed the supervision level of each youth was not changed until the non-licensed mental health clinical staff completed a further assessment or the youth was Baker Acted by local law enforcement. | |

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| 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. | **Exception** | Three reviewed youth observation logs included documentation that supervisory staff reviewed the logs but not consistently. The observation logs were completed and maintained in the youth's record. | The reviewed documentation indicated the program's shift supervisors did not consistently sign the precautionary observation logs on each shift, as required. Additionally, the non-licensed mental health clinical staff only initialed the precautionary observation logs and EIDS rather than signing them, as called for by the form. The program's policy requires the licensed clinician, or the trained non-licensed professional, to document any discontinuance or modification of alert status on both the chronological progress note form and the program logbook; however, the mental health clinical staff did not sign the suicide precaution observation log as called for on the form or document the discontinuance of precautions in a progress note form or in the program logbook as required by policy. |
| **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** | All three reviewed community counseling youth records showed each youth was immediately assessed by a licensed professional or a non-licensed professional who was under the direct supervision of a licensed mental health professional. | |
| 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. | **No eligible items for review** | Each youth was immediately assessed by a licensed professional or a non-licensed professional who was under the direct supervision of a licensed mental health professional. | |
| 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** | Each parent/guardian was advised of the suicide assessment results and information was provided pertaining to available resources in the community for further assessment. | |
| If the parent/guardian cannot be contacted, all efforts to contact them are documented in the case file. | **No eligible items for review** | The parents were contacted for each youth record reviewed. | |

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| When the screening was completed during school hours on school property, the appropriate school authorities were notified. | **No eligible items for review** | None of the three community counseling screenings were completed on school property or during school hours. | |
| ***Additional Comments:*** **There are no additional comments for this indicator.** | | | |
| **4.03 - Medications** | | | **Satisfactory with Exception** |
| **Provider has a written policy and procedure that meets the requirement for Indicator 4.03** | | **YES**<br>If NO, explain here:<br>The program has the required policy and procedures CHS/7403 Medications, approved on 4/29/2024 by the DOHP. | |
| **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 closed residential files**<br>**Staff Position(s) Interviewed** *(No Staff Names)* **: Residential Supervisor**<br>**Type of Documentation(s) Reviewed three residential youth records, monthly staff meeting agendas, Medication Distribution Log, alerts, medication errors, training records, Medical and Mental Health Assessment screening**<br>**Describe any Observations: Pyxis Med-Station Medication Cabinet and secured refrigerator used to store medications requiring refrigeration.** | | | |
| 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. | **No eligible items for review** | The program's nurse position has been vacant since February 4, 2024. | |
| The agency has evidence of the following for all non-nursing shelter staff designated to assist with the self-administration of medication:<br>a. Documentation of in-person self-administration of medication distribution training provided by a Registered Nurse<br>b. Evidence demonstrating their competency to assist with self-administration of medication distribution<br>c. Maintenance of their annual medication training re-certification | **Compliance** | The program's documentation showed compliance with requiring all non-nursing shelter staff designated who assist with self-administration of medication to receive annual in-person medication administration training provided by a registered nurse. Training records for three new shelter staff hired during the review period support new staff received medication training by a registered nurse. The residential manager indicated the Florida Network was contacted to arrange for annual medication re-certification training in the interim until a nurse is hired. | |
| The agency held at least quarterly staff meetings conducted by RN and/or Shelter Manager to review and assess:<br>a. strategies implemented to reduce medication errors shelter wide<br>b. analyze factors that contributed to medication errors<br>c. allow staff the opportunity to practice and role-play solutions | **Compliance** | The program maintained documentation of staff meetings conducted by the shelter manager at least quarterly which included review and assessment of medication error reduction strategies, analysis of factors contributing to medication errors, and opportunities for staff to practice/role-play solution. | |

