Florida Network for Youth and Family Services
Compliance Monitoring Report for

Hillsborough County – Children's Services Department

3110 Clay Mangum Lane
Tampa, Florida 33618

December 13-14, 2023

Compliance Monitoring Services Provided by

FOREFRONT

EXECUTIVE SUMMARY

On December 13-14, 2023, Forefront LLC conducted a joint Modified Quality Improvement (QI) and Florida Network of Youth and Family Services (FNYFS) compliance monitoring visit for Hillsborough County Children's Services Department (HCCS) for the FY 2023-2024 at its program office located at 3110 Clay Mangum Lane, Tampa, Florida 33618. 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 for July 1, 2023 through June 30, 2024.

The review was conducted by Keith Carr, Lead Reviewer/Consultant for Forefront LLC and assigned Peer Reviewers. Agency representatives from Hillsborough County Government Children's Services Department included Patrick Minzie, Director; Sarah Grimmig, Residential Services Operations Manager; Kayrinah Hunter, Clinical Manager; Doris Gillette, Senior Program Coordinator; Nasheika Martin, Quality Assurance Manager; Julie Edison, Manager (Residential Services/Training); David Gray, Senior Training Specialist and additional Hillsborough County Children's Services Department staff members were present for the entrance interview. The last QI visit was conducted October 19-20, 2022.

In general, the Reviewer found the Hillsborough County Children's Services to be in compliance with specific contract requirements. Athe Hillsborough County Children's Services Department received an overall **compliance rating of 100% for achieving full compliance on 13 applicable indicators** of the CINS/FINS Monitoring Tool. There were no corrective actions as a result of the monitoring visit.

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

2023-2024 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM-12-13-14-2023

Agency Name: Hillsborough County Children's Services Department	**Monitor Name: Keith Carr, Lead/Consultant Forefront**
Contract Type : CINS/FINS	**Region/Office: 3110 Clay Mangum Lane, Tampa, FL 33618**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): December 13-14, 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 exceeds the minimum of two required staff members that have been trained as Certified QI Peer Reviewers. At the time of this onsite program review, the agency has more than four Certified QI Peer Reviewers.	
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 additional funding/contracts outside of FNYFS funding which includes Children's Network of Hillsborough County – Emergency Shelter and National School Lunch Program.	
Limits of Coverage a. Provider shall provide and maintain during this contract, the following minimum kinds of insurance: Worker's Compensation and Employer's liability insurance as required by Chapter 440, F.S. with a minimum of $100,000 per accident, $100,000 per person and $500,000 policy aggregate. Commercial General Liability	☐	☐	☒	☐	☐	Documentation: Management Budget - Certificate of Self-Insurance. Hillsborough County Government has elected to self-insure for General Liability, Automobile Liability, Workers' Compensation, and certain Property	

2023-2024 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM-12-13-14-2023

Agency Name: Hillsborough County Children's Services Department	**Monitor Name: Keith Carr, Lead/Consultant Forefront**
Contract Type : CINS/FINS	**Region/Office: 3110 Clay Mangum Lane, Tampa, FL 33618**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): December 13-14, 2023**

Major Programmatic Requirements	**Explain Rating**					**Ratings Based Upon:** **I = Interview** **O = Observation** **D = Documentation** **PTV = Submitted Prior To Visit** **(List Who and What)**	**Notes** **Explain Unacceptable or Conditionally Acceptable:**
	Unacceptable	**Conditionally Unacceptable**	**Fully Met**	**Exceeded**	**Not Applicable**		
with a limit of $500,000 per occurrence, and $1,000,000 policy aggregate. Automobile Liability Insurance shall be required and shall provide bodily injury and property damage liability covering the operation of all vehicles used in conjunction with performance of this contract, with a minimum limit for bodily injury of $250,000 per person; with a minimum limit for bodily injury of $500,000 per accident; with a minimum limit for property damage of $100,000 per accident and with a minimum limit for medical payments or $5,000-$10,000 per person. Florida Network is listed as payee or co-payee. **PTV**						losses. This means that instead of purchasing commercial insurance policies, the County has budgeted funding to pay claims and recognize sufficient reserves for future claims. General Liability coverage and Automobile Liability coverage is authorized under FS 768.28. Under this statute, the County's Tort liability sovereign immunity has been waived to the following extent: $100,000 per person and $300,000 per occurrence. Workers' Compensation coverage is authorized under FS 440.38(6) and Hillsborough County is a qualified self-insurer. Damage and losses to County owned vehicles, equipment, and uninsured property is paid from the self-insurance fund when properly reported and documented. Date of coverage: October 1, 2020 until cancelled (continuous coverage).	

2023-2024 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM-12-13-14-2023

Agency Name: Hillsborough County Children's Services Department	**Monitor Name: Keith Carr, Lead/Consultant Forefront**
Contract Type : CINS/FINS	**Region/Office: 3110 Clay Mangum Lane, Tampa, FL 33618**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): December 13-14, 2023**

Major Programmatic Requirements	**Explain Rating**					**Ratings Based Upon:** **I = Interview** **O = Observation** **D = Documentation** **PTV = Submitted Prior To Visit** **(List Who and What)**	**Notes** **Explain Unacceptable or Conditionally Acceptable:**
	Unacceptable	**Conditionally Unacceptable**	**Fully Met**	**Exceeded**	**Not Applicable**		
External/Outside Contract Compliance a. Provider has corrective action item(s) cited by an external funding source (Fiscal or Non-Fiscal). **ON SITE**	☐	☐	☒	☐	☐	Interview: During the Entrance Conference, the Agency reported no outstanding corrective action item(s) cited by an external funding source.	
Fiscal Practice a. Agency must have employee and fiscal policy/procedures manuals that are in compliance with GAAP and provide sound internal controls. Agency maintains fiscal files that are audit ready. **PTV**	☐	☐	☒	☐	☐	Documentation: Documentation: Hillsborough County Clerk of the Circuit Court, BOCC Accounting Department, dated July 2004. The agency reported this is the most updated policy manual. Fiscal Policies and Procedures are issued and maintained by the Accounting Department. The procedures reviewed appear to be consistent with GAAP and provide for limited internal controls. Procedures are included for: cash collection and accounting; check disbursement; receipting system; bank deposits; collection security; armored car service; credit card services; electronic payments; escrow deposits; tax collection; and other general	

2023-2024 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM-12-13-14-2023

Agency Name: Hillsborough County Children's Services Department	**Monitor Name: Keith Carr, Lead/Consultant Forefront**
Contract Type : CINS/FINS	**Region/Office: 3110 Clay Mangum Lane, Tampa, FL 33618**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): December 13-14, 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:
						accounting procedures.	
b. Agency maintains a general ledger and the corresponding source documents. A general ledger must be set up to track the activity of the grant separately (standard account numbers / separate funds for each revenue source, etc.). **PTV**	☐	☐	☒	☐	☐	Documentation: Detailed General Ledger (GL) for the current FY 2023-2024 from July 2023 – November 2023 was provided. The ledger includes financial activities for the CINS/FINS program (13316) separately. The general ledger is structured to track all funding sources as well as activities for the CINS/FINS program. The GL includes the following items: Accounting Period, Ledger or Ledger Set. Fund, Center, Account, Sub Account, Activity, and Project Future.	
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: Reviewed Board Policy and Procedure 2.17 which was approved by the county Board of Commissioners on April 1, 2019. Per the Residential Services Operations Manager, the program does not have a petty cash fund for CINS/FINS. The agency utilizes Purchase cards for all	

2023-2024 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM-12-13-14-2023

Agency Name: Hillsborough County Children's Services Department	**Monitor Name: Keith Carr, Lead/Consultant Forefront**
Contract Type : CINS/FINS	**Region/Office: 3110 Clay Mangum Lane, Tampa, FL 33618**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): December 13-14, 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:
						authorized supervisors to make approved purchased related to Residential program services and activities.	
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 provided requested information bank statements from July–2023 – November 2023 for agency's Wells Fargo bank account. The program has access to the account. Financial records and reports are maintained offsite by Hillsborough County Clerk of the Court. The County Fiscal Officer completes bank reconciliation process. The Department Director approves all major purchases and the Business Manager monitors all major fiscal transactions.	
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 reported it has not purchased any capital equipment items with FNYFS funds.	

2023-2024 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM-12-13-14-2023

Agency Name: Hillsborough County Children's Services Department	**Monitor Name: Keith Carr, Lead/Consultant Forefront**
Contract Type : CINS/FINS	**Region/Office: 3110 Clay Mangum Lane, Tampa, FL 33618**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): December 13-14, 2023**

Major Programmatic Requirements	**Explain Rating**					**Ratings Based Upon:** **I = Interview** **O = Observation** **D = Documentation** **PTV = Submitted Prior To Visit** **(List Who and What)**	**Notes** **Explain Unacceptable or Conditionally Acceptable:**
	Unacceptable	**Conditionally Unacceptable**	**Fully Met**	**Exceeded**	**Not Applicable**		
f. Agency submits payroll taxes and deposits (and retirement deposits as applicable), Employee IRS Form W-2 and Independent Contractors IRS Form 1099 forms prior to federal requirements. **ON SITE**	☐	☐	☒	☐	☐	Documentation: The agency provided copies of 941s for the third quarters of 2023 from the EFTPS, of payroll taxes being paid. Agency fourth quarter payroll taxes are scheduled to be submitted December 31, 2023. No balances were noted as due on the quarterly reports.	
g. Budget to actual reports prepared and reviewed by appropriate management. Variance from the budget are investigated and explained. **PTV/ON SITE**	☐	☐	☒	☐	☐	Documentation: Agency provided a Revenue and Expenditures statement, as of July 2023 through November 2023, with budget to actual comparison for the current FY 2023-2024. A review of Budget versus Actuals Summary and Budget versus Actuals Detail documents for the aforementioned period was conducted. The Budget versus Actuals form captures Revenue/Expenditures, Fund, Fund Description, Character, Character Description, Current FY Budget, Commitments, Obligations, Current FY	

2023-2024 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM-12-13-14-2023

Agency Name: Hillsborough County Children's Services Department	**Monitor Name: Keith Carr, Lead/Consultant Forefront**
Contract Type : CINS/FINS	**Region/Office: 3110 Clay Mangum Lane, Tampa, FL 33618**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): December 13-14, 2023**

Major Programmatic Requirements	**Explain Rating**					**Ratings Based Upon:** **I = Interview** **O = Observation** **D = Documentation** **PTV = Submitted Prior To Visit** **(List Who and What)**	**Notes** **Explain Unacceptable or Conditionally Acceptable:**
	Unacceptable	**Conditionally Unacceptable**	**Fully Met**	**Exceeded**	**Not Applicable**		
						Actuals, Remaining Balance, % of Budget Spent. The report tracks the overall budget variances for the CINS/FINS program. Per the Program Director, the agency reconciles variances monthly. Invoices are submitted to the fiscal department monthly with supporting documentation.	
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 provided the FNYFS a copy of the most recent electronic copy of the audit prepared by the County Finance Department and audited by RSM US LLP 4/30/2020 for the fiscal year ended September 30, 2022.	
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	☐	☐	☒	☐	☐	Documentation: Review of the following policies and procedures: Information Management policy 1.20, effective 11/1/2019 and Storing/Disposition of Client Records, policy 4.37, effective 8/1/2018. All	

2023-2024 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM-12-13-14-2023

Agency Name: Hillsborough County Children's Services Department	**Monitor Name: Keith Carr, Lead/Consultant Forefront**
Contract Type : CINS/FINS	**Region/Office: 3110 Clay Mangum Lane, Tampa, FL 33618**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): December 13-14, 2023**

Major Programmatic Requirements	**Explain Rating**					**Ratings Based Upon:** **I = Interview** **O = Observation** **D = Documentation** **PTV = Submitted Prior To Visit** **(List Who and What)**	**Notes** **Explain Unacceptable or Conditionally Acceptable:**
	Unacceptable	**Conditionally Unacceptable**	**Fully Met**	**Exceeded**	**Not Applicable**		
documents are shredded and computer hard drives are wiped prior to discarding. **PTV**						policies are related to security and privacy of data and maintenance of a backup system in case of accidental power loss.	
j. Agency provided evidence that every direct care staff employee, as of October 1, 2023, is being paid at least $19.00 per hour. This also includes funding for additional staff as approved by the Department. **ON SITE**	☐	☐	☒	☐	☐	Documentation: The agency provided documentation of personnel action statements with information pertaining to minimum salary paid to direct care staff members. Documentation contains evidence of staff member compensated at minimum of $19 per hour.	

