Florida Network of Youth and Family Services
Compliance Monitoring Report for

Crosswinds Youth Services
1407 Dixon Blvd.
Cocoa, FL 32922

Compliance Monitoring Services Provided by

EXECUTIVE SUMMARY

On October 11-12, 2023, Forefront LLC conducted a joint Quality Improvement (QI) and Compliance Monitoring (CM) visit for Crosswinds Youth Services (Crosswinds) for the FY 2023-2024 at its program office located at 1407 Dixon Boulevard, Cocoa, FL 32922. 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. Crosswinds is contracted with the 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 1, 2023 through June 30, 2024.

The review was conducted by Keith Carr, Consultant for Forefront LLC, Nitara LaTouche, Consultant for Forefront, Andrea Haugabook, Consultant for Forefront, Teresa Clove, Chief Executive Officer (CEO), Thaise Education and Exposure Tours, Pam Palmer, Director, SMA Healthcare and Angela Patton, Clinician, Orange County Government. Agency representatives from Crosswinds included Kevin Maloney, CEO, Karen Locke, Chief Operations Officer, John Weiman, Director, Mike Scully, Director, Rebecca Cone, Director of Development, and several additional Crosswinds staff members were present for the entrance interview. The last QI visit was conducted November 2-3, 2022.

Crosswinds Youth Services received a performance rating of **unsatisfactory** on four out of twelve applicable Administrative and Fiscal Contract Compliance Monitoring indicators. Specifically, Crosswinds received an **overall numeric compliance rating of 67%.** A total of four (4) Contract Compliance Monitoring items were cited as requiring Corrective Action out of a total of thirteen during this review. The following report represents the results of the review of the agency's performance. 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 10-11-12-2023

Agency Name: Crosswinds Youth Services	**Monitor Name: Keith Carr, Lead Reviewer**
Contract Type: CINS/FINS	**Region/Office: 1407 Dixon Boulevard, Cocoa, FL 32922**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): October 11-12, 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: The agency has a minimum of two required staff members that have been trained as Certified QI Peer Reviewers.	No recommendation or corrective action required.
Additional Contracts a. Provider shall provide a listing of all current federal, state, or local government contracts, as well as other contracts entered into with for profit and not-for-profit organizations. Such a listing shall identify the awarding entity and contract start & end dates. **PTV**	☐	☐	☒	☐	☐	Documentation: The provider reported multiple additional funding/contracts outside of FNYFS funding which includes Basic Center Grant, Brevard Family Partnership, United Way of Brevard County, FNYFS – Single Contract, FNYFS – Special Populations, FNYFS – DV respite, non-contract placements from other Florida CBC's on a case by case basis, DCF, and Brevard County Board of County Commissioners.	No recommendation or corrective action required.
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	☐	☐	☒	☐	☐	Documentation: General Liability through Wesco Insurance Company with limits of coverage of $1,000,000 each/$3,000,000 aggregate, $5,000	No recommendation or corrective action required.

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$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**						medical expenses. Effective 10/21/2022 through 10/21/2023. Automobile Liability through Wesco Insurance Company with combined single limit of $1,000,000 and medical payments of $5,000. Effective 10/21/2022 – 10/21/2023. Workers Compensation and Employers Liability through Associated Industries Ins. Co. with limits of coverage of $100,000 each accident, $100,000 each employee, and $500,000 policy limit. Effective 5/1/2023 – 5/1/2024.	
External/Outside Contract Compliance a. Provider has corrective action item(s) cited by an external funding source (Fiscal or Non-Fiscal). **ON SITE**	☐	☐	☒	☐	☐	Interview: At the time of this onsite program review, the agency reported that the agency is currently under an ongoing Risk Monitoring Review per the FNYFS due to Board Governance and Fiscal Management concerns.	No recommendation or corrective action required.
Fiscal Practice	☐	☐	☒	☐	☐	Documentation:	No recommendation or corrective action required.

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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:
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**						The agency has an Accounting Procedures Manual that is designed to be consistent with Generally Accepted Accounting Procedures (GAAP) and provides for limited internal controls. The last documented revision to manual is dated June 2019 and was approved by the agency's previous CEO.	
b. Agency maintains a general ledger and the corresponding source documents. General ledger must be set up to track the activity of the grant separately (standard account numbers / separate funds for each revenue source, etc.). **PTV**	☐	☒	☐	☐	☐	Documentation: The agency did not provide evidence of a general ledger system with corresponding source documents. General Ledger (GL) is structured to track all funding sources and proof there are separate funds for each revenue source fund.	Corrective Action 1: The agency must provide a general ledger for review.
c. Petty cash ledger system is balanced and all cash disbursements are compliant with financial policies and allowable under the contract. (Disbursements/invoices are approved & monitored by management.) –**ON SITE**	☐	☐	☒	☐	☐	Documentation: The established petty cash fund amount is less than $300 and can be increased with approval from agency CEO or COO. The agency has provided reconciliations for the past six months. Copies of the petty cash process and fund reconciliations were reviewed. Petty cash expenditures are allowable per the agency's policy.	No recommendation or corrective action required.

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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:
d. Financial records and reports are current. Includes bank statements reconciled within 6 weeks of receipt. Vendor invoices past 6 months. Invoices are submitted on a monthly basis with supporting documentation. (Disbursements/invoices are approved & monitored by management). **ON SITE**	☐	☒	☐	☐	☐	Documentation: The agency did not provide evidence of bank statements reconciled within 6 weeks of receipt. Vendor invoices past 6 months.	Corrective Action 2: The agency must provide bank statements reconciled within 6 weeks of receipt and vendor invoices past 6 months.
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**	☐	☐	☐	☐	☒	N/A – The agency has not purchased any items with FNYFS monies since the last time on-site.	No recommendation or corrective action required.
f. Agency submits payroll taxes and deposits (and retirement deposits as applicable), Employee IRS Form W-2 and Independent Contractors IRS Form 1099 forms prior to federal requirements. **ON SITE**	☐	☒	☐	☐	☐	Documentation: The agency did not provide payroll taxes and deposits (and retirement deposits as applicable).	Corrective Action 3: The agency must provide the last 6 months of payroll taxes for review.

2023-2024 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
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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:
g. Budget to actual reports prepared and reviewed by appropriate management. Variance from the budget are investigated and explained. **PTV/ON SITE**	☐	☒	☐	☐	☐	Documentation: The agency did not provide budget to actual reports prepared and reviewed by appropriate management. Variance from the budget are investigated and explained.	Corrective Action 4: The agency must provide the last 6 months of the budget to actual statements for review.
h. A Single Audit is performed as part of the annual audit if expenses are greater than $750,000. The agency must submit a Corrective Action Plan for findings cited in the management letter and single audit. An annual financial audit was completed within 120 days after the previous fiscal year/calendar year and that a copy was provided to the Network unless and extension has been requested and approved in writing. Copy of Audit is submitted to the FNYFS by December 31st. **Can obtain from FNYFS**	☐	☐	☒	☐	☐	Documentation: The agency has a single audit that was completed by Grennan Fender Certified Public Accountants and Advisors for year ending June 30, 2022 and 2021. Per the audit report, a management letter was not required. This document had no reported audit findings. As a result of this, a corrective action response plan was not required. The program reported a copy was submitted directly to the FNYFS.	No recommendation or corrective action required.

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	Explain Rating						
Major Programmatic Requirements	**Unacceptable**	**Conditionally Unacceptable**	**Fully Met**	**Exceeded**	**Not Applicable**	**Ratings Based Upon:** **I = Interview** **O = Observation** **D = Documentation** **PTV = Submitted Prior To Visit** **(List Who and What)**	**Notes** **Explain Unacceptable or Conditionally Acceptable:**
i. Agency maintains confidentiality policy with written policies and procedures to ensure the security and privacy of all employee and client data. Personal information is not easily accessible. Agency maintains a backup system in case of accidental loss of financial information. Security procedures are in place to protect laptops. Obsolete documents are shredded and computer hard drives are wiped prior to discarding. **ON SITE**	☐	☐	☒	☐	☐	Documentation: The agency has a Confidentiality policy 1-9 Confidentiality that is applicable to all of it programs operated by Crosswinds. The agency has limited access to all personal identifiable information and has Record Retention, Record Loss Prevention, Client Record Management policies. No changes were reported to have been made to these documents.	No recommendation or corrective action required.

CONCLUSION

One of the thirteen total Administrative and Fiscal Contract Compliance Monitoring indicators is not applicable due to the agency not purchasing property with FNYFS funds. Following the review of Administrative and Fiscal Contract Compliance Monitoring requirements, the agency's performance results were deemed **unsatisfactory** on four out of twelve applicable Administrative and Fiscal Contract Compliance Monitoring indicators. Consequently, the overall compliance numeric rate for this contract monitoring visit is **67%.** There are four corrective actions cited that require a corrective action response as a result of the contract monitoring visit.

SUMMARY OF CORECTIVE ACTIONS

Corrective Action 1): The agency must provide evidence of the general ledger and the corresponding source documents for the last six months. The General ledger must be set up to track the activity of the grant separately (standard account numbers / separate funds for each revenue source, etc.).

Corrective Action 2): The agency must provide evidence of bank statements reconciled within 6 weeks of receipt and Vendor invoices past 6 months.

Corrective Action 3): The agency must provide the last 6 months of payroll taxes for review.

Corrective Action 4): The agency must provide the last 6 months of the budget to actual statements for review.

The agency is required to submit a Corrective Action Plan to address Administrative and Fiscal Contract Compliance Monitoring indicators cited as unacceptable in the corresponding section of this report. The provider's Corrective Action Plan should identify the unacceptable item cited, describe root cause(s) analysis, target date(s) and staff responsible for addressing infractions. Responses to items cited for corrective actions are due to the Florida Network and Forefront within fourteen (14) working days of receipt of this report. Upon receipt of the requested information to address the outstanding corrective action items, a review of the agency's plan will be conducted by FNYFS and Forefront to determine if the Corrective Action Plan satisfactorily address the unacceptable items. The agency will then implement the approved plan to address the unacceptable item(s) cited in the report. If the Corrective Action Plan is successful in resolving the items cited in the report the contract monitor will notify the agency in writing that the desired resolution has been achieved.

Florida Network of Youth and Family Services Quality Improvement Program Report

Crosswinds Youth Services - Cocoa Beach
CINS/FINS Program

October 11-12, 2023

Compliance Monitoring Services Provided by

FOREFRONT

CINS/FINS Rating Profile

Standard 1: Management Accountability

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

Percent of indicators rated Satisfactory: 57.14 %
Percent of indicators rated Limited: 28.57 %
Percent of indicators rated Failed: 14.29 %

Standard 2: Intervention and Case Management

2.01 Screening and Intake	Satisfactory
2.02 Needs Assessment	Satisfactory
2.03 Case/Service Plan	Limited
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	Limited
2.09 Stop Now and Plan (SNAP)	Satisfactory

Percent of indicators rated Satisfactory: 70 %
Percent of indicators rated Limited: 20 %
Percent of indicators rated Failed: 0 %

Standard 3: Shelter Care & Special Populations

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

Percent of indicators rated Satisfactory: 57.14 %
Percent of indicators rated Limited: 14.29 %
Percent of indicators rated Failed: 28.57 %

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: 68.97 %
Percent of indicators rated Limited: 17.24 %
Percent of indicators rated Failed: 10.34 %

Rating Definitions

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

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

Reviewers

Members

Keith Carr, Lead Reviewer Consultant-Forefront LLC/Florida Network of Youth and Family Services
Nitara LaTouche, Reviewer Consultant-Forefront LLC/Florida Network of Youth and Family Services
Andrea Haugabook, Reviewer Consultant-Forefront LLC/Florida Network of Youth and Family Services
Teresa Clove, CEO, Reviewer, Thaise Education and Exposure Tours
Pam Palmer, Director, Reviewer, SMA Healthcare, Inc. (Beach House)
Angela Patton, Licensed Clinician, Reviewer, Orange County Government

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	X	Case Manager		Nurse – Full time
	Chief Financial Officer	X	Counselor Non-Licensed	X	Nurse – Part time
X	Chief Operating Officer	X	Advocate	1	# Case Managers
	Executive Director	X	Direct – Care Full time	2	# Program Supervisors
X	Program Director	X	Direct – Part time		# Food Service Personnel
	Program Manager	X	Direct – Care On-Call	1	# Healthcare Staff
	Program Coordinator	X	Intern		# Maintenance Personnel
X	Clinical Director		Volunteer	4	# Other (listed Direct Care Workers, Clinicians
X	Counselor Licensed	X	Human Resources		

Documents Reviewed

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

Observations During Review

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

Surveys

12	# of Youth	12	# 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

Crosswinds Youth Services, Inc. (Crosswinds) is a contracted service provider with the Florida Network of Youth and Family Services, Inc. (FNYFS) to deliver Children in Need of Services and Families in Need of Services (CINS/FINS) to youth under 18 years of age who are most at risk, including those who have runaway, truant, and/or beyond parental control in Brevard County. Services are offered onsite in the short-term residential shelter as well as community-based at the facility, in the youth's school, or in their homes. The agency physical location is 1407 Dixon Boulevard in Cocoa, Florida. Since its accreditation in 2007 by the Council on Accreditation (COA), Crosswinds has maintained re-accreditation since that time. In addition to CINS/FINS, additional programs offered by Crosswinds includes Stop Now and Plan (SNAP), transitional living program, Safe Place, street outreach for homeless youth to help get them off the streets, family counseling to reunite and strengthen families, help for youth aging out of the foster care system, and intervention for young offenders.

The following programmatic updates were provided by the agency:

There have been several changes to the Organizational Structure of Crosswinds Youth Services (CYS) . The agency reported the position of Shelter Care Coordinator was added to support the Shelter Director and is in the process of being filled. The position of Director of Development was filled. This position supports the recruitment and retention efforts of staff outreach, as well as community outreach.

Salaries for Youth Care Workers was approved to be increased to $19.00 an hour effective 10/1. All YCW will be raised from $15.00 an hour to $19.00 effective this date.

CYS held its first ever job fair at the Shelter on 8/15/23. The agency reported the fair did not result in any direct hires, but was an opportunity for potential hires to meet the team and tour our facility.

The Merritt Island Rotary Club partnered with the CYS Shelter staff and youth for a gardening project. The youth participated in cultivating and planting herbs and vegetables that they can use in meal preparations. This is a valuable life skill, teaching youth teamwork and how they can use what they've learned for self-sufficiency.

