Florida Network for Youth and Family Services
Compliance Monitoring Report for

ARNETTE HOUSE

2310 NE 24th Street
Ocala, FL 34470

January 17-18, 2024

Compliance 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 the ARNETTE HOUSE for the FY 2023-2024 at its program office located at 2310 NE 24TH Street, Ocala, FL 34470. 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. Arnette House is contracted with the Florida Network of Youth and Family Services (FNYFS) to provide direct services to Children/Families in Need of Services (CINS/FINS). The services to be provided are identified in Contract Section A - Descriptions and Specifications and Section B - Delivery and Performance and are funded with General Revenue Funds effective from July 2023 through June 30, 2024.

The review was conducted by Andrea Haugabook, Consultant for Forefront LLC and Meghan Thrasher, LaToya Robinson, Alex Pruett, and Nesheika Martin. Agency representatives from Arnette House present for the entrance interview were: Cheri Pettitt, Shanda Hope, Melissa Grzyb, Iriana Pintol, Jason Kasten, Pamela Washington, Nicholas Benway, Herlyn Ferrer and Mark Shearon. The last onsite QI visit was conducted April 12-13, 2023.

In general, the Reviewer found that Arnette House is in compliance with specific contract requirements. **Arnette House received an overall compliance rating of 100% for achieving full compliance with 13 applicable indicators** of the CINS/FINS Monitoring Tool. There were no corrective actions as a result of the monitoring visit.

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

2023-2024 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 01-17-18-20232024

Agency Name: Arnette House, Inc.	**Monitor Name: Andrea Haugabook, Lead Reviewer**
Contract Type : CINS/FINS	**Region/Office: 2310 NE 24th Street, Ocala, FL 34470**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): January 17-18, 2023**

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 a. Provider shall demonstrate that a minimum of two (2) staff members have been trained to be certified as DJJ QI Peer reviewers. Provider shall participate in a minimum of one (1) on-site quality assurance review of a similar type of program in another judicial circuit during each 12-month period of the contract, if requested.	☐	☐	☒	☐	☐	Interview with the residential director reports there is a total of five certified peer reviewers. Two have recently been retrained and three are previously certified.	
Additional Contracts a. Provider shall provide a listing of all current federal, state, or local government contracts, as well as other contracts entered into with for profit and not-for-profit organizations. Such a listing shall identify the awarding entity and contract start & end dates. **PTV**	☐	☐	☒	☐	☐	The provider has contracts with the following state, local government and other for profit and not-for-profit organizations: United way (two year contract with one year remaining – 2024), County ARPA (three year contract ending 12-31-2024), Federal Basic Center Grant (four year contract through 09-30-2025), Emergency Solutions Grant (annually), Shelter/ Department of Children and Families (annually), Group Homes/ Department of Children and Families (annually), Food & Nutrition – National food lunch program (continuous), FEMA food	

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						program (annually) and Sexauer foundation grant (annually).	
Limits of Coverage a. Provider shall provide and maintain during this contract, the following minimum kinds of insurance: Worker's Compensation and Employer's liability insurance as required by Chapter 440, F.S. with a minimum of $100,000 per accident, $100,000 per person and $500,000 policy aggregate. Commercial General Liability with a limit of $500,000 per occurrence, and $1,000,000 policy aggregate. Automobile Liability Insurance shall be required and shall provide bodily injury and property damage liability covering the operation of all vehicles used in conjunction with performance of this contract, with a minimum limit for bodily injury of $250,000 per person; with a minimum limit for bodily injury of $500,000 per accident; with a minimum limit for property damage of $100,000 per accident and with a minimum limit for medical payments or $5,000-$10,000 per person. Florida Network is listed as payee or co-payee. **PTV**	☐	☐	☒	☐	☐	The agency provided a certificate of insurance with the following coverages shown: Worker's Compensation and Employer's liability insurance, with limits of $100,000 per accident, $100,000 per person and $500,000 policy aggregate. Commercial General Liability with a limit of $1,000,000 per occurrence, $1,000,000 damage to rented premises, $20,000 medical expense, $1,000,000 personal & adv injury, $3,000,000 general aggregate and $3,000,000 products-comp/op aggregate. Automobile Liability Insurance with a combined single limit of $1,000,000. Umbrella liability of $1,000,000 per occurrence and $1,000,000 aggregate. These policies are underwritten by Philadelphia Indemnity Insurance Company and Associated Industries Insurance Company and managed by Brown and Brown of Florida, Inc. The certificate	

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						of Insurance lists the Florida Network of Youth and Family Services as a certificate holder.	
External/Outside Contract Compliance a. Provider has corrective action item(s) cited by an external funding source (Fiscal or Non-Fiscal). **ON SITE**	☐	☐	☐	☐	☒	Interview with the CFO indicated there are no external corrective action items by any external funding sources.	
Fiscal Practice a. Agency must have employee and fiscal policy/procedures manuals that are in compliance with GAAP and provide sound internal controls. Agency maintains fiscal files that are audit ready. **PTV**	☐	☐	☒	☐	☐	A review of the agency's employee and fiscal policies are in compliance with GAAP and provides sound internal controls. The agency maintains fiscal files that are managed with accounting software allowing them to be audit ready.	
b. Agency maintains a general ledger and the corresponding source documents. A general ledger must be set up to track the activity of the grant separately (standard account numbers / separate funds for each revenue source, etc.). **PTV**	☐	☐	☒	☐	☐	An interview with the Chief Financial Officer and review of the agency's general ledger showed that it is set up to track the programs' activity. Each grant is set up with separate account numbers and separate funds for each revenue source have been established.	
c. Petty cash ledger system is balanced and all cash disbursements are compliant with financial policies and	☐	☐	☒	☐	☐	Petty cash is maintained by the Administrative Assistant. A $200 cash fund is kept in a cash box, inside a	

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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:**
allowable under the contract. (Disbursements/invoices are approved & monitored by management.) –**ON SITE**						locked drawer in the front office. The Administrative Assistant, Chief Financial Officer, Director, and Maintenance worker have keys to the front office drawer. The cash is used to reimburse employees for small expenses incurred for program related expenses.	
d. Financial records and reports are current. Includes bank statements reconciled within 6 weeks of receipt. Vendor invoices past 6 months. Invoices are submitted on a monthly basis with supporting documentation. (Disbursements/invoices are approved & monitored by management). **ON SITE**	☐	☐	☒	☐	☐	Bank statements are reconciled by the Chief Financial Officer within 6 weeks of receipt and reviewed and approved by the Chief Executive Officer.	
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**	☐	☐	☐	☐	☒	Interview with Chief Financial Officer reports there is no inventory of over $1,000 of Department of Juvenile Justice property. No property has been purchased with Florida Network funds.	
f. Agency submits payroll taxes and deposits (and retirement deposits as applicable), Employee IRS Form W-2 and	☐	☐	☒	☐	☐	The Chief Financial Officer provided proof of payment for all 941 quarterly tax reports filed and copies of all 941 quarterly tax returns. The agency	

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Independent Contractors IRS Form 1099 forms prior to federal requirements. **ON SITE**						uses a payroll company for all payroll related activity and tax filings.	
g. Budget to actual reports prepared and reviewed by appropriate management. Variance from the budget are investigated and explained. **PTV/ON SITE**	☐	☐	☒	☐	☐	The Chief Financial Officer reported that monthly the prepared budget to actual report is given to the Chief Executive Officer for review. They are presented to the executive leadership team monthly, and all variances are explained and investigated accordingly.	
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**	☐	☐	☒	☐	☐	Agency fiscal year ends June 30, 2023. The most recent audit report for the period ending June 30, 2022, was submitted to the Florida Network of Youth and Family Services. The audit was conducted by Purvis Gray, Certified Public Accountants. The audit was dated March 30, 2023, and contained no corrective action.	

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	Unacceptable	**Conditionally Unacceptable**	**Fully Met**	**Exceeded**	**Not Applicable**		
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**	☐	☐	☒	☐	☐	The agency maintains policies on confidentiality ensuring the security and privacy of all employee and client data. The agency also has policies and procedures to address record retention and the disposal/ relocation of equipment.	
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**	☐	☐	☒	☐	☐	Evidence of compliance was received. All employees are compliant with the minimum per hour wage. A proposed payroll change list was signed by the CFO and CEO and payroll reports from September 2023 further verified the wage increase of all employees when it became effective.	

CONCLUSION

Arnette House has met the requirements for the CINS/FINS contract as a result of full compliance with --- applicable indicators of the Administrative and Fiscal Contract Monitoring Tool. 1 of the 14 indicators were not applicable because the agency does make any purchases greater than $1000 with funds from the Florida Network or Youth and Family Services. Consequently, **the overall compliance rate for this contract monitoring visit is 100%.** There are no corrective actions cited and no recommendation is made as a result of the contract monitoring visit. Overall, the provider is performing satisfactorily in meeting the fiscal and administrative terms of its contract. In addition, the majority of indicators reviewed were carried out in a manner which meets the standard 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 Arnette House
CINS/FINS Program

Date: January 17-18, 2024

Compliance Monitoring Services Provided by

CINS/FINS Rating Profile

Standard 1: Management Accountability

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

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

Standard 2: Intervention and Case Management

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

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

Standard 3: Shelter Care & Special Populations

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

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

Standard 4: Mental Health/Health Services

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

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

Overall Rating Summary

Percent of indicators rated Satisfactory: 96.43 %
Percent of indicators rated Limited: 3.57 %
Percent of indicators rated Failed: 0 %

Rating Definitions

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

Rating	Definition
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

Andrea Haugabook, Consultant-Forefront LLC/Florida Network of Youth and Family Services
Meghan Thrasher, Regional Monitor, Department of Juvenile Justice
Nasheika Martin, Hillsbourgh County Children's Services, QA Manager
Alex Pruett, Youth and Family Alternatives - RAP House, Residential Supervisor
LaToya Robinson, CDS Family and Behavioral Health East, Residential Counselor

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

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

Documents Reviewed

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

Observations During Review

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

Surveys

9	# of Youth	11	# 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

Arnette House incorporates a vocational component that is very educational, impactful, and resourceful. Youth are taught carpentry skills that can be used in future career or real-life situations. Youth build projects that are used around the facility, for example, a shed that is used for storage behind the SNAP house. Youth built a mini camper. The vocational program has been such a success that the agency has secured funding to erect a standalone steel building with two open garage bays where youth work inside on various projects. The "Sexauer" building was donated by the Sexauer foundation and has allowed the youth to participate in vocational training while being protected from exposure to the heat and other natural elements of being outdoors.

The following programmatic updates were provided by the agency:

Staffing: The CEO reported that the program is almost fully staffed. There are only 2 vacancies at this time. The SNAP program is fully staffed. The program hired a part-time nurse as of 03/14/2023.

Program Updates: Arnette House is located at 2310 NE 24th Street, Ocala, FL 34470. The program serves the 5th Judicial Circuit including: Marion, Lake and Sumter counties. The program's current accreditation from the Council on Accreditation is dated from 06/21/2022 - 06/21/2026. The Department of Children and Families license is current through 01/28/2024. There are no new Children In Need of Services (CINS) initiatives to report. The current service practice model includes: individual counseling in schools, in the community, in the office, and virtual (if necessary), group counseling and family counseling. The program uses paper files and manual logbooks. There are several activities at the agency that are not CINS activities, which include: vocational, educational, and outdoor programs. The program served no special populations.

Facility updates and improvements: Arnette House purchased several new vehicles over the past year. One van is used for the girls group home (non-CINS program), four small cars for community counselor use and one mini-van for the CINS shelter use. There was additional playground equipment purchased and installed. Youth at the shelter reportedly, enjoy use of the playground equipment. There is a new pool table in the shelter. There was tree work completed (in-kind by Outdoor Solutions) around the grounds and asphalt millings laid for additional parking added. The installation of Christmas lights was done in-kind by Clean Cut Lawn Care, LLC. There is a pool on the premises, however it is not in operation at this time. The program is working on the pool and working on training a lifeguard. The pool will remain closed until then.

Planned facility updates: The program has future plans for additional tree work. Additional playground equipment will be added outside. There are plans to re-surface the basketball court and the flooring in the dayroom. There is also future plans to secure another van.

Funding and finance: The agency also receives numerous private and corporate donations and grants. The program receives American Rescue Protection Act Funding which supports one counselor position and United Way funding to support another counselor position. The following fundraising activities were reported by the agency: $10,000 give away, Mini-camper raffle, Foot Golf tournament and End of Year Ask. The program has submitted its most recent audit report to the Florida Network of Youth and Family Services as of June 30, 2022, completed by Purvis Gray, Certified Public Accounts. The CFO reported that the June 30, 2023 audit has been completed and report is forthcoming. There are currently no capital campaigns.

Governance and community: The program staff is actively involved in circuit advisory board, Marion County Children's Alliance, Marion County Nonprofit Council, Community Council Against Substance Abuse (CCASA), and Marion County Continuum o school Mental Health Services Meetings. There was also a binder of interagency agreements provided with community collaborations. Three board members resigned and one new board member joined the board of directors in 2023. Additionally, the board voted to meet six times per year instead of ten times per year. There are no corrective action plans pending from other funders and no major programmatic challenges reported at this time.