2023-2024 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM-12-13-14-2023

CONCLUSION

One of the fourteen total Administrative and Fiscal Contract Compliance Monitoring indicators, one indicator is not applicable due to the agency not purchasing property with FNYFS funds. Hillsborough County has met the requirements for the CINS/FINS contract compliance with 13 applicable indicators of the Administrative and Fiscal Contract Monitoring Tool. As a result, the **overall compliance rate for this contract monitoring visit is 100%.** There are no corrective actions cited. The agency is performing satisfactorily in meeting the fiscal and administrative terms of its contract. In addition, the majority of indicators reviewed were carried out in a manner which meets the compliance standard described in the report's findings.

SUMMARY OF RECOMMENDATIONS

None.

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

Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Hillsborough County Children's Services (Tampa)
CINS/FINS Program

December 13-14, 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	Satisfactory
1.03 Incident Reporting	Satisfactory
1.04 Training Requirements	Satisfactory
1.05 Analyzing and Reporting Information	Satisfactory
1.06 Client Transportation	Limited
1.07 Outreach Services	Satisfactory

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

Standard 2: Intervention and Case Management

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

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

Standard 3: Shelter Care & Special Populations

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

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

Standard 4: Mental Health/Health Services

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

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

Overall Rating Summary

Percent of indicators rated Satisfactory: 89.66 %
Percent of indicators rated Limited: 3.45 %
Percent of indicators rated Failed: 3.45 %

Rating Definitions

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

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

Reviewers

Members

Keith Carr, Lead Reviewer Consultant-Forefront LLC/Florida Network of Youth and Family Services
Alexis Sapp, Regional Monitor, Department of Juvenile Justice
Kelley Scott MCJ, Program Director, Youth and Family Alternatives
Mark Shearon, Chief Operations Officer, Arnette House
Shelley Gress, Residential Supervisor, Youth and Family Services - GWH

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		Nurse – Part time
	Chief Operating Officer		Advocate	2	# Case Managers
	Executive Director	X	Direct – Care Full time	1	# Program Supervisors
X	Program Director		Direct – Part time	1	# Food Service Personnel
	Program Manager		Direct – Care On-Call		# Healthcare Staff
	Program Coordinator		Intern		# Maintenance Personnel
X	Clinical Director		Volunteer	5	# Other (listed counselor, admin assistant, direct care staff
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	11	# 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	6	# Youth Records (Closed)
X	Egress Plans	X	Program Schedules	10	# Youth Records (Open)
X	Fire Inspection Report		List of Supplemental Contracts		# Other: ___
	Exposure Control Plan	X	Vehicle Inspection Reports		

Observations During Review

	Intake	X	Posting of Abuse Hotline	X	Staff Supervision of Youth
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

4	# of Youth	19	# 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 as Hillsborough County government service provider. 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

Hillsborough County Children Services Department (HCCS) is a Hillsborough County operated human services unit of the County which delivers services to children, young adults, and families. The HCCS agency provides services which includes Children in Need of Services/Families in Need of Services (CINS/FINS); Child Care; Case Management & Case Staffing; Safe Place; and Residential Group Care in Circuit 13. The CINS/FINS program focuses on providing services to runaway and ungovernable, truant and homeless children and their families. Further, the program offers individual, group and family counseling services to reunite families and prevent runaway behavior, as well as short-term residential respite and shelter stays. The HCCS agency provides Emergency Shelter care which is targeted for dependent, abused, or neglected children. The agency also provides training classes for parents to improve their parenting skills. The target population served by the agency includes community youth 10-17 years of age for Residential and youth 6-17 years of age for Community Based Counselling. The agency also provides services to special populations who meet the criteria for Staff Secure Shelter services, Domestic Minor Sex Trafficking and youth referred by the Juvenile Justice Court System. The agency also provides Domestic Violence Civil Citation, Probation Respite, and Intensive Case Management. HCCS is currently accredited by the Council of Accreditation (COA) effective through June 2025.

The following programmatic updates were provided by the agency:

The management structure of the HCCS program includes a Director, a Residential Services Operations Manager, a Clinical Services Program, a Prevention and Diversion Program Manager, a Quality Assurance Manager, and a Business Services Manager. Residential and Non-Residential staff member include two Tier 2 Treatment Counselors, eight Tier 1 Treatment Counselors, our Case Manager Positions, two Senior Program Coordinators, two Human Services Supervisors, on Residential Services Coordinator, 16 Tier 2 Youth Care Specialists, and 5 Tier 1 Youth Care Specialists. The agency reported staff vacancies which included – Residential Services Coordinator (1), Youth Care Specialist – Tier 2 (Intake Specialist) (2), Youth Care Specialist – Tier 2 (2), Youth Care Specialist (Tier1) (9), Registered Nurse (2), Case Manager – Tier 2 (1), Treatment Counselor (1), and Youth Care Specialist – Tier 1 Part Time (4).

The agency reported some internal changes in the Department. The Clinical Manager resigned and this position was filled by a new Clinical Manager which was an outside hire. The Child Care Licensing Manager position was reclassified to a Community Relations Coordinator position. The staffing and program services contract and infrastructure for the Child Care Licensing Division was transitioned and returned back to the Florida Department of Children and Families in July 2023.

The agency reported current positions with licensing credentials which include a Clinical Manager (1 LMHC), Treatment Counselors (3 LMHC and 4 LCSW). The agency also has two vacant nursing positions. There is currently Registered Nurse and Licensed Practical Nurse (LPN). The agency is actively in process of filling all vacant positions.

The agency provided an update on the current service delivery practice models in use (Groups, Virtual, Office, or in-home service provision). The agency reported the service provisions continue to be dynamic to meet the needs of the community. Groups counseling sessions are offered in shelter, and in the community. Virtual visits are offered when preferred by families, and in-home services are working with our intensive case management clients.

The agency reported they utilize client files in multiple formats. The agency uses paper methods to service Residential clients and electronic to service Community Based Counselling clients. The agency reported providing additional non-CINS activities to further enhance services to clients in their CINS/FINS programs. The agency continues to work with the Hillsborough County Collaborative to support Wrap-Around services with in-home Family Functional Therapy opportunities for clients. The agency also collaborates with other community partners to support stabilization of youth and families to remain together.

Narrative Summary

The Hillsborough County Department of Children's Services provides both Residential and Non-Residential CINS/FINS services for youth and their families in Hillsborough County, Florida. The program located at 3110 Clay Mangum Lane, Tampa, Florida is under the leadership of Hillsborough County Government. The Department Director oversees the residential and non-residential components of the program, including the volunteer and outreach initiatives. The shelter is licensed for 22 beds by the Department of Children and Families effective through August 2024. The agency's administrative offices and youth shelters are housed in the buildings located on a beautiful, large campus.

The agency does not utilize policy numbers, only titles. HCCS department policies and procedures will be reviewed at a minimum of every three years and modified as needed. HCCS Program Managers or their designees are responsible for reviewing, updating, or establishing policies under their area(s) of responsibility. The Program Manager or designee works with their QI workgroup to prepare a draft of the new or revised procedure. The updated policy is then submitted to the QI Committee Chair who forwards the draft policy to legal for review. If the legal review is completed and no edits are required, the QIC Chair completes the bottom section of the Revised Procedures Coversheet and forwards the policy and coversheet to the Department Director for approval.

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 **Satisfactory with Exceptions**, Indicator 1.03 Incident Reporting was rated **Satisfactory**, Indicator 1.04 Training Requirements was rated **Satisfactory with Exceptions**, Indicator 1.05 Analyzing and Reporting Information was rated **Satisfactory with Exceptions**, Indicator 1.06 Client Transportation was rated **Limited**, 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**, Indicator 2.02 Needs Assessment was rated **Satisfactory with Exceptions**, Indicator 2.03 Case/Service Plan was rated **Satisfactory with Exceptions**, 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 **Not Applicable**, Indicator 2.07 Youth Records was rated **Satisfactory**, Indicator 2.08 Specialized Additional Program Services was rated **Satisfactory**, and Indicator 2.09 Stop Now and Plan (SNAP) was rated **Not Applicable**.

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

Standard 4: There are five indicators for Standard 4. Indicator 4.01 Healthcare Admission Screening was rated **Satisfactory**, Indicator 4.02 was rated **Satisfactory**, Indicator 4.03 was rated **Failed**, 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 1.06 Transportation - **Limited**
There were three drivers currently on the list that no longer have valid driving licenses.

There is no time stamp showing the pre-approval was completed prior to the transport. There is no documentation in the logbook showing the time the logbook was pre-authorized.

The transportation forms reviewed do not consistently document vehicle start and end mileage.

Standard 4:
Indicator 4.03 Medication - **Failed**
The facility has not had a licensed Registered Nurse (RN) since 2021.

The delivery process was not in compliance with the FNYFS medication distribution policy. Staff members were observed pre-pouring medications and transporting them unsecured to the youth in their respective cottages on day one of the program review. Once the youth received the medication, the staff member did not require the youth to sign the medication distribution log to confirm they received he medication. The aforementioned medication distribution process witnessed by the reviewer is contrary to the agency's own policy.

A review of the medication distribution log indicated the youth had not been signing they received their medication in the six months reviewed.

There is no evidence of a documented perpetual inventory for over the counter medications. The facility only uses the Pyxis medication cabinet count to manage the number of medications counted. There had not been an official sharp count maintained until November of 2023 since the nurse left in 2021.

CINS/FINS QUALITY IMPROVEMENT TOOL

Quality Improvement Indicators and Results: Please select the appropriate outcome for each indicator for each item within the indicator.	**Summary/Narrative Findings:** (Column C) Narrative guidelines: The narrative write-up is a thorough summary of each assigned QI indicator worksheet, explain how you came to your finding(s).	**Deficiencies/Exceptions:** (Column D) Please add additional detailed explanations for any items that have any deficiencies or exceptions.
Standard One – Management Accountability		
1.01: Background Screening of Employees, Contractors and Volunteers		**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 1.01	**YES** If NO, explain here: The agency does not utilize policy numbers, only titles. The agency has a policy titled Employee Screenings. The entire policy manual was last reviewed and approved by the Children's Services Director on October 1, 2021. Department policies/procedures will be reviewed every three years and modified as needed.	
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: 11 **Total number of 5 Year Re-screen Employee Files:** **Staff Position(s) Interviewed** *(No Staff Names)* **:** **Type of Documentation(s) Reviewed:** **Describe any Observations: See indicator findings.**		
All positions providing direct services to youth has successfully passed pre-employment suitability assessment on the initial attempt.	**Exception**	The staff member roster was reviewed and indicated four employees were eligible for the completion of a pre-employment assessment. Two staff members completed and passed the assessment as required. One staff member did not complete the assessment. The Administrative Specialist over personnel compliance for the program reported this staff did not complete the assessment due to Youth Care Specialists completing the assessment, and this staff member was a Treatment Counselor. However, this staff member still has extensive youth contact in their daily work activities and should have completed an assessment. The remaining staff member scored low on the pre-employment suitability assessment, however, there was a memorandum of justification regarding the decision to hire this staff.	There is no evidence of documentation of one Treatment Counselor staff member completing the pre-employment suitability assessment.

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**	Six staff member files were reviewed for pre-employment assessments, and four were applicable for completion of a pre-employment assessment. Of the files reviewed, one staff member did not receive a passing score on the pre-employment assessment. The program provided a memorandum of justification explaining the reasoning for selecting this staff member. This staff member was hired before this policy took effect and the staff member was not applicable for mandatory retake of 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 it has not had any staff member re-hired in less than 18 months or who have had a break in services of 18 months or more.	
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**	The staff member roster was reviewed and indicated six staff members and five interns were eligible for initial background screen during the review period. Six employee files and five intern files were reviewed for background screening completion prior to start hire date. All employees and interns received an eligible background screen prior to hire date.	
Five-year re-screening is completed every 5 years from initial date of hire or prior to retained fingerprints expiration date.	**Compliance**	The staff member roster was reviewed and indicated nine staff members were eligible for a five year re-screen during the annual compliance review period.	
Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?	**Compliance**	The Annual Affidavit of Compliance with Level 2 Screening Standard was completed and sent to the Background Screening Unit by January 31st.	
Proof of E-Verify for all new employees obtained from the Department of Homeland Security	**Compliance**	The staff member roster was reviewed and indicated six new staff members were eligible for E-Verify during the review period. All six staff member files contained proof of E-Verify from the Department of Homeland Security.	
Additional Comments: **There are no additional comments for this indicator.**			
1.02: Provision of an Abuse Free Environment			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 1.02		**YES**	
		If NO, explain here:	
		The agency does not utilize policy numbers, only titles. The agency has a policy titled Reporting Criminal Behavior, Child Abuse, or Neglect. The entire policy manual was last reviewed and approved by the Children's Services Director on October 1, 2021. Department policies/procedures will be reviewed every three years and modified as needed.	