The agency reported that it has reestablished its community connection with two quilters that deliver quilts to youth in the facility. The youth upon intake are offered the opportunity to select their own hand-crafted quilt and that they can take with them upon discharge.

CYS requested and was awarded with support of Senator Mayfield and Representative Fine a sum of $232,000.00 for a funding initiative for Crosswinds Youth Services Campus Security to Protect Children, Youth, Families and Staff.
On 9/28, contract #10817 between the Department of Juvenile Justice and Crosswinds was executed.
Crosswinds received reaccreditation from the Council of Accreditation (COA). In addition, CYS was expedited through the Pre-Commission Review Report (PCR) process as a result of not receiving any out of compliance ratings in any of the fundamental practice standards.
CYS reported it has applied and received the following grants: Basic Center in the amount of $250K and United Way in the amount of $60K.
CYS reported collaboration with the Director of Development it is working to improve community awareness by attending a broad range of community and children's services industry events.

Narrative Summary

Crosswinds operates both the Robert E. Lehton Children's Shelter (residential) and Community Counseling CINS/FINS Program in Brevard County. The CINS/FINS program has a management team which is comprised of a Chief Executive Officer(CEO), Chief Operating Officer (COO), a Shelter Director, a Counseling Program Director, Clinical Supervisor and a Development Director. The agency's organization chart also list position including Program Coordinator, Senior Case Managers, Residential Counselors, Case Managers, Senior Youth Specialists, and Youth Specialist. The CEO oversees the activities of both the residential and the community counseling CINS/FINS Programs. Crosswinds' youth shelter is a licensed Child Caring Agency by The Florida Department of Children and Families. The agency is licensed for 20 beds effective through February 17, 2024.

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

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

Standard 2: There are nine indicators for Standard 2. Indicator 2.01 Screening and Intake was rated **Satisfactory with exceptions**, Indicator 2.02 Needs Assessment was rated **Satisfactory with exceptions**, Indicator 2.03 Case/Service Plan was rated **Limited**, Indicator 2.04 Case Management and Service Delivery was rated **Satisfactory**, Indicator 2.05 Counseling Services was rated **Satisfactory**, Indicator 2.06 Adjudication/Petition Process was rated **Satisfactory with exceptions**, Indicator 2.07 Youth Records was rated **Satisfactory**, Indicator 2.08 Specialized Additional Program Services was rated **Limited**, and Indicator 2.09 Stop Now and Plan (SNAP) was rated **Satisfactory with exceptions**.

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

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

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

Standard 1:

Indicator 1.02 - Limited

1) Agency did not adhere to the requirements of the indicator due to the following: No evidence of completing the daily task of checking the grievance box and documenting it in the program logbook.

Indicator 1.04 - Limited

1) Agency training records do not adhere to the requirements of the indicator due to the following: traing records reviewed are completed outside of the required timeframes; no evidence of all required trainings; not meeting total number of required training hours; training could not be fully verified as the date and initial sections were blank in the training plan/staff files; training records did not capture the total completed annual hours as required.

Indicator 1.05 - Failed

Agency did not meet the requirements of the indicator due to the following:

1) Analyzing and reporting information provided by the agency was limited and did not give sufficient explanation of the case record review process performed by the agency; only one monthly risk management report for 6/23/2023 was the provided in the last six months; no quarterly reports were provided from July 2023-September 2023; no evidence was provided to verify the program was reviewing the customer satisfaction data on a routine basis; no evidence presented by the agency which would verify the program was reviewing data entry practice for accuracy, timeliness and completion; no evidence provided that agency performance reports are provided to the Board of Directors, program management or staff; and no evidence of examples of planning or improvement efforts were provided for review to assess how the agency addresses monitoring its performance and implementing necessary plans of improvement.

Standard 2:

Indicator 2.03 - Limited

The agency did not meet the requirements of the indicator due to the following:

1) Randomly selected files which were required to have a service plan did not include target dates.

Indicator 2.08- Limited

1) Two out of three youth files reviewed did not contain evidence of the pending Domestic Violeance charge. Files lacked evidence of service plan indicating frequency as required; files lacked evidence of progress notes to demonstrate progress on goals reached; and no evidence of weekly sessions as mentioned in service plan in progress notes were observed.

Standard 3:

Indicator 3.05 - Limited

Agency did not meet to the requirements of the indicator due to the following:

1) Staff members were observed not consistently utilizing the Behavior Management System (BMS) with youth; in specific instances staff failed to engage and did not utilize BMS and or other redirection and de-escalation techniques techniques in group meeting, bedtime and on the overnight shift.

Indicator 3.06 - Failed

Agency did not meet the requirements of the indicator due to the following:

1) Bed checks not completed as required. Review of video camera surveillance revealed staff did not conduct bed checks every15 minutes in bedrooms and other other areas as required; no bed checks were conducted on the female side of the dorm, but staff documented in the logbook the checks were completed. Staff did not intervene or maintain supervision on the youth that left the building. Program staff fail to enforce program rules, maintain proper supervision of youth and or redirect or engage youth to return to their rooms.

Indicator 3.07 - Failed

Agency did not meet the requirements of the indicator due to the following:

1) The video camera system did not have back up battery capabilities functioning as required in the event of a power outage; Supervisory reviews not conducted on a consistent basis and it is unclear of the timeframes the reviews were conducted and all supervisory reviews were for 3rd shift only.

Quality Improvement Indicators and Results: Please select the appropriate outcome for each indicator for each item within the indicator.		Summary/Narrative Findings Must include Document Source: E.g. Interview/Surveys, Observation, and/or Type of Documentation	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			**Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 1.01		**NO**	
		If NO, explain here: Policy recently revised, however, doesn't addresses what scoring is considered as passing the assessment as required in the Florida Network of Youth and Family Services (FNYFS) Quality Improvement (QI) Standard.	
		The agency has a policy titled 1-4 Background Screening which was last revised in September 2023 by the Chief Operations 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 New Hire Employee/Intern/Volunteer Files: 15 total staff member files reviewed. **Total number of 5 Year Re-screen Employee Files: Three (3) files staff member files reviewed for re-screens.** **Staff Position(s) Interviewed** *(No Staff Names)***: 3 staff interviewed included HR staff, the agency COO and Residential Manager.** **Type of Documentation(s) Reviewed: Personnel documents, annual affidavit of compliance verification, and employee roster.**			
All positions providing direct services to youth has successfully passed pre-employment suitability assessment on the initial attempt.	**Compliance**	Twelve staff member files were reviewed for pre-employment suitability assessments. The agency uses the Berke Assessment Tool for suitability assessment of staff prior to hire. The agency's policy does not clearly state what is considered a passing score, however, when Human Resource staff was interviewed it was explained that applicants must score either a 'high' or 'medium' score to be considered for employment. Applicants that score a 'low' score are not considered for employment. Eleven (11) employee files demonstrated the suitability assessment was completed and passed prior to the date of hire. There was one file that was not applicable for needing a suitability assessment based on their role/position.	
For any applicant that did not pass the initial suitability assessment, there was evidence that the applicant retook the assessment and passed within five (5) business days of the initial attempt, not exceeding three (3) attempts within thirty (30) days.	**No eligible items for review**	No employees were reported to not have passed the suitability 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 program reported that there were no staff members at the time of the Quality Improvement (QI) program review that had a break in service. One staff was initially reported as resigning, however, HR clarified the staff member changed programs and never left the agency.	

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	**Compliance**	Twelve staff member files were reviewed for compliance with a completed background screening prior to hire date. All 12 files demonstrated evidence of the completed DJJ background screening confirming staff were eligible to work with youth prior to their date of hire into the CINS FINS program.	
Five-year re-screening is completed every 5 years from initial date of hire or prior to retained fingerprints expiration date.	**No eligible items for review**	Three staff member files were selected for review based on anniversary year. However, based on the retained fingerprint dates noted in the background screening, all staff were in compliance with this requirement. The agency utilizes the Clearinghouse for fingerprint scanning and maintains a Clearinghouse roster.	
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 that the Annual Affidavit of Compliance with Level 2 Screening Standards form was submitted to BSU prior to January 31st.	
Proof of E-Verify for all new employees obtained from the Department of Homeland Security	**Exception**	There were 11 out of 12 staff member files which contained evidence the completed E-Verify was located in the file.	One staff member file did not demonstrate the completed E-verify in the file.
Additional Comments: **There are no additional comments for this indicator.**			
1.02: Provision of an Abuse Free Environment			**Limited**
Provider has a written policy and procedure that meets the requirement for Indicator 1.02	**NO**		
	If NO, explain here:		
	Crosswind has written policies and procedures for this standard (1.02). It is located within 2 of their policies which are 1.02 and 1.21. The Abuse Reporting policy was revised in 2014 and signed by the agency's former CEO whom is no longer with the agency. There is no indication that this individual policy has been revised recently. The Grievance policy (1.21) was revised October 5, 2022, and signed by the COO. There is no indication that the Grievance policy has been revised recently. The overall policies were reviewed and signed September 2023 and signed by the COO as indicated on the Standard Operating Procedures Review.		
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)* **: Staff provided QI survey to provide any comments related to agency maintaining an Abuse Free Environment.** **Type of Documentation(s) Reviewed: Abuse Hotline flyers** **Describe any Observations: Posted Abuse Hotline flyers.**			
Agency has a code of conduct of policy and there is evidence that staff are aware of agency's code of conduct.	**Compliance**	The program staff adhere to the Code of Conduct that prohibits the use of physical abuse, profanity, threats, or intimidation and do not appear to be depriving the youth of basic needs. Crosswinds staff members sign a code of conduct contract when hired. It addresses the Code of Conduct items each staff member is required to complete prior to working in the programs. The signed Code of Conduct form is in the staff personnel file. It was observed that the facility provides an adequate residential group care environment, enough food and the facility was appropriately staffed at the time of this audit.	

The agency has a process in place for reporting and documenting child abuse hotline calls.	**Compliance**	The program has a process for reporting and documenting abuse calls. The youth are allowed to use the phone after requesting to call the Abuse Hotline as indicated by the Shelter Director. The clinical supervisor documents any Abuse Reports in the Abuse Reporting Book. There has been a total of nine calls to the Abuse Hotline within the past six months. All were documented and placed in the Abuse Reporting Book.	
Youth were informed of the Abuse and Contact Number	**Compliance**	Youth are informed of the abuse hotline and contact number during the program orientation process. It was observed that there were Abuse Hotline numbers listed on the wall of the shelter common area, dining hall and youth living area. The Abuse information is also addressed in the CINS/FINS Handbook that is given to the youth upon intake.	
Grievance			
Grievances are maintained on file at minimum for 1 year.	**Compliance**	Grievances are maintained in file for one year. The reviewer conducted a review of all past grievances completed by staff in the agency's grievance book.	
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 program has an accessible and responsive grievance process for youth or staff to provide feedback or complaints. There is a locked grievance box located in the group room where the youth can access it at any time. There are grievance forms right next to the grievance box for youth to file a grievance. The shelter director states that he is the only one that checks it daily and has the key.	
There is evidence that grievance boxes are checked by management or a designated supervisor at least daily as evidenced in the program logbook.	**Exception**	The Crosswinds policy states that the grievance box is to be checked by management or designated supervisor (Shelter Director for Crosswinds) at least daily (excluding weekends and holidays) and documented in the program logbook. There was a lack of evidence that daily checks of the grievance boxes were documented in the program logbook as required.	There was no evidence of documentation in the program logbook stating that the agency completed the daily task of checking the grievance box and documenting it in the logbook. During this program review, the Shelter Director created and presented a log sheet to be used when checking the grievance box.
All grievances are resolved within 72 hours and documented by program director/supervisor or escalated to higher leadership if grievance involves them directly.	**Compliance**	The grievance reports are being resolved within 72 hours as evidenced by the shelter director addressing, resolving, and signing off on the grievance report. The signature of the youth is also on the forms after the issue has been resolved. Crosswinds keeps the grievance forms in a grievance logbook.	
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: Crosswind has a written policy and procedure for standard (1.03) Incident Reporting. Their Incident Policy number is 1.11. The Incident Policy was revised September 2023 and signed by Karen Locke, COO. The overall policies were reviewed and signed September 2023 by the COO as indicated on the Standard Operating Procedures Review.	

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

Staff Position(s) Interviewed *(No Staff Names)* **: Residential Director**
Type of Documentation(s) Reviewed: Agency DJJ Central Communication Center incident reports, internal incident reports and agency logbook.

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**	During the past six months there were 15 reports sent to CCC and all were within two hours of the incident as shown on the Florida Department of Juvenile Justice Central Communication Center CCC Daily Report.	
The program completes follow-up communication tasks/special instructions as required by the CCC	**Compliance**	Crosswinds completed follow up communication as required by CCC. Crosswinds' CCC incident report document shows that all incidents were reported within 2 hours of notification of the incident. Of the 15 total incidents, fourteen (14) were reported and closed with a closure justification listed on the CCC incident report form.	
Agency internal incidents are documented on incident reporting forms and all CCC reportable incidents were consistently reported to CCC as required.	**Compliance**	Crosswinds internal incidents are documented on incident reporting forms and placed in the incident book and the ones that are reportable were sent to CCC as shown in the incident book and CCC Daily Report.	
Incidents are documented in the program logs and on incident reporting forms	**Compliance**	As observed in the log book, the incidents were documented in the log book and also documented on the incident reporting forms.	
All incident reports are reviewed and signed by program supervisors/ directors	**Compliance**	For the past 6 months Crosswinds has been reporting and notifying CCC of incidents that have occurred at their facility. There was a total of 15 reports in the past 6 months. There were eight (8) incidents for Program Disruptions, two (2) Escapes/Abscond, four (4) Mental Health, and one (1) Against a Staff reported to CCC within the time period reviewed. All incident reports were signed by the Director of Counseling Services and or the Chief Operating Officer.	

1.04: Training Requirements (Staff receives training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions)			Limited
Provider has a written policy and procedure that meets the requirement for Indicator 1.04	**NO**		
	If NO, explain here: The policies were lacking the recent revision of training updates at the time of the review and while the program made some revisions to the policy during the review it was observed that the full list of trainings and required timeframes are not written in the internal policy.		
	The program has 2 policies regarding training. 1-23 Training Requirements and 1-24 Training Records were revised in October 2023 by COO.		

