Florida Network for Youth and Family Services
Compliance Monitoring Report for

Lutheran Services Florida NW – Currie House

4610 Fairfield Drive
Pensacola, FL 32506

November 8-9, 2023

Compliance Monitoring Services Provided by

FOREFRONT

EXECUTIVE SUMMARY

Forefront LLC conducted a joint Quality Improvement (QI) and Florida Network of Youth and Family Services (FNYFS) monitoring visit for the Lutheran Services Florida NW Currie House (LSF NW Currie House) for the FY 2023-2024 at its program office located at 4610 Fairfield Drive, Pensacola, Florida 32506. 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. LSF NW Currie House is contracted with the Florida Network of Youth and Family Services (FNYFS) to provide direct services to Children/Families in Need of Services (CINS/FINS). The services to be provided are identified in Contract Section A - Descriptions and Specifications and Section B - Delivery and Performance and are funded with General Revenue Funds effective from July 2023 through June 30, 2024.

The review was conducted by Nitara LaTouche, Consultant for Forefront LLC and Peer Reviewer(s). Agency representatives from LSF NW Currie House present for the entrance interview were Sherri Kirkpatrick, Regional Director; Donna Bakermattson, Senior Administrative Assistant; Sheryl L'Huillier, Registered Nurse; Cyndy Freshour, Quality Services Manager; Karen Buskey, Shelter Manager; Jamie LaPointe, Outreach Coordinator; and Rachel Wilbourn, Counselor I. The last onsite QI visit was conducted January 25-26, 2023.

In general, the Reviewer found that LSF NW Currie House is in compliance with specific contract requirements. **LSF NW Currie House received an overall compliance rating of 90.9% for achieving full compliance with 11 indicators** of the CINS/FINS Monitoring Tool. There were no corrective actions as a result of the monitoring visit; however, one recommendation was made for an indicator rated as conditionally acceptable.

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 11-09-20232024

Agency Name: Lutheran Services Florida (Currie House)						**Monitor Name: Nitara LaTouche, Lead Reviewer**	
Contract Type : CINS/FINS						**Region/Office: 4610 W. Fairfield Dr., Pensacola FL**	
Service Description: Comprehensive Onsite Compliance Monitoring						**Site Visit Date(s): November 8-9, 2023**	
	Explain Rating						
Major Programmatic Requirements	**Unacceptable**	**Conditionally Unacceptable**	**Fully Met**	**Exceeded**	**Not Applicable**	**Ratings Based Upon:** **I = Interview** **O = Observation** **D = Documentation** **PTV = Submitted Prior To Visit** **(List Who and What)**	**Notes** **Explain Unacceptable or Conditionally Acceptable:**
I. Administrative and Fiscal							
DJJ Quality Improvement Peer Reviewer a. Provider shall demonstrate that a minimum of two (2) staff members have been trained to be certified as DJJ QI Peer reviewers. Provider shall participate in a minimum of one (1) on-site quality assurance review of a similar type of program in another judicial circuit during each 12-month period of the contract, if requested.	☐	☒	☐	☐	☐	Interview/Documentation: The agency reports that the current certified peer reviewers: Cynthia Freshour, QA Manager. The Regional Director made an inquiry about upcoming trainings for a new staff member.	**Recommendation:** The program will need to obtain QI Peer reviewer certification for additional staff member(s) to meet minimum compliance for the contract requirement.
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 listing shall identify the awarding entity and contract start & end dates. **PTV**	☐	☐	☒	☐	☐	Documentation: A list of additional grant contracts for FY 2023-2024 was provided by the provider. The list includes fund identification number, program name, funding source name, contract period start and end dates and contract amount.	**No recommendation or Corrective Action.**
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	☐	☐	☐	☒	☐	Documentation: The provider has a policy with Market Global Reinsurance Company for General Liability insurance with limits of coverage of $1,000,000	**No recommendation or Corrective Action.**