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| The agency has strategies implemented to ensure medications are provided within the 2-hour time frame. | **Compliance** | The strategy for medication to be given on time is the medication board posted in the medical office, showing the time for administration of each medication. An alarm clock on the staff desk outside the medical office is set for medication times and is utilized as back-up reminder. | |
| 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** | The non-nursing staff member responsible for assisting with the self-administration of medications on each shift is identified with an "M" next to their name on the two-week schedule posted which is printed and posted on the interior of the medical office door. Per program manager, If a team member is to call out from his/her shift, the relief team member or other existing team member are qualified to administer medication on that shift/day. The bi-weekly schedules are a running draft; at the end of the two-week schedule the Residential Supervisor and/or Residential Program Manager edit the schedule with any relief team members who happen to fill-in for a team member call-out and saves the edited schedule as a “FINAL” draft. This it to ensure that schedule and time-sheets coordinate with one another for time-card approvals per pay period. | |
| 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** | Informal interview with the Residential Supervisor verified there is a clear method of communicating which youth are on medication with the times and dosage easily discernable by all staff on each shift. Communication of medication is documented on the medication board in the medication room where the Pyxis med-station is located, and in the youth’s record as well as reviewed during shift change. | |
| 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:<br>a. to ensure appropriate medication management and distribution methods<br>b. to track medication errors<br>c. to identify systemic issues and implement mitigation strategies, as appropriate. | **Compliance** | The program has a delivery process of medications which is consistent with the FNYFS Medication Management and Distribution Policy. The program has an internal quality assurance process which ensures the appropriate medication management, and distribution methods are in place, and tracks medication errors. The Pyxis Med-Station alerts staff to discrepancies with red error messages on the screen and the user must enter correct counts before the Med-Station will allow access to the medications. In addition, the program's system is able to identify systemic issues and implement migration strategies, as needed. Any medication discrepancies are to be cleared after each shift. | |
| **Admission/Intake of Youth** | | | |

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| 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.*<br><br>b. Upon intake/admission, there is evidence that the on-shift certified supervisor of higher level staff did review all | **Compliance** | Three reviewed youth records verified upon admission, the youth and parent/guardian were interviewed about the youth's current medications as part of the Medical and Mental Health Assessment screening and were reviewed by administration staff by the next business day. | |
| **Medication Storage** | | | |
| a. All medications are stored in a Pyxis ES Medication Cabinet that is inaccessible to youth (when unaccompanied by authorized staff)<br>b. Pyxis machine is stored in accordance with guidelines in FS 499.0121 and policy section in Medication Management<br>c. Oral medications are stored separately from injectable epi-pen and topical medications<br>d. Medications requiring refrigeration are stored in a secure refrigerator that is used only for this purpose, at temperature range 2-8 degrees C or 36-46 degrees F. (If the refrigerator is not secure, the room is secure and inaccessible to youth.)<br>e. Narcotics and controlled medications are stored in the Pyxis ES Station<br>f. Pyxis keys with the following labels are accessible to staff in the event they need to access medications if there is a Pyxis malfunction: a TOP COVER b BACK PANEL- LEFT TALL CABINET LOCK- LEFT, c BACK PANEL- RIGHT TALL CABINET LOCK- RIGHT | **Compliance** | Observations and an informal interview with the Residential Supervisor validated the program stores medications in the Pyxis Med-Station Medication Cabinet. The Pyxis machine is stored in accordance with Florida statute guidelines. The program had no topical medication on-site at the time of this review and it is the program's practice not to admit youth with prescribed injectable medication. A locked dedicated medication refrigerator is maintained in the medical office, however no medication requiring refrigeration was present in the program at the time of this review. The program maintains all medication, including narcotics/controlled medication in a Pyxis ES Medication Cabinet which is inaccessible to youth. In the event the Pyxis machine will not open to access a medication, the provider will contact the manufacturer to reset the Pyxis. If the reset does not work, the provider has special keys stored in a secured safe which open the top cover, and the back panel to access the medication. | |
| **Medication Distribution** | | | |

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| a. Agency maintains a minimum of 2 site-specific System Managers for the Pyxis ES Station<br>b. Only designated staff delineated in User Permissions have access to secured medications, with limited access to controlled substances (narcotics)<br>c. A Medication Distribution Log shall be used for distribution of medication by non-licensed and licensed staff<br>d. Agency verifies medication using one of three methods listed in the FNYFS Policies & Procedures Manual<br>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.<br>f. Agency does not accept youth currently prescribed injectable medications, except for epi-pens<br>h. Non-licensed staff have received training in the use of epinephrine auto-injectors provided by a registered nurse | **Compliance** | The program's medication management policy and documentation reviewed demonstrate the program maintains at least two system managers for the Pyxis station. At the time of the review, there were ten staff trained to assist with medication distribution, each of whom has access to the Pyxis station. A review of Medication Distribution Logs verified they are used for distribution of medication by non-licensed and licensed staff. The provider verifies medication using one of three methods listed in the FNYFS Policies & Procedures Manual. In cases when a nurse is on duty, the medication processes are always conducted by the nurse, and when the nurse is not onsite, then the designated trained staff provides the medication. The provider does not accept youth currently prescribed injectable medications, except for epi-pens. A review of staff training records verified they have received training, provided by a registered nurse, for the use of epinephrine auto-injectors. | |
| The medication distribution log documentation includes:<br>a. the time of medication administration<br>b. evidence of youth initials that the dosage was given<br>c. evidence of staff initials that the dosage was given | **Compliance** | A review of one open record and two closed records of youth receiving medication was conducted. Documentation verified a Medication Distribution Log was used for the distribution of medication by non-licensed and licensed staff for all three reviewed youth. Documentation included the time of administration on the Medication Distribution Log, youth and staff initials, and the dosage 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. | **Compliance** | A review of three youth records verified staff assisted youth with medications within one hour of the scheduled time of delivery in two of the three records. The third youth was discharged the following day after intake and youth's record included the medication intake form showing medication received at intake; however, at the time of intake it was too late to call the pharmacy for medication verification as it was closed. Medications were not entered into Pyxis or administered prior to discharge due to not being verified by pharmacy, or with parent/guardian. | |
| 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 where youth missed their medication due to failure to open the pyxis machine. | |