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

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

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 with Exception.**
Indicator 2.03 Case/Service Plan was rated **Satisfactory with Exception.**
Indicator 2.04 Case Management and Service Delivery was rated **Satisfactory with Exception.**
Indicator 2.05 Counseling Services was rated **Satisfactory with Exception.**
Indicator 2.06 Adjudication/Petition Process was rated **Satisfactory.**
Indicator 2.07 Youth Records was rated **Satisfactory.**
Indicator 2.08 Specialized Additional Program Services was rated **Satisfactory.**
Indicator 2.09 Stop Now and Plan (SNAP) was rated **Satisfactory with Exception.**

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

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

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

Standard 3:
Indicator 3.04 was rated limited due to several factors with exception ratings in the indicator.
The name and signature of persons making entries, as required per the standard, are not present in the logbooks. Evidence of voided entries did not include dates or initials and words were written over in lieu of a strikethrough. The logbook contained at least one occurrence where there was no signature indicating the dates reviewed by the program director or designee. Logbook entries reviewed are not signed and dated indicating the dates reviewed. Entries reviewed did not contain a shelter counselor signature indicating shift reviews and date range and shift supervisor initials did not indicate a date reviewed.

CINS/FINS QUALITY IMPROVEMENT TOOL

Quality Improvement Indicators and Results: Please select the appropriate outcome for each indicator for each item within the indicator.		Summary/Narrative Findings: The narrative write-up is a thorough summary of each assigned QI indicator worksheet, explain how you came to your finding(s).	Deficiencies/Exceptions: Please add additional detailed explanations for any items that have any deficiencies or exceptions.
Standard One – Management Accountability			
1.01: Background Screening of Employees, Contractors and Volunteers			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 1.01		**YES** If NO, explain here: The agency has a policy numbered FLN 1.01, titled Background Screening. The policy was last revised 01/23/2023 and approved by CEO.	
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: Four **Total number of 5 Year Re-screen Employee Files: Four** **Staff Position(s) Interviewed: HR Director** **Type of Documentation(s) Reviewed: Suitability assessment summaries, E-Verify confirmation, Agency for Healthcare Administration background screening results, Department of Juvenile Justice Background screening unit annual affidavit, agency policy and procedure**			
All positions providing direct services to youth has successfully passed pre-employment suitability assessment on the initial attempt.	**Compliance**	Four of four new hire employee files reviewed showed evidence of passing the pre-employment suitability assessment on the initial attempt.	
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.	**Not Applicable**	All new hire employee files reviewed passed the suitability assessment on the initial attempt and did not need to retake the assessment.	
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**	The agency has no employees who have had a break in service greater than 18 months.	
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**	Four of four new hire employee files reviewed showed evidence of completing background screening prior to the date of hire.	

Five-year re-screening is completed every 5 years from last screening or prior to retained fingerprints expiration date.	**Compliance**	Four of four employee files reviewed requiring a five year re-screen showed evidence of a re-screening with retained fingerprint dates that are not expired.	
Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?	**Compliance**	The agency provided email verification of a completed annual affidavit of compliance with level 2 screening standards form being sent to the background screening unit on January 2, 2024.	
Proof of E-Verify for all new employees obtained from the Department of Homeland Security	**Compliance**	Four of four new employee files reviewed showed evidence of compliant E-Verify checks obtained from the Department of Homeland Security.	
Additional Comments: **There are no additional comments for this indicator.**			
1.02: Provision of an Abuse Free Environment			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 1.02		**YES**	
		If NO, explain here:	
		The agency has the following policies: Behavior Management System (5/29/18), Behavioral Interventions (10/11/21), Abuse Reporting (1/23/23), Grievance Youth and Families (1/23/23), and the Arnette House Client Handbook. The Dress Code & Behavioral Expectations – Staff (1/18/24) policy that was provided and updated while on site. HR policy Ethical Conduct (6/12/11) addresses employee conflict of interest behaviors approved by CEO.	
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: Shelter Supervisor **Type of Documentation(s) Reviewed:** Six applicable policies and program client handbook **Describe any Observations:** Facility tour was provided by a client where the grievance box was observed and the abuse hotline number was observed posted in a common area. Nine youth surveys were reviewed. The youth survey responses support that agency is an abuse-free environment.			
Agency has a code of conduct of policy and there is evidence that staff are aware of agency's code of conduct.	**Compliance**	The agency has a policy titled HR policy Ethical Conduct. The policy is dated 06/11/2011 and addresses employee conflict of interest behaviors.	
The agency has a process in place for reporting and documenting child abuse hotline calls.	**Compliance**	The agency has a process for reporting and documenting child abuse calls. There have been no child abuse calls reported in the last six months.	
Youth were informed of the Abuse and Contact Number	**Compliance**	All youth files reviewed indicated that the youth were informed of the abuse reporting contact number during intake.	
Grievance			
Grievances are maintained on file at minimum for 1 year.	**Compliance**	The agency maintains grievances on file for at least one year.	

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**	The agency has a formal grievance process. The locked grievance box is located in a common area where youth congregate for activities and meals. Grievance forms are easily accessible next to the grievance box.	
There is evidence that grievance boxes are checked by management or a designated supervisor at least daily as evidenced in the program logbook.	**Exception**	Interview with the shelter supervisor reported that the grievance box is checked daily Monday - Thursday. No grievances have been reported since May 2022.	There was no documentation in the program logbook of the grievance box being checked daily and no grievances being reported.
All grievances are resolved within 72 hours and documented by program director/supervisor or escalated to higher leadership if grievance involves them directly.	**No eligible items for review**	Shelter Supervisor reports that grievances are immediately addressed upon receipt and almost all are resolved without any escalation. There were no grievances to review for the last six months or back to the date of the last review.	
1.03: Incident Reporting			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 1.03		**YES** If NO, explain here: The agency has a policy, FLN 1.03 - Incident Reporting, that was last reviewed on 1/23/2023 by the CEO.	

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: Shelter Supervisor
Type of Documentation(s) Reviewed: Incident Report logs, Program Logbook, CCC Reports
Describe any Observations: Incident report logs were very organized. The report form itself contains all information needed to satisfy the QI Indicator.

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	**Compliance**	All ten CCC reportable incidents reviewed were reported within a two-hour timeframe.	
The program completes follow-up communication tasks/special instructions as required by the CCC	**Compliance**	Email verifications were present with each of the ten CCC reportable incidents notating that follow-up questions were answered.	
Agency internal incidents are documented on incident reporting forms and all CCC reportable incidents were consistently reported to CCC as required.	**Compliance**	All internal incidents are recorded on incident report forms and all CCC reportable incidents were consistently reported to the CCC as required.	

Incidents are documented in the program logs and on incident reporting forms	**Compliance**	All ten CCC reportable incidents reviewed were notated in the program logbook and on incident reporting forms.	
All incident reports are reviewed and signed by program supervisors/ directors	**Compliance**	A total of ten incidents were reviewed. Three were medical error incidents, six were Baker Act incidents, and one was a program disruption incident. All ten incidents were signed by program supervisors with appropriate follow-up documentation.	
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		**NO** Policy FLN 1.04 - Training does not meet the requirements of the indicator. Policy has not been updated to reflect the trainings listed in the FL Network QI Standard manual effective July 1, 2023. The agency has a policy numbered FLN 1.04, titled Training, last reviewed January 23, 2023 by the CEO.	
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: Three **Total number of Annual In-Service Staff Files: Four** **Annual Training Plan Timeframe:** January 1 - December 31 **Staff Position(s) Interviewed:** Shelter Supervisor **Type of Documentation(s) Reviewed: Employee** Training files **Describe any Observations:** Training plans for each staff are prepared according to what training needed for their respective position. As a result of the program policy not being updated as of July 1, 2023, individual training plans are not up to date, rendering them noncompliant to the 2023-2024 FL Network QI standard.			
First Year Direct Care Staff			
All direct care staff have completed new hire pre-service training requirements for safety and supervision as required.	**Compliance**	Three of three new hire files reviewed completed new hire pre-service training requirements for safety and supervision as required.	
All staff completed the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days from date of hire.	**Exception**	Three pre-service files were reviewed. Two of three files reviewed completed the United States Department of Justice Civil Rights training within 30 days of hire.	One of the three did not complete this training within 30 days from date of hire. Date of hire was on 8/24/23 and the date of course completion was 9/28/23.
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**	Four of four direct care CINS/FINS staff files reviewed demonstrated 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.	**Exception**	Three new hire files reviewed. Most mandatory training during the first 90 days of employment was complete.	All three new hire files reviewed had not completed the Cultural Humility/Cultural and Linguistic Diversity training. One of the three had not completed the Confidentiality training within the first 90 days. Two of the three did not complete the Fire Safety Equipment training.

Staff Required to Complete Data Entry for NIRVANA or access the Florida Department of Juvenile Justice Information System (JJIS)			
Any designated staff that is responsible for entering NIRVANA or ensuring accurate and complete data entry in the Florida Department of Juvenile Justice Information System (JJIS) have completed all of the required trainings.	**Compliance**	Of the three new hire files reviewed, two of them were for Clinical staff positions. These two employees completed the NIRVANA training.	
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**	This training has not been scheduled due to the availability of the Department of Juvenile Justice Attorney. No evidence of future date for this training has been set.	
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 had not eligible staff to meet this criteria for review.	
In-Service Direct Care Staff			
Direct care staff completes 24 hours of mandatory refresher Florida Network, SkillPro, and job-related training annually *(40 hours if the program has a DCF child caring license).*	**Exception**	Four in-service training files were reviewed. All four files exceeded the 40 hours required as Arnette House holds a Department of Children and Families child caring license.	Of the four in-service employee training files reviewed, two employees had missing annual/bi-annual trainings. There was no evidence of completion of training for one employee who was due to complete the fire safety equipment training on 11/21/23 and one employee file did not contain the child abuse: recognition, reporting and prevention due on 1/3/24 and the crisis intervention training approved by the Network (ex: Managing Aggressive Behavior (MAB) due on 12/9/23.
Required Training Documentation			
The agency has a training plan that includes all of the required training topics including the pre-service and in-service.	**Compliance**	The agency has a training plan that includes all of the required training topics including the pre-service and in-service.	
The agency has a designated staff member responsible to manage all employee's individual training files and completes routine tracking and reviews of staff files to ensure compliance.	**Compliance**	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.	
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 for each employee and a training log which is compliant with the Florida Network training log.	
Additional Comments: **There are no additional comments for this indicator.**			

1.05 - Analyzing and Reporting Information			Satisfactory with Exception
Provider has a written policy and procedure that meets the requirement for Indicator 1.05		**NO** If NO, explain here: The following indicators are not reflected within policy: •Quarterly case record review reports. These reviews may be completed by peers. A summary report of case record reviews, identifying compliance with the CINS/FINS requirements, which is reviewed by management and communicated with staff on a quarterly basis at minimum. •Quarterly review of incidents, accidents, and grievances. •Annual review of customer satisfaction data. •Annual review of outcome data. The agency has a policy numbered FLN 1.05, titled Contract Management & Monitoring, Data Analyzing, Data Entry & Collection, Quality Improvement policies last reviewed January 23, 2023 by the CEO.	
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: COO, CEO **Type of Documentation(s) Reviewed:** PQI Meeting agendas and minutes, Board of Directors meeting agendas and minutes, two FL Network monthly reports within the review period			
Case record review reports demonstrate reviews are conducted quarterly, at a minimum	**Exception**	Upon requesting quarterly case record review reports, only Clinical supervision schedules were provided.	There was no evidence that a summary report of case record reviews, identifying compliance with the CINS/FINS requirements are done or reviewed by management and communicated with staff on a quarterly basis at minimum.
The program conducts reviews of incidents, accidents, and grievances quarterly, at a minimum	**Compliance**	The practice of reviewing incidents, accidents and grievances quarterly are documented in PQI Council/Committee meetings minutes.	
The program conducts an annual review of customer satisfaction data	**Exception**	Customer satisfaction surveys raw data reported by NetMIS was provided for review.	There was no evidence provided by the program that supported an annual review of customer satisfaction data occurs.
The program conducts an annual review of outcome data and (if applicable) there is evidence of annual reconciliation that occurs through communication from the Florida Network via email or phone call when corrections are needed and the information is corrected and submitted within the requested timeframes.	**Compliance**	Monthly outcome data is reviewed regularly during bi-monthly Executive board meetings where management staff are in attendance. An annual board meeting occurs in August where outcome data is share at that time as well.	
The program has a process in place to review and improve accuracy of data entry & collection	**Compliance**	The program has a process in place to review and improve accuracy of data entry and collection.	
There is documentation that findings are regularly reviewed by management and communicated to staff and stakeholders.	**Compliance**	Monthly review of the statewide End-of-Month (‘EOM”) report generated by the Florida Network Office is evidenced in bi-monthly executive board of director meetings and quality improvement policy.	