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: Four staff
Total number of Annual In-Service Staff Files: Four staff
Total number of Non-Licensed Mental Health Clinical Shelter Staff Files: N/A
Annual Training Plan Timeframe (*Program timeframe for annual trainings*)**:**
Staff Position(s) Interviewed *(No Staff Names)* **: Director, Shelter Manager, COO, SNAP Staff**
Type of Documentation(s) Reviewed: Training records for new and existing staff
Describe any Observations: Cumulative hours are not consistently being tracked across all files. Residential and Community Counseling has separate designee staff responsible for tracking and monitoring training files. The Shelter Director was interviewed and stated that annual training is currently completed by the anniversary date of hire for each employee but the agency will be transitioning to calendar year in the future, however, in a follow-up conversation it was advised that staff only adhere to anniversary date that initial year but staff follow the calendar year after the 2nd year. This practice doesn't appear to be consistent across all program types yet as community counseling still adheres to anniversary date.

First Year Direct Care Staff			
All direct care staff have completed new hire pre-service training requirements for safety and supervision as required.	**Exception**	A total of four files were reviewed for new hire trainings for safety and supervision. The majority of all new hire pre-service training for safety and supervision were completed by the two residential staff files reviewed. Two staff files completed some of the required pre-service trainings.	One training appeared to be completed outside of the required timeframe for one residential staff person. Behavior Management Strategies (BMS) training could not be fully verified as the date and initial sections were blank on the orientation form that captures BMS training.
All staff completed the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days from date of hire.	**Exception**	Three out of four new hire staff files completed the Civil Rights & Federal Funds training within the required timeframe.	One new hire file was missing evidence that the Civil Rights & Federal Funds training was completed in the file and was due 7/28/23. HR verified that the staff person's date of hire was 6/28/23 based on when they transferred from another program into CINS FINS.
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.	**Exception**	Two out of four new hire files contained a manual calculation of the current total hours of training accumulated in the file that is tracked by a separate sticky note. The residential training files had the total training hours accumulated manually calculated on a blue sticky note at the front of each training log for the staff files. Community counseling and SNAP do not calculate training hours on an ongoing basis and report reviewing the files with staff to complete any missing trainings.	Two out of four new hire files did not contain the complete total hours accumulated in the file. Per the agency policy, all staff are required to complete 80 hours within the 1st year of hire.

All staff receives all mandatory training during the first 90 days of employment from date of hire.	**Exception**	Two out of four staff have completed all of the mandatory trainings, however, the trainings were not all completed within the 90 day timeframe. The training plan lists 'Crosswinds Behavioral Model' in the training plan that provides 24 training hours, however, the program reported they have not yet implemented this training for all staff and provide behavior management as part of the on the job training orientation checklist. The shelter staff have a 'Pre-service Orientation Checklist' for job shadowing that has a 'Job Shadowing Task' column that lists the following trainings: Review SOP/HR procedures; work with staff on shift documentation; interview youth to complete intake; interview youth to complete discharge; complete screening for potential clients and refer to counselor/CM; how to verify, document and administer medications and sharps; how to put together case files; how to break down case files; how to use alert system; how to implement behavioral management system; how to document files; and review resource books. Additionally the form includes date, hours, staff initials, and trainer initials for each training completed on the form. At the bottom of the form it indicates all trainings covered is a total of 8 hours and there is a statement that staff are confirming they possess knowledge of all items listed above with a signature line and date, Shelter Director signature and date, and program coordinator signature and date. The Shelter Director advised each separate line should be initialed by staff and dated at the time of completion since to achieve all items while shadowing it make span over several days/dates depending on what intakes or discharges they may have at the time but the practice to date each line by staff is not always consistent. The Shelter Director stated that a signature at the bottom means it was discussed as part of job shadowing and supervisor verbally discusses with new staff during sit down but reported if staff do not bring training paperwork it is not always documented in file on the day. SNAP training files did not appear to have a training tracker document. One training log provided contained only four trainings for the SNAP staff file, however, there was no evidence of the actual SNAP training for the SNAP Co-facilitator. Program determined that the required documentation was not submitted to FN as required and will be looking into getting this staff member registered for a future SNAP training.	All four new hire staff files indicated training was not always completed and/or completed within the required timeframe. The 1st staff (SNAP) had 19 missing trainings required within the 90 days and three late trainings; the 2nd staff (CC) had three missing trainings and all over training completed within 90 days as required; the 3rd staff (Res) had two late trainings; the 4th staff (Res) had only one late training and all other trainings were completed within 90 days.
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.	**No eligible items for review**	There were no staff that met this requirement at the time of the review period.	

Staff Participating in Case Staffing & CINS Petitions (within first year of employment)			
Documentation of instructor led FL Statute 984 CINS Petition Training by a local DJJ Attorney. *Effective for staff hired after 7/1/23*	**No eligible items for review**	One staff member's file reviewed meets this requirement, however, they still have time to complete this requirement based on their date of hire.	
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**	There were no staff that met this requirement at the time of the review period.	
In-Service Direct Care Staff			
Direct care staff completes 24 hours of mandatory refresher Florida Network, SkillPro, and job-related training annually *(40 hours if the program has a DCF child caring license).*	**Exception**	Two out of four staff reviewed had the completed all of the annual trainings as required and one of the files met the required training hours. Two files in total had over 40 training hours. The files that contained the training plan review trackers appear to be completed within the required timeframes. It was observed that some notes int he training review did not specify exactly which trainings were needed or a specific target date for completion when out of compliance but provided a general overview when staff 'need to pick up the pace' to complete trainings. Per the agency policy, and training trackers all staff are required to complete 40 hours annually after the 1st year of hire including community counseling staff.	Two out of four in-service staff files did not contain the complete total hours accumulated in the file. One staff file only obtained 19 training hours out of the required 40 hour minimum requirement for the year. Another staff had only 30 training hours completed but did have complete all of the annual requirements.
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 training logs utilized by the agency incorporates all of the trainings completed by staff.	
The agency has a designated staff member responsible to manage all employee's individual training files and completes routine tracking and reviews of staff files to ensure compliance.	**Exception**	The agency has a designated staff member for residential employee files, a designated staff member for community counseling employee files and another staff reviewing the SNAP employee records. Both residential and community counseling program types utilize a document labeled 'Training Plan Reviews' to track and monitor staff's compliance with training. The document includes the staff's name, supervisor name, (quarterly) review by date, notes, date reviewed, and staff initials. The files that contained the training plan review trackers appear to be completed within the required timeframes.	The agency does not have a designated staff member to manage all individual training files. There are separate leaders responsible for the staff within the designated program type to monitoring compliance for training. It was observed that each program type had a different way of monitoring staff training files.

The program maintains an individual training file or employee file AND a FLN Training Log (Or similar document) 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.	**Exception**	The program maintains individual training files for all staff files reviewed. The files are equipped to maintain a training log for each staff, annual employee tracking hours tracking form, and sections that capture the supporting documentation of training in the form or certificates, sign-in sheets, and/or electronic transcripts. Seven files that contained a training plan included the training, hours, date completed, method of training, and supervisor initials completed on the form. None of the files reviewed captured the total current achieved training hours in the training log form, however, this was manually tracked in some files and added as a separate note in the file. Two out of four new hire files captured the annual training hours individually and cumulatively. Three out of four in-service staff files captured the annual hours of completed training.	One new hire staff training file reviewed did not have a training plan in the file and only contained a printed summary of the four trainings completed. Two out of four new hire files did not contain the completed total hours accumulated in the file. One annual in-service staff file did not capture the total annual hours. It was noted that this was consistently tracked manually for the residential staff training files only.
Additional Comments: **There are no additional comments for this indicator.**			
1.05 - Analyzing and Reporting Information			**Failed**
Provider has a written policy and procedure that meets the requirement for Indicator 1.05		**NO** If NO, explain here: Crosswind has a written policy and procedure for standard (1.05) Analyzing and Reporting Information. Crosswinds Analyzing and Reporting Policy number is 1.27. Their Analyzing and Reporting Policy was revised October of 2022 and signed by Karen Locke, COO. No further revision date was listed on the policy as Florida Network has revised their policy as of 2023. The overall policies for the agency were reviewed and signed September 2023 by the COO as indicated on the Standard Operating Procedures Review, but no evidence that the policy was revised or updated as of 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.*			
Staff Position(s) Interviewed *(No Staff Names)* **: COO** **Type of Documentation(s) Reviewed: Agency policy and file review documentation.**			
Case record review reports demonstrate reviews are conducted quarterly, at a minimum	**Exception**	A review of the current agency policy for this indicator was conducted. Throughout this policy there was very minimal documentation provided by Crosswinds. There were two analyses of file reviews conducted by the Director of Counseling Services reported on March 31, 2023 and June 30, 2023.	Analyzing and reporting information provided by the agency was limited and did not give sufficient explanation of the case record review process performed by the agency. The documentation provided for this indicator did not give a summary report of case report reviews, it did not identify the level of compliance with the CIN/FINS requirement and did not report that specific areas of file reviews discussed were reviewed by management and communicated to staff.

The program conducts reviews of incidents, accidents, and grievances quarterly, at a minimum	**Exception**	A review of the current agency policy for this indicator was conducted. The agency provided evidence of conducting two quarterly reviews. The documentation to verify the agency's efforts to review major areas associated with management risks such as accident, grievance and incidents contained limited information. The agency provided documentation of two quarterly reviews for Incidents, Grievance and Accidents dated 2/2/2023 and 6/22/2023.	The agency risk management report for 6/23/2023 was the only document provided for review. The document did include an agenda but this document did not report if the agency had any incidents, grievances or accidents during that reporting period. There were no quarterly reports during the quarter July-September 2023. It was reported that they had none to give due to the person responsible for implementing this policy resigning and agency leadership has not yet assigned this responsibility to another staff member.
The program conducts an annual review of customer satisfaction data	**Exception**	There were no evidence presented that the program was annually reviewing the customer satisfaction data.	No evidence was provided to verify the program was reviewing the customer satisfaction data on a routine basis.
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.	**No eligible items for review**	The did not have any eligible items for review for this review category.	
The program has a process in place to review and improve accuracy of data entry & collection	**Exception**	The agency did not produce evidence of a process and or any associated examples indicating a consistent and ongoing practice of review its data entry practice.	No evidence presented by the agency which would verify the program was reviewing data entry practice for accuracy, timeliness and completion.
There is documentation that findings are regularly reviewed by management and communicated to staff and stakeholders.	**Exception**	Throughout this policy there was very little documentation provided by Crosswinds. There were two quarters of a Program Report shared with management and the Board of Directors in February and May of 2023 as reported by the COO. A copy of this report was given to be reviewed in this policy. The document addressed statistics, deliverables and supportive services for the Shelter, CINS/FINS, and SNAP programs.	There was no evidence provided that agency performance reports are provided to the Board of Directors, program management or staff. It was reported by the COO that the Board of Directors are provided details of the QI or program performance on a quarterly basis in the Board of Director's meeting. The meetings are held on a quarterly basis and were last held in May 2023. The COO reported that the board did not meet during the previous quarter (July-September).
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.	**Exception**	The agency was not able to produce evidence of examples of related to staffing, program or operations which indicate that these reports were submitted to the Board of Directors.	The agency did not provide evidence of reports associated with the organization's performance were submitted to the agency's Board of Directors, including reports indicating QI program review reports where the agency received Limited or Failed performance ratings.

There is evidence that strengths and weaknesses are identified, improvements are implemented or modified, and staff are informed and involved throughout the process.	**Exception**	The agency did not produce evidence of examples of related to demonstrating evidence of identifying a performance issue addressing performance challenges associated with staffing, program or operations.	No examples of planning or improvement efforts were provided for review to assess how the agency addresses monitoring its performance and implementing necessary plans of improvement.
Additional Comments: **There are no additional comments for this indicator.**			
1.06: Client Transportation			**Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 1.06		**NO** If NO, explain here: Agency's policy does not coincide with the requirements and procedures outlined in the Florida Network's Policy and Procedure Manual. Policy #5-12, Transportation of Youth, policy is signed by the COO, date of last revision is Nov. 2022. No indication of this individual policy being reviewed recently. Overall policy manual last reviewed October 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: May 2023 - October 2023 **Staff Position(s) Interviewed** *(No Staff Names)* **: Residential Director** **Type of Documentation(s) Reviewed: Transportation logs and agency logbook.**			
Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	**Compliance**	Observation of list of all (50) approved employees was reviewed. Interview with staff members identified 18 shelter employees who are approved by the administrative personnel to drive clients in agency vehicles.	
Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	**Compliance**	List of all staff members contained driver's license number and date of birth for each individual. Verbal indication from Human Resources personnel confirmed the entire list is approved and covered under the company insurance policy.	
Agency's Transportation policy prohibit transporting a client without maintaining at least one other passenger in the vehicle during the trip and include exceptions in the event that a 3rd party is NOT present in the vehicle while transporting	**Compliance**	Agency's transportation policy indicates an approved third party person will be present when transporting a youth.	
In the event that a 3rd party cannot be obtained for transport, the agency's supervisor or managerial personnel consider the clients' history, evaluation, and recent behavior	**Compliance**	The agency's policy does indicate that the client's history, evaluation and recent behavior is considered when determining suitability for single transport.	
The 3rd party is an approved volunteer, intern, agency staff, or other youth	**Compliance**	The agency's policy does indicate that an approved 3rd party person can be another staff, a volunteer, an intern or a youth.	