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 and service delivery staff.** **Type of Documentation(s) Reviewed: Policy and procedure and** **Describe any Observations: Program orientation policy and youth interviews.**			
Agency has a code of conduct of policy and there is evidence that staff are aware of agency's code of conduct.	**Exception**	The agency's policies and procedures were reviewed. The agency's policy states it will be the responsibility of staff members to conduct themselves in a manner to model the behaviors expected of clients. The policy prohibits the use of physical abuse, threats, profanity, or intimidation. None of the youth surveyed reported hearing adults use curse words when speaking with youth.	Two staff surveys reported use of profanity by staff members in front of youth. No staff member was personally identified.
The agency has a process in place for reporting and documenting child abuse hotline calls.	**Compliance**	The Operations Manager for the program reported abuse calls are documented in the individual youth records. There is no collective location where all calls for the program are documented, and therefore, it is unknown how many abuse calls were made in the last six months.	
Youth were informed of the Abuse and Contact Number	**Compliance**	Youth in the residential program are informed and provided abuse hotline contact information during the program orientation process. The agency also posts abuse hotline contract information in each residential cottage. Youth interviewed onsite indicated they are aware of the abuse hotline number and have been informed residents can call the number on an as needed basis.	
Grievance			
Grievances are maintained on file at minimum for 1 year.	**Compliance**	The Operations Manager reported the grievance forms are scanned and maintained electronically once they are completed. The grievances are maintained on file for at least one year.	
There are formal grievance procedures for youth, including grievance forms, and a locked box which are easily accessible to youth in a common area.	**Compliance**	There are formal grievance procedures for youth, which are posted on the wall next to the grievance box. The locked grievance box is located in a central location and easily accessible to youth. The grievance forms are located on the grievance box. These were observed by the reviewer on a program tour.	

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 electronic logbooks for the program were reviewed, and indicated the grievances boxes are not checked daily as required. The review of this practice indicated that the boxes are checked once a week. This practice was also supported by emails provided by the Operations Manager indicating when the grievances box are checked	A review of the Grievance box review practices indicated that the boxes are currently not checked daily as required.
All grievances are resolved within 72 hours and documented by program director/supervisor or escalated to higher leadership if grievance involves them directly.	**Compliance**	Four grievance forms were reviewed, and all four forms were resolved within seventy-two hours and documented as required.	
1.03: Incident Reporting			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 1.03		**YES** If NO, explain here: The agency does not utilize policy numbers, only titles. The agency has a policy titled Communications Center (CCC) reporting. The entire policy manual was last reviewed and approved by the Children's Services Director on October 1, 2021. Department policies/procedures will be reviewed every three years and modified as needed.	
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 management and supervisory staff members.** **Type of Documentation(s) Reviewed: Last six months of DJJ CCC Incident Center reportable incidents.** **Describe any Observations: See indicator findings.**			
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**	The program had ten incident reports on record with the Florida Department of Juvenile Justice (DJJ) Central Communications Center (CCC) in the last six months. Five incident reports were reviewed and all five were reported within two hours of the program learning of the incident as required.	
The program completes follow-up communication tasks/special instructions as required by the CCC	**Compliance**	A total of five DJJ CCC incident reports were reviewed, and each report indicated the program completed follow-up communication tasks/ special instructions as required by the DJJ CCC. This was evidenced by follow-up emails attached to applicable DJJ CCC reports.	
Agency internal incidents are documented on incident reporting forms and all CCC reportable incidents were consistently reported to CCC as required.	**Compliance**	Agency internal incident forms were reviewed, and were documented on incident reporting forms. Five DJJ CCC reports were reviewed and each had an agency incident form associated with the incident. There was no documentation of DJJ CCC reportable incidents not being reported to the DJJ CCC.	

Incidents are documented in the program logs and on incident reporting forms	**Compliance**	Agency internal incident forms were reviewed, and were documented on incident reporting forms. Five DJJ CCCs were reviewed and each had an agency incident form associated with the incident.	
All incident reports are reviewed and signed by program supervisors/ directors	**Compliance**	The program had ten DJJ CCC incident reports for the review period. One report was for escape/ abscond, four reports were medical incidents, two were mental health/ substance abuse, and the remaining two were complaints against staff. Five DJJ CCCs were reviewed, and all five incident reports were reviewed and signed by a supervisor/director.	
1.04: Training Requirements (*Staff receives training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions*)			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 1.04		**YES** If NO, explain here: The agency does not utilize policy numbers, only titles. The agency has a policy titled Required Staff Training. The entire policy manual was last reviewed and approved by the Children's Services Director on October 1, 2021. Department policies/procedures will be reviewed every three years and modified as needed.	
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 members and one intern. **Total number of Annual In-Service Staff Files: Four in-service staff** **Staff Position(s) Interviewed** *(No Staff Names)* **: Two staff members.** **Type of Documentation(s) Reviewed: Staff member training records.**			
First Year Direct Care Staff			

All direct care staff have completed new hire pre-service training requirements for safety and supervision as required.	**Exception**	New hire training was reviewed for four staff members and one intern. All four staff members had completed all required trainings. The intern completed confidentiality training.	The intern did not complete any other required trainings.
All staff completed the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days from date of hire.	**Exception**	New hire training was reviewed for four staff members and one intern. All four staff members completed Civil Rights and Federal Funds training within the first thirty days of employment. The intern did not complete Civil Rights and Federal Funds Training.	The intern did not complete Civil Rights and Federal Funds Training.
All direct care CINS/FINS staff (full time, part time, or on-call) demonstrated a minimum of 80 hours of training or more for the first full year of employment.	**Compliance**	New hire training was reviewed for four staff members and one intern. Three staff members completed more than eighty hours of training in the first year of employment. The remaining staff members has completed sixty-three hours of training. However, the agency is still within their first year of employment and are not considered a direct care member of staff. The intern has only completed eleven hours of training but has not yet reached one year.	
All staff receives all mandatory training during the first 90 days of employment from date of hire.	**Exception**	New hire training was reviewed for four staff members and one intern. Three staff members were direct care staff and had completed all required trainings. The remaining staff member does not have contact with youth, and completed all trainings they were applicable for. The intern is a clinical intern with youth contact, and did not complete several required trainings.	The intern did not complete any of the required SkillPro trainings, Behavior Management training, CPR, First-Aid, CINS/FINS Core Training, Florida Network Suicide Prevention, Adverse Childhood Experiences (ACE), Diversity, Fire Safety Equipment, Mental Health and Substance Abuse, and Adolescent behavior training.
Staff Required to Complete Data Entry for NIRVANA or access the Florida Department of Juvenile Justice Information System (JJIS)			
Any designated staff that is responsible for entering NIRVANA or ensuring accurate and complete data entry in the Florida Department of Juvenile Justice Information System (JJIS) have completed all of the required trainings.	**Compliance**	Four new hire staff member records were reviewed. Two were applicable for completion of NIRVANA training, and two were applicable for completion of JJIS training. Both staff member files applicable for completion of NIRVANA training contained documentation to reflect the staff member completed Motivational Interviewing and Nirvana Training. Staff member files for the two staff members required to complete JJIS training contained documentation to indicate JJIS training was completed as required.	

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**	None of the staff members reviewed participated in case staffings or CINS petitions, and none were applicable for completion of CINS Petition training.	
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).	**Compliance**	One staff member was applicable for completion of non-licensed mental health clinical staff member suicide assessment training. The applicable staff member's file was reviewed and contained documentation to support that staff member receiving the required training and experience within the required timeframe. The remaining clinical staff member hired during the review period was not applicable for this training due to being a licensed clinical staff member.	
In-Service Direct Care Staff			
Direct care staff completes 24 hours of mandatory refresher Florida Network, SkillPro, and job-related training annually *(40 hours if the program has a DCF child caring license).*	**Compliance**	Four in-service staff member training files were reviewed for annual training hours. All four staff members had completed the mandatory forty hours of annual training. All reviewed staff members had completed all required refresher trainings.	
Required Training Documentation			
The agency has a training plan that includes all of the required training topics including the pre-service and in-service.	**Compliance**	The program's training plan was reviewed. The training plan includes all required training topics.	
The agency has a designated staff member responsible to manage all employee's individual training files and completes routine tracking and reviews of staff files to ensure compliance.	**Compliance**	The program staff member roster was reviewed. The program roster reflects the program has a training manager. The Training Manager position is responsible for overseeing all training at the program.	
The program maintains an individual training file or employee file AND a FLN Training Log (or similar document that includes all requirements) for each staff, which includes an annual employee training hours tracking form and related documentation, such as electronic record/transcript, training certificates, sign-in sheets, and agendas for each training attended.	**Compliance**	Training was reviewed for four new hire staff members, and four in-serviced staff member. The program maintains one training file or each staff member. Additionally, the training file contains the Florida Network training log for each staff member. The training file also contained all training documents for the staff member.	
Additional Comments: **There are no additional comments for this indicator.**			

1.05 - Analyzing and Reporting Information			Satisfactory with Exception
Provider has a written policy and procedure that meets the requirement for Indicator 1.05		**YES** If NO, explain here: The agency does not utilize policy numbers, only titles. The agency has a policy titled Quality Improvement. The entire policy manual was last reviewed and approved by the Children's Services Director on October 1, 2021. Department policies/procedures will be reviewed every three years and modified as needed.	
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)* **: Human Service Specialist, Operations Manager, Youth Care Worker Tier Two** **Type of Documentation(s) Reviewed: QA File review Report, Quarterly QI reports, Staff Emails** **Describe any Observations: See indicator findings.**			
Case record review reports demonstrate reviews are conducted quarterly, at a minimum	**Compliance**	The agency's Quality Assurance Specialist reviews files monthly and documents errors. These identified errors are shared with the staff members during their staff meetings.	
The program conducts reviews of incidents, accidents, and grievances quarterly, at a minimum	**Compliance**	The quarterly QI reports sent to the Board of Directors contain a breakdown of all incidents, accidents and grievances.	
The program conducts an annual review of customer satisfaction data	**Exception**	The satisfaction surveys are uploaded to NETMIS, however there is not a clear process in place.	The agency lacks a process for conducting an annual review of customer satisfaction.
The program conducts an annual review of outcome data and (if applicable) there is evidence of annual reconciliation that occurs through communication from the Florida Network via email or phone call when corrections are needed and the information is corrected and submitted within the requested timeframes.	**Compliance**	There is no clear process or document to review. At the time of this program review, the agency does not have annual review process or yearly compilation of data. The agency provided documented evidence of a process in which program service deliver metrics are reviewed quarterly and addressed on a consistent basis.	
The program has a process in place to review and improve accuracy of data entry & collection	**Compliance**	The program has monthly reviews for data collection and entry. The program services have metrics which are shared with the staff members quarterly.	
There is documentation that findings are regularly reviewed by management and communicated to staff and stakeholders.	**Compliance**	The program shares the quarterly metrics with staff members and sends out emails regarding major practice changes to all staff.	

There is evidence the program demonstrates that critical performance data reports are shared with the Board of Directors frequently. All final reports that include a Limited or Failed score is submitted electronically or by mail to the providers Executive Committee on the Board of Directors.	**Compliance**	The program metrics are shared with the Board of Directors electronically each quarter.	
There is evidence that strengths and weaknesses are identified, improvements are implemented or modified, and staff are informed and involved throughout the process.	**Compliance**	The program emails staff member updates and shares case file metrics regularly to improve their own metrics. The supervisors also meet in a one-on-one coaching method with individual staff members if something comes up that is not a trend across the program.	
Additional Comments: **There are no additional comments for this indicator.**			
1.06: Client Transportation			**Limited**
Provider has a written policy and procedure that meets the requirement for Indicator 1.06		**YES** If NO, explain here: The agency does not utilize policy numbers, only titles. The agency has a policy titled Use of Vehicles for County Business and a policy Use of Vehicles for County Business last reviewed. The entire policy manual was last reviewed and approved by the Children's Services Director on October 1, 2021. Department policies/procedures will be reviewed every three years and modified as needed.	
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: 6/23-10/23 **Staff Position(s) Interviewed** *(No Staff Names)* **: Human Service Specialist, Operations Manager, Youth Care Worker Tier Two, Program Director** **Type of Documentation(s) Reviewed: Physical logbook, Digital Logbook, Authorization for Off Campus Activities, Approval Emails, Position Description for Youth Care Specialist Tier 2**			
Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	**Compliance**	The agency has an approved drivers list of staff members. A review of the list resulted in all of the reviewed transports being completed only by those on the list. On the most recent drivers license list, there were 3 drivers that no longer have valid driving licenses.	

Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	**Exception**	The staff member drivers licenses are reviewed annually. A few were out of date as they expired on 12/8/2023, however the organization was able to show proof they submitted a request for updated licenses repeatedly in November and December via email. The agency was informed that they would be provided an updated list of licenses at a later date. The agency received the results of the Motor Vehicle Record (MVR) list and gained knowledge of the status of all drivers at 5 pm on day one 12/12/2023. The agency provided the list to the reviewer on the morning of day two 12/13/2023. The agency policy and HR department reviews validity of licenses on annual basis. Upon review of the list, the agency became aware of one approved driver on the list had a invalid license. Two approved drivers were pending invalidation. On day two the agency reported the staff member with the invalid license would be removed from the approved driver's list. Per agency policy staff are required to inform the agency if their license becomes invalid for any reason.	Upon receipt of the MVR list, the agency gained knowledge of one approved staff member on the approved driver's list had a invalid license. This staff person was immediately removed from the approved driver's list.
Agency's Transportation policy prohibit transporting a client without maintaining at least one other passenger in the vehicle during the trip and include exceptions in the event that a 3rd party is NOT present in the vehicle while transporting	**Compliance**	The agency's policy supports Florida Network policy which requires a limitation on single transports. The agency policy includes provision which requires a third party participant in transportation events and exception when a third party is not present. The agency has a policy does include a pre-approval request be made prior to the transport and regular check-ins during the transportation event.	
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 policy requires the employee and client backgrounds to be considered prior to approving the single transports, and only Tier 2 Youth Care Specialists and above can approve a single transport.	
The 3rd party is an approved volunteer, intern, agency staff, or other youth	**Compliance**	Policy includes provisions which require only an approved staff, intern or other youth to act as an official thirty party participant.	
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 transportation process was conducted. There was a total of 160 single transports over 5 months, only 35 have documented time stamps showing pre-approval prior to the start of the transport event. The transportation document has a signature line for an approval by a Tier Two staff member or above, however there is no time stamp showing the pre-approval was completed prior to the aforementioned number of transport events.	There is no time stamp showing the pre-approval was completed prior to the transport. There is no documentation in the log book showing the time the logbook was pre-authorized.

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.	**Exception**	The forms include the driver name, date and time of travel, number of passengers and purpose of travel.	The transportation forms reviewed do not consistently document vehicle start and end mileage.
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: The current policy labelled Community Outreach and Partnerships is appropriate to cover the guidelines. The policy was reviewed 10/1/2021. The agency's practice is to review the policy every 3 years. The organization does not label their policies with a number. The policy was approved and signed by Director of Children's Services.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Staff Position(s) Interviewed *(No Staff Names)* **: Counseling Supervisor, Operations Manager, Human Services Supervisor** **Type of Documentation(s) Reviewed: Net mis Reporting, DJJ meeting minutes, event presentation reviewed.** **Describe any Observations: The organization has a significant number of outreach programs, and goes above and beyond in variety and positive attempts to connect with the community.**			
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 agency has a staff person designated to participate in local DJJ Board, Circuit and Council meetings. The agency's Operations Manager is the lead staff designated to attend the aforementioned meetings. The organization was able to provide meeting minutes from three of the DJJ meetings this quarter showing the Operations Manager or a designee attended the meeting.	
The program maintains written agreements with other community partners which include services provided and a comprehensive referral process.	**Compliance**	An interview with the Operations Manager was conducted. The agency reported they have partnerships with multiple community partners that refer youth to their services.	
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**	Interviews with the Operations Manager and Counseling Supervisor were conducted. All of the outreach programs are logged into Net mis, and the agency had evidence of 76 outreach activities entered in Net mis in the last six months.	

The program has designated staff that conducts outreach which is defined in their job description.	**Compliance**	The agency's Operations Manager was interviewed. The agency does not have a specific staff member that is designated to conduct outreach. However the counseling program, the Safe Place department and the Prevention department all complete events in the community that represent specific events which account for the program's outreach activities.	
Additional Comments: **There are no additional comments for this indicator.**			
2.01 - Screening and Intake			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.01		**YES** If NO, explain here: The agency does not utilize policy numbers, only titles. The agency has a policy titled Screening and Eligibility. The entire policy manual was last reviewed and approved by the Children's Services Director on October 1, 2021. Department policies/procedures will be reviewed every three years and modified as needed.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open (Residential & Community) Files: 2 **Total number of Closed (Residential & Community) Files: 5** **Staff Position(s) Interviewed** *(No Staff Names)* **: Clinical director.** **Type of Documentation(s) Reviewed: Client files** **Describe any Observations: See indicator findings.**			
Shelter youth: Eligibility screening is completed immediately for all shelter placement inquiries.	**Compliance**	A total of two residential counseling files were randomly to assess the agency's adherence to the requirements of this indicator. All shelter files reviewed followed all protocol regarding screening a youth immediately following their admission to shelter.	
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 files were randomly to assess the agency's adherence to the requirements of this indicator. All community counseling files followed all protocol regarding screening a youth within 3 days of the referral.	
There is evidence all referrals for service is screened for eligibility and is logged in NetMIS within 72 hours of screening completion.	**Compliance**	All referrals received by shelter and community counseling were logged into NETMIS within the 72 hours time frame.	

Youth and parents/guardians receive the following in writing: a. Available service options b. Rights and responsibilities of youth and parents/guardians	**Compliance**	Of the shelter files reviewed, there was one file that did not have parent signatures as the parent was in jail and youth was put into shelter as a respite and parent had a no contact order against her to constitute the shelter stay of the youth.	

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**	The shelter file does not have parent signature and it is noted clearly throughout the file that mother is in jail as a result of child abuse and a no contact order regarding she with youth.	
During intake, all youth were screened for suicidality and assessed as required if needed.	**Compliance**	All seven files reviewed in shelter, community counseling, DV and ICM were screened appropriately for suicidality.	
Additional Comments: **There are no additional comments for this indicator.**			
2.02 - Needs Assessment			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 2.02		**YES** If NO, explain here: The agency does not utilize policy numbers, only titles. The agency has a policy titled Case Staffing Referrals and Services. The entire policy manual was last reviewed and approved by the Children's Services Director on October 1, 2021. Department policies/procedures will be reviewed every three years and modified as needed.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open (Residential & Community) Files: 2 **Total number of Closed (Residential & Community) Files: 5** **Staff Position(s) Interviewed** *(No Staff Names)* **: Clinical Director.** **Type of Documentation(s) Reviewed: youth files** **Describe any Observations: See indicator findings.**			
Shelter Youth: NIRVANA is initiated within 72 hours of admission	**Exception**	Of the five files reviewed for shelter. Four files completed the NIRVANA within 72 hours of admission to the program.	Two client files did not complete the NIRVANA within the 72 hours. One file was 7 days from the admission, an additional file was 8 days from the admission.
Non-Residential youth: NIRVANA is initiated at intake and completed within 2 to 3 face-to-face contacts after the initial intake **OR** updated, if most recent assessment is over 6 months old	**Compliance**	All Community Counseling client files followed protocol and completed the NIRVANA within the required time frame following the client completing their intake session.	
Supervisor signatures is documented for all completed NIRVANA assessments and/or the chronological note and/or interview guide that is located in the youths' file.	**Compliance**	All shelter, ICM, DV and Community Counseling client files have evidence of completed NIRVANA assessments and other notes and interview guides and are in compliance.	

(Shelter Only) NIRVANA Self-Assessment (NSR) is completed within 24 hours of youth being admitted into shelter. If unable to complete, there must be documentation in NetMIS and the youth's file explaining the barriers to completion.	**Compliance**	All shelter client files have completed the NIRVANA Self-Assessment and contain evidence of being completed with the 24 hour timeframe. All sections in the NIRVANA are completed within the required 24 hour timeframe.	
A NIRVANA Post-Assessment is completed at discharge for all youth who have a length of stay that is greater than 30 days.	**No eligible items for review**	All client files reviewed for shelter did not have a stay 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**	All client files reviewed for shelter and community counseling did not have a stay greater than 90 days.	
All files include the interview guide and/or printed NIRVANA.	**Compliance**	All client files reviewed for shelter and community counseling contained printed copies of the completed NIRVANA.	
Additional Comments: **There are no additional comments for this indicator.**			
2.03 - Case/Service Plan			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 2.03		**YES** If NO, explain here: The agency does not utilize policy numbers, only titles. The agency has a policy titled Case Staffing Referrals and Services. The entire policy manual was last reviewed and approved by the Children's Services Director on October 1, 2021. Department policies/procedures will be reviewed every three years and modified as needed. Patrick Minzie 1/15/20	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open (Residential & Community) Files: 2 **Total number of Closed (Residential & Community) Files: 5** **Staff Position(s) Interviewed** *(No Staff Names)* **: Clinical Director.** **Type of Documentation(s) Reviewed: youth files** **Describe any Observations: See report.**			
The case/service plan is developed on a local provider-approved form or through NETMIS and is based on information gathered during the initial screening, intake, and NIRVANA.	**Compliance**	All shelter and community counseling client files reviewed contained evidence of service plan. All treatment plans reviewed continued initial information gathered form the screening and are in compliance with this indicator.	
Case/Service plan is developed within 7 working days of NIRVANA	**Compliance**	All community counseling files service plans were developed within 7 working days of the NIRVANA being initiated. All shelter service plans were developed within the 7 working days.	

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**	Of the shelter client files reviewed, one open client file contained an Individual Treat Plan (ITP) that was completely blank. The youth refused to engage with the staff member to create the ITP. All community counseling client files reviewed were contained evidence of meeting treatment plan compliance requirements.	One shelter client file did not have the treatment goals identified by the NIRVANA. One shelter file did not have the service type, frequency and location. Two closed shelter files did not have the persons responsible. One closed shelter file did not have the target date for completion. One closed shelter file did not contain the actual completion date. One closed shelter file did not have the signature of youth. Four closed shelter files did not have the signature of the parent/guardian. One open shelter file and one closed shelter file did not have the date the ITP was initiated with the youth/parent.
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**	Of the five shelter client files reviewed, these files were not applicable as youth were admitted and discharged inside of a 30 day period. One community counseling file was in compliance as it was reviewed every 30 days while open with the agency.	
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: The agency does not utilize policy numbers, only titles. The agency has a policy titled Case Management and Service Delivery. The entire policy manual was last reviewed and approved by the Children's Services Director on October 1, 2021. Department policies/procedures will be reviewed every three years and modified as needed.	

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

Total number of Open (Residential & Community) Files: 2
Total number of Closed (Residential & Community) Files: 5
Staff Position(s) Interviewed *(No Staff Names)* **: Clinical Director.**
Type of Documentation(s) Reviewed: Client files
Describe any Observations: See indicators.

Counselor/Case Manager is assigned	**Compliance**	All client files reviewed within the shelter and the community counseling program were in compliance. There was evidence in each that identified a case manager/counselor was assigned to work with the youth.	
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**	Of all the shelter client files reviewed, it was evident via progress notes that the if necessary at case manager/counselor referred youth and family out for more intensive services. All community counseling files contained evidence of the youth being referred to more intensive services if needed based off of engagement with the family and the youth. All community counseling files contained evidence which demonstrated the agency coordinating all necessary services in the implementation of the treatment plan. Of the shelter files, one open file is not able to have a service plan implementation as the youth refuses to engage with the development of the ITP with the counselor. Of all the files reviewed (shelter and community counseling) it is evidenced by the progress notes in each file that the case manager/counselor monitors the youth's and family's progress while in services and provides continued support for families. Of the shelter and community counseling files, four shelter files were previously monitored as court ordered youth. Of all the files reviewed no files were referred to the case staffing process. Of all the files reviewed within shelter and community counseling there were no files noted that youth needed to be accompanied to court or appointments. If deemed necessary referrals were made by the case manager/counselor to additional services.	
The program maintains written agreements with other community partners that include services provided and a comprehensive referral process	**Compliance**	The agency has established partnerships with local area government agencies such as Hillsborough County Schools, community base care agency, Hillsborough County Sheriff's Officer, Tampa Police Department, Children's Services Council, and several local community based organizations.	
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		**YES** If NO, explain here: The agency does not utilize policy numbers, only titles. The agency has a policy titled Case Staffing Referrals and Services and Individual, Group, and Family Counseling. The entire policy manual was last reviewed and approved by the Children's Services Director on October 1, 2021. Department policies/procedures will be reviewed every three years and modified as needed.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open (Residential & Community) Files: 2 **Total number of Closed (Residential & Community) Files: 5** **Staff Position(s) Interviewed** *(No Staff Names)* **: Clinical Director.** **Type of Documentation(s) Reviewed: Client files.** **Describe any Observations: See indicator findings.**			
Shelter Program			
Shelter programs provides individual and family counseling	**Compliance**	All client files reviewed for shelter contained detailed progress notes to denote continued counseling provided for the youth and the parent/guardian while in services.	
Group counseling sessions held a minimum of five days per week	**Compliance**	Evidence was provided that demonstrated group sessions are conducted as required.	
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**	Evidence was provided that demonstrated a clear record of the facilitator, the topic of the session, the continuous opportunity for the youth to be a participant in the discussion and the length of time the group sessions are conducted.	
Documentation of groups must include date and time, a list of participants, length of time, and topic.	**Compliance**	Group rosters were provided for review that reflected the date, time, list of youth in the class, the topic and the length of each particular group session was held.	