There is evidence the program demonstrates that critical performance data reports are shared with the Board of Directors frequently. All final reports that include a Limited or Failed score is submitted electronically or by mail to the providers Executive Committee on the Board of Directors.	**Compliance**	Findings are regularly reviewed by management and communicated to staff and stakeholders at bi-monthly executive board pf director meetings.	
There is evidence that strengths and weaknesses are identified, improvements are implemented or modified, and staff are informed and involved throughout the process.	**Compliance**	Strengths and weaknesses are identified, improvements are implemented or modified, and staff are informed and involved throughout the process is evidenced in bi-monthly executive board of director meetings.	
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** If NO, explain here: Program Client Transportation Policy dated 1/23/23 does not address the following as stated in the FL Network QI Standard 1.06 Client Transportation. •Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle. •Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy. •Documentation of use of vehicle that notes name or initials of driver, date and time, mileage, number of passengers, purpose of travel and location. The agency has a policy numbered FLN 1.06, titled Client Transportation and FLN 5.07 - Transportation of Youth both reviewed January 23, 2023 by the CEO.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Dates or Timeframe Reviewed: July 2023 - December 2023 **Staff Position(s) Interviewed:** Shelter Supervisor, Human Resources manager **Type of Documentation(s) Reviewed:** Program policy, Transportation logs, program logbook, agency automobile insurance policy, Driver's licenses (and checks) of a sample of five direct care staff.			
Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	**Compliance**	Interviewed HR personnel and verified that license checks are completed annually. Program states that all staff are approved drivers and provided an updated driver list dated January 3, 2024.	
Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	**Exception**	The agency's approved drivers list also indicates individuals who are covered under the program's automobile insurance. A sample of five shelter staff driver's licenses were cross-checked with program's Property & Casualty insurance policy period 12/1/23 – 12/1/24. Of the five driver's licenses reviewed, all were valid.	One driver was not listed under the insurance and according to the transportation logs, the driver has driven in the past 6 months.
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**	A review of the agency's transportation policy prohibits 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.	

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**	In a review of the agency's policy indicated that if a 3rd party cannot be obtained for transport, the agency's supervisor or managerial personnel consider the clients' history, evaluation, and recent behavior.	
The 3rd party is an approved volunteer, intern, agency staff, or other youth	**Compliance**	The program's policy does indicate the 3rd party is an approved volunteer, intern, agency staff, or other youth.	
The agency demonstrated evidence via logbook or other written verification that supervisor approval was obtained prior to all single youth transports.	**No eligible items for review**	There was one single transport done during the review period, however it was a DCF client. Program followed protocol for single transport evidenced by the program supervisor being aware (prior to the transport) and consent as documented in the program logbook. No single transports with CINS clients took place during this review period or back to the date of the last review.	
There is documentation of use of vehicle that notes name or initials of driver, date and time, mileage, number of passengers, purpose of travel and location.	**Compliance**	The program maintains a vehicle log that notes name/ initials of driver, date and time, mileage, number of passengers, purpose of travel and location.	
Additional Comments: **There are no additional comments for this indicator.**			
1.07 - Outreach Services			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 1.07		**YES** If NO, explain here: Arnette House Policy FLN 1.07 does not reflect the updated 1.07 Outreach Services indicator in the 23-24 FL Network QI Standard manual effective July 1, 2023. •The agency 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. The agency has a policy numbered FLN 1.07, titled Outreach Services, last reviewed January 23, 2023 by the CEO.	
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)***:** COO, program Receptionist, Intake Specialist **Type of Documentation(s) Reviewed:** Outreach tracking forms, program policy, DJJ Circuit 5 Advisory Board Meeting Minutes, Community Outreach Coordinator job description, NetMIS report of Outreach events within review period, Community partnership agreement binder			
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**	DJJ Circuit 5 Advisory Board Meeting Minutes for 9/21/23 and 10/19/23 was provided by the designated representative, COO.	

The program maintains written agreements with other community partners which include services provided and a comprehensive referral process.	**Compliance**	The program maintains a binder of collaborative and inter-agency agreements with other community partners. Each agreement details services and a comprehensive referral process.	
The program will maintain documentation of outreach activities and enter into NetMIS the title, date, duration (hours), zip code, location description, estimated number of people reached, modality, target audience and topic.	**Exception**	The COO attends DJJ Circuit 5 Advisory meetings.	No outreach events were entered into NetMIS documenting the: title, date, duration, zip code, location, description, estimated number of people reached, modality, target audience and topic.
The program has designated staff that conducts outreach which is defined in their job description.	**Compliance**	This reviewer was provided the job description of the Community Outreach Coordinator. COO attends DJJ Circuit 5 Advisory Board Meetings monthly.	
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** If NO, explain here: The agency has a policy numbered FLN 2.01, titled Centralized Intake and Screening, last reviewed April 4, 2023 by the CEO.	
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: Four **Total number of Closed (Residential & Community) Files: Four** **Staff Position(s) Interviewed: Clinical Supervisor and Intake Coordinator** **Type of Documentation(s) Reviewed: Case files**			
Shelter youth: Eligibility screening is completed immediately for all shelter placement inquiries.	**Compliance**	All five residential files reviewed contained eligibility screenings completed at intake.	
Community counseling: Eligibility screening is completed within 3 business days of referral by a trained staff using the Florida Network screening form.	**Exception**	One community counseling youth file reviewed contained eligibility screenings completed within three business days of referral by a trained staff using the Florida Network screening form.	One youth's referral form did not have a date, therefore, unable to discern if intake was within three days of the referral. Another youth was referred on 8/21/23, however he was not seen until 9/18/23. Notes indicated rescheduled appointments but the dates listed are also after the three business days of the referral date.
There is evidence all referrals for service is screened for eligibility and is logged in NetMIS within 72 hours of screening completion.	**Compliance**	All eight youth files reviewed contained evidence of entry into NetMIS within 72 hours of screening completion.	
Youth and parents/guardians receive the following in writing: a. Available service options b. Rights and responsibilities of youth and parents/guardians	**Compliance**	All eight youth files reviewed contained evidence of youth and parent/ guardian receiving the available service options and the rights and responsibilities of the youth and parent/guardian at intake.	

The following is also available to the youth and parents/guardians: a. Possible actions occurring through involvement with CINS/FINS services (case staffing committee, CINS petition, CINS adjudication) b. Grievance procedures	**Compliance**	All eight youth files reviewed showed evidence the youth and parent/ guardian was informed of possible actions occurring through involvement with CINS/FINS services and the program's grievance procedures.	
During intake, all youth were screened for suicidality and assessed as required if needed.	**Compliance**	All eight youth files reviewed had evidence of completion of screening for suicidality and further assessment as required if needed.	
Additional Comments: **There are no additional comments for this indicator.**			
2.02 - Needs Assessment			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 2.02		**YES** If NO, explain here: The agency has a policy numbered FLN 2.02, titled Network Inventory of Risk, Victories and Needs Assessment (NIRVANA) last reviewed April 4, 2023 by the CEO.	
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: Four **Total number of Closed (Residential & Community) Files: Four** **Staff Position(s) Interviewed: Clinical Supervisor and Intake Coordinator** **Type of Documentation(s) Reviewed: Case file**			
Shelter Youth: NIRVANA is initiated within 72 hours of admission	**Compliance**	All five residential files reviewed showed evidence of NIRVANA initiation within 72 hours of youth 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 three non-residential files reviewed contained NIRVANA assessments initiated within two to three face-to-face contacts.	
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**	All files reviewed contained completed NIRVANA assessments with supervisor signatures.	
(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**	Five of five residential youth files reviewed contained NIRVANA self-assessments completed within 24 hours of admission 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**	There was one file with a length of stay longer than 30 days with post-assessment completed timely.	

A NIRVANA Re-Assessment is completed every 90 days excluding files for youth receiving SNAP services.	**Exception**	Six of eight youth files reviewed contained NIRVANA re-assessments completed every 90 days.	One youth filed contained a NIRVANA re-assessment that was 14 days late, the initial was completed on 10/3/2023, reassessment done 1/15/2024, was due on 1/1/2024. A second youth file had an initial NIRVANA completed on 9/18/2023, and the reassessment was not completed, which was due on 12/17/23.
All files include the interview guide and/or printed NIRVANA.	**Compliance**	All youth files reviewed contained an interview guide or printed NIRVANA.	
Additional Comments: **There are no additional comments for this indicator.**			
2.03 - Case/Service Plan			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 2.03		**YES** If NO, explain here: The agency has a policy numbered FLN 2.03, titled Case/Service Plan, last reviewed April 4, 2023 by the CEO.	
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: Four **Total number of Closed (Residential & Community) Files: Four** **Staff Position(s) Interviewed: Clinical Supervisor** **Type of Documentation(s) Reviewed: Case File**			
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**	Eight of eight youth files reviewed contained case/service plans developed based on information gathered during the initial screening, intake and NIRVANA assessment.	
Case/Service plan is developed within 7 working days of NIRVANA	**Compliance**	Eight of eight youth files reviewed contained case/service plans developed within 7 working days of the NIRVANA.	
Case plan/service plan includes: 1. Individualized and prioritized need(s) and goal(s) identified by the NIRVANA 2. Service type, frequency, location 3. Person(s) responsible 4. Target date(s) for completion and Actual completion date(s) 5. Signature of youth, parent/ guardian, counselor, and supervisor 6. Date the plan was initiated	**Exception**	Six of eight youth case/ service plans were detailed and included: individualized goals identified by the NIRVANA, service type, frequency, location, person responsible, target dates for completion, actual completion dates, signature of youth, parent/ guardian, counselor and supervisor. The plans are dated upon initiation.	One youth case/service plan was not signed. A second youth's case/service plan was signed on 12/11/23, however, initiated on 12/12/23.
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	**Exception**	Seven of eight youth files reviewed showed evidence of case/ service plans reviewed for progress every 30 days for the first three months.	One youth file does not contain a 30 review; date of intake was on 11/13/23, 30 day reviews should have been completed on 12/13 and 1/12.
Additional Comments: **There are no additional comments for this indicator.**			

2.04 - Case Management and Service Delivery			Satisfactory with Exception
Provider has a written policy and procedure that meets the requirement for Indicator 2.04		**YES** If NO, explain here: The agency has a policy numbered FLN 2.04, titled Case Management Services, last reviewed by the CEO on April 4, 2023.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open (Residential & Community) Files: Four **Total number of Closed (Residential & Community) Files: Four** **Staff Position(s) Interviewed (No Staff Names): Clinical Supervisor** **Type of Documentation(s) Reviewed: Case File**			
Counselor/Case Manager is assigned	**Compliance**	All files reviewed contained evidence of an assigned counselor/ case manager.	
The Counselor/Case Manager completes the following as applicable: 1. Establishes referral needs and coordinates referrals to services based upon the on-going assessment of the youth's/family's problems and needs 2. Coordinates service plan implementation 3. Monitors youth's/family's progress in services 4. Provides support for families 5. Monitoring of progress for court ordered youth in shelter 6. Makes referrals to the case staffing to address problems and needs of the youth/family 7. Accompanies youth and parent/guardian to court hearings and related appointments 8. Refers the youth/family for additional services when appropriate 9. Provides case monitoring and reviews court orders 10. Provides case termination notes 11. Provides follow-up after 30 days of exit 12. Provides follow-up after 60 days of exit	**Exception**	Eight files were reviewed for compliance with services provided by counselor/case management staff. Seven of eight youth files reviewed showed evidence of a counselor/case manager completing applicable service referrals such as: referrals to services based upon the on-going assessment of the youth's/family's problems and needs, coordination of service plan implementation, monitoring of youth and family's progress, 30/60 day follow-up after exit.	One youth file does not have a 30 or 60 day follow up completed, he was discharged on 10/2, reviews should have been completed on 11/4/2023 and 12/4/2023.
The program maintains written agreements with other community partners that include services provided and a comprehensive referral process	**Compliance**	The program maintains a binder of written agreements with other community partners which include services provided and a comprehensive referral process.	
Additional Comments: **There are no additional comments for this indicator.**			

2.05 - Counseling Services			Satisfactory with Exception
Provider has a written policy and procedure that meets the requirement for Indicator 2.05		**YES** If NO, explain here: The agency has a policy titled Centralized Intake and Screening with no policy number and it was last reviewed on April 4, 2023 by the CEO.	
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: Four **Total number of Closed (Residential & Community) Files: Four** **Staff Position(s) Interviewed: Clinical Supervisor** **Type of Documentation(s) Reviewed: Youth file and group log book** **Describe any Observations: Eight files were reviewed, five residential, three non-residential, four open and four closed cases.**			
Shelter Program			
Shelter programs provides individual and family counseling	**Compliance**	Youth files reviewed indicates that the shelter provides individual and family counseling.	
Group counseling sessions held a minimum of five days per week	**Compliance**	Group log book reviewed indicated the youth are engaged in five group sessions weekly.	
Groups are conducted by staff, youth, or guests and group counseling sessions consist of : 1. A clear leader or facilitator 2.Relevant topic - educational/informational or developmental 3. Opportunity for youth to participate 4. 30 minutes or longer	**Compliance**	Groups are conducted by staff or guests. All group sessions have a clear leader and topic, youth are able to participate and are longer than 30 minutes in duration.	
Documentation of groups must include date and time, a list of participants, length of time, and topic.	**Compliance**	Documentation of group is recorded on the group activity education summary sheet. It includes the date, time and duration, group leader's name and if the youth participated in the group.	
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 current service practice of the program provides services in schools, in the community and in the office. Virtual services are provided if necessary.	