The agency demonstrated evidence via logbook or other written verification that supervisor approval was obtained prior to all single youth transports.	**Exception**	A review of the agency's single youth transport events over the last six months was conducted. The reviewer assessed the agency's current practice of documenting prior approval by supervisors prior to all single youth transport events. Not all single youth transport events are documented with evidence of prior approval.	A total of 49 total single youth transport events were noted on the transportation logs provided. Six (6) of the Forty-nine (49) entries on the transportation log did not indicate prior approval from the program supervisor.
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**	Transportation logs are maintained for both agency vehicles. All logs have areas to document use of the agency vehicles which include: initials of the 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**
Provider has a written policy and procedure that meets the requirement for Indicator 1.07		**YES** If NO, explain here: Crosswinds has a written policy and procedure for standard (1.07) Outreach Services. The Outreach Policy number is 1.14. The Outreach Policy was revised in September 2023 and signed by the COO. The overall policy was reviewed and signed September	
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: Director of Juvenile Justice. **Type of Documentation(s) Reviewed: NETMIS 3 Outreach Activities.**			
The program has a lead staff member designated to participate in local DJJ board, Circuit and Council meetings with evidence that includes minutes of the event or other verification of staff participation.	**Compliance**	The Director of the Juvenile Assessment Center is the lead staff member that is designated to participate in local DJJ Board, Circuit and Council meeting. There is evidence that the DJJ Board, Circuit and Council meeting were attended as listed in NETMIS 3 Outreach and meeting agendas. There were two DJJ Circuit Advisory Board meetings attended by the Director of the JAC, and one attended by agency's Chief Executive Officer (CEO). Both staff members are on the list to do outreach for Crosswinds. The Director of the JAC also attended two DJJ Circuit Board meetings on April 20, 2023 and July 20, 2023. There was evidence of attending all the above events by the Board meeting agendas and roster of attendees.	
The program maintains written agreements with other community partners which include services provided and a comprehensive referral process.	**Compliance**	There is an agency's Partnership book that contains written agreements with other community partners which also includes service providers and a comprehensive client referral process.	
The program will maintain documentation of outreach activities and enter into NetMIS the title, date, duration (hours), zip code, location description, estimated number of people reached, modality, target audience and topic.	**Compliance**	Crosswinds attended a total of 31 Outreach Activities from May 2023 to October 2023 as reported in NETMIS 3 under Outreach. There was evidence of Crosswinds staff members participating in the Outreach activities such as the agendas, rosters of attendees and flyers. All the mandatory information such as title, date, duration, zip code, location, description, estimate number of people reached, modality, target audience and topic for Outreach was listed in the NETMIS 3 system as required.	

The program has designated staff that conducts outreach which is defined in their job description.	**Compliance**	The Director of the JAC is the lead staff member that is designated to participate in local DJJ Board, Circuit, Council meeting and community meeting. The Director of Development was hired four months ago as the Outreach Coordinator for Crosswinds. The President/CEO also participates in Outreach Services at Crosswinds. This job duty was verified in CEO and Director of the JAC job descriptions.	
Additional Comments: **There are no additional comments for this indicator.**			
2.01 - Screening and Intake			**Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 2.01		**NO** Policy is missing the information regarding suicide assessments from Florida NetMIS updated policy on 7/1/23. Overall policies were signed and reviewed by the agency's COO in September 2023. Crosswinds has a policy 2-2 Screening and Intake that was revised October 2023 per policy by COO.	
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: Ten files. **Total number of Closed (Residential & Community) Files: Four open and six closed.** **Staff Position(s) Interviewed: Licensed Clinician and Case Manager** **Type of Documentation(s) Reviewed: Open and closed client case files.**			
Shelter youth: Eligibility screening is completed immediately for all shelter placement inquiries.	**Compliance**	A total of five shelter files were reviewed. Four open and one closed files were reviewed to assess adherence to the requirements of this indicator. All eligibility screenings were completed immediately for all shelter placements.	
Community counseling: Eligibility screening is completed within 3 business days of referral by a trained staff using the Florida Network screening form.	**Compliance**	A total of five community counseling client files were reviewed to assess adherence to the requirements of this indicator. Files reviewed included five closed Community Counseling cases. All eligibility screenings were completed within three business days of referral to Crosswinds by a trained staff using the Florida Network screening form.	
There is evidence all referrals for service is screened for eligibility and is logged in NetMIS within 72 hours of screening completion.	**Exception**	Reviewed 10 files, five closed community counseling files, four open shelter files and one closed shelter file	In two community counseling files (out of the 10 files reviewed), the reviewer was unable to verify if the client was logged in NetMIS within 72 hours of screening completion. It was not documented in the file and when agency staff were interviewed, they reported that the date the NIRVANA was entered in NetMIS shows that data entry was done within 72 hours. However, one file was opened 6/13/23 and the NIRVANA was entered 7/26/23. NetMIS printouts in the file also indicated the date of 7/26/23. Another file was opened 4/26/23 and NIRVANA entered on 8/31/23.
Youth and parents/guardians receive the following in writing: a. Available service options b. Rights and responsibilities of youth and parents/guardians	**Compliance**	All ten client files reviewed showed evidence that the parents/guardians received available service options and rights and responsibilities of youth and parents/guardians and or caregiver as evident by the parents/guardians or caregivers signature on the rights and responsibilities form.	

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**	A review of Crosswinds client file practices indicated that the agency provided the family with a handbook during the Intake process. The handbook discusses the possible actions occurring through involvement with CINS/FINS services (case staffing committee, CINS petition, CINS adjudication) and the grievance procedures. The parents/guardians acknowledge the receipt of this information by signing a form. All ten files client files reviewed contained evidence of this required form which verified this information was received by the client and family.	
During intake, all youth were screened for suicidality and assessed as required if needed.	**Compliance**	A total of ten client files were reviewed. Of these ten files, five were closed community counseling files, four open shelter files and 1 closed shelter file. All youth were screened for suicidality and assessed as required if they responded positively with a yes response to any of the suicide questions.	
Additional Comments: **There are no additional comments for this indicator.**			
2.02 - Needs Assessment			**Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 2.02		**YES** If NO, explain here: Policy 2-3 Nirvana that was revised and reviewed October 2023 by COO	
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: Ten files. **Total number of Closed (Residential & Community) Files: Four open and six closed client files.** **Staff Position(s) Interviewed (No Staff Names): Licensed Clinician and Case Manager.** **Type of Documentation(s) Reviewed: Open and closed client case files.**			
Shelter Youth: NIRVANA is initiated within 72 hours of admission	**Exception**	A review of all ten client files was conducted. Of the ten client files, nine had evidence that the NIRVANA is initiated within 72 hours of the client's admission to the program.	The NIRVANA was late in being completed in one of the closed residential files. The client's intake date was 5/22/23 and the NIRVANA was completed on 5/31/23.
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**	a total of five closed community counseling files were reviewed and in all five files the NIRVANA was initiated at intake and completed within two to three face-to-face contacts after the initial intake. Further review indicated it is the agency's practice to complete the NIRVANA at intake as all five NIRVANA assessments were completed at intake.	
Supervisor signatures is documented for all completed NIRVANA assessments and/or the chronological note and/or interview guide that is located in the youths' file.	**Compliance**	A supervisor signature was documented in all 10 files reviewed on the completed NIRVANA assessment.	
(Shelter Only) NIRVANA Self-Assessment (NSR) is completed within 24 hours of youth being admitted into shelter. If unable to complete, there must be documentation in NetMIS and the youth's file explaining the barriers to completion.	**Compliance**	The NIRVANA Self-Assessment (NSR) was completed within 24 hours of the youth being admitted into the shelter in all of the 5 Shelter files that were reviewed.	

A NIRVANA Post-Assessment is completed at discharge for all youth who have a length of stay that is greater than 30 days.	**Compliance**	A NIRVANA Post-Assessment was completed at discharge for all youth with lengths of stay greater than 30 days in all five community counseling closed files. The shelter files were not applicable for the NIRVANA Post-Assessment as four of the files are still open and one closed shelter file, the youth stay was not greater than 30 days.	
A NIRVANA Re-Assessment is completed every 90 days excluding files for youth receiving SNAP services.	**No eligible items for review**	Not applicable as no youth file was opened over 90 days.	
All files include the interview guide and/or printed NIRVANA.	**Compliance**	All ten files reviewed included the printed NIRVANA assessment.	
Additional Comments: **There are no additional comments for this indicator.**			
2.03 - Case/Service Plan			**Limited**
Provider has a written policy and procedure that meets the requirement for Indicator 2.03		**YES** If NO, explain here: Crosswinds has a policy 2-4 Case/Service Plan that was revised July 2023 per policy. The overall policies were signed and reviewed by the COO in September 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: Ten files. **Total number of Closed (Residential & Community) Files: Four open and six closed client files.** **Staff Position(s) Interviewed: Licensed Clinician and Case Manager.** **Type of Documentation(s) Reviewed: Open and closed client case files.**			
The case/service plan is developed on a local provider-approved form or through NETMIS and is based on information gathered during the initial screening, intake, and NIRVANA.	**Compliance**	The agency is using the Case Plan generated through NetMIS 3.0. All nine case plans reviewed were based on information gathered during the initial screening, intake, and NIRVANA. One closed shelter file did not have a case plan due to the youth being discharged before a case plan could be developed.	
Case/Service plan is developed within 7 working days of NIRVANA	**Exception**	Ten client files were reviewed, five closed community counseling files, four open shelter files and one closed shelter file. In eight out of ten files the case/service plan was developed within seven working days of the NIRVANA. The service plan was not applicable for the closed shelter due to the youth discharging early.	One community counseling file had a late service plan. The service plan was due on 7/6/23, however it was done on 7/7/23. There was no documentation as to why the counselor met with the family past the due date.
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**	Reviewed ten files, five closed community counseling files, four open shelter files and one closed shelter file. All nine required service plans were individualized and prioritized needs and goals identified by the NIRVANA. All nine service plans also included service type, frequency, location and persons responsible. Eight out of nine case plans had the signature of youth, parent/guardian, counselor, and supervisor as one was missing the father's signature; however, it was documented that they meet with the father on-line. One client signature was missing, but it was noted that the client refused to sign the form. The date the plan was initiated was also included on each of the service plans reviewed.	At the time of this program review, the randomly selected client files contained service plans which do not include target dates. Eight out of the nine files which were required to have a service plan did not include target dates. One file service plan did have areas designated for target dates as the service plan appears to be an old service plan the agency that the agency is no longer using. However, the completion dates were not filled in on the service plan for that file. On day 2, the agency provided a draft (plan) to address this issue and reported they would be going back to using their old services plan format which includes target dates.

Case/service plans are reviewed for progress/revised by counselor and parent (if available) every 30 days for the first three months and every 6 months after	**Compliance**	The five closed community counseling files case/service plans were reviewed for progress by a counselor and parent when available every 30 days for the first three months. A total of four shelter files were not applicable for case/service plan review as the cases have not been opened for 30 days at the time of review. One shelter closed case was also not applicable as youth was discharged prior to a service plan being developed.	
Additional Comments: **There are no additional comments for this indicator.**			
2.04 - Case Management and Service Delivery			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.04		**YES** If NO, explain here: Indicate policy number, authorized signee, date(s) of last review/revision/approval: The agency has a policy 2-5 titled Services and 2-6 Case Management that was revised August 2014 and signed by the previous COO who is no longer with the agency. The overall policies were signed and reviewed September 2023 by the current COO.	
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: Ten files. **Total number of Closed (Residential & Community) Files: Four open and six closed client files.** **Staff Position(s) Interviewed: Licensed Clinician and Case Manager.** **Type of Documentation(s) Reviewed: Open and closed client case files.**			
Counselor/Case Manager is assigned	**Compliance**	All ten files reviewed were assigned to a counselor or 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	**Compliance**	A total of ten files were reviewed for this indicator. Files reviewed included five closed community counseling files, four open shelter files and one closed shelter file. The Counselor/Case Manager established referral needs and coordinated referrals to services based upon the on-going assessment of youth and family problems and needs when appropriate as noted in four community counseling files. This was not applicable for six of the files. Nine files documented the coordination of service plan implementation. One closed shelter file contained a service plan which was not applicable due to the youth's length of stay. Documentation in all ten files noted that the staff monitors the youth and family progress and provides support for families. Only four open shelter files were applicable for staff to monitor progress of court ordered youth in the shelter. Referrals to case staffing committee to address problems and needs of the youth and family were completed on two community counseling cases as needed. None of the 10 files reviewed were applicable for the staff accompanying the youth to court hearings and related appointments or recommending them for judicial intervention. Cases were referred for additional services when appropriate. The four open shelter cases provided documentation of case monitoring and staffing reviewing court orders. The six closed files reviewed each had case termination notes in the files. Four of the closed cases had completed 30 and 60 day follow-ups. Six cases were not applicable for 30/60 day follow ups at the time of review.	

The program maintains written agreements with other community partners that include services provided and a comprehensive referral process	**Compliance**	The agency maintains written agreements with other community partners that include services provided and a comprehensive referral process.	
Additional Comments: **There are no additional comments for this indicator.**			
2.05 - Counseling Services			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.05		**NO** If NO, explain here: Crosswinds policy 2-7 Counseling/Youth Records which was revised November 2021. The policy does not include information from Florida Network policy that was effective July 1. 2023. Crosswinds policy 2-7 Counseling/Youth Records which was revised November 2021.	
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: Five residential client files. **Total number of Closed (Residential & Community) Files: Four open and one closed client files.** **Staff Position(s) Interviewed (No Staff Names): Licensed Clinician and Case Manager.** **Type of Documentation(s) Reviewed: Open and closed client case files.**			
Shelter Program			
Shelter programs provides individual and family counseling	**Compliance**	Five shelter files were reviewed and each client file contained evidence and documentation of individual and family counseling in all five files.	
Group counseling sessions held a minimum of five days per week	**Compliance**	Five shelter files were reviewed and four contained documentation verifying youth participation in group counseling was held a minimum of five days per week. One client file was not applicable for group counseling as the client's length of stay was less than 5 days.	
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**	The agency utilizes a binder which captures evidence of attendance all you participating in group sessions. The sheet has the title of the group, the staff member conducting the group, the time of the group and the names of the youth that attended the group. Each topic was relevant, educational/informational or developmental. Each group was also at least 30 minutes or longer. Five shelter files were reviewed and each youth was listed in the binder indicating they attended these groups.	
Documentation of groups must include date and time, a list of participants, length of time, and topic.	**Compliance**	Five shelter client files were reviewed and four client files included documentation of the group dates, time, list of participants, length of time, and the topic. One client file was not applicable due to the youth length of stay.	
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**	Five closed community counseling files were reviewed and contained evidence of program providing therapeutic community-based services designed to provide the intervention necessary to stabilize the family. Services are provided in the agency's counseling office. No services were provided virtually.	