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**	All client files reviewed for community counseling reflected continued support for the youth and the family at a location denoted in the best interest of the youth and parent/guardian.	
Counseling Services			
Reflect all case files for coordination between presenting problem(s), psychosocial assessment, case/service plan, case/service plan reviews, case management, and follow-up	**Compliance**	All client cases reviewed contained documented evidence of case coordination. One open shelter client file did not reflect the coordination of the case plan as the file clearly documented in great detail the continued efforts to engage the youth in working through presenting issues. The youth to date continues to refuse any type of engaged discussions of the ITP.	
Maintain individual case files on all youth and adhere to all laws regarding confidentiality	**Compliance**	All youth are assigned a FNYFS/FLN number via Net mis and have a confidential and comprehensive individual client file.	
Case notes maintained for all counseling services provided and documents youth's progress	**Compliance**	Client file progress notes are clear and detailed to denote the continued support and engagement of the youth and parent/guardian.	
On-going internal process that ensures clinical reviews of case records and staff performance	**Compliance**	All client files reflect consistent evidence of review via signatures of the supervisor or clinician.	
Additional Comments: **There are no additional comments for this indicator.**			
2.06 - Adjudication/Petition Process			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.06		**YES** If NO, explain here: The agency does not utilize policy numbers, only titles. The agency has a policy titled Case Staffing Adjudication and Petitions. The entire policy manual was last reviewed and approved by the Children's Services Director on October 1, 2021. Department policies/procedures will be reviewed every three years and modified as needed.	
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:
Total number of Closed (Residential & Community) Files:
Staff Position(s) Interviewed *(No Staff Names)* **: Clinical Director.**
Type of Documentation(s) Reviewed: Client files.
Describe any Observations: See indictor findings.

Must include: a. DJJ rep. or CINS/FINS provider b. Local school district representative	**Compliance**	There were no Hillsborough County client files that resulted in a Case Staffing, but Staffings were held for other local outside agency Youth Advocate Program (YAP).	
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**	Forms were reviewed as a Case Staffing was held for a YAP referral by Hillsborough County as YAP does not facilitate Case Staffing Meetings.	
The program has an established case staffing committee, and has regular communication with committee members	**Compliance**	Forms were reviewed as a Case Staffing was held for a YAP referral by Hillsborough County as YAP does not facilitate Case Staffing Meetings.	
The program has an internal procedure for the case staffing process, including a schedule for committee meetings	**No eligible items for review**	Forms were reviewed as a Case Staffing was held for a YAP referral by Hillsborough as YAP does not facilitate Case Staffing Meetings.	
The youth and family are provided a new or revised plan for services	**No eligible items for review**	The agency had no eligible items related to case staffings adjudication or petition requirements.	
Written report is provided to the parent/guardian within 7 days of the case staffing meeting, outlining recommendations and reasons behind the recommendations	**No eligible items for review**	The agency had no cases which met case staffing, adjudication and petition requirements.	
If applicable, the program works with the circuit court for judicial intervention for the youth/family	**No eligible items for review**	The agency had no cases which met case staffing, adjudication and petition requirements.	
Case Manager/Counselor completes a review summary prior to the court hearing	**No eligible items for review**	The agency had no cases which met case staffing, adjudication and petition requirements.	

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

2.07 - Youth Records			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 2.07		**YES** If NO, explain here: The agency does not utilize policy numbers, only titles. The agency has a policy titled Client Records and Confidentiality. The entire policy manual was last reviewed and approved by the Children's Services Director on October 1, 2021. Department policies/procedures will be reviewed every three years and modified as needed.	
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)* **: Clinical Director** **Type of Documentation(s) Reviewed: Residential and Community Counseling client files.** **Describe any Observations: See indicator findings.**			
All records are clearly marked 'confidential'.	**Compliance**	All client files for shelter and community counseling that were reviewed were clearly marked as confidential.	
All records are kept in a secure room or locked in a file cabinet that is marked "confidential"	**Compliance**	All client files are securely stored when not in use and are transported in a locked box with wheels when in use.	
When in transport, all records are locked in an opaque container marked "confidential"	**Compliance**	All client files for shelter and community counseling are transported in a locked box with wheels when in use.	
All records are maintained in a neat and orderly manner so that staff can quickly and easily access information	**Compliance**	All client files for shelter and community counseling were observed to be very neat and orderly.	
Additional Comments: **There are no additional comments for this indicator.**			

2.08 - Specialized Additional Program Services			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 2.08		**YES** If NO, explain here: The agency does not utilize policy numbers, only titles. The agency has a policy titled Specialized Population Services. The entire policy manual was last reviewed and approved by the Children's Services Director on October 1, 2021. Department policies/procedures will be reviewed every three years and modified as needed.	
Staff Secure			
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: No eligible items for this indicator. **Total number of Closed Files: No eligible items for this indicator.** **Staff Position(s) Interviewed** *(No Staff Names)* **: Clinical Director.** **Type of Documentation(s) Reviewed: No eligible items for this indicator.** **Describe any Observations: See indicator findings.**			
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 agency had no cases which met staff secure requirements.	
Staff Secure policy and procedure outlines the following: a. In-depth orientation on admission b. Assessment and service planning c. Enhanced supervision and security with emphasis on control and appropriate level of physical intervention d. Parental involvement e. Collaborative aftercare	**No eligible items for review**	The agency had no cases which met staff secure requirements.	
Program only accept youth that meet legal requirements of F.S. 984 for being formally court ordered in to Staff Secure Services	**No eligible items for review**	The agency had no cases which met staff secure requirements.	
Staff Assigned: a. One staff secure bed and assigned staff supervision to one staff secure youth at any given time b. Program assign specific staff during each shift to monitor location/ movement of staff secure youth c. Agency clearly documents the specific staff person assigned to the staff secure youth in the logbook or any other means on each shift	**No eligible items for review**	The agency had no cases which met staff secure requirements.	
Agency provides a written report for any court proceedings regarding the youth's progress	**No eligible items for review**	The agency had no cases which met staff secure requirements.	

Domestic Minor Sex Trafficking (DMST)			
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: No eligible items for this indicator. **Total number of Closed Files: No eligible items for this indicator.** **Staff Position(s) Interviewed** *(No Staff Names)* **: Children's Services Program Manager.** **Type of Documentation(s) Reviewed: No eligible items for this indicator.** **Describe any Observations: See indicator findings.**			
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 agency had no cases which met Domestic Minor Sex Trafficking requirements.	
Agency has evidence that the FNYFS was contacted for approval prior to admission for all Domestic Minor Sex Trafficking (DMST) placements.	**No eligible items for review**	The agency had no cases which met Domestic Minor Sex Trafficking requirements.	
There is evidence the youth was entered into NetMIS as a Special Populations youth at admission and a Human Trafficking Screening Tool (HTST) was completed.	**No eligible items for review**	The agency had no cases which met Domestic Minor Sex Trafficking requirements.	
Services provided to these youth specifically designated services designed to serve DMST youth	**No eligible items for review**	The agency had no cases which met Domestic Minor Sex Trafficking requirements.	
Did the placement of DMST youth require additional supervision for the safety of the youth or the program? If so, did the agency provide the appropriate level of supervision and safety measures?	**No eligible items for review**	The agency had no cases which met Domestic Minor Sex Trafficking requirements.	
Length of Stay: a. Youth in program do not have length of stay in DMST placement that exceeds seven (7) days b. Agency has approval for stays and support beyond seven (7) days for DMST placements that are obtained on a case-by-case basis? (If applicable.)	**No eligible items for review**	The agency had no cases which met Domestic Minor Sex Trafficking requirements.	
Agency has evidence that staff assigned to DMST youth under this provision are to enhance the regular services available through direct engagement in positive activities designed to encourage the youth to remain in shelter	**No eligible items for review**	The agency had no cases which met Domestic Minor Sex Trafficking requirements.	
All other services provided to DMST youth are consistent with all other general CINS/FINS program requirements	**No eligible items for review**	The agency had no cases which met Domestic Minor Sex Trafficking requirements.	
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: 0
Total number of Closed Files: 2
Staff Position(s) Interviewed *(No Staff Names)* **: No Staff Interviewed.**
Type of Documentation(s) Reviewed: Residential DV client case files.
Describe any Observations: See indicator findings.

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")	**Compliance**	Two closed shelter files were reviewed for agency's adherence to the requirements of this indicator.	
Youth admitted to DV Respite placement have evidence in the file of a pending DV charge	**Compliance**	Two closed shelter files contained court documents which denoted the Domestic Violence (DV) charge.	
Data entry into NetMIS within (3) business days of intake and discharge	**Compliance**	Two closed shelter files were entered into NetMIS within the 3 business day required input.	
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**	The shelter cases reviewed and the length of stay reviewed did not exceed 21 days.	
Case plan in file reflects goals for aggression management, family coping skills, or other intervention designed to reduce propensity for violence in the home	**Compliance**	Two closed shelter files contained evidence which reflected goals to support the presenting issues resulting in DV throughout the progress notes and within the treatment plans.	
All other services provided to Domestic Violence Respite youth are consistent with all other general CINS/FINS program requirements	**Compliance**	Two closed shelter files clearly reflected the continued support provided to the youth and parent/guardian. This was verified by review of documentation contained in the progress notes and outside support referrals.	

Probation Respite

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

Total number of Open Files: 0
Total number of Closed Files: 0
Staff Position(s) Interviewed (No Staff Names): Children's Services Program Manager.
Type of Documentation(s) Reviewed: No eligible items for this indicator.
Describe any Observations: 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 agency had no cases which met Probation Respite requirements.	
All probation respite referrals are submitted to the Florida Network.	**No eligible items for review**	The agency had no cases which met Probation Respite requirements.	
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**	The agency had no cases which met Probation Respite requirements.	
Data entry into NetMIS and JJIS within (3) business days of intake and discharge	**No eligible items for review**	The agency had no cases which met Probation Respite requirements.	
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**	The agency had no cases which met Probation Respite requirements.	
All case management and counseling needs have been considered and addressed	**No eligible items for review**	The agency had no cases which met Probation Respite requirements.	
All other services provided to Probation Respite youth are consistent with all other general CINS/FINS program requirements	**No eligible items for review**	The agency had no cases which met Probation Respite requirements.	
Intensive Case Management (ICM)			
Case plan in file reflects goals for aggression management, family coping skills, or other intervention designed to reduce propensity for violence in the home			
Total number of Open Files: 2 **Total number of Closed Files: 0** **Staff Position(s) Interviewed** *(No Staff Names)* **: Clinical Director.** **Type of Documentation(s) Reviewed: Client case files.** **Describe any Observations: See indicator findings.**			
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")	**Compliance**	A total of two client cases were reviewed to determine the agency's adherence to the requirements of this indicator. A total of one ICM open shelter youth and one ICM open community counseling youth client files were reviewed.	
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.	**Compliance**	The ICM open shelter youth and one ICM open community counseling youth reviewed were each deemed eligible via truancy court previously held ICM recommended.	