Counseling Services			
Reflect all case files for coordination between presenting problem(s), psychosocial assessment, case/service plan, case/service plan reviews, case management, and follow-up	**Exception**	Six of eight youth files reviewed reflected coordination between presenting problems, psychosocial assessment, case service plan, reviews, case management and follow-up.	Two out of the eight files reviewed did not receive counseling services according to the case/service plan.
Maintain individual case files on all youth and adhere to all laws regarding confidentiality	**Compliance**	The program maintains individual case files on all youth and adheres to all laws regarding confidentiality.	
Case notes maintained for all counseling services provided and documents youth's progress	**Compliance**	Case notes were present in all eight files reviewed. Case notes document youths' progress or lack of progress.	
On-going internal process that ensures clinical reviews of case records and staff performance	**Compliance**	The clinical supervisor completes weekly treatment team and case staffing, which was verified by her schedule.	

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

2.06 - Adjudication/Petition Process		**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.06	**YES** If NO, explain here: The agency has a policy numbered FLN 2.06 - CINS Adjudication Services, last reviewed on April 4, 2023 by the CEO.	

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: None
Total number of Closed (Residential & Community) Files: None
Staff Position(s) Interviewed: Clinical supervisor
Type of Documentation(s) Reviewed: Agency policy and procedure manual
Describe any Observations: There is no current practice or files to review for the Adjudication/Petition process standard. The agency has a policy and procedure addressing CINS adjudication services.

Must include: a. DJJ rep. or CINS/FINS provider b. Local school district representative	**No eligible items for review**	The program did not serve any youth under the CINS adjudication/ petition process during the review period or back to the date of the last review.	
Other members may include: a. State Attorney's Office b. Others requested by youth/ family c. Substance abuse representative d. Law enforcement representative e. DCF representative f. Mental health representative	**No eligible items for review**	The program did not serve any youth under the CINS adjudication/ petition process during the review period or back to the date of the last review.	
The program has an established case staffing committee, and has regular communication with committee members	**Compliance**	The program does have an established case staffing committee and maintains communication with its members, however, there has been no cases requiring case staffing, back to the date of the last review.	

The program has an internal procedure for the case staffing process, including a schedule for committee meetings	Compliance	The program does have an internal procedure for the case staffing process, including a schedule for committee meetings. The program's policy is in alignment with the standard, however, there is currently no practice to review.	
The youth and family are provided a new or revised plan for services	No eligible items for review	The program did not serve any youth under the CINS adjudication/ petition process during the review period or back to the date of the last review.	
Written report is provided to the parent/guardian within 7 days of the case staffing meeting, outlining recommendations and reasons behind the recommendations	No eligible items for review	The program did not serve any youth under the CINS adjudication/ petition process during the review period or back to the date of the last review.	
If applicable, the program works with the circuit court for judicial intervention for the youth/family	No eligible items for review	The program did not serve any youth under the CINS adjudication/ petition process during the review period or back to the date of the last review.	
Case Manager/Counselor completes a review summary prior to the court hearing	No eligible items for review	The program did not serve any youth under the CINS adjudication/ petition process during the review period or back to the date of the last review.	
Additional Comments: **There are no additional comments for this indicator.**			
2.07 - Youth Records			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.07		**YES** If NO, explain here: The agency has a policy numbered FLN 2.07, titled Case Records, last reviewed on April 4, 2023, by the CEO.	
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: Intake Coordinator **Type of Documentation(s) Reviewed: case files and observed and assessed location of records** **Describe any Observations: All records are marked "confidential," records are kept in the office with the intake coordinator and files are locked.**			
All records are clearly marked 'confidential'.	Compliance	All program records are marked confidential.	
All records are kept in a secure room or locked in a file cabinet that is marked "confidential"	Compliance	All program records kept in a secure office in file cabinets that are marked confidential.	
When in transport, all records are locked in an opaque container marked "confidential"	Compliance	All program records are transported in locked opaque containers which are marked confidential.	
All records are maintained in a neat and orderly manner so that staff can quickly and easily access information	Compliance	All program records are maintained in a neat and orderly fashion. Records are easily accessible.	
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** If NO, explain here: The agency has a policy numbered FLN 2.09, titled Specialized Additional Services, last reviewed on April 4, 2023, by the CEO.	
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.*			
Total number of Open Files: None **Total number of Closed Files: None** **Staff Position(s) Interviewed: Clinical and shelter supervisor** **Type of Documentation(s) Reviewed: None** **Describe any Observations: The program did not have any youth in the staff secure to review during the review period.**			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? **(If no, select rating "No eligible items for review")**	**No eligible items for review**	The program did not have any staff secure files to review for the review period and has not had any back to the date of the last review.	
Staff Secure policy and procedure outlines the following: a. In-depth orientation on admission b. Assessment and service planning c. Enhanced supervision and security with emphasis on control and appropriate level of physical intervention d. Parental involvement e. Collaborative aftercare	**No eligible items for review**	The program did not have any staff secure files to review for the review period and has not had any back to the date of the last 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**	The program did not have any staff secure files to review for the review period and has not had any back to the date of the last review.	
Staff Assigned: a. One staff secure bed and assigned staff supervision to one staff secure youth at any given time b. Program assign specific staff during each shift to monitor location/ movement of staff secure youth c. Agency clearly documents the specific staff person assigned to the staff secure youth in the logbook or any other means on each shift	**No eligible items for review**	The program did not have any staff secure files to review for the review period and has not had any back to the date of the last review.	
Agency provides a written report for any court proceedings regarding the youth's progress	**No eligible items for review**	The program did not have any staff secure files to review for the review period and has not had any back to the date of the last 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.*			
Total number of Open Files: None **Total number of Closed Files: None** **Staff Position(s) Interviewed** *(No Staff Names)* **: Clinical and Shelter Supervisor** **Type of Documentation(s) Reviewed: None** **Describe any Observations: The program did not have any youth in the domestic minor sex trafficking to review during this review period.**			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	**No eligible items for review**	The program did not have any files to review for domestic minor sex trafficking for the review period and has not had any back to the date of the last 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**	The program did not have any files to review for domestic minor sex trafficking for the review period and has not had any back to the date of the last 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**	The program did not have any files to review for domestic minor sex trafficking for the review period and has not had any back to the date of the last review.	
Services provided to these youth specifically designated services designed to serve DMST youth	**No eligible items for review**	The program did not have any files to review for domestic minor sex trafficking for the review period and has not had any back to the date of the last 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**	The program did not have any files to review for domestic minor sex trafficking for the review period and has not had any back to the date of the last review.	
Length of Stay: a. Youth in program do not have length of stay in DMST placement that exceeds seven (7) days b. Agency has approval for stays and support beyond seven (7) days for DMST placements that are obtained on a case-by-case basis? (If applicable.)	**No eligible items for review**	The program did not have any files to review for domestic minor sex trafficking for the review period and has not had any back to the date of the last 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**	The program did not have any files to review for domestic minor sex trafficking for the review period and has not had any back to the date of the last review.	
All other services provided to DMST youth are consistent with all other general CINS/FINS program requirements	**No eligible items for review**	The program did not have any files to review for domestic minor sex trafficking for the review period and has not had any back to the date of the last review.	

Domestic Violence			
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: One **Total number of Closed Files: None** **Staff Position(s) Interviewed** *(No Staff Names)* **: Clinical Supervisor** **Type of Documentation(s) Reviewed: Case file** **Describe any Observations: One youth was DV, no deficiencies noted.**			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	**Yes**	There was one domestic violence case during the period of this review.	
Youth admitted to DV Respite placement have evidence in the file of a pending DV charge	**Compliance**	Evidence of domestic violence charge was present in one of one domestic violence file reviewed.	
Data entry into NetMIS within (3) business days of intake and discharge	**Compliance**	Data entry into NetMIS was within three business days of intake for the one domestic violence youth file reviewed. Youth file is still open and data entry into NetMIS at discharge is not applicable at the time of this review.	
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**	One of one domestic youth file reviewed did not exceed 21 days length of stay.	
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**	Case plan goals in the one domestic violence file reviewed reflects goals for aggression management, family coping skills, or other intervention designed to reduce propensity for violence in the home.	
All other services provided to Domestic Violence Respite youth are consistent with all other general CINS/FINS program requirements	**Compliance**	Evidence that all other services provided were consistent with all other general CINS/FINS program requirements was present in the one domestic violence file reviewed.	

Probation Respite			
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: None **Total number of Closed Files: One** **Staff Position(s) Interviewed** *(No Staff Names)* **: Clinical and Shelter Supervisor** **Type of Documentation(s) Reviewed: Case File** **Describe any Observations: One youth was probation respite, the DOI was on 12/7, according to the NetMIS lag report, the youth was entered in NetMIS after 24 hours of intake on 12/11.**			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	**Yes**	One of one file review was a probation respite case.	

All probation respite referrals are submitted to the Florida Network.	**Compliance**	One of one probation respite case file contained a referral to the Florida Network.	
All Probation Respite Referral come from DJJ Probation and there is evidence that the youth is on Probation regardless of adjudication status.	**Compliance**	Evidence of probation status was present in the youth file reviewed.	
Data entry into NetMIS and JJIS within (3) business days of intake and discharge	**Compliance**	One youth probation respite file reviewed showed a date of intake of 12/07/2023.	
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.	**No eligible items for review**	Youth length of stay did not exceed 30 days in the one probation respite file reviewed.	
All case management and counseling needs have been considered and addressed	**Compliance**	Proof of compliance with case management and counseling needs were evidenced in the service plan in the youth probation respite file reviewed.	
All other services provided to Probation Respite youth are consistent with all other general CINS/FINS program requirements	**Compliance**	All other services provided to probation respite youth are consistent with all other general CINS/FINS program requirements as evident on the youth service plan.	

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.*

Total number of Open Files: None
Total number of Closed Files: None
Staff Position(s) Interviewed: Clinical and Shelter Supervisor
Type of Documentation(s) Reviewed: None
Describe any Observations: The program did not have any youth in the intensive case management.

Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	**No eligible items for review**	The program did not have any intensive case management cases during the period of this review or back to the date of the last review.	
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.	**No eligible items for review**	The program did not have any intensive case management cases during the period of this review or back to the date of the last review.	

Services for youth and family include: a. Two (2) direct contacts per month b. Two (2) collateral contacts per week c. Direct and collateral contacts not obtained must have documentation to support attempts made to obtain them. All reasonable attempts (at minimum of three) must be made to reach all contacts (direct and collateral) and documented in the case file and NetMIS.	**No eligible items for review**	The program did not have any intensive case management cases during the period of this review or back to the date of the last review.	
Assessments include a. NIRVANA at intake b. NIRVANA Re-Assessment every 90 days c. Post NIRVANA at discharge as aligned with timeframe requirements	**No eligible items for review**	The program did not have any intensive case management cases during the period of this review or back to the date of the last review.	
Service/case plan demonstrates a strength-based, trauma-informed focus	**No eligible items for review**	The program did not have any intensive case management cases during the period of this review or back to the date of the last review.	
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	**No eligible items for review**	The program did not have any intensive case management cases during the period of this review or back to the date of the last review.	

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.*

Total number of Open Files: None
Total number of Closed Files: None
Staff Position(s) Interviewed: Clinical and Shelter Supervisor
Type of Documentation(s) Reviewed: None
Describe any Observations: The program did not have any youth in the Family & Youth Respite aftercare services.

Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	**No eligible items for review**	The program did not have any case of family and youth respite after care services for the review period or back to the date of the last 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**	The program did not have any case of family and youth respite after care services for the review period or back to the date of the last review.	
Agency has evidence that all FYRAC referrals have documented approval from the Florida Network office	**No eligible items for review**	The program did not have any case of family and youth respite after care services for the review period or back to the date of the last review.	