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required by Chapter 440, F.S. with a minimum of $100,000 per accident, $100,000 per person and $500,000 policy aggregate. Commercial General Liability with a limit of $500,000 per occurrence, and $1,000,000 policy aggregate. Automobile Liability Insurance shall be required and shall provide bodily injury and property damage liability covering the operation of all vehicles used in conjunction with performance of this contract, with a minimum limit for bodily injury of $250,000 per person; with a minimum limit for bodily injury of $500,000 per accident; with a minimum limit for property damage of $100,000 per accident and with a minimum limit for medical payments or $5,000-$10,000 per person. Florida Network is listed as payee or co-payee. **PTV**						each/$3,000,000 aggregate and $10,000 each for medical expenses. Additional policies with this carrier include Professional Liability insurance provides limits of coverage of $1,000,000 each/$3,000,000 aggregate and Abuse/Molestation insurance provides limits of coverage of $1,000,000 each/$3,000,000 aggregate. The provider has a policy with Florida Insurance Trust for Automobile insurance that provides limits of coverage of $1,000,000 combined for each accident. The provider has a policy with Century Surety Company for Excess/Umbrella Liability insurance which provides limits of coverage of $1,000,000 each/aggregate. Coverage for the above policies is in effect for the current FY 6/01/2023-6/01/2024. The certificate does list the	

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						Florida Network on the consolidate certificate of liability as a certificate holder.	
External/Outside Contract Compliance a. Provider has corrective action item(s) cited by an external funding source (Fiscal or Non-Fiscal). **ON SITE**	☐	☐	☐	☐	☒	Documentation/Interview: N/A – Regional Director indicated that there are no outstanding corrective action item(s) cited by an external funding source.	**No recommendation or Corrective Action.**
Fiscal Practice a. Agency must have employee and fiscal policy/procedures manuals that are in compliance with GAAP and provide sound internal controls. Agency maintains fiscal files that are audit ready. **PTV**	☐	☐	☒	☐	☐	Documentation: The provider has several policies that address general accounting practices which are maintained by the Chief Financial Officer for the agency. Fiscal Policies and Procedures are contained in the agency's Financial Services Policy and Procedures Manual. The procedures reviewed appear to be consistent with GAAP and provide for limited internal controls. Provider provided 45 policies that covered procedures for general ledger, cost accounting, payroll, petty cash, computer backup, and other relevant financial processes.	**No recommendation or Corrective Action.**

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b. Agency maintains a general ledger and the corresponding source documents. General ledger must be set up to track the activity of the grant separately (standard account numbers / separate funds for each revenue source, etc.). **PTV**	☐	☐	☒	☐	☐	Documentation: Detailed General Ledger for the current FY2023-2024 for July – Sept 2023. Provider maintains a detailed general ledger that includes breakdown of GL code, GL title, effective date, Doc number, ID number, Name of funding source, Transaction description, fund code, year code, program code, location code, and debit and credit columns. Ledgers included current balances and differences.	
c. Petty cash ledger system is balanced and all cash disbursements are compliant with financial policies and allowable under the contract. (Disbursements/invoices are approved & monitored by management.) –**ON SITE**	☐	☐	☒	☐	☐	Observation/Documentation: The agency maintains the same system of managing petty cash since the last program review. At the time of this program review, the agency's Sr. Administrative Assistant is the steward of the agency's petty cash, if she is not available the Regional Director is the only other party with access to the petty cash drawer. The petty cash on-hand, checks, and receipts were reconciled onsite on day 2 with the Senior Administrative Assistant and	**No recommendation or Corrective Action.**

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						was verified to be consistent with October petty cash reconciliation documentation. Petty cash is stored in a secure locked location and must be verified and approved by management on a monthly basis.	
d. Financial records and reports are current. Includes bank statements reconciled within 6 weeks of receipt. Vendor invoices past 6 months. Invoices are submitted on a monthly basis with supporting documentation. (Disbursements/invoices are approved & monitored by management). **ON SITE**	☐	☐	☒	☐	☐	Documentation: Reviewed Bank Statements and Bank Reconciliations for months March 2023-August 2023 for one account with Ameris Bank. Bank reconciliations are conducted each month for the activities and bank statements for the preceding month and are reviewed by two parties. Invoices are submitted on a monthly basis with supporting documentation.	**No recommendation or Corrective Action.**
e. Agency maintains inventory in accordance with a written policy and FNYFS contractual requirements. If over $1,000 inventory has DJJ Property Inventory Number/Tag. In the event the provider has purchased computer equipment an Informational Resources Request (IRR) been submitted to DJJ. **PTV/ON SITE**	☐	☐	☐	☐	☒	Documentation/Interview: N/A – The agency has not purchased any items with FNYFS funds since the last time on-site.	**No recommendation or Corrective Action.**
f. Agency submits payroll taxes and deposits (and retirement deposits as applicable), Employee IRS Form W-2 and	☐	☐	☒	☐	☐	Documentation: Provider submitted evidence of payroll taxes and deposits for first and second	**No recommendation or Corrective Action.**