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.	**Compliance**	Of the two files reviewed, each client file contained detailed information regarding direct contacts and collateral contacts. All monthly direct contact and weekly collateral contact attempts are documented. The content meets guidelines in each documented attempt and also meets the minimum number of required contacts.	
Assessments include a. NIRVANA at intake b. NIRVANA Re-Assessment every 90 days c. Post NIRVANA at discharge as aligned with timeframe requirements	**Compliance**	Shelter ICM and community ICM files were in compliance with NIRVANA assessments. At the time of this review, there is no discharge NIRVANA as each file is still open.	
Service/case plan demonstrates a strength-based, trauma-informed focus	**Compliance**	Shelter ICM and community ICM files reflected in the treatment plan and progress notes demonstrated continued support for the youth and parent/guardian with an intense emphasis on presenting issues.	
For any virtual services provided, there is written documentation in the youths' file as to why virtual contact is in the best interest of the youth and family	**Not Applicable**	There is documented proof of all services provided being conducted in person and virtual if required as needed.	
Family and Youth Respite Aftercare Services (FYRAC)			
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: 0 **Total number of Closed Files: 0** **Staff Position(s) Interviewed** *(No Staff Names)* **: Note required.** **Type of Documentation(s) Reviewed: None available.** **Describe any Observations: Category not applicable.**			
Youth is referred by DJJ for a domestic violence arrest on a household member, and/or the youth is on probation regardless of adjudication status and at risk of violating.	**No eligible items for review**	The agency had no cases which met FYRAC requirements, therefore no applicable youth files to review.	
Agency has evidence that all FYRAC referrals have documented approval from the Florida Network office	**No eligible items for review**	The agency had no cases which met FYRAC requirements, therefore no applicable youth files to review.	

Intake and initial assessment sessions meets the following criteria: a. Services shall be documented through the signature of the youth and his/her parent/guardian as well as orientation to the program which is kept in the youths file. b. The initial assessment shall be face-to-face, in person or through virtual means, to include a gathering of all family history and demographic information, as well as the development of the service plan. c. For youth on probation, a copy of the youths Community Assessment Tool (CAT) to assist with development of the family service plan.	**No eligible items for review**	The agency had no cases which met FYRAC requirements, therefore no applicable youth files to review.	
Life Management Sessions meets the following criteria: a. Sessions are face-to-face, sixty (60) minutes in length and focus on strengthening the family unit b. Services are highly supportive, individualized, and flexible and require a "whole family" approach to dealing with the problems affecting the youth and family.	**No eligible items for review**	The agency had no cases which met FYRAC requirements, therefore no applicable youth files to review.	
Individual Sessions: a.The program conducted sessions with the youth and family to focus on work to engage the parties and identify strengths and needs of each member that help to improve family functioning. b. Issues to be covered through each session include but are not limited to: Identifying emotional triggers; body cues; healthy coping strategies through individual, group and family counseling; understanding the cycle of violence and the physical and emotional symptoms of anger; developing safety plans; and educating families on the legal process and rights.	**No eligible items for review**	The agency had no cases which met FYRAC requirements, therefore no applicable youth files to review.	
Group Sessions: a. Focus on the same issues as individual/family sessions with application to youth pulling on similar experiences with other group members with the overall goal of strengthening relationships and prevention of domestic violence. b. Shall be no more than eight (8) youth at one (1) time and shall be for a minimum of sixty (60) minutes per session	**No eligible items for review**	The agency had no cases which met FYRAC requirements, therefore no applicable youth files to review.	
There is evidence of completed 30 and/or 60 day follow-ups and is documented in NetMIS following case discharge.	**No eligible items for review**	The agency had no cases which met FYRAC requirements, therefore no applicable youth files to review.	

Youth and family participate in services for thirteen (13) sessions or ninety (90) consecutive days of services, or there is evidence in the youth's file that an extension is granted by DJJ circuit Probation staff	**No eligible items for review**	The agency had no cases which met FYRAC requirements, therefore no applicable youth files to review.	
Any service that is offered virtually, is documented in the youth's file why it was in the youth and families best interest.	**No eligible items for review**	The agency had no cases which met FYRAC requirements, therefore no applicable youth files to review.	
All data entry in NetMIS is completed within 3 business days as required.	**No eligible items for review**	The agency had no cases which met FYRAC requirements, therefore no applicable youth files to review.	
Additional Comments: **There are no additional comments for this indicator.**			

2.09- Stop Now and Plan (SNAP)		Not Applicable
Provider has a written policy and procedure that meets the requirement for Indicator 2.09	**NO** If NO, explain here: The agency does not utilize policy numbers, only titles. The agency does not operate a Stop Now and Plan (SNAP) program. The entire policy manual was last reviewed and approved by the Children's Services Director on October 1, 2021. Department policies/procedures will be reviewed every three years and	

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.*

NOT APPLICABLE

SNAP Clinical Groups Under 12			
Youth are screened to determine eligibility of services.	**Not Applicable**	Agency does not participate in SNAP program service delivery.	
The NIRVANA was completed at initial intake, or within two sessions.	**Not Applicable**	Agency does not participate in SNAP program service delivery.	
There is evidence of the completed Child Behavior Checklist (CBCL) by the caregiver (pre and post) and is located within the file.	**Not Applicable**	Agency does not participate in SNAP program service delivery.	
There is evidence of the completed Teacher Report Form (TRF) is completed by the teacher (pre and post) and is located within the file.	**Not Applicable**	Agency does not participate in SNAP program service delivery.	
SNAP Clinical Groups Under 12 - Discharge			
There is evidence of the completed SNAP Discharge Report located within the file for any discharged youth.	**Not Applicable**	Agency does not participate in SNAP program service delivery.	
There is evidence of the completed SNAP Discharge Report located within the file for any discharged youth.	**Not Applicable**	Agency does not participate in SNAP program service delivery.	
There is evidence of the SNAP Boys/SNAP Girls Child Group Evaluation Form located in the file.	**Not Applicable**	Agency does not participate in SNAP program service delivery.	
There is evidence of the SNAP Boys/SNAP Girls Parent Group Evaluation Form located in the file.	**Not Applicable**	Agency does not participate in SNAP program service delivery.	
SNAP Clinical Groups for Youth 12-17			
Youth are screened to determine eligibility of services.	**Not Applicable**	Agency does not participate in SNAP program service delivery.	

The Consent to Treatment and Participation in Research Form is completed and located within the file.	**Not Applicable**	Agency does not participate in SNAP program service delivery.	
The NIRVANA was completed at initial intake, or within two sessions.	**Not Applicable**	Agency does not participate in SNAP program service delivery.	
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**	Agency does not participate in SNAP program service delivery.	
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**	Agency does not participate in SNAP program service delivery.	
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**	Agency does not participate in SNAP program service delivery.	
SNAP for Schools & Communities			
The program demonstrated all of the required weekly attendance sheets that included youth names and/or identifying numbers completed with the teacher and trained SNAP Facilitator signatures. (*This must include a total of 13 attendance sheets for a full cycle*)	**Not Applicable**	Agency does not participate in SNAP program service delivery.	
The program maintained evidence of a completed "Class Goal" Document for the class reviewed.	**Not Applicable**	Agency does not participate in SNAP program service delivery.	
The program maintained evidence of both pre AND post Measure of Classroom Environment (MoCE) completed documents for the class reviewed.	**Not Applicable**	Agency does not participate in SNAP program service delivery.	
The program maintained evidence of completed pre and post evaluation documents for the class reviewed.	**Not Applicable**	Agency does not participate in SNAP program service delivery.	
There is evidence of the fidelity adherence checklist maintained in the file for each class reviewed.	**Not Applicable**	Agency does not participate in SNAP program service delivery.	
Additional Comments: **There are no additional comments for this indicator.**			

3.01 - Shelter Environment			Satisfactory with Exception
Provider has a written policy and procedure that meets the requirement for Indicator 3.01		**YES** If NO, explain here: The agency does not utilize policy numbers, only titles. The agency has a policy titled Shelter Environment. The entire policy manual was last reviewed and approved by the Children's Services Director on October 1, 2021. Department policies/procedures will be reviewed every three years and modified as needed.	
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)* **: Operations Officer, Training Specialist, Direct Care Worker** **Type of Documentation(s) Reviewed: Cottage tour, Policy and Procedure, Agency inspections** **Describe any Observations: See indicators findings.**			
Facility Inspection: a. Furnishings are in good repair. b. The program is free of insect infestation. c. Bathrooms and shower areas are clean and functional, free of foul odors, leaks, dust, and mildew and in good working order. d. There is no graffiti on walls, doors, or windows. e. Lighting is adequate for tasks performed there. f. Exterior areas are free of debris; grounds are free of hazards. g. Dumpster and garbage can(s) are covered. h. All doors are secure, in and out access is limited to staff members and key control is in compliance. i. Detailed map and egress plans of the facility, general client rules, grievance forms, abuse hotline information, DJJ Incident Reporting Number and other related notices are posted. j. Interior areas (bedrooms, bathrooms, common areas) do not contain contraband and are free from hazardous unauthorized metal/foreign objects.	**Compliance**	Agency has two Cottages on-site that provide housing which includes one for the male clients and one for the female clients. Both cottages were clean and inviting. Reviewer walked through all bedrooms and bathrooms which were clean and operational. The laundry facilities were clean and free of lint. The kitchen was free of debris and refrigerator was clean and a thermometer present in both cottages. There was egress maps posted through out the cottage. The exterior grounds are clean and free from any debris. All exterior doors are locked and staff have key control to unlock the doors. All required postings of abuse hotline and program rules were visible for clients to review as needed.	

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**	This reviewer observed both Agency vehicles and both were locked at the time of observance. Keys were brought out by Mr. Gray. Each vehicle is equipped with a small fire extinguisher and a first aid kit is checked out from the main of when keys are picked up. Each first aid kit was equipped with required items and all items were not expired. Staff carry a metal clipboard that has van registration and stuff in it as well as the seat belt cutter and flashlight.	
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**	All chemicals are secured in a locked closet with staff members only having access to them. Facility stores all it's chemicals in a locked closet and the MSDS sheets for the chemicals is kept in the staff office as well as a daily perpetual count of the chemicals.	
Facility Inspection: Washer/dryer are operational & general area/lint collectors are clean. Agency has a current DCF Child Care License which is displayed in the facility. Each youth has own individual bed with clean covered mattress, pillow, sufficient linens and blanket. Youth have a safe, lockable place to keep personal belongings, if requested.	**Compliance**	This reviewer observed both cottages laundry facilities and both were clean and free from any lint or other debris. The DCF License was observed and was taped to the staff member office window for everyone to see. Each youth is provided their own room. Both cottages are equipped with four bedrooms in each cottage that has the potential to place two youth in the bedroom. There is a locked closet in each cottage that youth can place personal belongings if requested.	
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**	The facility had there annual Fire Marshall inspection on 5/16/23 and the facility did not have any discrepancies noted at that time. The facility completes one fire drill per month and mock drills are conducted at least once a quarter and additional mock drill exercises were also documented. The facilities Fire Extinguishers were inspected on 3/17/23, sprinklers were inspect on 10/11/23, Alarm system was inspected on 8/2/23. All inspections were deemed to be satisfactory with no discrepancies. The Facility vehicles had small fire extinguisher that were within the green zone. The agency conducts fire drills at least once a month. However, Florida Network Policy and Procedure states that Fire Drills should be conducted once a month on each shift. The Agency provided the other Cottages Fire Drill book that showed the second shift fire drills.	
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.	**Compliance**	The Agency was inspected by the County Health department for their annual Group Care Inspection on 6/1/23 and there were no discrepancies found. The agency's last Health inspection was completed on 6/20/23 and another inspection will be conducted before the end of the fiscal year. The refrigerators in the cottages are free from clutter and are equipped with a thermometer. The food storage in the kitchen areas are clean and the temperatures are within required temperature thresholds. The agency has menus posted in each Cottage and in the cafeteria. The agency's menus were last reviewed on 8/2/22 and are reviewed by the Dietician ever three years in correspondence with there COA reaccreditation.	