Intake and initial assessment sessions meets the following criteria: a. Services shall be documented through the signature of the youth and his/her parent/guardian as well as orientation to the program which is kept in the youths file. b. The initial assessment shall be face-to-face, in person or through virtual means, to include a gathering of all family history and demographic information, as well as the development of the service plan. c. For youth on probation, a copy of the youths Community Assessment Tool (CAT) to assist with development of the family service plan.	**No eligible items for review**	The program did not have any case of family and youth respite after care services for the review period or back to the date of the last review.	
Life Management Sessions meets the following criteria: a. Sessions are face-to-face, sixty (60) minutes in length and focus on strengthening the family unit b. Services are highly supportive, individualized, and flexible and require a “whole family” approach to dealing with the problems affecting the youth and family.	**No eligible items for review**	The program did not have any case of family and youth respite after care services for the review period or back to the date of the last review.	
Individual Sessions: a. The program conducted sessions with the youth and family to focus on work to engage the parties and identify strengths and needs of each member that help to improve family functioning. b. Issues to be covered through each session include but are not limited to: Identifying emotional triggers; body cues; healthy coping strategies through individual, group and family counseling; understanding the cycle of violence and the physical and emotional symptoms of anger; developing safety plans; and educating families on the legal process and rights.	**No eligible items for review**	The program did not have any case of family and youth respite after care services for the review period or back to the date of the last review.	
Group Sessions: a. Focus on the same issues as individual/family sessions with application to youth pulling on similar experiences with other group members with the overall goal of strengthening relationships and prevention of domestic violence. b. Shall be no more than eight (8) youth at one (1) time and shall be for a minimum of sixty (60) minutes per session	**No eligible items for review**	The program did not have any case of family and youth respite after care services for the review period or back to the date of the last 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**	The program did not have any case of family and youth respite after care services for the review period or back to the date of the last 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**	The program did not have any case of family and youth respite after care services for the review period or back to the date of the last review.	

Any service that is offered virtually, is documented in the youth's file why it was in the youth and families best interest.	**No eligible items for review**	The program did not have any case of family and youth respite after care services for the review period or back to the date of the last review.	
All data entry in NetMIS is completed within 3 business days as required.	**No eligible items for review**	The program did not have any case of family and youth respite after care services for the review period or back to the date of the last review.	
Additional Comments: **There are no additional comments for this indicator.**			
2.09- Stop Now and Plan (SNAP)			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 2.09		**YES** If NO, explain here: The agency has a policy titled, For Schools and Communities, SNAP, which in not numbered, approved by the CEO and last reviewed on April 4, 2023.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: One **Total number of Closed Files: One** **Staff Position(s) Interviewed: Clinical supervisor** **Type of Documentation(s) Reviewed: Youth files** **Describe any Observations: A total of two files reviewed, one closed SNAP clinical file and one open SNAP clinical file. A total of three SNAP in schools sessions were reviewed, two completed and one current SNAP in schools session.**			
SNAP Clinical Groups Under 12			
Youth are screened to determine eligibility of services.	**Compliance**	Two of two files contained screening for eligibility.	
The NIRVANA was completed at initial intake, or within two sessions.	**Compliance**	Two of two files reviewed contained NIRVANA assessments completed at initial intake.	
There is evidence of the completed Child Behavior Checklist (CBCL) by the caregiver (pre and post) and is located within the file.	**Compliance**	One of two files contained completed child behavior checklist. the second youth file is still open and a post child behavior checklist is 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.	**Compliance**	One of two files contained completed teacher report forms. The second file is still open contained a completed pre teacher report form. A post teacher report form is not applicable at this time for the second youth file.	

SNAP Clinical Groups Under 12 - Discharge			
There is evidence of the completed SNAP Discharge Report located within the file for any discharged youth.	Compliance	One of two files reviewed contained evidence of the SNAP discharge report. One file is open and a discharge is not applicable.	
There is evidence of the completed SNAP Discharge Report located within the file for any discharged youth.	Compliance	One of two files reviewed contained evidence of the SNAP Boys/ SNAP girls parent group evaluation form located in the file. One file is still open.	
There is evidence of the SNAP Boys/SNAP Girls Child Group Evaluation Form located in the file.	Compliance	Two of two files reviewed contained evidence of the SNAP Boys/ SNAP girls child group evaluation form located in the file.	
There is evidence of the SNAP Boys/SNAP Girls Parent Group Evaluation Form located in the file.	Compliance	Two of two files reviewed contained evidence of the SNAP Boys/ SNAP girls parent group evaluation form located in the file.	
SNAP Clinical Groups for Youth 12-17			
Youth are screened to determine eligibility of services.	Not Applicable	The program does not serve this population.	
The Consent to Treatment and Participation in Research Form is completed and located within the file.	Not Applicable	The program does not serve this population.	
The NIRVANA was completed at initial intake, or within two sessions.	Not Applicable	The program does not serve this population.	
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	The program does not serve this population.	
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	The program does not serve this population.	
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	The program does not serve this population.	
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*	Compliance	Three of three SNAP in schools groups reviewed contained completed attendance sheets for all sessions.	
The program maintained evidence of a completed "Class Goal" Document for the class reviewed.	Exception	Two of three SNAP in school groups reviewed did document class goals.	One SNAP in schools group session reviewed did not document class goals.
The program maintained evidence of both pre AND post Measure of Classroom Environment (MoCE) completed documents for the class reviewed.	Exception	Two of three SNAP in schools groups reviewed showed evidence of completion of MoCE post-assessment.	There was no evidence of completion of MoCE post-assessment in the one completed SNAP in schools session reviewed.
The program maintained evidence of completed pre and post evaluation documents for the class reviewed.	Compliance	Three of three SNAP in schools groups reviewed contained completed pre and post evaluation documents for the class.	

There is evidence of the fidelity adherence checklist maintained in the file for each class reviewed.	Compliance	Three of three SNAP in schools groups reviewed contained completed fidelity adherence checklists.	
Additional Comments: **There are no additional comments for this indicator.**			
3.01 - Shelter Environment			Satisfactory with Exception
Provider has a written policy and procedure that meets the requirement for Indicator 3.01		**YES** If NO, explain here: The agency has a policy numbered, FLN 4.01 and titled Shelter Program Services, last reviewed April 4, 2023 by the CEO.	
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.*			
Type of Documentation(s) Reviewed: Policy and Procedure Manual **Describe any Observations: Shelter Tour**			
Facility Inspection: a. Furnishings are in good repair. b. The program is free of insect infestation. c. Bathrooms and shower areas are clean and functional, free of foul odors, leaks, dust, and mildew and in good working order. d. There is no graffiti on walls, doors, or windows. e. Lighting is adequate for tasks performed there. f. Exterior areas are free of debris; grounds are free of hazards. g. Dumpster and garbage can(s) are covered. h. All doors are secure, in and out access is limited to staff members and key control is in compliance. i. Detailed map and egress plans of the facility, general client rules, grievance forms, abuse hotline information, DJJ Incident Reporting Number and other related notices are posted. j. Interior areas (bedrooms, bathrooms, common areas) do not contain contraband and are free from hazardous unauthorized metal/foreign objects.	Compliance	Furnishings appeared in good repair. Program appeared free of insect infestation. Bathrooms and shower areas appeared clean and functional. One instance of graffiti was found on an interior closet door and was readily covered while on site. Lighting appeared adequate. Exterior area and grounds appeared free of debris and hazards. Dumpster contained a latch and was securely fastened and covered; exterior garbage cans were covered. All doors appeared secure and were reported to be magnetically locked, requiring a key fob or code to open. Maps and egress plans were located at throughout; client rules are provided in the intake handout and during a daily morning PowerPoint; grievance box located in living room with policy and procedure posted in the dorm hallways and intake handout; abuse hotline information posted in dormitory, nurse/intake office, and intake handbook; DJJ Incident Report number contained in a CCC binder and while on site was posted in the direct care workers' office.	
Facility Inspection: a. All agency and staff vehicles are locked. b. Agency vehicles are equipped with major safety equipment including first aid kit, (all items in the first aid kit are current and do not have expired items; all expired items should be replaced regularly), fire extinguisher, flashlight, glass breaker and, seat belt cutter.	Compliance	All agency and staff vehicles were locked. Initial inspection of agency vehicles indicated one vehicle contained expired saline solution and a newly acquired vehicle did not contain a flashlight/glass breaker/seat belt cutter; both instances were amended while on site. Agency vehicles were equipped with major safety equipment.	

Facility Inspection: All chemicals are listed, approved for use, inventoried weekly and perpetually, stored securely and Material Safety Data Sheets (MSDS) are maintained on each item (minimum 1 time per week or per agency policy). A perpetual inventory will be the primary means of maintaining a current and real-time inventory. The weekly inventory will be conducted weekly at a minimum to ensure that a perpetual inventory is being maintained consistently and accurately. If more than one location is used to store chemicals, there is an inventory wherever chemicals are stored that is current and well maintained unless previously approved by the Network.	**Exception**	The primary chemical closet contained MSDS for each chemical. Perpetual inventory sheets are kept for male and female supply closets for frequently used cleaning chemicals. The female side maintained a consistent and perpetual count. Both closets contained hand soap, which was removed and placed in the general chemical closet, where it is meant to be stored. No MSDS sheet was being used in the laundry room which contained a box of detergent pods, a disinfectant spray can, and a container of white distilled vinegar; MSDS sheets were added while on site.	The male chemical closet contained a perpetual count of what was being checked out, but did not list the overall inventory; amendments were made while on site. No MSDS were being used in the laundry room which contained a box of detergent pods, a disinfectant spray can, and a container of white distilled vinegar; MSDS were added while on site. It was unable to be determined how long chemicals had been stored in the laundry room. Kitchen did not contain an inventory for soap and sanitization solution used in an automatic dispenser set up; no documentation was present for when the chemicals arrive or are replaced.
Facility Inspection: Washer/dryer are operational & general area/lint collectors are clean. Agency has a current DCF Child Care License which is displayed in the facility. Each youth has own individual bed with clean covered mattress, pillow, sufficient linens and blanket. Youth have a safe, lockable place to keep personal belongings, if requested.	**Compliance**	Washers and dryers were operational; general area and lint collectors appeared clean. Certificate of License posted in front lobby, effective date 1/29/23, expiration 1/28/24. Each dorm room contained two individual beds for two youth; youth were provided one blanket in closet, one blanket on bed, one fitted sheet, one flat sheet, two pillowcases, and two pillows. Youth are allowed a locker storage for personal belongings, located behind a locked door in the dormitory.	
Additional Facility Inspection Narrative (if applicable)			
Fire and Safety Health Hazards: a. Annual facility fire inspection was conducted, and the facility is in compliance with local fire marshal and fire safety code within jurisdiction. b. Agency completes a minimum of 1 fire drill on each shift monthly (within 2 minutes or less). c. Completes 1 mock emergency drill per shift per quarter. d. All annual fire safety equipment inspections are valid and up to date (extinguishers, sprinklers, alarm system and kitchen overhead hood, including fire extinguishers in all vehicles).	**Exception**	Facility was in compliance with annual fire inspection, last conducted 7/25/23. Six fire extinguishers in building and three fire extinguishers in vehicles were valid and up to date. Alarm system and kitchen overhead hood were valid and up-to-date.	Two dates observed in the last six months for Fire Drill Logs 2023, 7/31 4:24pm 1m2s and 12/28 3:28pm 1m18s, indicated fire drills being performed on the 11pm-7am shift outside the confines of the shift. Upon clarification by on site staff, these fire drills were performed outside of the shift due to factors such as inclement weather. Mock emergency drills had not been conducted. No document for quarterly sprinkler inspection present between 5/30/23 and 11/21/23.