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Independent Contractors IRS Form 1099 forms prior to federal requirements. **ON SITE**						quarters for FY2023. A Deposit Recap report showed funds deposited every two weeks via EFT or check and showed all payments made.	
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 detailed CINS FINS Budget Report as of 9/30/2023, including months June 2023-Sept 2023. The report tracks all budget categories by current period actual and current period contract separately. Variances if applicable are identified.	**No recommendation or Corrective Action.**
h. A Single Audit is performed as part of the annual audit if expenses are greater than $750,000. The agency must submit a Corrective Action Plan for findings cited in the management letter and single audit. An annual financial audit was completed within 120 days after the previous fiscal year/calendar year and that a copy was provided to the Network unless and extension has been requested and approved in writing. Copy of Audit is submitted to the FNYFS by December 31st. **Can obtain from FNYFS**	☐	☐	☒	☐	☐	Documentation: Financial audit was conducted for the fiscal year beginning June 30, 2021 – 2021 by RSM US LLP. A letter dated December 22, 2022, stated no corrective action was needed. A copy was submitted directly to the Florida Network of Youth and Family Services. The agency reported that the auditors are still working on the FY2023 audit which should be issued by 12/31/23.	**No recommendation or Corrective Action.**

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i. Agency maintains confidentiality policy with written policies and procedures to ensure the security and privacy of all employee and client data. Personal information is not easily accessible. Agency maintains a backup system in case of accidental loss of financial information. Security procedures are in place to protect laptops. Obsolete documents are shredded and computer hard drives are wiped prior to discarding. **ON SITE**	☐	☐	☒	☐	☐	Documentation: The agency maintains a procedure manual with several sections (Information Technology, Risk Prevention and Management) to address security and privacy of employee and client data. The agency provided 7 Policies and Procedures for review including: Confidentiality of Clients, Records Retention, IT Disposal of Hardware, IT Security, Data Backup Retention and Recovery, Access to Case Records, and Case Record Keeping. The agency CEO oversees authority for administration for these policies and the Senior Director of Information Technology is responsible for maintaining policies are current.	**No recommendation or Corrective Action.**

CONCLUSION

Lutheran Services Florida NW Currie House has met the requirements for the CINS/FINS contract as a result of full compliance with 11 applicable indicators of the Administrative and Fiscal Contract Monitoring Tool. Two of thirteen indicators were not applicable because 1) the provider does not have any outstanding corrective action item(s) cited by an external funding source, and 2) does not have any current inventory purchased with DJJ/FN Funds. Consequently, **the overall compliance rate for this contract monitoring visit is 90.9%.** There are no corrective actions cited but one recommendation is made as a result of the contract monitoring visit. Overall, the provider is performing satisfactorily in meeting the fiscal and administrative terms of its contract. In addition, the majority of indicators reviewed were carried out in a manner which meets the standard described in the report findings.

SUMMARY OF RECOMMENDATIONS

Recommendation:

1. The program will need to ensure there are enough certified staff trained to maintain compliance with this contract requirement for the entire fiscal year including considerations for any staff retiring or resigning prior to the end of the fiscal year.

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

Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Lutheran Services Florida NW - Currie House
CINS/FINS Program

Date: November 8-9, 2023

Compliance Monitoring Services Provided by

FOREFRONT

CINS/FINS Rating Profile

Standard 1: Management Accountability

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

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

Standard 2: Intervention and Case Management

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

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

Standard 3: Shelter Care & Special Populations

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

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

Standard 4: Mental Health/Health Services

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

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

Overall Rating Summary

Percent of indicators rated Satisfactory: 75.86 %
Percent of indicators rated Limited: 17.24 %
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
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

Nitara LaTouche - Lead Reviewer Consultant-Forefront LLC/Florida Network of Youth and Family Services
Stephanie Solano– Regional Monitor, Department of Juvenile Justice
Gina Dozier – CCYS
Naret Morales – Anchorage Children's Home of Bay County, Inc.
Tamika Gloston – Youth Crisis Center, Inc.