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| **If applicable:**<br>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.<br>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. | **Compliance** | The program had one staff deemed responsible for a medication error during the review period, and the staff received refresher training from a nurse. There were no instances of a staff responsible for three medication errors within the last year. | |
| **Medication Inventory** | | | |
| a. For controlled substances, a perpetual inventory with running balances is maintained as well as a shift-to shift count verified by a witness and documented<br>b. Over-the-counter medications that are accessed regularly and inventoried weekly<br>c. Syringes and sharps (needles, scissors, etc.) are secured, and counted and documented weekly | **Compliance** | The program utilizes a shift-to-shift log when conducting shift-to-shift medication counts. The team member coming on to shift, who has been assigned the responsibility for medications, will meet with the outgoing team member to physically inventory all medications in the Pyxis, including OTC meds. If both team members are in agreement with the count outcome, they then compare that count with the youth's medication distribution sheet to ensure that there isn't an error with the numbers/documentation. The Pyxis count should match the last count on each of the med distribution sheets. Both team members will then initial on the shift-to-shift log confirming the correct count.<br>It is the program's practice to inventory all non-controlled and over-the-counter medication weekly. An interview with the residential manager indicated the program does not maintain any syringes or sharps, including scissors, thereby eliminating the requirement for a weekly documented sharps count. | |

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| There are monthly reviews of the Pyxis reports to monitor medication management practice. | **Compliance** | The residential supervisor runs four to five Pyxis reports daily upon arrival to the shelter, copies of which were reviewed onsite. These reports are used to monitor medication practices. | |
| Medication discrepancies are cleared after each shift. | **Exception** | Any discrepancies found with the Pyxis Med-Station must be cleared each shift prior to giving medications. Instructions for clearing/printing discrepancies are posted for reference. Staff are to print discrepancies, sign, and place in binder. | An interview with the residential manager indicated there were no medication errors or discrepancies during the previous six months; however a review of Pyxis reports showed a count discrepancy of one over-the-counter tablet that was not cleared for three consecutive days in May. |
| ***Additional Comments:*** **There are no additional comments for this indicator.** | | | |
| **4.04 - Medical/Mental Health Alert Process** | | | **Limited** |
| **Provider has a written policy and procedure that meets the requirement for Indicator 4.04** | | **YES**<br>If NO, explain here:<br>The program has the required policy and procedures CHS/7404 Medical, Mental Health Alert Process, approved on 4/29/2024 by the DOHP. | |
| **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: 2 open residential files**<br>**Total number of Closed Files:3 closed residential files**<br>**Staff Position(s) Interviewed** *(No Staff Names)* **: Residential Supervisor**<br>**Type of Documentation(s) Reviewed: provider's alert system, logbook**<br>**Describe any Observations: Food allergy alert in the kitchen, census board, a medication alert board where the Pyxis med-station is located, General Alert form located in the youth's record** | | | |
| Youth with a medical, mental health, or food allergy was appropriately placed on the program's alert system | **Exception** | The program utilizes two forms to document alerts: the "Alert document for Medical Health History/Allergies", as well as the "General Alerts" form in the Medical section. Reviewed documentation indicated all five reviewed youth had a medical or mental health condition or allergy. Two of the five records reviewed clearly identify existing alerts for the youth with an alert label on the exterior of the youth file and a General Alert Form in the file. | Three of five youth were not appropriately placed on the program's alert system. The program's policy requires for those youth with medical/ mental health needs to have a medical/ mental health alert sticker placed on the outside of the client's record; however, the active records did not have any indication of alerts on the outside of the records. Neither of the two forms used to document alerts include youth on medication as an alert status. |