Fire and Safety Health Hazards: a. Agency has a current Satisfactory Residential Group Care inspection report from the Department of Health. b. Agency has a current Satisfactory Food Service inspection report from the Department of Health and food menus are posted, current and signed by Licensed Dietician annually. c. All cold food is properly stored, marked and labeled and dry storage/pantry area is clean and food is properly stored. d. Refrigerators/Freezers are clean and maintained at required temperatures and all small and medium sized appliances are operable and clean for use as needed.	**Exception**	Department of Health County Health Department Group Care Inspection Report, result: Satisfactory dated 1/5/24. Department of Health County Health Department Food Service Inspection Report, Result: Satisfactory, Dated 10/2/23. Food menu initially posted in the living room and kitchen. Menu posted displays the date range Monday December 15-Sunday December 21, which suggests the correct days for January with the incorrect month listed, as December 15 was a Friday. Dietician license was provided upon request. Cold food appeared properly stored in fridge and freezer. Employee stated items in unmarked containers were items to be used the same day. Items inspected in fridge and freezer were within best by date. Fridge Temperature: Medication Room Fridge 40 degrees F, Double Door Fridge 37 degrees F, Single Door Fridge 36 degrees F. Freezer Temperature: -3 degrees F. Small and medium appliances appeared operable and clean for use as needed. Staff advised cleaning appliances, particularly the microwave, is a daily chore.	Food menu posted during initial shelter tour did not contain a dietician signature. Per staff on site, Florida National Food and Lunch program for schools allowed dietician to approve Breakfast and Lunch menus, but not dinner menus. On site cook is responsible for preparing the dinner menu. Dietician approved breakfast and lunch menus for three weeks were provided upon request, but did not match the posted menu nor the meals being served at time of visit. Dietician approved menus did not indicate a date signed.
Additional Fire and Safety Health Hazards Narrative (if applicable)			
Youth Engagement			
a. Youth are engaged in meaningful, structured activities (e.g., education, recreation, counseling services, life and social skill training) seven days a week during awake hours. Idle time is minimal. b. At least one hour of physical activity is provided daily. c. Youth are provided the opportunity to participate in a variety of faith-based activities. Non-punitive structured activities are offered to youth who do not choose to participate in faith-based activities. d. Daily programming includes opportunities for youth to complete homework and access a variety of age appropriate, program approved books for reading. Youth are allowed quiet time to read. e. Daily programming schedule is publicly posted and accessible to both staff and youth.	**Compliance**	Shelter schedule indicated educational activities occurring Monday through Friday from 8:00am to 3:00pm. Recreation indicated across the schedule including Free time, Free time Outside, Movie, and Leisure/Movies. Evening Group indicated from 8:30pm to 8:45pm Monday to Thursday and Sunday, and Friday to Saturday from 9:00pm to 9:30pm. Documentation was present in logbook indicating youth went with counselors. Shift schedule indicated Cleanup and Chores listed across every day. Shelter schedule indicates 10:00am to 11:30am as Physical Education Monday through Friday. Free time outside is scheduled Monday through Friday 5:00pm-5:30pm. Free time outside is scheduled Saturday 10:30am to 11:00am, 1:00pm to 2:30pm, and 4:00pm to 5:30pm. Free time outside is scheduled Sunday 1:00pm to 2:30pm. Shelter schedule indicates 12:00pm to 12:30pm on Sunday as Spiritual Services or Free time. Shelter schedule includes a note at the bottom of the page stating "church arrangements can be made based on client needs". Shelter schedule indicates 4:00pm to 5:00pm on Monday through Friday as Homework Time. Shelter schedule indicates 8:45pm to 9:00pm on Monday through Thursday, 9:30pm to 10:00pm Friday/Saturday, and 9:00 to 9:30pm Sunday as Bed Prep/Quiet Time. Stocked bookshelves were observed throughout initial shelter tour in common areas; this section is not listed in current policy Shelter Program Services. A copy of the daily programming schedule was provided. The programming schedule was not seen posted upon initial shelter tour; staff stated the initial schedule is provided during a daily morning PowerPoint and is contained in the handbook upon intake. Additionally, the afternoon schedule is marked on a white board in the living room.	
Additional Comments: **There are no additional comments for this indicator.**			

3.02 - Program Orientation			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 3.02		**YES** If NO, explain here: The agency has a policy numbered 3.03, titled Orientation-Client last reviewed April 4, 2023 by the CEO.	
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: Two **Total number of Closed Files: Three** **Type of Documentation(s) Reviewed: Youth files**			
Youth received a comprehensive orientation and handbook provided within 24 hours	**Compliance**	A review of five of five youth files showed evidence of youth receiving orientation handbook at intake.	
Orientation includes the following: a. Youth is given a list of contraband items b. Disciplinary action is explained c. Dress code explained d. Review of access to medical and mental health services e. Procedures for visitation, mail and telephone f. Grievance procedure g. Disaster preparedness instructions h. Physical layout of the facility i. Sleeping room assignment and introductions j. Suicide prevention- alerting staff of feelings or awareness of others having suicidal thoughts	**Compliance**	Proof of orientation was present in five of five youth files reviewed: Orientation included: a. Youth is given a list of contraband items b. Disciplinary action is explained c. Dress code explained d. Review of access to medical and mental health services e. Procedures for visitation, mail and telephone f. Grievance procedure g. Disaster preparedness instructions h. Physical layout of the facility i. Sleeping room assignment and introductions j. Suicide prevention- alerting staff of feelings or awareness of others having suicidal thoughts	
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**	Five of five youth files reviewed contained orientation documentation with signatures of the youth and staff involved indicating orientation topics and dates within.	
Additional Comments: **There are no additional comments for this indicator.**			

3.03 - Youth Room Assignment		Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 3.03	**YES** If NO, explain here: The agency has a policy numbered 3.03, titled Room/ Bed assignment, last reviewed April 4, 2023 by the CEO.	
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: Two **Total number of Closed Files: Three** **Type of Documentation(s) Reviewed: Youth file**			
A process is in place that includes an initial classification of the youths, to include:			
a. Review of available information about the youth's history, status and exposure to trauma b. Initial collateral contacts, c. Initial interactions with and observations or the youth d. Separation of younger youth from older youth, e. Separation of violent youth from non-violent youth f. Identification of youth susceptible to victimization g. Presence of medical, mental or physical disabilities h. Suicide risk i. Sexual aggression and predatory behavior j. Acute health symptoms requiring quarantine or isolation	**Compliance**	A review of five of five youth files showed documentation of the following evidence in consideration of youth room/ bed assignment: a. Review of available information about the youth's history, status and exposure to trauma b. Initial collateral contacts, c. Initial interactions with and observations or the youth d. Separation of younger youth from older youth, e. Separation of violent youth from non-violent youth f. Identification of youth susceptible to victimization g. Presence of medical, mental or physical disabilities h. Suicide risk i. Sexual aggression and predatory behavior j. Acute health symptoms requiring quarantine or isolation	
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**	Upon intake, 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. It is indicated in several places including but not limited to: the youths' record, on the shift report form, and program logbook.	
Additional Comments: **There are no additional comments for this indicator.**			
3.04 - Log Books			**Limited**
Provider has a written policy and procedure that meets the requirement for Indicator 3.04		**YES** If NO, explain here: The agency has a policy number 3.04, titled Log Books, reviewed on April 4, 2023 and signed by the CEO.	**3.04 Log Books**
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: 7/26/23, 8/7/23, 8/31/23, 11/4/23-11/10/23. **Staff Position(s) Interviewed** *(No Staff Names)*: **Type of Documentation(s) Reviewed: Logbook** **Describe any Observations: Camera footage**			
Log book entries that could impact the security and safety of the youth and/or program are highlighted	**Compliance**	Entries reviewed across 7/26/23, 8/7/23, 8/31/23, and 11/4/23-11/10/23 contained highlighted safety and security issues.	

Standard	Rating	Findings	Comments
All entries are brief, legibly written in ink and include: • Date and time of the incident, event or activity • Names of youth and staff involved • Brief statement providing pertinent information • Name and signature of person making the entry	**Exception**	Entries reviewed primarily contained date and time, names, brief statement with pertinent information.	The name and signature of person making the entry is required per the standard, logbook was using initials and not the name and signature of the person making the entry.
Recording errors are struck through with a single line. The staff person must initial and date the correction. The use of whiteout and erasures is prohibited.	**Exception**	Most entries reviewed contained a single strikethrough line and initials.	Voided entries reviewed did not include dates. On 8/31, the number 8 is struck through with no initial. On 8/31, a word appearing to be "zap" has the word "zip" written over the word in lieu of a strikethrough. on 11/6, two instances of voided words do not contain the initials or date.
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**	No correction, recommendation, or follow-up was present during the dates reviewed.	Program director or designee initials the top of each page individually. During the week of 11/4/23-11/10/23, there was no signature indicating dates reviewed by program director or designee.
All staff review the logbook of the previous two shifts and makes an entry signed and dated into the logbook indicating the dates reviewed	**Exception**	Entries reviewed across 7/26/23, 8/7/23, 8/31/23, and 11/4/23-11/10/23. Program staff are using a shift review form which is completed by the shift supervisor prior to the start of the next shift.	Logbook entries reviewed are not signed and dated indicating dates reviewed. On 11/6, two staff are listed as coming onto shift at 11:00pm and reviewing logbook; this entry is not initialed by either staff. Five staff are listed as coming onto shift at 7:00am and reviewing logbook; this entry is initialed by one staff. Four staff are listed as coming onto shift at 3:00pm and reviewing logbook; this entry is initialed by one staff. Similar occurrences can be found on 8/30 11pm initials by one of two staff, 8/31 7am initials by one of five staff, 8/31 3pm which does not have initials by any of four staff, 8/6 11pm initials by one of two staff.
At the beginning of their shift, oncoming supervisor and shelter counselor reviews the logbook of all shifts since their last log entry and makes a signed and dated entry and into log book indicating the dates reviewed.	**Exception**	Oncoming shift supervisors reportedly review book upon the start of the shift and initial doing so.	Entries reviewed did not appear to contain a shelter counselor signature indicating shift reviews and date range. Shift supervisor initials did not indicate a date reviewed.
Logbook entries include: a. Supervision and resident counts b. Visitation and home visits	**Compliance**	Logbook entries contained supervision, resident counts, and visitations.	

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

<table>
<tr><td colspan="3">3.05 - Behavior Management Strategies</td><td>Satisfactory</td></tr>
<tr><td colspan="2" rowspan="3">Provider has a written policy and procedure that meets the requirement for Indicator 3.05</td><td>YES</td><td rowspan="3"></td></tr>
<tr><td>If NO, explain here: No Policy Number</td></tr>
<tr><td>The program has a policy which does not contain a policy number, titled Behavior Management System, signed by the CEO and last reviewed April 4, 2023.</td></tr>
<tr><td colspan="4">Type of Documentation(s) Reviewed: Intake Handbook, Policy, Shift Review Checklist
Describe any Observations: Policy is mostly sufficient regarding the Behavior Management System (BMS); during the time frame observed, the BMS appeared to be followed, but consequences were unclear for certain actions; some instances involved writing sentences while others involved youth being separated for similar actions.</td></tr>
<tr><td>The program has a detailed written description of the BMS and it is explained during program orientation</td><td>Compliance</td><td>Handbook provided upon intake contained rules and behavior expectations, as well as the points sheet and explains how points are earned. Interview with the COO revealed the program uses natural consequences.</td><td></td></tr>
<tr><td colspan="4">Behavior Management Strategies must include:</td></tr>
<tr><td>a.BMS is designed to teach youth new behaviors and help youth understand the natural consequences for their actions
b.Behavioral interventions are applied immediately, with certainty, and reflect the severity of the behavior
c.BMS uses a wide variety of awards/incentives to encourage participation and completion of the program
d.Appropriate consequences and sanctions are used by the program and consequences for behavior are logical and designed to promote skill-building for the youth
e.Counseling, verbal intervention and de-escalation techniques are used prior to physical intervention (Only techniques approved by the Florida Network and DJJ are used if physical intervention is required)
f.Only staff discipline youth. Group discipline is not imposed
g.Room restriction is not used as part of the system or for youth who are physically and/or emotionally out of control
h.Youth should never be denied basic rights such as meals, clothing, sleep, services, exercise, or correspondence privileges</td><td>Compliance</td><td>Youth are offered multiple different privileges for positive behavior which includes using a PlayStation or swimming in the pool, in addition to the point store, where youth are able to use points accumulated from good behavior. Youth are informed of opportunities for games, activities, television, and outings will be available to individuals who have demonstrated appropriate behavior on-site. Youth are encouraged to earn points by demonstrating good behavior. Youth who are not demonstrating appropriate behavior do not have their points taken from them, but are unable to earn more points. Consequences are provided to staff on the Shift Review forms, and are handled on a case by case basis. Youth possessing illegal contraband are subject to notification of parent/guardian and law enforcement. Youth are informed in the handbook upon intake physical violence and intentional destruction of any item or property will result in notification of parent/guardian and law enforcement. Youth are informed they can lose privileges such as swimming. Staff appeared to be the only ones disciplining youth; a written system was noted indicating youth serving as peer leaders, but made no indication of discipline. Room restrictions did not appear to be used as part of the system.

Evidence of natural consequences were documented in the program logbook 11/05/2023 and 11/07/2023. Youth were given appropriate consequences in accordance with the shift review form provided by the supervisor at the beginning of the shift. Supervisors consider the natural consequences appropriate for each youth and record them on shift review form, in the event a youth's behavior warrants the need to enforce a consequence.</td><td></td></tr>
<tr><td colspan="4">Program’s use of the BMS</td></tr>
</table>

All staff are trained in the theory and practice of administering BMS rewards and consequences	**Compliance**	The Shift Review forms provided to the following shift contain several possible consequences. The agency's policy uses natural consequences. There is a point system used to earn rewards. Youth earn points but do not have points taken away as an adverse consequence. Youth use points earned to shop for various goods, treats, etc. in the program's point store. The Program Supervisor trains staff on the administration of the points in relation to rewards and consequences.	
There is a protocol for providing feedback and evaluation of staff regarding their use of BMS rewards and consequences	**Compliance**	Grievance form provides the opportunity to escalate from another resident or staff member to shift supervisor to shelter supervisor to chief operating officer. Grievance Youth and Families Policy is indicated under FLN 1.02, last revised 4/4/23.	
Supervisors are trained to monitor the use of rewards and consequences by their staff	**Compliance**	The agency has developed a point based system of positive reinforcement. The Program Supervisor has in-depth knowledge and experience in the implementation and use of the system. The Program Supervisor trains and monitors staff in the use or rewards and consequences through the point based system. Shift Review forms prepared by the supervisors which contain suggested natural consequences for each youth. Staff may use those suggested consequences as adverse behavior warrants the need for enforcement of rules or as a reward for compliance of rules. Training and monitoring of the use of rewards and consequences by the supervisors is closely monitored by the Program Supervisor.	