Counseling Services			
Reflect all case files for coordination between presenting problem(s), psychosocial assessment, case/service plan, case/service plan reviews, case management, and follow-up	**Compliance**	Five Community Counseling files were reviewed and each had documentation of coordination between the youth/family presenting problems, NIRVANA assessment, case/service plan, case/service plan reviews and follow-ups.	
Maintain individual case files on all youth and adhere to all laws regarding confidentiality	**Compliance**	A total of ten files were reviewed. This file review contained five closed community counseling files, four open shelter files and one closed shelter file. The agency maintains individual case files on all youth and adhere to all laws regarding confidentiality.	
Case notes maintained for all counseling services provided and documents youth's progress	**Compliance**	Five community counseling files were reviewed and each file maintained case notes for all counseling services provided and documented the youth's progress.	
On-going internal process that ensures clinical reviews of case records and staff performance	**Compliance**	A total of ten client files were reviewed for this indicator. Of these files, five were closed community counseling files, 4 were open shelter files and 1 closed shelter file. The agency has an on-going internal process that ensures clinical reviews of case records and staff performances. According to agency staff, the Director of Counseling Services meet with the counselors weekly for supervision and discusses status of cases at random. The Director of Counseling Services keeps a log book on what youth was discussed during supervision. Each community counseling file contains evidence of the supervisor's signature on the front cover indicating it was reviewed as required. The shelter files have supervisor signatures throughout the file on documentation indicating it was reviewed by a supervisor.	
Additional Comments: **There are no additional comments for this indicator.**			
2.06 - Adjudication/Petition Process			**Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 2.06		**NO** If NO, explain here: The agency has a policy 2-10 Case Staffing Committee that was revised October 2014 by the previous COO. There is no indication that the policy has been revised or reviewed since that date per policy. The agency has a policy 2-10 Case Staffing Committee that was revised October 2014 by the previous COO.	
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: Three community client files. **Total number of Closed (Residential & Community) Files: Two open and one closed client files.** **Staff Position(s) Interviewed (No Staff Names): Community counseling staff members.** **Type of Documentation(s) Reviewed: Client community counseling case files.**			
Must include: a. DJJ rep. or CINS/FINS provider b. Local school district representative	**Compliance**	A total of three Case Staffing Committee cases were reviewed and each case staffing included a DJJ representative, a CINS/FINS provider and a local school district representative. The agency had many representatives from the Brevard County School system.	

Other members may include: a. State Attorney's Office b. Others requested by youth/ family c. Substance abuse representative d. Law enforcement representative e. DCF representative f. Mental health representative	**Compliance**	Three Case Staffing's Committee cases were reviewed and each case staffing included a member of the State Attorney's Office. The agency has a large attendance at their case staffing committee meetings which shows they are working with the community to ensure the needs of the family and youth are being met by bringing other service provides to the table.	
The program has an established case staffing committee, and has regular communication with committee members	**Compliance**	The program has an established case staffing committee which is held monthly, and has regular communication with committee members. A review of the schedule for the last six months indicates meeting being held on a consistent basis. The agency has a yearly schedule for case staffings and a schedule for the CINS court dates.	
The program has an internal procedure for the case staffing process, including a schedule for committee meetings	**Compliance**	The program has an internal procedure for the case staffing process, including a schedule for committee meetings. The program staff sends out case staffing committee meeting notifications via email to all required parties.	
The youth and family are provided a new or revised plan for services	**Compliance**	The three Case Staffing Committee cases were reviewed and each case contained evidence of a revised service plan for the youth following the case staffing committee meeting.	
Written report is provided to the parent/guardian within 7 days of the case staffing meeting, outlining recommendations and reasons behind the recommendations	**Exception**	The three Community Counseling files were reviewed. Two closed cases and one open case contained evidence of a written report. One case was opened by parent, one by the school and one by an agency staff member. There is evidence that the notification to the family and committee is no less than five working days prior to the Case Staffing Committee meeting in two of three cases. The notification for the third case was not completed in the required time frame.	One client's file case staffing was held on 4/28/23. This written report was provided to the parents late on 5/22/23. Staff reported this was noticed and time frames have been addressed with staff.
If applicable, the program works with the circuit court for judicial intervention for the youth/family	**Not Applicable**	Three Community Counseling files were reviewed which included two closed cases and one open case. No cases were referred for judicial intervention.	
Case Manager/Counselor completes a review summary prior to the court hearing	**Not Applicable**	Three Community Counseling files were reviewed which included two closed cases and one open case. No cases had a court hearing.	
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	**NO**		
	Agency has policy 2-07 Counseling/ Youth Records and 1-09 Confidentiality. The policies do not indicate a review date. The overall policies were signed by the COO in September 2023.		
	Agency has policy 2-07 Counseling/ Youth Records and 1-09 Confidentiality. 2-07 was revised November 2021 and 1-09 was revised December 2015. 1-09 was signed by previous COO who is no longer with the agency. 2-07 was signed by current COO.		
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: Ten files.
Total number of Closed (Residential & Community) Files: Four open and six closed client files.
Staff Position(s) Interviewed: Licensed Clinician and Case Manager.
Type of Documentation(s) Reviewed: Open and closed client case files.

All records are clearly marked 'confidential'.	**Compliance**	All ten files were clearly marked "confidential" and were organized in the same file format according to the file type.	
All records are kept in a secure room or locked in a file cabinet that is marked "confidential"	**Compliance**	All records were observed to be locked in a file cabinet that is marked "confidential" and kept in a secure room.	
When in transport, all records are locked in an opaque container marked "confidential"	**Compliance**	The agency uses a locked opaque container that requires a combination lock when transporting files. The container is marked "confidential".	
All records are maintained in a neat and orderly manner so that staff can quickly and easily access information	**Compliance**	All ten files were maintained in a neat and orderly manner so that staff can quickly and easily access information.	

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

2.08 - Specialized Additional Program Services		**Limited**
Provider has a written policy and procedure that meets the requirement for Indicator 2.08	**YES** If NO, explain here: The program has five polices relating to Special Populations. The five policies are 3-27 Staff Secure Services, 3-31 Domestic Violence Respite last revised July 2023, 3-32 Domestic Minor Sex Trafficking, 3-33 Probation Respite, and 3-35 Family Youth Respite Aftercare Services (FYRAC). The policies were reviewed and signed by the Chief Executive Officer.	

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 Files: None

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 reports not serving any youth meeting this requirement during the period of 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	**No eligible items for review**		
Program only accept youth that meet legal requirements of F.S. 984 for being formally court ordered in to Staff Secure Services	**No eligible items for review**		

Staff Assigned: a. One staff secure bed and assigned staff supervision to one staff secure youth at any given time b. Program assign specific staff during each shift to	**No eligible items for review**		
Agency provides a written report for any court proceedings regarding the youth's progress	**No eligible items for review**		
Domestic Minor Sex Trafficking (DMST)			
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Files: None			
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 reports not serving any youth meeting this requirement during the period of review.	
Agency has evidence that the FNYFS was contacted for approval prior to admission for all Domestic Minor Sex Trafficking (DMST) placements.	**No eligible items for review**		
There is evidence the youth was entered into NetMIS as a Special Populations youth at admission and a Human Trafficking Screening Tool (HTST) was completed.	**No eligible items for review**		
Services provided to these youth specifically designated services designed to serve DMST youth	**No eligible items for review**		
Did the placement of DMST youth require additional supervision for the safety of the youth or the program? If so, did the agency provide the appropriate level of supervision and safety measures?	**No eligible items for review**		
Length of Stay: a. Youth in program do not have length of stay in DMST placement that exceeds seven (7) days b. Agency has approval for stays and support beyond seven (7) days for DMST placements that are obtained on a case-by-case basis? (If applicable.)	**No eligible items for review**		
Agency has evidence that staff assigned to DMST youth under this provision are to enhance the regular services available through direct engagement in positive activities designed to encourage the youth to remain in shelter	**No eligible items for review**		
All other services provided to DMST youth are consistent with all other general CINS/FINS program requirements	**No eligible items for review**		

Domestic Violence			
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: No open cases. **Total number of Closed Files: Three closed residential client files.** **Staff Position(s) Interviewed: Residential counseling staff.** **Describe any Observations: Internal policy includes youth must be screened by the JAC/Detention or screening unit but does not meet the criteria for secure detention.**			
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**	Three closed files were randomly selected and reviewed for this indicator.	
Youth admitted to DV Respite placement have evidence in the file of a pending DV charge	**Exception**	One out of three youth files reviewed contained evidence of the pending domestic violence (DV) charge in the file. Upon further interview with the Program Director and a review of files, the program explained they were unable to provide evidence of the pending DV charge in the files that missed this evidence but stated the program has a new practice recently implemented to request the booking documentation from the officer upon drop off.	Two out of three youth files reviewed did not contain evidence of the pending DV charge. During the interview with the Program Director it was explained the documents must not have been provided at the time the youth was dropped off.
Data entry into NetMIS within (3) business days of intake and discharge	**Compliance**	All three files completed data entry within the required timeframe. One file demonstrated that NetMis added after 24 hours per progress note. NetMIS data entry not consistently noted in file or progress notes.	
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**	All three files reviewed demonstrated that the youth's length of stay was within the required timeframe.	
Case plan in file reflects goals for aggression management, family coping skills, or other intervention designed to reduce propensity for violence in the home	**Exception**	One out of two applicable files reviewed contained a completed case plan that reflected goals for aggression management and/or family coping skills.	One file did not contain goals as required.
All other services provided to Domestic Violence Respite youth are consistent with all other general CINS/FINS program requirements	**Exception**	Two files were reviewed for all services being consistent with CINS FINS requirements. All files reviewed contained a screening for eligibility, NIRVANA assessment and other various documentation was contained within the file to include services were provided to youth. It was observed of the applicable files with service plans, one file had a internal service plan that met all of the requirements and the other file used the NETMIS service plan but had dates and other information missing to verify services initiated. One youth file was not applicable due to the progress note indicating the youth refused to complete the initial NIRVANA and was discharged after 1 day due to having to be baker acted. One out of three 30 day follow-ups were completed and noted in NETMIS. The remaining follow-ups were attempted and noted all three required attempts in NETMIS, however, it was observed a 2nd or 3rd attempt may have been a minute later than the initial attempt.	One of the two applicable files lacked a completed service plan indicating type, frequency, and location of service(s); person(s) responsible listed youth but staff was missing or not included for supporting youth to achieve goals; or target date(s) for completion as required with service plan requirements and the document in the file appears to be more of a service plan review and not the original initial service plan. The file also lacked evidence of progress notes to demonstrate any progress on goals reached. The 2nd service plan appeared to lack supporting evidence of weekly sessions being completed or attempted as mentioned in service plan in progress notes or in the file.

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 Files: None			
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 reports not serving any youth meeting this requirement during the period of review.	
All probation respite referrals are submitted to the Florida Network.	**No eligible items for review**		
All Probation Respite Referral come from DJJ Probation and there is evidence that the youth is on Probation regardless of adjudication status.	**No eligible items for review**		
Data entry into NetMIS and JJIS within (3) business days of intake and discharge	**No eligible items for review**		
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**		
All case management and counseling needs have been considered and addressed	**No eligible items for review**		
All other services provided to Probation Respite youth are consistent with all other general CINS/FINS program requirements	**No eligible items for review**		
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 **Staff Position(s) Interviewed** *(No Staff Names)* **: The program stated they do not provide ICM services currently.**			
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 reports not serving any youth meeting this requirement during the period of 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**		

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**		
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**		
Service/case plan demonstrates a strength-based, trauma-informed focus	**No eligible items for 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**		
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 Files: None			
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 reports not serving any youth meeting this requirement during the period of review.	
Youth is referred by DJJ for a domestic violence arrest on a household member, and/or the youth is on probation regardless of adjudication status and at risk of violating.	**No eligible items for review**		
Agency has evidence that all FYRAC referrals have documented approval from the Florida Network office	**No eligible items for review**		
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	**No eligible items for review**		

Life Management Sessions meets the following criteria: a. Sessions are face-to-face, sixty (60) minutes in length and focus on strengthening the family unit b. Services are highly supportive, individualized, and flexible and require a "whole family" approach to dealing with the problems affecting the youth and family.	**No eligible items for review**		
Individual Sessions: a. The program conducted sessions with the youth and family to focus on work to engage the parties and identify strengths and needs of each member that help to improve family functioning. b. Issues to be covered through each session include but are not limited to: Identifying emotional triggers; body cues; healthy	**No eligible items for review**		
Group Sessions: a. Focus on the same issues as individual/family sessions with application to youth pulling on similar experiences with other group members with the overall goal of strengthening relationships and prevention of domestic violence. b. Shall be no more than eight (8) youth at one (1) time and shall be for a minimum of sixty (60)	**No eligible items for review**		
There is evidence of completed 30 and/or 60 day follow-ups and is documented in NetMIS following case discharge.	**No eligible items for review**		
Youth and family participate in services for thirteen (13) sessions or ninety (90) consecutive days of services, or there is evidence in the youth's file that an extension is granted by DJJ circuit Probation staff	**No eligible items for review**		
Any service that is offered virtually, is documented in the youth's file why it was in the youth and families best interest.	**No eligible items for review**		
All data entry in NetMIS is completed within 3 business days as required.	**No eligible items for review**		
Additional Comments: **There are no additional comments for this indicator.**			

2.09- Stop Now and Plan (SNAP)			Exception
Provider has a written policy and procedure that meets the requirement for Indicator 2.09		**YES** If NO, explain here: The program has several policies relating to Stop Now and Plan (SNAP) including the following; 6-1 SNAP – Group Delivery; 6-2 SNAP – Fidelity; 6-3 SNAP – Intake; 6-4 SNAP – Discharge; 6-5 SNAP – In Schools. The policies were reviewed September 2023 by the COO.	
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: Three files** **Type of Documentation(s) Reviewed: Client files, NETMIS, policy.**			
SNAP Clinical Groups Under 12			
Youth are screened to determine eligibility of services.	**Compliance**	A total of three of three SNAP youth files reviewed contained completed screenings.	
The NIRVANA was completed at initial intake, or within two sessions.	**Compliance**	A total of three of three SNAP youth files reviewed contained NIRVANA assessments completed withing two sessions.	
There is evidence of the completed Child Behavior Checklist (CBCL) by the caregiver (pre and post) and is located within the file.	**Compliance**	A completed Child Behavior Checklists were documented in each of the three SNAP youth files reviewed.	
There is evidence of the completed Teacher Report Form (TRF) is completed by the teacher (pre and post) and is located within the file.	**Exception**	A total of three of three SNAP youth files were reviewed. The file review included determining if there was evidence of a completed Teacher Report Form during pre and post test service delivery phases in each of the files.	No Pre-Teacher Report Forms (TRF) was present in the youth files. Two of three SNAP files reviewed only had one Teacher Report Form (TRF). Both were dated closer to the youths' discharge date and may have been considered a post TRF. The third client file contained no TRF.
SNAP Clinical Groups Under 12 - Discharge			
There is evidence of the completed SNAP Discharge Report located within the file for any discharged youth.	**Compliance**	Completed SNAP discharge reports were contained in three of three SNAP youth files reviewed.	
There is evidence of the completed SNAP Discharge Report located within the file for any discharged youth.	**Compliance**	Completed SNAP discharge reports were contained in three of three SNAP youth files reviewed.	
There is evidence of the SNAP Boys/SNAP Girls Child Group Evaluation Form located in the file.	**Compliance**	Three of three SNAP youth files reviewed contained completed SNAP Girls/ SNAP Boys Child group evaluation forms.	
There is evidence of the SNAP Boys/SNAP Girls Parent Group Evaluation Form located in the file.	**Compliance**	Three of Three SNAP youth files contained completed SNAP bays/ SNAP girls Parent group evaluation forms.	