Methodology

This review was conducted in accordance with FDJJ-2000 (Quality Assurance Policy and Procedures), and focused on the areas of (1) Management Accountability, (2) Intervention and Case Management, (3) Shelter Care/Health Services, and (4) Mental Health/Health Services, which are included in the Children/Families in Need of Services (CINS/FINS) Standards (Effective July 1, 2023).

Persons Interviewed

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

Documents Reviewed

X	Accreditation Reports	X	Table of Organization		Visitation Logs
X	Affidavit of Good Moral Character		Fire Prevention Plan	X	Youth Handbook
X	CCC Reports	X	Grievance Process/Records		# Health Records
X	Logbooks		Key Control Log		# MH/SA Records
X	Continuity of Operation Plan	X	Fire Drill Log		# Personnel /Volunteer Records
	Contract Monitoring Reports	X	Medical and Mental Health Alerts		# Training Records
	Contract Scope of Services	X	Precautionary Observation Logs		# Youth Records (Closed)
X	Egress Plans	X	Program Schedules		# Youth Records (Open)
X	Fire Inspection Report	X	List of Supplemental Contracts		# Other: ___
X	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
	Recreation	X	Toxic Item Inventory & Storage	X	First Aid Kit(s)
X	Searches		Discharge		Group
X	Security Video Tapes		Treatment Team Meetings		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	7	# of Direct Staff		# of Other		

Comments

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

Monitoring Purpose

The purpose of this monitoring is to provide an annual quality improvement program review. This is to verify the agency adheres to all current CINS/FINS standards and contract compliance requirements for residential and/or community counseling services.

Strengths and Innovative Approaches

Lutheran Services Florida NW - (Currie House) is part of the statewide, non-profit, Lutheran Services Florida (LSF) agency that contracts with the Florida Network of Youth and Family Services (Florida Network) to operate Children In Need of Services/Families In Need of Services (CINS/FINS) residential and community counseling services to youth and families in Escambia County. LSF Currie House serves all eligible youth between the ages of ten to seventeen year old in its residential program and six to seventeen year old who are runaway, ungovernable and/or truant, locked out, homeless, abused, neglected, or possess other presenting problems. In addition to CINS/FINS, the agency provides services to special populations who meet the criteria for youth referred for domestic violence (DV) respite, probation (PR) respite, Family and Youth Respite Aftercare services (FYRAC), and Stop Now and Plan (SNAP).

The following programmatic updates were provided by the agency:

Staffing:
Sherri Kirkpatrick is the Regional Director, overseeing all of the LSF Northwest programming. Currie House has been supervised by Sherry Kuss since 8/21/23, and is now overseen by Karen Buskey, Shelter Manager. Currently there are three full-time and two part-time YCS vacancies. There are three applicants in process for the fulltime positions. The agency is currently in the recruiting and interviewing process for the other vacancies; Lead Counselor and a Residential Counselor position. There have been several staff changes that continue to impact the program. The most positive change has been the introduction of a new Shelter Manager, Karen Buskey. The Shelter Manager will oversee both Currie House and HOPE House. In June of this year, the Lead Counselor took another position within the Network. The agency is recruiting for that position, which is vacant, and the Regional Director is covering the role in the interim. Donna Bakermattson was promoted internally from Administrative Assistant II to the Senior Administrative Assistant position in mid-August. The agency had to eliminate the Administrative Assistant II position due to budget constraints along with three other positions.

Sherri Kirkpatrick, Regional Director is a LMHC. Karen Buskey, Shelter Manager has a Masters of Public Administration and a Bachelor's of Science in Psychology. Sheryl L'Huiller is a Registered Nurse. There are three masters level counselors, one bachelors level counselor staff member and one staff counselor currently pursuing her masters degree, which will be complete in med-December.

Program updates:
The program has dedicated the past year to rebuilding and stabilizing services and has not started any new initiatives at this time. The program primarily serves youth in the Escambia and Santa Rosa counties, however, when HOPE House is full and Currie House has availability, the program serves youth from Okaloosa and Walton Counties. Community Counseling is provided primarily in the office, however, virtual and home visit options are utilized when clients cannot otherwise attend. Groups are provided in the school setting, as well as within the shelter. The agency continues to maintain paper files.

Facility:
The agency recently updated the technology wiring for the entire property. The old wiring was outdated, and frequently lost service during certain weather conditions. The program replaced the HVAC systems covering the shelter. Additionally, there were internal renovations to include removing a wall between the dining room and dayroom to allow for improved supervision and use of the space. The washer and dryer was recently replaced through a donation from a local laundromat.
In the future, the program would like to eventually combine locations (Currie and HOPE House) into a more centralized location to allow the program the opportunity to better maximize the use of staff.