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

3.06 - Staffing and Youth Supervision			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 3.06		**YES** If NO, explain here: No Policy Number The agency has a policy with no number, titled Staffing and Youth Supervision, last reviewed by the CEO on April 4, 2023.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Dates or Timeframe Reviewed: 12/21/23 12am-1am, 12/25 3am-4am, 1/3 3am-4am, 1/8 12am-1am **Staff Position(s) Interviewed: COO** **Type of Documentation(s) Reviewed: Logbook** **Describe any Observations: Overnight staff are performing the checks on time, but are not documenting checks in real time.**			
The program maintains minimum staffing ratios as required by Florida Administrative Code and contract. • 1 staff to 6 youth during awake hours and community activities • 1 staff to 12 youth during the sleep period	**Compliance**	Staff schedules were reviewed for the most recent six months. Program maintained minimum 1:6 staffing ratio throughout shifts reviewed. At least three staff on day shift and two staff on overnight shift with thirteen youth on roster during review periods.	
All shifts must always provide a minimum of two direct care staff present that have met the minimum training requirements	**Compliance**	Staff schedules were reviewed for the most recent six months. All shifts reviewed contained at least two staff present.	
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**	Program staff included background screened and trained youth care workers.	
The staff schedule is provided to staff or posted in a place visible to staff	**Compliance**	Program schedule is posted in direct care workers' office. Staff stated schedule is primarily set and emails are used to notify any changes.	
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**	Roster of staff with emails and phone numbers are contained in direct care workers' office, as well as with the receptionist.	

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	**Compliance**	A review of 34 bed checks showed staff observe youth at least every 15 minutes for bed checks. Documentation on 12/25/2023, stated checks were completed at 3:00 for both dorms, 3:15 for both dorms, 3:30 for both dorms, and 3:45 for both dorms; footage showed checks were documented in real time. 1/3/2024 documentation stated checks were completed at 3:15, 3:30, 3:45, and 4:00; footage showed checks were documented at 3:15 for both dorms, 3:30 for one dorm, 3:45 for one dorm, 4:00 for one dorm. 1/8/2024 documentation stated checks were completed at 12:00, 12:15, 12:30, 12:45, and 1:00; footage showed checks were documented at 12:15 for the first dorm, 12:30 for both dorms, 12:45 for the second dorm, 1:00 for both. It is the program's practice to conduct bed checks of both hallways simultaneously. It is evident upon review of the video cameras that staff are walking the halls and documenting the bed check in the logbook upon return to the direct care worker's office.	

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

3.07 - Video Surveillance System	**Satisfactory with Exception**

Provider has a written policy and procedure that meets the requirement for Indicator 3.07	**YES** If NO, explain here: The agency has a policy numbered FLN 3.07, titled Video Surveillance System last reviewed by the CEO on April 4, 2023.	

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

Dates or Timeframe Reviewed: 7/26/23-1/4/24
Type of Documentation(s) Reviewed: Video surveillance log, logbook
Describe any Observations: Facility tour (interior and exterior cameras)

Surveillance System

The agency, at a minimum, shall demonstrate: a. A written notice that is conspicuously posted on the premises for the purpose of security b. System can capture and retain video photographic images which must be stored for a minimum of 30 days c. System can record date, time, and location; maintain resolution that enables facial recognition d. Back-up capabilities consist of cameras' ability to operate during a power outage e. Have cameras placed in interior and exterior general locations of the shelter where youth and staff congregate and where visitors enter and exit. Cameras are never placed in bathrooms or sleeping quarters. f. All cameras are visible	**Compliance**	A "Notice all activities monitored by video cameras" sign is posted in parking lot. Cameras are present throughout the interior and exterior of the facility. Exterior of buildings are monitored by cameras. Outdoor recreation areas are monitored by cameras. Multiple cameras are present in lobby where visitors enter and exit. Staff stated there are twenty-eight cameras on site. Youth are searched in the medication room/intake office, direct care workers' office, or the hallways, all of which are on camera. Cameras are visible. No cameras are placed in bathrooms or sleeping quarters. Video footage is captured and retained for thirty days.	
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 who can access the video surveillance system was provided, last updated 1/3/24.	
Supervisory review of video is conducted a minimum of once every 14 days and timeframes reviewed are noted in the logbook.	**Exception**	Video surveillance log provided indicated supervisory review of cameras is being conducted once every 14 days across a six month span: 7/26/23, 8/7/23, 8/21/23, 8/31/23, 9/11/23, 9/25/23, 10/9/23, 10/19/23, 11/1/23, 11/9/23, 11/23/23, 12/7/23, 12/21/23, 1/4/24.	Timeframes reviewed were not notated in the logbook, but were notated in a separate video surveillance log.
The reviews assess the activities of the facility and include a review of random sample of overnight shifts	**Exception**	The program maintains a video surveillance log. Video surveillance log contained general comments regarding shelter activity.	Video surveillance log contained vague comments which do not assess the activities of the facility according to the standard. Time ranges were listed in the log but do not specifically list AM or PM.
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 the ability to grant requests of video recordings. The COO provides video recordings when requested.	
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**	Last work order for cameras being down was dated 5/1/21 and completed 5/3/21. Most recent work order provided requested for an increase in the memory on the camera dated 5/11/22 and documented a phone call to provider being made 5/11/22 for a larger hard drive.	
Additional Comments: **There are no additional comments for this indicator.**			

4.01 - Healthcare Admission Screening		**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 4.01	**YES** If NO, explain here: The agency has a policy titled Healthcare Admission Screening. The policy was last reviewed and signed by the Chief Executive Officer on January 17, 2024.	

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: 3 open youth residential files
Total number of Closed Files: 2 closed youth residential files
Type of Documentation(s) Reviewed: CINS/FINS Intake Form, Physical Health Screening and Client Room Assignment Form

Screening includes : a. Current medications b. Existing (acute and chronic) medical conditions c. Allergies d. Recent injuries or illnesses e. Presence of pain or other physical distress f. Observation for evidence of illness, injury, physical distress, difficulty moving, etc. g. Observation for presence of scars, tattoos, or other skin markings h. Acute health symptoms requiring quarantine or isolation	**Compliance**	Five youth case management records were reviewed; three open and two closed. All records included a health screening form containing all required elements indicating whether or not each youth was on any medications, had any existing medical conditions, allergies, recent injuries or illnesses, any presence of pain or other physical distress, staff observations for presence of any symptoms or physical markings, or had any acute health related issues 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**	A review of five youth case management records indicated none of the selected youth suffered from any chronic conditions. An informal interview with the Chief Operations Officer, indicated the agency had no youth during the review period with chronic conditions.	
When needed, the parent is involved with the coordination and scheduling of follow-up medical appointments	**No eligible items for review**	A review of five youth case management records indicated none of the selected youth suffered from any chronic conditions. An informal interview with the Chief Operations Officer, indicated the agency had no youth during the review period with chronic conditions.	
All medical referrals are documented on a daily log.	**No eligible items for review**	A review of five youth case management records indicated none of the selected youth suffered from any chronic conditions. An informal interview with the Chief Operations Officer, indicated the agency had no youth during the review period with chronic conditions.	
The program has a thorough referral process and a mechanism for necessary follow-up medical care as required and/or needed	**Compliance**	The program has a thorough referral process and a mechanism for follow-up medical care as required and/or needed. Per the agency's policy in the case of an emergency staff are to call 9-1-1. If the condition is not a medical emergency, staff are to notify their team leader and document any pertinent information on the youth's chronological, in the agency's pass down log, and shift review log as well as complete any necessary alerts, and attach a color-coded label to the record.	

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

4.02 - Suicide Prevention			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 4.02		**YES** If NO, explain here: The agency has a policy FLN 4.02 in place to address the requirements of the indicator titled Suicide Prevention. The policy was last reviewed by the Chief Executive Officer on April 4, 2023.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open (Residential & Community) Files: 1 open youth residential file and 2 open community counseling files **Total number of Closed (Residential & Community) Files: 2 closed youth residential files and 1 closed community counseling file** **Staff Position(s) Interviewed: Clinical Supervisor** **Type of Documentation(s) Reviewed: CINS/FINS Intake Form, Assessment of Suicide Risk Form, Precautionary Observation Log Form**			
Suicide Risk Screening and Approval (*Residential and Community Counseling*)			
Suicide risk screening occurred during the initial intake and screening process. Suicide screening results reviewed and signed by the supervisor and documented in the youth's case file.	**Compliance**	Six youth residential and non-residential case management records were reviewed; three open and three closed. All records contained a suicide screening completed during the initial intake and screening process. The suicide screening results were all reviewed and signed by the supervisor and documented in the youth's case record.	
The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	**Compliance**	The agency utilizes the CINS/FINS intake form which includes a suicide risk assessment that 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**	All three youth in shelter services were applicable for being placed on constant sight and sound supervision. All three youth were placed appropriately based on the results of the suicide risk assessment.	
Staff person assigned to monitor youth maintained one-to-one supervision or constant supervision and documented his/her observations of the youth's behavior at 30 minute or less intervals	**Compliance**	All applicable youth were placed on constant sight and sound. While on constant sight and sound supervision, the staff person assigned to the youth documented the youth's behavior at ten-minute 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**	Three applicable youth were placed on constant sight and sound supervision. Documentation on the precautionary observation log forms include the time of day, behavioral observations, any warning signs observed, and the observer's 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**	Three applicable youth were placed on constant sight and sound supervision. This supervision level was not changed or reduced until a licensed mental health professional or a non-licensed mental health professional under the supervision of a licensed professional completed a further assessment.	

There was evidence that documentation was reviewed by supervisory staff each shift. If program uses an observation log, completed logs are maintained in the youth's file.	**Compliance**	Three applicable youth were placed on constant sight and sound supervision. Reviewed documentation indicates the precautionary observation log forms were reviewed by a supervisory staff each shift and the completed log was maintained in the youth case management record.	
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.	**No eligible items for review**	Three community youth case management records were reviewed. No youth were identified for suicide risk during intake.	
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**	Three community youth case management records were reviewed. No youth were identified for suicide risk during intake.	
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.	**No eligible items for review**	Three community youth case management records were reviewed. No youth were identified for suicide risk during intake.	
If the parent/guardian cannot be contacted, all efforts to contact them are documented in the case file.	**No eligible items for review**	Three community youth case management records were reviewed. No youth were identified for suicide risk during intake.	
When the screening was completed during school hours on school property, the appropriate school authorities were notified.	**No eligible items for review**	Three community youth case management records were reviewed. No youth were identified for suicide risk during intake.	
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		**NO** If NO, explain here: Policy indicates when nurse is on premise they are to handle all medication responsibilities and when not on premise it is delegated to "the staff member responsible"; however, per policy, the staff member responsible each shift is to be clearly designated on the staff schedule as well as the daily shift report and the agency policy makes no mention of this. The agency has a policy FLN 4.03 in place to address the requirements of the indicator titled Medication Management and Distribution. The policy was last reviewed on April 4, 2023 by the Chief Executive Officer.	
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 youth residential files **Total number of Closed Files: 3 closed youth residential files** **Staff Position(s) Interviewed: Registered Nurse, Direct Care Supervisor** **Type of Documentation(s) Reviewed: Physical Health Screening Form, Medication Distribution Logs, Inventory (weekly and perpetual) for controlled substances and non-controlled substances, Sharps Inventory, First Aid Kits inventory, Shift-to-Shift Medication Count Log, Agency Quarterly Meeting Minutes, Training Certificates for staff permitted to dispense and have access to medications and Pyxis, Central Communications Center (CCC) Reports** **Describe any Observations: Med pass was observed with the Registered Nurse (RN). Youth were brought inside the medical office individually. The RN verified their demographics and inquired what medications they were supposed to get. The RN counted the medication prior to and after administering it to the youth. Prior to the youth taking the medication they verified that they were receiving the correct medication and after they took it, the youth and the RN initialed the medication distribution log.**			
The agency has a Registered Nurse (RN) and/or a Licensed Practical Nurse (LPN) that is being supervised by RN and all of their credentials have been verified.	**Compliance**	The agency has one Registered Nurse (RN) on staff. She has a clear and active license in the state of Florida that expires until July 31, 2024.	
The agency has evidence of the following for all non-nursing shelter staff designated to assist with the self-administration of medication: a. Documentation of in-person self-administration of medication distribution training provided by a Registered Nurse b. Evidence demonstrating their competency to assist with self-administration of medication distribution c. Maintenance of their annual medication training re-certification	**Compliance**	Through training records and review of medication distribution logs, the agency has evidence of in-person self-administration of medication distribution training, maintained annually, provided by a Registered Nurse (RN) and demonstration of staff competency to assist with self-administration of medication distribution.	