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| Alert system includes precautions concerning prescribed medications, medical/mental health conditions | **Compliance** | Alert system includes precautions concerning prescribed medications, medical/mental health conditions. | |
| Staff are provided sufficient training, information and instructions to recognize/respond to the need for emergency care for medical/mental health problems | **Compliance** | A review of eight staff training records verified staff are provided sufficient training, information and instructions to recognize/respond to the need for emergency care for medical/mental health problems. | |
| A medical and mental health alert system is in place that ensures information concerning a youth's medical condition, allergies, common side effects of prescribed medications, foods and medications that are contraindicated, or other pertinent mental health treatment information, is communicated to all staff | **Exception** | In addition to the two alert forms mentioned above to identify alerts in each youth record, the program has an Alert Board that reflects the Alert System by color. A magnet with a designated alert color is placed by each youth's alert accordingly. The program's policy requires the alert system to communicate to staff all information regarding each youth's medical and mental health conditions, allergies, and the common side effects of prescribed medication, food, contraindicated meds, and other pertinent treatments. The alert board posted in the medical office on day one of the annual compliance review included only two of the six youth in residence on this date. The posted alert board in the medical office was updated on day two of the annual compliance review to remove one youth who was discharged overnight leaving one youth listed on the Alert Board. | Reviewed documentation indicated one youth scored for suicide risk and was placed on precautionary observation but was not identified on the General Alert sheet in his record as a suicide risk, which then differed from alert forms in the medical section of the youth records which did identify suicide risk as an active alert. The General Alert form in another youth's record did not notate an alert for runaway behavior while the alert forms in the medical section of the record did. One youth was prescribed three psychotropic medications at the time of admission; however, there was no alert for the youth being on medication or for medication side effects.<br><br>The Alert Board on Day 1 of the review did not indicate one youth's allergy to penicillin and amoxicillin, although this was noted on the Alert Form in the youth's individual healthcare record. None of the five other youth in the shelter on Day 2, all of whom were identified on the room assignment board as having open alerts, were listed on the Alert Board. |
| ***Additional Comments:*** **There are no additional comments for this indicator.** | | | |

| 4.05 - Episodic/Emergency Care | | | Satisfactory with Exception |
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| **Provider has a written policy and procedure that meets the requirement for Indicator 4.05** | | **YES**<br>If NO, explain here:<br>The program has the required policy and procedures CHS/7405 Episodic Emergency Care, approved on 4/29/2024 by the DOHP. | |
| **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 residential file**<br>**Total number of Closed Files: 2 closed residential files**<br>**Staff Position(s) Interviewed** *(No Staff Names)* **: Residential Supervisor**<br>**Type of Documentation(s) Reviewed: Youth records for off-site emergency care events, Episodic/Emergency Care Log**<br>**Describe any Observations: knife-for-life and first aid kits.** | | | |
| **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<br>b. Upon youth return, there is a verification receipt of medical clearance via discharge instructions with follow-up is present in file<br>c. Youth's parent/guardian was notified<br>d. A daily log is maintained for emergency care provided | **Exception** | The program's policy requires all instances of first aid and emergency care to be documented in the logbook, youth's individual file, and in the CHS Eco Online data base. Upon return to shelter from seeking outside medical treatment, verification of medical clearance, discharge instructions and follow-up care are to be provided to staff and included in the youth's file. Three records were reviewed; two for youth who received off-site emergency care and one who received emergency care at the program through emergency Medical Services (EMS) response. Two youth returned to the facility with discharge instructions following the emergency care visit; one youth did not return and was later discharged. Discharge instructions for one of the youth (transported by his uncle on April 11, 2024, for a sports injury where an x-ray was taken) indicated the need for follow up with an orthopedic physician in one to two days. All three records documented notification was made to each parent/guardian, as required. All three off-site emergency events were documented on the program's Emergency Care Log. | One of three reviewed records did not document an incident report was submitted for the youth having gone off-site to the emergency room and there was no indication of the incident having been reported to the Department's Central Communications Center (CCC).<br><br>Discharge paperwork indicated the need for follow up with an orthopedic physician in one to two days for one youth; however, there was no documentation of any follow up medical care. |
| All staff are trained on emergency medical procedures | **Compliance** | A review of eight staff training records verified all were trained on emergency medical procedures. | |
| The program has a Knife-for-life and wire cutters accessible to staff in a secure location(s) | **Compliance** | The program maintains one Knife-for-Life on each shelter unit. The program has four first aid kits which are inspected weekly and located in the medical office, pantry, and one for each of the program's two transport vans. | |
| ***Additional Comments:*** **There are no additional comments for this indicator.** | | | |