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.	**Exception**	Agency has a very precise daily activities schedule that includes a broad range of activities. The activities list is posted in the common areas. The schedule requires that all youth complete education, recreation, counseling, life and social skills training on a daily bias. The youth are also offered the option of other services such as faith-based activities and other non-faith-based activities.	Even though the daily schedule provides adequate time to do a variety of activities there is not the required one hour of physical activity a day listed on the schedule.
Additional Comments: **There are no additional comments for this indicator.**			
3.02 - Program Orientation			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 3.02		**YES** If NO, explain here: The agency does not utilize policy numbers, only titles. The agency has a policy titled Residential Client Orientation. The entire policy manual was last reviewed and approved by the Children's Services Director on October 1, 2021. Department policies/procedures will be reviewed every three years and modified as needed.	
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: 4 open charts **Total number of Closed Files: 3 closed Charts** **Staff Position(s) Interviewed** *(No Staff Names)* **: Operations Officer, Clinical Director** **Type of Documentation(s) Reviewed: Youth Charts, Policies and Procedures.** **Describe any Observations: The Agency has very clear and precise forms and policies to address all contractual requirement for this Standard**			

Youth received a comprehensive orientation and handbook provided within 24 hours	**Compliance**	During the intake process each youth and parent are provided with a copy of the handbook.	
Orientation includes the following: a. Youth is given a list of contraband items b. Disciplinary action is explained c. Dress code explained d. Review of access to medical and mental health services e. Procedures for visitation, mail and telephone f. Grievance procedure g. Disaster preparedness instructions h. Physical layout of the facility i. Sleeping room assignment and introductions j. Suicide prevention- alerting staff of feelings or awareness of others having suicidal thoughts	**Compliance**	The Agency has very precise program orientation form that collects all required items and it is also available in the Youth Handbook.	
Documentation of each component of orientation, including orientation topics and dates of presentation, as well as signatures of the youth and staff involved is maintained in the individual youth record	**Compliance**	The agency has a form that collects the signature of the youth, parent, and staff acknowledging they read and understand the expectation of the program.	
Additional Comments: **There are no additional comments for this indicator.**			
3.03 - Youth Room Assignment			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 3.03		**YES** If NO, explain here: The agency does not utilize policy numbers, only titles. The agency has a policy titled Shelter Environment - Section J. The entire policy manual was last reviewed and approved by the Children's Services Director on October 1, 2021. Department policies/procedures will be reviewed every three years and modified as needed.	

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: 4 files
Total number of Closed Files:3 files
Staff Position(s) Interviewed *(No Staff Names)* **: Operations Officer, Clinical Directors**
Type of Documentation(s) Reviewed: Youth Files and Policies and Procedures
Describe any Observations: See indicator findings.

A process is in place that includes an initial classification of the youths, to include:			
a. Review of available information about the youth's history, status and exposure to trauma b. Initial collateral contacts, c. Initial interactions with and observations or the youth d. Separation of younger youth from older youth, e. Separation of violent youth from non-violent youth f. Identification of youth susceptible to victimization g. Presence of medical, mental or physical disabilities h. Suicide risk i. Sexual aggression and predatory behavior j. Acute health symptoms requiring quarantine or isolation	**Compliance**	The agency has a Intake procedure that captures all contractual required items. The agency has an Intake form which includes the client's history, status, classification, medical, mental or physical disabilities and other collateral areas that are associated with the intake process.	
An alert is immediately entered into the program's alert system when a youth is admitted with special needs and risks such as risk of suicide, mental health, substance abuse, physical health or security risk factors	**Compliance**	The agency has an alert system in place that allows staff member to know if any youth has any alerts and what they are. There is an alert board in the staff member office that is covered by paper to ensure privacy.	
Additional Comments: **There are no additional comments for this indicator.**			
3.04 - Log Books			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 3.04		**YES** If NO, explain here: The agency does not utilize policy numbers, only titles. The agency has a policy titled Log books. The entire policy manual was last reviewed and approved by the Children's Services Director on October 1, 2021. Department policies/procedures will be reviewed every three years and modified as needed.	
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: Agency provided the last six months of logbook for sampling **Staff Position(s) Interviewed** *(No Staff Names)* **: Operation Officer** **Type of Documentation(s) Reviewed: Reviewed the Electronic Logbook as well as Hard copies provided by the Agency** **Describe any Observations: Electronic Logbooks are used appropriately.**			
Log book entries that could impact the security and safety of the youth and/or program are highlighted	**Compliance**	The agency uses the Electronic Logbook that captures all logged. The Electronic Logbook has several functions that allows for highlighting different entries.	

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**	The agency logbook automatically captures date, time, activity, youth, and staff. The agency documents effectively utilizing all the functions of the Electronic Logbook.	
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**	The agency uses the Electronic Logbook and they use the strike through errors function appropriately. No white out is involved in utilizing the electronic logbook.	
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**	The agency's residential supervisors conducts reviews of the logbook. The agency conducts logbook reviews weekly and documents general observation of staff member logbook documentation practices.	
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**	The agency requires all staff members to review the previous two work shifts upon arriving on their job post. A review of random logbook entries of the agency's logbook indicated evidence of staff members documenting reviewing the previous two work shifts.	
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 agency requires all supervisors to review the logbook of all entries since their last logbook entry upon arriving on their job post. A review of random logbook entries of the agency's logbook indicated evidence of supervisors signing and dating that they have reviewed all entries since the last time they were on duty.	
Logbook entries include: a. Supervision and resident counts b. Visitation and home visits	**Compliance**	A review of the agency's logbook was conducted to determine if the agency's logbook contained evidence of specific logbook entries. A review of the logbook over the last six month indicated that the agency is documenting supervision and youth counts, as well as outings and other visits.	
Additional Comments: **There are no additional comments for this indicator.**			
3.05 - Behavior Management Strategies			**Satisfactory**
		YES	
		If NO, explain here:	

Provider has a written policy and procedure that meets the requirement for Indicator 3.05		The agency does not utilize policy numbers, only titles. The agency has a policy titled Behavior Management. The entire policy manual was last reviewed and approved by the Children's Services Director on October 1, 2021. Department policies/procedures will be reviewed every three years and modified as needed.	
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)* **: The Operations Officer, and the Training Specialist** **Type of Documentation(s) Reviewed: Policies and Procedures, Youth Handbook, Youth Records** **Describe any Observations: Agency has a good practice going and should keep going with what they are doing.**			
The program has a detailed written description of the BMS and it is explained during program orientation	**Compliance**	The agency has a detailed system that is utilized during the intake process. The youth sign off that they have been made aware of the Behavior Management process.	
Behavior Management Strategies must include:			
a. BMS is designed to teach youth new behaviors and help youth understand the natural consequences for their actions b. Behavioral interventions are applied immediately, with certainty, and reflect the severity of the behavior c. BMS uses a wide variety of awards/incentives to encourage participation and completion of the program d. Appropriate consequences and sanctions are used by the program and consequences for behavior are logical and designed to promote skill-building for the youth e. Counseling, verbal intervention and de-escalation techniques are used prior to physical intervention (Only techniques approved by the Florida Network and DJJ are used if physical intervention is required) f. Only staff discipline youth. Group discipline is not imposed g. Room restriction is not used as part of the system or for youth who are physically and/or emotionally out of control h. Youth should never be denied basic rights such as meals, clothing, sleep, services, exercise, or correspondence privileges	**Compliance**	The agency has clear and precise policies and procedure discussing the Behavior Management System (BMS) and the behavior interventions the agency utilizes according to the situation and severity of youth's behavior. The policies and procedures meet the requirements of the standard. A reviewer observed interactions with the youth and staff members. Youth are never denied any basic rights including any counseling, shelter, meals, clothing, sleep, or exercise. Staff members are all trained in Managing Aggressive Behavior which is a situation-based physical intervention training course approved by the Florida Network of Youth and Family Services.	
Program's use of the BMS			

All staff are trained in the theory and practice of administering BMS rewards and consequences	**Compliance**	All agency staff were trained on the Behavior Management system and has refresher course yearly.	
There is a protocol for providing feedback and evaluation of staff regarding their use of BMS rewards and consequences	**Compliance**	The agency reviews how each Youth Care Specialist staff person applies the behavior management training and method of practice on behavior events with each youth. Supervisors provide feedback on staff member's initial us and give guidance on the use of the system.	
Supervisors are trained to monitor the use of rewards and consequences by their staff	**Compliance**	Residential Leads and supervisors observe staff member engagement with youth, interventions use and results of the youth's behavior to assess how staff use BMS awards and consequences.	
Additional Comments: **There are no additional comments for this indicator.**			
3.06 - Staffing and Youth Supervision			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 3.06		**YES** If NO, explain here: The agency does not utilize policy numbers, only titles. The agency has a policy titled Staffing and Youth Supervision. The entire policy manual was last reviewed and approved by the Children's Services Director on October 1, 2021. Department policies/procedures will be reviewed every three years and modified as needed.	
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: Schedules for the last six months were observed **Staff Position(s) Interviewed** *(No Staff Names)* **: Director, Operations Officer, Training Specialist** **Type of Documentation(s) Reviewed: Reviewed the Staff schedules, and toured the facility.** **Describe any Observations: Agency has very clear and precise schedule that does not leave room for mistakes.**			
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**	The agency has staff members schedules posted in each cottage in the staff office. The schedule shows that the required staff members to youth ratio is being met. If necessary, a Shift Leader is available to assist and support services being delivered in the shelter. The agency does schedule and provide additional staff in real time if the ratio goes above the required number.	
All shifts must always provide a minimum of two direct care staff present that have met the minimum training requirements	**Compliance**	The agency has a low census and because of this the agency has one staff member on shift. In instances when the census is less than six youth per cottage, there is an extra staff person scheduled on shift on the campus in the event of new incoming admissions to the shelter.	

Program staff included in staff-to-youth ratio includes only staff that are background screened and properly trained youth care workers, supervision staff, and treatment staff	**Compliance**	The agency meets all contractual requirements for staff-to-youth ratio and does provide extra staff members if the ratio increases.	
The staff schedule is provided to staff or posted in a place visible to staff	**Compliance**	Staff schedules are posted in all the staff offices and in the control room.	
There is a holdover or overtime rotation roster which includes the telephone numbers of staff who may be accessed when additional coverage is needed	**Compliance**	The agency posts the staff member schedule in the control room. The schedule provides information to assist available staff members with contact information in case coverage is required on a work shift.	
Staff observe youth at least every 15 minutes while they are in their sleeping room, either during the sleep period or at other times, such as during illness or room restriction	**Compliance**	A total of four days of bed checks were reviewed on the camera system and logbook documentation to assess the agency's adherence to all requirements. All checks were recorded in the agency's logbooks in real time and match the actual bed check activity in the cottages to the minute.	

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

3.07 - Video Surveillance System		**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 3.07	**YES** If NO, explain here: The agency does not utilize policy numbers, only titles. The agency has a policy titled Video Surveillance System.. The entire policy manual was last reviewed and approved by the Children's Services Director on October 1, 2021. Department policies/procedures will be reviewed every three years and modified as needed.	

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 thirty days.
Staff Position(s) Interviewed *(No Staff Names)* **: Operations Officer.**
Type of Documentation(s) Reviewed:Logbooks,Policy and Procedures, and Camera systems itself.
Describe any Observations: Staff need to remember to use the bed check logo on the electronic logbook.

Surveillance System

The agency, at a minimum, shall demonstrate: a. A written notice that is conspicuously posted on the premises for the purpose of security b. System can capture and retain video photographic images which must be stored for a minimum of 30 days c. System can record date, time, and location; maintain resolution that enables facial recognition d. Back-up capabilities consist of cameras' ability to operate during a power outage e. Have cameras placed in interior and exterior general locations of the shelter where youth and staff congregate and where visitors enter and exit. Cameras are never placed in bathrooms or sleeping quarters. f. All cameras are visible	**Compliance**	The agency has a camera system that meets all contractual requirements and backs up for the required thirty days. The agency has an emergency generator that serves all cottages and main building which would keep the camera system operational during power outages.	
A list of designated personnel who can access the video surveillance system is maintained (includes off-site capability per personnel)?	**Compliance**	The agency has designated specific staff members access to the camera system which includes the Children's Services Department Director, Operations officer, two Shift Leaders, and the IT Director.	
Supervisory review of video is conducted a minimum of once every 14 days and timeframes reviewed are noted in the logbook.	**Compliance**	The supervisor is required to review the camera system three times a week. The supervisor reviews and checks bed checks practice performed by the staff members to ensure they are conducted.	
The reviews assess the activities of the facility and include a review of random sample of overnight shifts	**Compliance**	The agency's residential supervisors are required to review overnight facility and program activities on an intermittent basis.	
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's camera system can provide recordings to authorized parties. The agency can submit video recordings within the required contractual standards in the form of a thumb drive that is encrypted.	
Camera service order/requests will be made within 24 hours of discovery of camera malfunctioning or being inoperable. All efforts made to obtain repairs are documented and maintained	**Compliance**	If the camera system fails to operate properly, the agency has to fill out a work order for the County Maintenance Department to repair the camera system.	
Additional Comments: **There are no additional comments for this indicator.**			
4.01 - Healthcare Admission Screening			**Satisfactory**
	YES		
	If NO, explain here:		

Provider has a written policy and procedure that meets the requirement for Indicator 4.01		The agency does not utilize policy numbers, only titles. The agency has a policy titled Residential Health Care Screening. The entire policy manual was last reviewed and approved by the Children's Services Director on October 1, 2021. Department policies/procedures will be reviewed every three years and modified as needed.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: 2 **Total number of Closed Files: 4** **Staff Position(s) Interviewed** *(No Staff Names)* **: None required.** **Type of Documentation(s) Reviewed: Client files.** **Describe any Observations: See indicator findings.**			
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 six closed residential youth records were reviewed to determine the agency's adherence to the requirements of this indicator for healthcare screening. All six records contained screening forms with evidence of being completed by staff members. The agency's health admission screening forms captured up to date information on each client's acute medical/mental health status. At the time of this onsite program review, the agency Registered Nurse and Nurse Assistance positions are vacant.	
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**	The agency has a detailed referral process in the event that medical attention is required during the shelter stay. Of the client files reviewed, none of the six youth presented with chronic medical conditions required a referral for medical services or care.	
When needed, the parent is involved with the coordination and scheduling of follow-up medical appointments	**Compliance**	The agency has procedures in place to contact parents, caregivers in the event of a medical emergency. The agency works with the youth's family if the need for medical follow up requires outside medical appointments.	