The agency held at least quarterly staff meetings conducted by RN and/or Shelter Manager to review and assess: a. strategies implemented to reduce medication errors shelter wide b. analyze factors that contributed to medication errors c. allow staff the opportunity to practice and role-play solutions	**Compliance**	Agency staff meeting minutes reviewed indicate the agency held staff meetings quarterly conducted by the Shelter Manager and/or the Registered Nurse (RN) to review and assess strategies implemented to reduce medication errors shelter wide, analyze factors that contributed to medication errors, and allow staff the opportunity to practice and role-play solutions. Date(s) of quarterly meetings held: May 10, 2023; July 12, 2023; September 13, 2023; and November 8, 2023.	
The agency has strategies implemented to ensure medications are provided within the 2-hour time frame.	**Compliance**	An interview with the Registered Nurse (RN) and review of shift reports evidenced the agency has strategies implemented to ensure medications are provided within the two hour required timeframe through daily shift reports, alarms, and checking in with fellow staff members.	
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**	Review of shift reports and staff schedules indicated all non-licensed staff members are clearly identified and designated on the shift change report and staff schedules for assistance with self-administration of medications on each shift.	
The agency has clear methods of communicating which youth are on medications with the times and dosage easily discernable by all staff on each shift.	**Compliance**	The agency utilizes the daily shift change report and medication distribution logs to clearly communicate which youth are on medications with the times and dosage easily discernable by all staff on each shift.	
The delivery process of medications is consistent with the FNYFS Medication Management and Distribution Policy and the agency has an internal quality assurance process to include the following: a. to ensure appropriate medication management and distribution methods b. to track medication errors c. to identify systemic issues and implement mitigation strategies, as appropriate.	**Compliance**	Observation of medpass at the agency indicates the agency delivery process of medications is consistent with the Florida Network of Youth and Family Services (FYNFS) medication management and distribution policy. Review of perpetual and weekly inventory logs shows evidence the agency has an internal quality assurance process to include ensuring appropriate medication management and distribution methods, tracking errors, and identifying systemic issues and implement mitigation strategies.	
Admission/Intake of Youth			
a. Upon admission, the youth and parent/guardian (if available) were interviewed by the Registered Nurse (when on-site) about the youth's current medications as part of the Medical and Mental Health Assessment screening process and/or an interview was conducted by the RN within three (3) business days if the RN was not on the premise at admission. **If the agency does not have a RN, there was a medication review conducted by a certified Leadership position.* b. Upon intake/admission, there is evidence that the on-shift certified supervisor of higher level staff did review all medication forms by the next business day.	**Compliance**	A review of seven youth case management records indicates upon admission of a youth, staff speak with and interview the youth and parent/guardian regarding the youth's current medications as part of the medical and mental health assessment screening process. All seven youth's admission forms showed evidence the on-shift certified supervisor or higher level staff reviewed all medication forms 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) b. Pyxis machine is stored in accordance with guidelines in FS 499.0121 and policy section in Medication Management c. Oral medications are stored separately from injectable epi-pen and topical medications d. Medications requiring refrigeration are stored in a secure refrigerator that is used only for this purpose, at temperature range 2-8 degrees C or 36-46 degrees F. (If the refrigerator is not secure, the room is secure and inaccessible to youth.) e. Narcotics and controlled medications are stored in the Pyxis ES Station f. Pyxis keys with the following labels are accessible to staff in the event they need to access medications if there is a Pyxis malfunction: a TOP COVER b BACK PANEL- LEFT TALL CABINET LOCK- LEFT, c BACK PANEL- RIGHT TALL CABINET LOCK- RIGHT	**Compliance**	The Pyxis Med-Station is located within the medical room of the shelter building and is inaccessible to youth as it has two locked doors and is stored in accordance with guidelines in Florida Statute. All medications are stored in the Pyxis Med-Station 4000 medication cabinet. Oral medications are stored separately in a locked cabinet apart from topical medications and epi-pens. There is a secure refrigerator in the medical room used only for medical purposes and maintained within the required temperature range. At the time of the review, there were no medications on-site requiring refrigeration. All narcotic and controlled medications are stored in the Pyxis Med-Station 4000 medical cabinet. Within a Sterlite organizer next to the Pyxis Med-Station there are Pyxis Keys accessible to staff in the event they need to access medications during a Pyxis Med-Station malfunction and all are labeled appropriately.	
Medication Distribution			
a. Agency maintains a minimum of 2 site-specific System Managers for the Pyxis ES Station b. Only designated staff delineated in User Permissions have access to secured medications, with limited access to controlled substances (narcotics) c. A Medication Distribution Log shall be used for distribution of medication by non-licensed and licensed staff d. Agency verifies medication using one of three methods listed in the FNYFS Policies & Procedures Manual e. When nurse is on duty, medication processes are ALWAYS conducted by the nurse or when the nurse is not onsite, then the designated staff who has been trained by a licensed Registered Nurse provides the medication. f. Agency does not accept youth currently prescribed injectable medications, except for epi-pens h. Non-licensed staff have received training in the use of epinephrine auto-injectors provided by a registered nurse	**Compliance**	A virtual tour of the Pyxis Med-Station and medical room was completed with the Registered Nurse (RN) and Direct Care Supervisor. A list of system managers was provided as well as a list of designated staff delineated to have access to the secure medication. Training documents support all applicable staff were trained by the agency's medical staff in medication distribution. A review of the agencies medication distribution logs verified the agency's non-licensed and licensed staff are utilizing this tracking log appropriately. The agency verifies medication using one of the required three methods listed in the Florida Network of Youth and Family Services (FYNFS) policies and procedures manual. When the nurse is on-site, the nurse is the only person who conducts medication processes and the delivery process is consistent with the FNYFS medication management and distribution policy as evidenced in observations of med pass during the on-site review. The agency does not accept youth into the shelter who are currently prescribed any injectable medication, except epi-pens. A review of three pre-service and four in-service staff training records was conducted. Of the seven staff training records reviewed, three were required to have epi-pen training. All three applicable staff had documented proof of completion of epi-pen training.	

The medication distribution log documentation includes: a. the time of medication administration b. evidence of youth initials that the dosage was given c. evidence of staff initials that the dosage was given	**Compliance**	A review of the agency's medication distribution logs in five youth case management records indicate, the forms include the time of the medication administration, evidence of youth initials that the dosage was given, and evidence of staff initials that the dosage was given.	
There is evidence that staff provide youth with medications within one hour of the scheduled time of delivery as ordered by the medication. Documentation is provided for instances this does not occur within the required timeframe.	**Compliance**	A review of medication prescriptions and medication distribution log forms evidenced staff provide youth with medications within one hour of the scheduled time of delivery as indicated by the medication order. Documentation was provided for instances where this did not occur and three corroborating Central Communication Center (CCC) reports were reviewed regarding the distribution of the medications outside of the required timeframe. CCC report numbers reviewed were: 2023-03963, 2023-04477, and 2023-04355.	
During the review period, there were no instances where youth missed their medication due to failure to open the pyxis machine.	**Compliance**	A review of medication distribution log forms, Pyxis Med-Station inventories, and Central Communication Center (CCC) reports verified there were no instances where youth missed their medication due to failure to open the Pyxis machine.	
If applicable: Any staff member deemed responsible for a medication error, there was evidence that the staff member received refresher training from an RN and demonstrated competency prior to being assigned future medication administration responsibilities. There is evidence that any staff member deemed responsible for 3 errors within a 1-year time frame, had their certification suspended and was not recertified until the completion of the full **in-person** medication administration training, demonstrating competency and re-certification from an RN.	**No eligible items for review**	The agency had three medication distribution errors and they were reported under Central Communications Center (CCC) Report numbers 2023-03963, 2023-04477, and 2023-04355. Per the CCC because it was each staff member's first time making an error, refresher training was not necessary at this time. There have been no staff who have made three errors within a one year time period at the agency.	

Medication Inventory			
a. For controlled substances, a perpetual inventory with running balances is maintained as well as a shift-to shift count verified by a witness and documented b. Over-the-counter medications that are accessed regularly and inventoried weekly c. Syringes and sharps (needles, scissors, etc.) are secured, and counted and documented weekly	**Exception**	The agency utilizes their Pyxis Med-Station and medication distribution logs to maintain a perpetual inventory of all controlled substances. The medication distribution log contains a running balance for each youth as well as a shift to shift count that is verified by a witness and documented. The agency's medication distribution log also contains weekly inventories maintained on over-the-counter medications that are accessed regularly. The agency maintains a weekly syringe and sharps inventory count. Medication shift-to-shift counts were reviewed from July 6, 2023 at a rate of twice per day. Many had date, time and witness signatures. Logbook documentation showed counts occurred as required on July 6, 2023 (AM); July 7, 2023 (AM); July 8, 2023 (AM), August 13, 2023 (AM); September 8, 2023 (PM); October 16, 2023 (AM); November 4, 2023 (PM), and November 26, 2023 (PM). On December 29, 2023 there were no medications on-site to conduct a count on.	No count could be located for the following shift periods: July 6, 2023 (AM), July 7, 2023 (AM), July 8, 2023 (AM and PM), September 7, 2023 (PM), September 8, 2023 (PM), November 4 (PM), November 26, 2023 (PM), December 1, 2023 (PM), December 16, 2023 (PM), December 28, 2023 (PM), December 29, 2023 (AM and PM). No second witness signatures was present for July 15, 2023 (AM), August 13, 2023 (AM), October 16, 2023 (AM), December 1, 2023 (AM), and December 11, 2023 (AM).
There are monthly reviews of the Pyxis reports to monitor medication management practice.	**Compliance**	The agency conducts monthly reviews of Pyxis Med-Station reports to monitor medication management practice by printing the reports and then the Registered Nurse (RN) reviews them.	
Medication discrepancies are cleared after each shift.	**Compliance**	The agency maintains a binder with all discrepancies and how they were cleared. Review of the binder revealed no open discrepancies.	

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

4.04 - Medical/Mental Health Alert Process		Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 4.04	**YES** If NO, explain here: The agency has a policy with no number in place to address the requirements of the indicator titled Medical, Mental Health and Substance Abuse Screening and Alert. The policy was last reviewed by the Chief Executive Officer on January 17, 2024.	

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: 3 open youth residential files
Total number of Closed Files: 2 closed youth residential files
Staff Position(s) Interviewed: Clinical Director, Direct Care Supervisor
Type of Documentation(s) Reviewed: agency alert log, shift review log

Youth with a medical, mental health, or food allergy was appropriately placed on the program's alert system	**Compliance**	Five youth case management records were reviewed and all five youth had a medical or mental health condition or a food allergy. All five youth were appropriately placed on the program's alert system.	
Alert system includes precautions concerning prescribed medications, medical/mental health conditions	**Compliance**	The agency's alert system was reviewed and includes precautions concerning prescribed medications and medical and 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**	The agency's staff are provided sufficient training, information and instructions to recognize and/or respond to the need for emergency care for medical and/or 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	**Compliance**	The agency has a medical and mental health alert system in place that ensures information concerning a youth's medical condition, allergies, common side effects of prescribed medications, foods and medications that are contraindicated, and/or other pertinent mental health treatment information. Every staff member receives this information at the beginning of their shift via printed shift report.	

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

4.05 - Episodic/Emergency Care		**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 4.05	**YES**	
	If NO, explain here:	
	The agency has a policy FLN 4.05 to address the requirements of the indicator titled Episodic/Emergency Care. The policy was last reviewed by the Chief Executive Officer on April 4, 2023.	

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

Total number of Open Files: 2 open youth residential files
Total number of Closed Files: 3 closed youth residential files
Staff Position(s) Interviewed: Registered Nurse, Direct Care Supervisor
Type of Documentation(s) Reviewed: Episodic and Emergency Care Log

Off Site Emergency Care			
a. If off-site emergency medical or dental care was provided, an incident report was submitted for the medical or dental care b. Upon youth return, there is a verification receipt of medical clearance via discharge instructions with follow-up is present in file c. Youth’s parent/guardian was notified d. A daily log is maintained for emergency care provided	**Compliance**	A review of five youth case management records indicated one youth required off-site emergency medical care and it was provided. The youth's grandmother transported him. After discharge from the hospital the youth did not return to the shelter; therefore, receipt of medical clearance was not required. Upon being transported to the hospital an incident report was made to the Central Communications Center (CCC). The four remaining youth did not require off-site emergency care; however, one youth did require a topical ointment not covered and approved by the parent/guardian at intake and the parent/guardian was contacted, informed of the injury, and gave approval for the over the counter ointment needed. All five youth's emergency care was documented within the agency's episodic and emergency care log.	
All staff are trained on emergency medical procedures	**Compliance**	Three pre-service and four in-service training records were reviewed. All reviewed staff 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 agency has one Knife-For-Life kit located in a secure location within the direct care workers' office, centralized within the dormitory building. There are seven first aid kits in the following locations: inside the three passenger vans, in the direct care workers' office inside the shelter, inside the kitchen, inside the school house and inside the Brannan Center.	
Additional Comments: **There are no additional comments for this indicator.**			