SNAP Clinical Groups for Youth 12-17			
Youth are screened to determine eligibility of services.	**Not Applicable**	Program only serves youth under 12.	
The Consent to Treatment and Participation in Research Form is completed and located within the file.	**Not Applicable**	Program only serves youth under 12.	
The NIRVANA was completed at initial intake, or within two sessions.	**Not Applicable**	Program only serves youth under 12.	
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**	Program only serves youth under 12.	
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**	Program only serves youth under 12.	
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**	Program only serves youth under 12.	
SNAP for Schools & Communities			
The program demonstrated all of the required weekly attendance sheets that included youth names and/or identifying numbers completed with the teacher and trained SNAP Facilitator signatures. (*This must include a total of 13 attendance sheets for a full cycle*)	**Compliance**	Two completed SNAP classroom groups sessions were reviewed in its entirety and the program had all documents well organized and complete. Weekly attendance sheets included all required information and a total of 13 weekly sign-in sheets were present representing a full cycle for each class.	
The program maintained evidence of a completed "Class Goal" Document for the class reviewed.	**Compliance**	Classroom goal sheets were present in both classroom group cycles reviewed.	
The program maintained evidence of both pre AND post Measure of Classroom Environment (MoCE) completed documents for the class reviewed.	**Exception**	Each of the two classroom group cycles reviewed contained completed post Measure of Classroom Environment (MoCE) documents.	One classroom did not have evidence of the pre-MoCE evidenced in the file.
The program maintained evidence of completed pre and post evaluation documents for the class reviewed.	**Compliance**	Each of the two classroom group cycles reviewed contained pre and post surveys documents completed by the youth.	
There is evidence of the fidelity adherence checklist maintained in the file for each class reviewed.	**Compliance**	Fidelity adherence checklist were completed in each of the two classroom group cycles reviewed.	
Additional Comments: **There are no additional comments for this indicator.**			

3.01 - Shelter Environment			Exception
Provider has a written policy and procedure that meets the requirement for Indicator 3.01		**YES** If NO, explain here: The program has several policies relating to Shelter environment including the following; Policy 3-6 daily schedule, 3-7 faith based opportunities, 3-9 Linens, 3-14 shelter environment, cleanliness and maintenance, 3-30 sleeping rooms and 4-1 emergency drills. The policies were reviewed September 2023 by the COO.	
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.	**Exception**	The shelter environment was inspected in person with a tour of the facility during day one and day two of the onsite visit. During the tour it was observed that the grounds were landscaped and well-maintained and the furnishings were in good repair. At the time of this onsite program review, the program's air conditioning (AC) unit was not functioning out in the youth's sleeping area, kitchen and dining area. The program informed the review team that the AC unit malfunctioned on 9/9/2023. The agency has been working with the AC company to get the part fixed from 9/11/23-9/25/23. A Department of Juvenile Justice (DJJ) Central Communications Center (CCC) was called on 9/25/23 and portable AC units were placed in the youth sleeping areas on 9/27/23. On 9/29/23 the AC vendor informed the program that the AC will not be fixed for another 18-20 weeks. The program provided a timeline of activities related to the AC system outage with events involving the AC starting on 8/10/23 to 9/29/23. Each girls' and boy's dorm areas have five rooms with 2 beds in each room. All bathrooms are clean and functioning. Each youth has their own bed with clean sheets and pillows, as well as a dresser for their clothing. Further observation revealed the dorm rooms were free of mold, mildew, foul orders and leaks. Shelter bathrooms were also inspected and rust was detected. At the time of the program review, there were no sighs of insect infestation in the dorms, kitchen and common areas. The program had detailed maps and egress plans of the facility, client rules, grievance forms, the abuse hotline information and the DJJ incident reporting number and other related notices were posted. All interior areas do not contain contraband and are free from hazardous unauthorized objects.	The facility had two stalls and showers on both the male and female sides. Both shower stalls in the girl's bathroom had rust showing around shower handles. The dining area had stains on the wall by the serving area and where the garbage can is located. In room five, in the male dorm, graffiti was found on the white metal light fixture and an egress plan had a broken plastic cover that had jagged edges. The dumpster had a lid, but it was left open. After this was brought to the program's attention, this was corrected onsite. A large hole was observed on the pavement just outside the back door of the kitchen. The program has submitted a work order to get the pavement repaired. Multiple televisions affixed to the wall had power and media cords that needed to be bound to prevent possible entanglement.
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**	At the time of this onsite program review and tour of the facility, all staff vehicles were locked. All official agency transportation vehicles were equipped with all major safety equipment. All first aid kits had evidence of current medical supplies and had no items that were beyond the manufacturers date of expiration. Both agency vehicles had fire extinguishers with inspection tags, flashlights, glass breakers and seat belt cutters.	

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.	**Compliance**	A review of the current chemical inventory practices were assessed to determine the agency's adherence to the requirements of this indicator. The Material Safety Data Sheets (MSDS) binder and chemical inventory is located in a locked janitor closet within a locked cabinet. It was observed that all chemicals are listed, approved for use, inventoried weekly and perpetually. The chemicals are behind 2 locked doors and the MSDS are maintained on each item once a week.	
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	**Exception**	The shelter is equipped with three washers and three dryers. During the tour, the reviewer observed one washer was broken which left the program with 2 operational washers. All 3 dryers worked and the lint collectors screens were free of lint. The agency had evidence of a Department of Children and Families Child (DCF) Care Facility License that is effective through February 17, 2024.	There was no evidence of a work order or replacement plan for the one non-operational washer. The DCF Child Caring license is active and effective through February 17, 2024. The Child Care License is displayed in an interior area of the shelter and not in a common area.
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 per month 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).	**Compliance**	Documentation was reviewed that confirmed the date of current fire inspection was conducted on 2/14/2023. The Fire Inspector commented that facility was inspected for fire code compliance. During the inspection, no specific violations or substandard conditions were observed. Please note that during the inspection, recommendations for upgraded housekeeping practices were made including: Notify sprinkler company that some sprinkler head escutcheons were noted to be "gapping" and to correct/re-seat during next annual inspection. The agency completes at minimum one fire drill monthly for each shift within two minutes or less. The agency exceeds that indicator requirements by completing one mock drill monthly per shift. The program completed fire alarms inspection, fire detection and suppression system was inspected on 11/29/22. The kitchen fire suppression system was inspected May 2023 and all fire extinguishers were inspected November 2022.	

Fire and Safety Health Hazards: a. Agency has a current Satisfactory Residential Group Care inspection report from the Department of Health. b. Agency has a current Satisfactory Food Service inspection report from the Department of Health and food menus are posted, current and signed by Licensed Dietician annually. c. All cold food is properly stored, marked and labeled and dry storage/pantry area is clean and food is properly stored. d. Refrigerators/Freezers are clean and maintained at required temperatures and all small and medium sized appliances are operable and clean for use as needed.	**Exception**	The Department of Health conducted an inspection on 1/10/2023 and the agency received a Satisfactory rating. The Department of Health commented no violations and specifically wrote "please review educational material on proper handwashing". The Dietician's license was posted and expires 5/31/2024. All food menus were posted and signed off by the licensed dietician. Cold food stored in the commercial refrigerator was found and no date of expiration was listed. The refrigerator and freezer were clean and well maintains along with all small appliances. The freezer temperature was -4 degrees Fahrenheit and the refrigerator was 37 Fahrenheit.	Large blocks of sliced cheese were removed from the original manufacturer's packaging and no date of expiration was found. The program removed the cheese that was not labeled as required.
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**	The program's daily schedule revealed the youth are engaged in meaningful, structured activities daily seven days a week. The youth were observed participating in recreational activities at least one hour a day. The youth were also provided the opportunity to participate in faith-based activities and youth who did not want to participate were offered alternative activities. The posted shelter schedule and log book entries detailed these faith based activities. The daily schedule includes opportunities for youth to complete homework and access to a variety of books to read in the program loft library area. The daily schedule is posted and accessible to staff members and youth.	
Additional Comments: **There are no additional comments for this indicator.**			

3.02 - Program Orientation			Exception
Provider has a written policy and procedure that meets the requirement for Indicator 3.02		**YES** If NO, explain here: The policy 3-12 Orientation was reviewed September 2023 by the COO.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Staff Position(s) Interviewed: Residential Director **Type of Documentation(s) Reviewed: Residential program documentation.**			
Youth received a comprehensive orientation and handbook provided within 24 hours	**Compliance**	A total of six files were reviewed to assess the agency's adherence to the requirements of this indicator. Of these cases, three are open and three are closed. All youth received program orientation about the program and a handbook within 24 hours. All files have documented evidence that the orientation occurred the same day.	
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	**Exception**	A total of six files were reviewed, all youth have documented evidence each received program orientation. All files reviewed contained an orientation checklist that staff reviewed the following; contraband, disciplinary action, dress code, access to medical and mental health services, procedures for visitation, mail and the telephone process, grievance procedure, disaster preparedness, physical layout of the program, sleeping room assignments suicide prevention and alerting staff or awareness of others. The orientation checklist was signed by staff, the guardian and the youth that all items were reviewed. One client file did not have a parent's signature because they refused to sign.	Two out of six client files reviewed did not document the youth's room assignment.
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**	All charts reviewed contained documentation that orientation occurred, including all of the required topics, dates completed and was signed by the youth and the staff involved in the orientation process.	
Additional Comments: **There are no additional comments for this indicator.**			
3.03 - Youth Room Assignment			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 3.03		**YES** If NO, explain here: Policy 3-05 Classification was last reviewed August 2014 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: Three open residential client files. **Total number of Closed Files: Three closed residential client files.** **Staff Position(s) Interviewed** *(No Staff Names)* **: Residential program director and residential direct care staff.** **Type of Documentation(s) Reviewed: Client files.**			
A process is in place that includes an initial classification of the youths, to include:			
a. Review of available information about the youth's history, status and exposure to trauma b. Initial collateral contacts, c. Initial interactions with and observations or the youth d. Separation of younger youth from older youth, e. Separation of violent youth from non-violent youth f. Identification of youth susceptible to victimization g. Presence of medical, mental or physical disabilities h. Suicide risk I. Sexual aggression and predatory behavior j. Sexual orientation gender identity/ expression k. Acute health symptoms requiring quarantine or isolation	**Compliance**	A total of six client files were reviewed which included three open and three closed files. All charts contained documentation on the residential intake form that a classification process was used to appropriately assign youth to their rooms. The documentation included a review of the available information about the youth's history, status and exposure to trauma, initial staff interactions and observations of the youth collateral contacts, separation of younger youth from older youth, identification of youth susceptible to victimization, presence of medical, mental or physical disabilities, suicide risk, sexual aggression and predatory behaviors, sexual orientation, gender identity and expression and 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**	A total of six client files were reviewed which included three open and three closed files. All six charts reviewed contained documentation of alerts on the front of the chart that aligned with the documentation in the chart. The alerts were entered on the census board in the staff office upon admission that indicated risk of suicide, mental health, substance abuse, physical health, aggression and security risk factors.	
Additional Comments: **There are no additional comments for this indicator.**			
3.04 - Log Books			**Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 3.04		**YES** If NO, explain here: Policy 3.28 Logbook reviewed 11/2018 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: May 2023 through October 2023 (date of program review) **Staff Position(s) Interviewed** *(No Staff Names)* **: Residential Director, COO, Licensed Clinician, Direct Care staff.** **Type of Documentation(s) Reviewed: Electronic logbook.**			
Log book entries that could impact the security and safety of the youth and/or program are highlighted	**Compliance**	A review of the program's logbook entries was conducted for entries saved into the electronic logbook from May 2023 through October 11-12, 2023 program review date. In reviewing the program's electronic logbook entries that impact security and safety of the youth, all entries were highlighted according the policy and procedure.	

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	**Compliance**	In reviewing the program's electronic logbook all entries were brief, legible and included the date and time of the incident, names of the youth and staff involved, a brief statement with pertinent information and signed by staff. All errors were noted with a strikethrough and signed and dated by staff.	
Recording errors are struck through with a single line. The staff person must initial and date the correction. The use of whiteout and erasures is prohibited.	**Compliance**	All errors were noted with a strike through with a single line, signed by staff with initials and dates of the correction.	
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	**Compliance**	In reviewing logbook entries the Program Director reviewed the log books weekly and documented any corrections, recommendations, follow up that was needed, signed and dated.	
All staff review the logbook of the previous two shifts and makes an entry signed and dated into the logbook indicating the dates reviewed	**Compliance**	All staff reviewed the logbook of the previous two shifts and documented it in the logbook with the dates reviewed and signed their entries.	
At the beginning of their shift, oncoming supervisor and shelter counselor reviews the logbook of all shifts since their last log entry and makes a signed and dated entry and into log book indicating the dates reviewed.	**Compliance**	The programs electronic logbooks reviewed revealed the oncoming supervisor and counselors reviewed the logbook of previous shifts since their last entry, signed and dated the logbook with the dates reviewed.	
Logbook entries include: a. Supervision and resident counts b. Visitation and home visits	**Exception**	A review of the logbook for the period for the last 30-45 days was conducted to assess the agency's adherence to proper documentation of supervision, counts, visitation and home visits. All areas are generally documented as required except for supervision of youth on the overnight shift. The reviewer identified discrepancies in entries documented in the logbook on randomly selected dates by verifying bed checks conducted utilizing camera video footage against entries logged in the logbook.	In reviewing video surveillance it was observed that staff did not conduct several bed checks, but documented that they occurred. The program was instructed to contact the DJJ CCC to report the program review team's identification of falsification of documented bed checks by current staff. Staff also missed several required checks on two separate days of video reviews. One youth who was sleeping in the loft received no bed checks for four and a half hours.
Additional Comments: **There are no additional comments for this indicator.**			
3.05 - Behavior Management Strategies			**Limited**
Provider has a written policy and procedure that meets the requirement for Indicator 3.05	**YES**		
	If NO, explain here:		
	Policy 3.05 Behavior Management/Motivation system reviewed August 2023 by the COO.		