All medical referrals are documented on a daily log.	**Compliance**	The agency has a process has for documenting all medical referrals. When applicable the agency requires that all aforementioned medical referrals be documented in the program logbook and Episodic Care log.	
The program has a thorough referral process and a mechanism for necessary follow-up medical care as required and/or needed	**Compliance**	The agency has a process for medical referrals, as well as follow-up medical care. Nursing assessments were not present in any of the client files. At the time of this onsite program review, the agency Registered Nurse and Nurse Assistance positions are vacant.	
Additional Comments: **There are no additional comments for this indicator.**			
4.02 - Suicide Prevention			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 4.02		**YES** If NO, explain here: The agency does not utilize policy numbers, only titles. The agency has a policy titled Suicide Prevention and Intervention. The entire policy manual was last reviewed and approved by the Children's Services Director on October 1, 2021. Department policies/procedures will be reviewed every three years and modified as needed.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open (Residential & Community) Files: 2 **Total number of Closed (Residential & Community) Files: 2** **Staff Position(s) Interviewed** *(No Staff Names)* **: Clinical Director.** **Type of Documentation(s) Reviewed: Client files.** **Describe any Observations: See indicator findings.**			
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 total of four residential youth records (2 open and 2 closed) were reviewed to determine the agency's adherence to the requirements of this indicator for suicide prevention. All four records contained a suicide risk screening completed during the initial screening and process. All youth have documented evidence as meeting a minimum of at least one positive response for one of five questions on the suicide risk instrument.	
The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	**Compliance**	The agency utilizes an Assessment of Suicide, Homicide, Assault Risk tool. The tool and its contents have not changed since the last onsite program review.	

Supervision of Youth with Suicide Risk *(Shelter Only)*			
Youth are placed on the appropriate level of supervision based on the results of the suicide risk assessment.	**Compliance**	All four youth files contained documentation that they were placed on sight and sound supervision. All youth client files contained evidence of satisfactorily completed Assessment of suicide risk form being conducted by a mental health counselor or a mental health clinician that oversees all counselors.	
Staff person assigned to monitor youth maintained one-to-one supervision or constant supervision and documented his/her observations of the youth's behavior at 30 minute or less intervals	**Compliance**	A review of the agency's observation logs were conducted. The review of the supervision logs found documented observation checks conducted on each youth by a staff member every 30 minutes while on constant supervision. The youth's behavior, and the staff's initials were documented every thirty minutes or less. Three of the four youth were placed on elevated supervision. These files contained observation logs in which the youth's behavior was documented every ten-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**	A review of the observation log detail for all four client files included date, time, client observations, warning signs, writer's initial and documentation of the Shift Supervisor or Lead.	
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 four youth files contained evidence of an assessment which was completed as required. The status of the supervision in which the youth was placed on was not changed unless directed to do so by 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 four client files contained evidence that the Shift Supervisor or Lead reviewed the observation logs at the end of the work shift. Each log was stored in the client file as required.	
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 applicable items for review for 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 applicable items for review for 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 applicable items for review for 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 applicable items for review for 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 applicable items for review for this indicator.	
Additional Comments: **There are no additional comments for this indicator.**			

4.03 - Medications			Failed
Provider has a written policy and procedure that meets the requirement for Indicator 4.03		**YES** If NO, explain here: The agency does not utilize policy numbers, only titles. The agency has a policy titled Medication Administration. The entire policy manual was last reviewed and approved by the Children's Services Director on October 1, 2021. Department policies/procedures will be reviewed every three years and modified as needed.	
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: reviewed 4 open cases **Total number of Closed Files: reviewed 4 closed cases** **Staff Position(s) Interviewed** *(No Staff Names)* **: Tier 2 Youth Care Specialist/superuser, Human Services Supervisor, Operations Manager** **Type of Documentation(s) Reviewed: MARs, Medication Verification Forms, Pyxis current counts** **Describe any Observations: While all current staff are trained to pass medication, it seems to be the same 5 staff members that are actually passing medication. Prior to our arrival all documentation and interviews stated that the found policies were in place, and documentation from all files reviewed showed the same information.**			
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.	**Exception**	The agency currently has a vacancy for the licensed Registered Nurse (RN) position.	The facility has not had a licensed Registered Nurse (RN) since 2021.
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	**Exception**	The medication room is locked at all times, and the medication is stored in either the Pyxis medication cabinet or a built in locker next to the Pyxis until it can be uploaded. There is a refrigerator in the room in case the staff member receives medications that require refrigeration, however the temperatures are not checked regularly. There is a lock present on the front of the fridge. The staff member has the Pyxis drawers labelled accordingly for a type of medication, creams and topical medications are kept in the top drawer, oral medications are kept in the second drawer, over the counter medications are kept in the third drawer, and any medications too large are kept in the bottom drawer. One of the storage boxes on the wall are designated for Pyxis keys, and the key to access are kept on the staff keys. All required Pyxis keys were located in the storage box.	All medication that is not refrigerated as required to be stored in the Pyxis medication cabinet. The agency reported not entering medication in the medication cabinet until it can be uploaded and not immediately upon receipt from the client/family.
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	**Exception**	The distribution list has five Super Users, all who were trained in person by a registered nurse in April of 2023. Only staff members who have received medication training are allowed to access the pyxis or other medications. There is a medication distribution log available for who is allowed to pass medication, however it has not been updated since July of 2023, as the newest member of staff is not located on the list, however has received training in July and has passed medication since. The agency verifies medications by contacting the pharmacy and verifying the instructions on the label, however of the eight files reviewed, two of them were verified after the medication began to be dispersed to the youth. There is no current nurse to be able to assist in medication passing. Staff members were aware that the only injectable medication accepted at the facility are epi-pens. The super users received in person training from a registered nurse on how to use an epi-pen, the remainder of the staff learned threw a PowerPoint presentation.	The delivery process was not in compliance with the FNYFS medication distribution policy. Staff members were observed pre-pouring medications and transporting them unsecured to the youth on day one of the program review. Once the youth received the medication the youth were not signing advising they received it the medication. The aforementioned medication distribution process witnessed by the review is contrary to the agency's own policy.

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	**Exception**	The current medication log only displays staff signature and time medication was passed.	A review of the medication distribution log indicated the youth had not been signing they received their medication in the six months reviewed.
There is evidence that staff provide youth with medications within one hour of the scheduled time of delivery as ordered by the medication. Documentation is provided for instances this does not occur within the required timeframe.	**Exception**	There were two medication errors within the last 6 months where medication was not passed out timely which was reported. The remainder of the medication passes shows medication is distributed to youth on a consistent basis almost to the minute.	There were two medication errors during the period of review that were reported timely.
During the review period, there were no instances where youth missed their medication due to failure to open the pyxis machine.	**No eligible items for review**	There is no documented instances where the Pyxis medication cabinet did not allow the youth to receive their medications.	
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 only youth the facility had in the last 6 months that had controlled substances was a DCF youth. The staff member was able to describe the process for controlled substances, where two party authentication was required and they completed a medication count between each shift. The facility has been maintaining the list the last two months, and did not have evidence of sharps being accounted for prior to November 2023.	There is no evidence of a documented perpetual inventory for over the counter medications. The facility only uses the Pyxis cabinet count to manage the number of medications counted. There had not been an official sharp count maintained until November of 2023 since the nurse left in 2021.
There are monthly reviews of the Pyxis reports to monitor medication management practice.	**Compliance**	The organization pulls the Pyxis reports bi-weekly, and is shared and stored regularly in agency G-drive for those who need access.	
Medication discrepancies are cleared after each shift.	**Compliance**	The Pyxis reports reviewed showed the discrepancies which were found were cleared within the same shift. This was generally observed as being completed within an hour of the discrepancy.	
The agency has an internal quality assurance process to ensure appropriate medication management and distribution methods.	**Exception**	A review of the internal quality assurance (QA) process for ensuring appropriate, accurate and complete medication management and distribution was conducted.	There is no process in place to show QA for medication, as the supervisor only double checks the information in the Pyxis medication cart and on the Medication Distribution Logs when they are in the medication room.
Additional Comments: **There are no additional comments for this indicator.**			

4.04 - Medical/Mental Health Alert Process			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 4.04		**YES** If NO, explain here: The agency does not utilize policy numbers, only titles. The agency has a policy titled Medical, Mental Health, Substance Abuse Screening & Alerts. The entire policy manual was last reviewed and approved by the Children's Services Director on October 1, 2021. Department policies/procedures will be reviewed every three years and modified as needed.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: 3 **Total number of Closed Files: 4** **Staff Position(s) Interviewed** *(No Staff Names)* **: None.** **Type of Documentation(s) Reviewed: 3 open residential and four closed residential.** **Describe any Observations: See indicator report findings.**			
Youth with a medical, mental health, or food allergy was appropriately placed on the program's alert system	**Compliance**	Review of the agency's General Alert system was conducted to determine of the agency's current practice meets the requirements of this indicator. A review of a multiple Residential and Community Counseling files indicate that all client files have documented evidence of youth having been properly screened for health history, medical, mental health and all acute health issues.	
Alert system includes precautions concerning prescribed medications, medical/mental health conditions	**Compliance**	All Residential and Community Counseling client files reviewed contained documented evidence of youth having been screened for medications.	
Staff are provided sufficient training, information and instructions to recognize/respond to the need for emergency care for medical/mental health problems	**Compliance**	A review of all new staff member training records were reviewed and contained documentation of training in MHSA, CPR and First Aid.	
A medical and mental health alert system is in place that ensures information concerning a youth's medical condition, allergies, common side effects of prescribed medications, foods and medications that are contraindicated, or other pertinent mental health treatment information, is communicated to all staff	**Compliance**	The agency utilizes a color-coded alert system with specific colors to ensure all staff members are aware of the following youth deemed to have the following alert including mental health/suicide alert, medical issues, substance abuse issues, behavioral issues, domestic violence, and exigent youth.	
Additional Comments: **There are no additional comments for this indicator.**			

4.05 - Episodic/Emergency Care			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 4.05		**YES** If NO, explain here: The agency does not utilize policy numbers, only titles. The agency has a policy titled Medical Emergencies. The entire policy manual was last reviewed and approved by the Children's Services Director on October 1, 2021. Department policies/procedures will be reviewed every three years and modified as needed.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: 3 residential. **Total number of Closed Files: 1 closed.** **Staff Position(s) Interviewed** *(No Staff Names)* **: None.** **Type of Documentation(s) Reviewed: General client files.** **Describe any Observations: See indicator findings.**			
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**	All applicable emergency medical youth records were reviewed. Documentation supported parental notification was made in all four incidents. All incidents were reported to the Central Communications Center (CCC). All incidents were documented in the daily log.	
All staff are trained on emergency medical procedures	**Compliance**	In review of staff training files, there was evidence that all of them had training in Emergency Response through the agency.	
The program has a Knife-for-life and wire cutters accessible to staff in a secure location(s)	**Compliance**	There is a knife-for-life located on the campus along with wire cutters. There is a first aid kit on campus and one in each of the transportation vans. In reviewing the first aid kit on the campus and 4 vans, all required items were located. The kits are checked monthly and there was evidence indicating checks.	
Additional Comments: **There are no additional comments for this indicator.**			