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

Staff Position(s) Interviewed *(No Staff Names)* **: Program Director and Direct Care staff.**
Type of Documentation(s) Reviewed: Program Behavior Management provided to staff and residents.
Describe any Observations: Engagement of youth observed at random times during onsite two day program review.

The program has a detailed written description of the BMS and it is explained during program orientation	**Compliance**	The agency has a process which includes providing documentation and full explanation of its Behavior Management System (BMS). The current plan has a detailed written description of the BMS and it is explained to the youth during the program orientation process and is in the client handbook.	
Behavior Management Strategies must include:			
a.BMS is designed to teach youth new behaviors and help youth understand the natural consequences for their actions b.Behavioral interventions are applied immediately, with certainty, and reflect the severity of the behavior c.BMS uses a wide variety of awards/incentives to encourage participation and completion of the program d.Appropriate consequences and sanctions are used by the program and consequences for behavior are logical and designed to promote skill-building for the youth e.Counseling, verbal intervention and de-escalation techniques are used prior to physical intervention (Only techniques approved by the Florida Network and DJJ are used if physical intervention is required) f.Only staff discipline youth. Group discipline is not imposed g.Room restriction is not used as part of the system or for youth who are physically and/or emotionally out of control h.Youth should never be denied basic rights such as meals, clothing, sleep, services, exercise, or correspondence privileges	**Exception**	Observations of the direct care staff's engagement and interactions with current clients in the youth shelter were conducted during the onsite program review. Reviewers conducted observations of daily activities including observations of the agency providing residents meals, groups, free time and recreation during the onsite program review. Observations also included assessing the direct care staff's ability to implement the program's Behavior Management System. Further, observations of consequences applied by program staff for youth that violated program rules were observed to determine if responses to these behaviors are applied logically and consistently.	Although staff were present during group activities, direct care staff members were observed not consistently utilizing the BMS with youth who had their heads down during group with the guest speaker. Staff did not engage youth and the Guest Speaker had to awake wake the youth up himself. It was also observed in the house meeting that a youth that was leading the group had a punitive tone towards the other youth as only the two youth with all of their points could speak. Video surveillance also revealed staff members allowing youth to go in and out of the building in the middle of the night without engaging youth utilizing the BMS and other redirection and de-escalation techniques. In two different days of video reviews, the youth were going in and out of other youth's rooms throughout the night and staff did not intervene. The agency's staff members did not demonstrate Behavioral interventions which are applied immediately, with certainty, and reflect the severity of the behavior exhibited by youth not abiding by bedtime /lights out requirement to be in their own rooms and beds at night.
Program's use of the BMS			
All staff are trained in the theory and practice of administering BMS rewards and consequences	**Compliance**	The program has a detailed written description of the Behavior Management System (BMS). All direct care staff must complete a training session on understanding and proper use of the program's BMS. All direct care staff are informed and educated on the program's BMS per the Shelter Director. All staff are trained in the theory and practice of administering the BMS and applicable consequences.	
There is a protocol for providing feedback and evaluation of staff regarding their use of BMS rewards and consequences	**Exception**	The program reported that it trains its supervisors to monitor the use of behavioral interventions by their staff to include the use of point-based and level-based interventions. The agency also reported that direct care staff are trained and observed while shadowing in the orientation/on-boarding process when hired.	There was no formal process is in place to provide feedback and evaluation of staff regarding their use of positive and negative consequences on an ongoing basis.
Supervisors are trained to monitor the use of rewards and consequences by their staff	**Exception**	The supervisory staff reported that they are trained by the Residential Program Director to use all aspects including rewards and consequences when using the program's BMS.	There was no evidence provided by the program of a formal process to provide ongoing feedback and evaluation by Directors and leadership monitoring the effective delivery of the BMS by supervisors and direct care staff of residential program.
Additional Comments: **There are no additional comments for this indicator.**			

3.06 - Staffing and Youth Supervision			Failed
Provider has a written policy and procedure that meets the requirement for Indicator 3.06		**NO**	
		The overall agency policies were signed by the COO in September 2023. In reviewing the policy and procedure for 3-19 Staffing and Youth Supervision, the policy does not indicate that two staff are required to be on shift at all times.	
		The policy and procedure for 3-19 Staffing and Youth Supervision and was signed by the COO in September 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: Last 30-45 days of video camera footage and last six months of staffing schedules. **Staff Position(s) Interviewed: Residential Director and director care staff.** **Type of Documentation(s) Reviewed: Video camera footage and staff schedule.**			
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**	A review of staff schedules for April 2023 through the current schedule for October 2023 confirmed that the agency scheduled the minimum staff members required to meet ratios for each work shift.	
All shifts must always provide a minimum of two direct care staff present that have met the minimum training requirements	**Compliance**	A review of staff member training records confirmed a minimum of two direct care staff were present for each work shift and the staff working met the minimum training requirements from April 2023 through the current schedule for October 2023. In reviewing the logbook and observing staff ratios for first, second and third shifts, the program meets the indicator.	
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	**Exception**	A review of the documentation found all background screening documentation confirmed for youth care workers, supervisors and treatment staff members working in the shelter from April 2023 up to October 11th, 2023. A review of training files indicated staff were generally provided all required trainings.	Results from the review of Indicator 1.04 Training indicates that staff members working in the shelter from April 2023 up to October 11th, 2023, received the majority of required trainings.

The staff schedule is provided to staff or posted in a place visible to staff	**Compliance**	During the tour of the facility, it was observed that the staff member schedule was posted in the direct care staff office area visible for staff to see.	
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**	An overtime roster with telephone numbers of all staff members and those who can be called to help cover shifts, if needed, is posted in the staff member office area behind the work station.	
Staff observe youth at least every 15 minutes while they are in their sleeping room, either during the sleep period or at other times, such as during illness or room restriction	**Exception**	A review of the program's video camera surveillance system and electronic logbook was conducted to assess the agency's adherence to the requirements of this indicator. Video surveillance review was conducted for three separate randomly selected days. The reviewer selected five randomly selected days to conduct camera video coverage to determine if the agency completed bed check on residents according to the requirement of this indicator. A review of only three days out of the five were able to be assessed due to severe weather in the area which impacted the connectivity of the digital camera system. In observing three separate timeframes of video surveillance, staff consistently did not enforce program rules, maintain proper supervision of youth and utilize the program's behavior management system or redirect or engage youth to return to their rooms.	During video surveillance and logbook review for August 9, 2023, from 12am to 5am bed checks were not completed for the female side at 1:15am and 1:45am and staff failed to document check in the logbook. Video surveillance revealed that staff did not conduct a bed check at 2:45am, but staff documented in the logbook that a bed check was completed. At 12:15am a youth leaves the dorm and goes to the loft to sleep. At 12:22am staff checks on the youth in the loft and does not return to check on the youth until 5am. No bed checks were completed from 12:22am to 5am. Youth were awake and not in their beds and going in and out of each other's rooms and wandering around the dorm on and off from 12:15am until 2am. On September 29, 2023, video surveillance was reviewed from 12am until 3:30am and no bed checks were completed at 12:15am and 12:45am for both the male and female youth, but staff documented the bed checks were completed. At 1:30am and 2:16am no bed checks were conducted on the female side of the dorm, but staff documented in the logbook the checks were completed. Youth were observed going in and out of each other's rooms on the male side and several male youth left the dorm and went outside. Staff did not intervene or maintain supervision on the youth that left the building at 1:45am and the logbook documented the youth came back through the window of a youth's bedroom. The security of the physical structure does not ensure the security of the youth. The reviewer instructed the agency to report the falsified documentation of logbook entries on the overnight shift to the DJJ CCC.
Additional Comments: **There are no additional comments for this indicator.**			

3.07 - Video Surveillance System			Failed
Provider has a written policy and procedure that meets the requirement for Indicator 3.07		**YES**	
		If NO, explain here:	
		Agency has policy 5-14 Video Surveillance System. The overall agency policies were signed by the COO in September 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: Last 30-45 days of video camera footage and last six months of staffing schedules.
Staff Position(s) Interviewed: Residential Director and director care staff.
Type of Documentation(s) Reviewed: Video camera footage and staff schedule.

Surveillance System			
The agency, at a minimum, shall demonstrate: a. A written notice that is conspicuously posted on the premises for the purpose of security b. System can capture and retain video photographic images which must be stored for a minimum of 30 days c. System can record date, time, and location; maintain resolution that enables facial recognition d. Back-up capabilities consist of cameras' ability to operate during a power outage e. Have cameras placed in interior and exterior general locations of the shelter where youth and staff congregate and where visitors enter and exit. Cameras are never placed in bathrooms or sleeping quarters. f. All cameras are visible	**Exception**	During the tour it was observed that the program has a written notice that is posted around the campus for the purpose of security. The Program Director confirmed during video camera review that the video surveillance system can capture and retain photographic images stored for 6 months which does go above and beyond the 30 day minimum requirement. It was observed that the program's video surveillance system can record the date, time, location and has resolution that enables facial recognition. While conducting the video surveillance review the system went down twice preventing further video surveillance reviews. At the time of this onsite program review, the Cocoa area was experiencing major thunder and wind storms, as well as a Tornado warning being issued on the afternoon of day one. The agency reported to the review team severe storms can impact the agency's ability to view camera footage. During the tour of the program it was observed that cameras were placed in interior and exterior locations in the shelter were the youth and staff congregate and where visitors enter and exit. All cameras are visible and no cameras were observed in the youth's rooms or bathrooms.	At the time of this onsite program review, the agency camera did not have back up battery capabilities functioning as required in the event of a power outage.
A list of designated personnel who can access the video surveillance system is maintained (includes off-site capability per personnel)?	**Compliance**	The program maintains a list of staff members that can access the video surveillance system. The program does not have the capabilities for off-site camera reviews.	
Supervisory review of video is conducted a minimum of once every 14 days and timeframes reviewed are noted in the logbook.	**Exception**	A review of the agency's practice regarding video surveillance was conducted to determine the agency's adherence to this indicator. In reviewing the electronic logbook for supervisory review of the camera system every two weeks it was confirmed that reviews were not conducted consistently within the 2 week timeframe. The Program Director provided logbook documentation of supervisory reviews of the cameras that occurred on the following timeframes: 2/1/23-2/28/23, 3/11/23-4/11/23, 4/16/23-5/16/23, 5/17/23-5/25/23 and 5/26/23-6/6/23. The agency provided a list of staff members designated to access video surveillance system which included CEO, COO, Director of Counseling Services, Director of Juvenile Assessment Center and Shelter Director.	No supervisory reviews of the cameras were documented until 10/1/23-10/4/23. Of the supervisory reviews conducted it is unclear of the timeframes the reviews were conducted. Of these reviews, all supervisory reviews were for 3rd shift only and did not include a random sample from other work shifts.

The reviews assess the activities of the facility and include a review of random sample of overnight shifts	**Exception**	A review of five randomly selected dates were identified to determine the agency's adherence to the requirements of this indicator. Three of the five dates selected dates were reviewed to assess activities and general supervision and other practices completed by the agency on the overnight work shift. Two remaining dates were not able to viewed due to technical difficulties as a result of the bad weather.	Randomly selected dates to determine status of overnight supervision practice revealed that agency staff on the overnight work shift did not demonstrate proper supervision and interaction practices related to managing youth behavior and proper documentation of bed checks.
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 agency has a process for providing video camera footage by need to know parties. The agency is able to provide camera footage of specific areas of coverage when necessary for incidents, investigations or for general quality improvement efforts.	
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	**Exception**	The cameras were not functioning from October 5-10, 2023, and the Program Director was not made aware until he checked the cameras on October 10, 2023. The repairs were made the same day and the Program Director provided an email to support the dates the cameras were out and repairs were made.	The agency's cameras were inoperable for five days prior to any supervisor or staff member reporting the need for the cameras to be repaired. The agency does not have a process in place to detect and report malfunctioning of its camera system in a timely manner.
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: A policy is in place titled 3-17 Healthcare Admission Screening. The overall agency policies were signed by the COO in September 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: None. **Total number of Closed Files: Three closed residential client files.** **Staff Position(s) Interviewed: Residential Director and Case management staff.** **Type of Documentation(s) Reviewed: Closed residential client files.**			
Preliminary Healthcare Screening			
Screening includes : a. Current medications b. Existing (acute and chronic) medical conditions c. Allergies d. Recent injuries or illnesses e. Presence of pain or other physical distress f. Observation for evidence of illness, injury, physical distress, difficulty moving, etc. g. Observation for presence of scars, tattoos, or other skin markings h. Acute health symptoms requiring quarantine or isolation	**Compliance**	A total of five randomly selected open residential client files were reviewed to assess the agency's adherence to the requirements of this indicator. The review of these five files indicated that each contained evidence of a completed CINS/FINS Intake Screening completed on the day of intake. Two of the five youth were taking medications at the time of the admission according to the intake screening. Four out of five of the youth were admitted with chronic medical conditions. None of the five clients reported any recent injuries, presence of pain of their physical ailments or illness, injury, physical stress and scars, tattoos or skin markings. One client file indicated the youth had a documented allergy. None of the youth screened had a positive response to an acute health symptom 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.)	**Compliance**	A review of the five files admitted to the program resulted in none of these youth possessing a major health issues which required referral for medical treatment for a major chronic health condition.	
When needed, the parent is involved with the coordination and scheduling of follow-up medical appointments	**Compliance**	A review of the agency's policy related to follow up requirements when clients receive medical care was conducted. The current policy outlines specific steps that the agency is required to fulfill based on the medical issue. When applicable, the agency engages the parent or caregiver in the coordination of providing the youth the follow up medical appointment and care needed to address the condition(s).	
All medical referrals are documented on a daily log.	**Compliance**	When an event occurs with a medical related issue involving a youth, the agency has a practice which requires the agency to include documenting all medical referrals in a specific daily log.	
The program has a thorough referral process and a mechanism for necessary follow-up medical care as required and/or needed	**Compliance**	The program does have a policy in place for referring youth for necessary medical care, as well as medical care follow up. The agency also has a designated process to document these event in specific log and in the progress notes and medical related areas in each client file.	
Additional Comments: **There are no additional comments for this indicator.**			

4.02 - Suicide Prevention		**Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 4.02	**YES** If NO, explain here: The program has several policies relating to Suicide Prevention including the following: 4-12 Suicide Prevention; 4-13 Non-Residential Suicide Risk Screening; 4-14 Suicide Prevention Plan – Identification; 4-15 Suicide Prevention Plan - Risk Screening; 4-16 Suicide Prevention Plan – Assessment; 4-17 Suicide Prevention Plan - Suicide Precautions; 4-18 Suicide Prevention Plan – Discontinuation; and 4-19 Clinical Staff Direct Supervision The policies were reviewed September 2023 by the COO.	

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: Two open residential client files.
Total number of Closed (Residential & Community) Files: Three closed residential client files.
Staff Position(s) Interviewed: Licensed clinician and residential case management staff.
Type of Documentation(s) Reviewed: Residential client files.

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**	A review of five randomly selected closed residential client files was conducted to determine the agency's adherence to the requirements of this indicator. All five client files contained evidence of the intake screening which contained the official questions to assess past and current risk of suicide. A suicide risk screening form was completed during the screening and contained evidence of being reviewed and signed by a supervisor.	

The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	**Compliance**	The current suicide risk assessment tool used by the agency has not changed since the last onsite program review in November 2022.	
Supervision of Youth with Suicide			
Youth are placed on the appropriate level of supervision based on the results of the suicide risk assessment.	**Compliance**	All five client files had evidence that each client was screened and asked the risk screening questions and answered yes to at least one of the questions. As a result of being screened with the proper questions, all five youth were placed on sight-and-sound supervision until being able to be screened by the appropriate staff overseen by the agency's licensed clinician.	
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	**Exception**	A review of the elevated suicide observation checks for all five clients were completed as required for the duration the time the client was placed on elevated supervision. Staff assigned to monitor the youth consistently documented the youth's behavior at exactly thirty-minute intervals or less.	The agency's documented elevated supervision observation checks are written for every 30 minutes and not in real-time intervals of 30 minutes.
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**	All five clients file forms used for clients on elevated supervision have evidence of the time of the observation check, actual status of the client's behavior or state of being, initials of the staff member conducting the check and shift review and signature section which requires the supervisor to confirm with a signature that all checks have been completed. The agency utilizes a comprehensive observation check form to document all observation checks.	
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**	All five clients received an suicide assessment completed by the licensed clinician. All five clients assessments were completed within the required timeframe. All five clients were maintained on constant elevated supervision until the licensed professional was consulted and gave instructions to remove the client from constant supervision. None of the five clients were removed from elevated supervision status unless granted permission from the licensed clinician.	
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**	All five client files had evidence that each client's elevated supervision logs were reviewed and signed by the supervisor each work shift while on supervision status.	
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**	The agency did not have any eligible samples for review to assess the agency's adherence to this indicator.	

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**	The agency did not have any eligible samples for review to assess the agency's adherence to this indicator.	
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**	The agency did not have any eligible samples for review to assess the agency's adherence to this indicator.	
If the parent/guardian cannot be contacted, all efforts to contact them are documented in the case file.	**No eligible items for review**	The agency did not have any eligible samples for review to assess the agency's adherence to this indicator.	
When the screening was completed during school hours on school property, the appropriate school authorities were notified.	**No eligible items for review**	The agency did not have any eligible samples for review to assess the agency's adherence to this indicator.	
Additional Comments: **There are no additional comments for this indicator.**			
4.03 - Medications			**Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 4.03		**YES** If NO, explain here: The program has several policies relating to Medication including the following: 4-6 Medication Verification at Admission & Consent; 4-7 Medication Storage, Access, Inventories & Disposal; and 4-8 Medication Supervision & Monitoring. The policies were reviewed September 2023 by the COO.	

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 open residential client files.
Total number of Closed Files: Two closed residential client files.
Staff Position(s) Interviewed: Registered nurse and Residential Director.
Type of Documentation(s) Reviewed: Medication distribution log, client files with medication related documentation.
Describe any Observations: Witnessed onsite medication distribution to clients on day 2 of program review.

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 a Registered Nurse (RN). The RN's credentials were confirmed and she was interviewed onsite about the status of the agency's medication practice and all job duties and responsibilities regarding training and review of practice of all non-licensed staff members assisting in the delivery of medications to youth.	
Medication Storage			
a. All medications are stored in a Pyxis ES Medication Cabinet that is inaccessible to youth (when unaccompanied by authorized staff) b. Pyxis machine is stored in accordance with guidelines in FS 499.0121 and policy section in Medication Management c. Oral medications are stored separately from injectable epi-pen and topical medications d. Medications requiring refrigeration are stored in a secure refrigerator that is used only for this purpose, at temperature range 2-8 degrees C or 36-46 degrees F. (If the refrigerator is not secure, the room is secure and inaccessible to youth.) e. Narcotics and controlled medications are stored in the Pyxis ES Station f. Pyxis keys with the following labels are accessible to staff in the event they need to access medications if there is a Pyxis malfunction: a TOP COVER b BACK PANEL- LEFT TALL CABINET LOCK- LEFT, c BACK PANEL- RIGHT TALL CABINET LOCK- RIGHT	**Compliance**	Oral medications, controlled medications, and narcotics are stored separately from injectables epi-pens and topical medications in the required Pyxis medication cabinet. The Pyxis machine is located in a locked room adjacent to the direct care staff work desk and is not accessible to youth. The agency has a refrigerator stored in the medication distribution room for medication requiring refrigeration. All oral medications are stored separately from topical medications located in the locked medical cabinet. All narcotic and controlled medications are stored in the Pyxis Med-Station medication cabinet. Keys to the Pyxis medication station are accessible to the staff in case on potential power loss or malfunctioning of the medication cabinet.	

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 conducted by the nurse f. The delivery process of medications is consistent with the FNYFS Medication Management and Distribution Policy g. Agency does not accept youth currently prescribed injectable medications, except for epi-pens h. Non-licensed staff have received training in the use of epi-pens provided by a registered nurse	**Compliance**	The agency provided a User's list that includes the names of all staff designated to assist in the delivery of medication to clients admitted to the program requiring medication during their shelter stay. The agency meets the minimum number of two Super users trained for the use of the Pyxis medication cabinet and several additional designated staff members. Five randomly selected client files of which were prescribed medications were reviewed. All five youth had evidence that each was on a regular prescribed or a controlled medication. The agency utilizes the medication cabinet to secure and keep inventory of all medications and a paper medication distribution log was used to document medication delivery to the five youth by licensed and non-licensed staff. The reviewer verified through interview with the RN that medication distribution is also conducted by the nurse when she is on duty. In all four records the medication delivery process was consistent with the FNYFS medication management and distribution policy. The agency does not accept youth currently prescribed injectable medications, except for epi-pens. No youth were prescribed injectables as required and staff received the required training on how to use an epi-pen.	
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**	The agency provided a copy of the medication distribution log (MDL) currently in use at the shelter. The current distribution log allows the agency to document the following categories: medication, dosage directions, type of medication (oral, topical, inhalant, etc.), spaces for daily counts for a 30 day period, youth name and initials, and staff name and initials. All five client medication distribution logs were reviewed to assess the agency's degree of accuracy and completion of the MDL. Each MDL had evidence of the time of the medication distribution, both the youth receiving the file and the initials of the staff person assisting in the delivery of each medication distribution session.	
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 member of the review team assessed all medication delivery times and documents of youth on medication during the onsite program review. At the time of this onsite programs review, all medication required to be provided to clients was delivered as required within one hour of prescribed time or at the scheduled time of delivery. A member of the review team witnessed the morning medication distribution session on day two of the onsite program review. The reviewer did not observe any deficiencies or abnormalities during the medication distribution session.	
During the review period, there were no instances where youth missed their medication due to failure to open the pyxis machine.	**Exception**	The reviewer assigned to the indicator accounted for all medication delivery session and did not witness any client missing their medication due to failure to access the Pyxis medication cabinet. A review of the medication distribution logs of five clients was conducted to assess for accuracy, timeliness and completeness.	A review of the medication distribution log was conducted and found on one occasion that the client's medication regimen required three doses be given to the client per day and only two were documented as given.

Medication Inventory			
a. For controlled substances, a perpetual inventory with running balances is maintained as well as a shift-to shift count verified by a witness and documented b. Over-the-counter medications that are accessed regularly are inventoried weekly by maintaining a perpetual inventory c. Syringes and sharps (needles, scissors, etc.) are secured, and counted and documented weekly	**Exception**	The agency provided all inventory documents associated with shift to shift counts of prescribed medications, over the counter medications, and sharps. The agency conducts counts of all prescribed medications as required. The agency conducts weekly counts of all medication on a shift to shift basis. The agency maintains all over the counter medication and sharps and maintains these counts on a weekly basis.	A daily pill count for one pill a day does not include documented evidence of the agency count for the 75th pill. The count goes from 76 to 74. This discrepancy was reported to the agency. At the time of the program review, the agency did not have an explanation for the cause of the discrepancy.
There are monthly reviews of the Pyxis reports to monitor medication management practice.	**Compliance**	The agency has access to Pyxis reports and produces general reports on a monthly basis. The agency also produces other reports from Pyxis on an as needed basis.	
Medication discrepancies are cleared after each shift.	**Compliance**	A review of the current practice to review and assess medication discrepancies found all discrepancies are required to be cleared by all staff utilizing the medication cabinet at prior to the end of each work shift. An interview of the agency's protocol for monitoring and clearing discrepancies was conducted with the RN. At the time of this program review, the agency did not have any discrepancies.	
The agency has an internal quality assurance process to ensure appropriate medication management and distribution methods.	**Compliance**	The agency has a process to review its medication distribution practice. The agency's RN and Residential Director reviews medication distribution sessions for accuracy, timeliness and full completion of all documents.	
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: Agency has policy 4-11 Medical and Mental Health Alert Processes. The overall agency policies were signed by the COO in September 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: Four open residential client files
Total number of Closed Files: Four closed residential client files
Staff Position(s) Interviewed: Direct care staff.
Type of Documentation(s) Reviewed: General alert policy and general system used in youth shelter.
Describe any Observations: General alert board.

Youth with a medical, mental health, or food allergy was appropriately placed on the program's alert system	**Compliance**	A total of eight client files were reviewed. Of these files, 4 were open and four were closed residential client files. All eight youth required an alert for a medical or mental health conditions, or a food allergy. Each client file contained evidence of alerts and each was completed and documented in the client's file per requirements of the agency's policy.	

Alert system includes precautions concerning prescribed medications, medical/mental health conditions	**Compliance**	The agency's general alert system included precautions concerning prescribed medications on four of the four applicable youth taking medications. The alert system included precautions for youth with mental health conditions or being placed on sight and sound supervision for all five youth. The alert system included precautions concerning prescribed medications on four of the four applicable youth taking medications. The alert system included precautions for youth with mental health conditions or being placed on sight and sound supervision for all five youth.	
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 provides staff members with trainings for medical and mental health alert systems and the need for emergency care for medical/mental health problems to all staff members. The reviewer verified that the agency provides medical and mental health, first aid and various medical and injury related mock exercises.	
A medical and mental health alert system is in place that ensures information concerning a youth's medical condition, allergies, common side effects of prescribed medications, foods and medications that are contraindicated, or other pertinent mental health treatment information, is communicated to all staff	**Compliance**	The program uses a general alert system and board to communicate the current alert status of each client. The program utilizes a color-coded alert notification system. Each alert has designated colors that represents a status of the youth's conditions. Yellow is for suicide of elevated supervision; Red is for medication/medical; Green is for allergies; Orange is for mental health; Blue is for continuous sight and sound; Purple is for physical aggression; Black is for staff secure. An assessment is completed on each clients and as a result of the assessment, a color-coded sticker is placed on the client's file and on the program's alert board to inform staff of the alerts status of each client. The alerts are also logged in the logbook and it is documented that each staff reviews the logbook prior to starting each work shift.	
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	**NO**		
	If NO, explain here: Upon observation and review, the written policy does not indicate that the incident report must be completed and reported to the CCC and the Florida Network. Additionally, the written policy did not indicate implementation of a daily log, upon return to the shelter, verification of receipt of medical clearance, discharge instructions. Policy was revised by the COO before the completion of this audit.		
	Policy #4-9, Episodic / Emergency Care was effective November 1, 2004 and last revised August 2014. The policy is signed by a designee with no review date indicated for this policy.		
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: Three closed files.** **Staff Position(s) Interviewed: Direct Care staff.** **Type of Documentation(s) Reviewed: Program documentation**			
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**	The program's written policy addresses the following mandatory components: obtaining off-site emergency services; Parental notification requirements. The written policy indicates that an incident report must be completed and reported. The policy stated the episode would be in the youth's case file and the shelter log book. Plans for future treatment (follow-up) is also addressed in policy. Upon observation of the program's practice, evidence of verification of receipt of medical clearance, discharge instructions and follow-up care was witnessed in three youth records. There was also indication of notice to parents and reports to both the DJJ CCC and Florida Network. A review of the electronic log book showed proof of daily entries of the number of incidents occurring per shift. All three youth files reviewed for episodic care were compliant in evidence of practice in the: progress notes, agency's emergency medical/dental care log, incident reports, CCC reports, youth records, and electronic log books.	
All staff are trained on emergency medical procedures	**Compliance**	Agency policy states that all staff are trained in administration of CPR. Three of three staff files reviewed had current CPR certifications.	
The program has a Knife-for-life and wire cutters accessible to staff in a secure location(s)	**Compliance**	During a tour of the facility the program has 2 different knife for life devices along with wire cutters were observed in a cabinet inside the control room centrally located between the male and female dorms.	
First aid kit/supplies are fully equipped and inventoried	**Compliance**	First aid kits and supplies are stored in the control room centrally located between both male and females dorm rooms. The agency's RN is responsible for conducting an inventory and replenishment of first aid kits in the youth shelter and transportation vehicles. At the time of this program review, all first aid kits are fully equipped and inventoried.	
Additional Comments: **There are no additional comments for this indicator.**			