Funding:
The program was recently awarded a new 3-year grant with Health and Human Services (HHS).The program benefits from supplemental funding through HHS to support a Life Skills Coach and part of the Outreach Coordinator position, as well as several YCS positions. This funding allows the program to fully support youth who are aging out of their childhood and have no other supports. The corporate office continues to fundraise throughout the year. A capital campaign was initially planned for this year but was put on hold in an effort to stabilize programming.

Governance and Community:
Currie House has several ongoing partnerships. Homeless Reduction Taskforce of NWF, Opening Doors of NWF (CoC), Human Trafficking Task Force (4 counties), Point in Time Count, Greater Pensacola Chamber of Commerce event, Northwest Florida Prevention Coalition, Suicide Prevention Coalition, Community Alliance (FWM), Community Alliance FWB, Legislative Luncheon, State of Military Affairs Luncheon, School Counselors preschool year meeting, resource officers, open house alternative education school, Opioid Summit, Circuit 1 Alliance Provider Fair, High Risk Victim meeting, National Night Out, Real Change Escambia.
The agency has had a dedicated supporter of Currie House clients for several years who will be starting a new business. They are eager to continue the partnership with Currie House and are excited to share and promote the services provided by Currie House with new business partners and plans to encourage them to join continued support of the program. Additional partnerships include; George Stone for GED and technical training, and a local church that has provided back to school support for Currie House clients for several years. This year, the event was moved to their youth building and it was such a success, the youth pastor has offered youth from both shelters to attend their 1st Sunday of each month “gathering” to use their youth building to hang out, play games etc. The program has partnered with several schools this year to provide services: Achieve, SL Jones, Global Learning Academy, and Ferry Pass.

Major Challenges:
The agency has observed that the salary expectations are a huge barrier to eligible applicants. In response, LSF has increased the salary significantly (16%), but still struggles to compete with the School System and other providers.

Narrative Summary

Lutheran Services Florida NW - Currie House and the administrative office is located at 4610 W. Fairfield Dr. Pensacola, FL 32506. The Community Counseling office is located at 5643 Stewart St, Milton, FL 32570. Lutheran Services Florida/NW (Currie House) is contracted to provide Children In Need of Services and Families In Need of Services (CINS/FINS) in Circuit 1; which includes counties Escambia, Santa Rosa, Okaloosa and Walton County. The agency maintains an accreditation through February 28, 2026 with the Council on Accreditation (COA). The program maintains a Department of Children and Families (DCF) child caring license through September 27, 2024, for 12 beds at Currie House.

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

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

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

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

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

Standard 1:

Indicator 1.01 - Limited: Three staff and one volunteer, who provide direct services to youth, did not have evidence of the suitability assessment being on file prior to date of hire. One employee file was found to have an expired retained fingerprint date 5/14/22 on the background screening at the time of the review.

Indicator 1.04 - Limited: Five applicable new hire staff training records were inconsistent for the required pre-service and completion of all 90-day training. One staff still had not yet reached 90 days from date of hire. All new staff training records lacked evidence of completion of pre-service trainings; Cultural Humility and Understanding Youth/Adolescent Development. Annual in-service trainings were inconsistent across all five training records reviewed due to late and/or missing trainings.

Indicator 1.06 - Failed: One out of the 20 drivers had a suspended license as of 6/26/23 and was listed as transporting youth during the period reviewed. There were inconsistencies with the transportation log being completed for all required entries. There were 28 single transports that were not approved prior to transport. 70 of the 72 applicable single transports with prior approval did not have documentation of check in calls during that transport from the time the policy was in effect between July 2023 - November 2023.

Standard 2:

Indicator 2.05 - Limited: Documentation for groups provided to youth was not maintained consistently. Unable to verify that groups were held a minimum of 5 days per week between May 2023 thru Oct. 2023. Four of the five shelter files reviewed did not have group notes documented. Attendance sheets were not consistently completed for groups held from May 2023 - Sept.2023. Due to a lack of documentation, it was not possible to confirm if groups were being held for 30 minutes or longer. Documentation did not consistently list group participants between May 23 - Sept. 2023. One community counseling file did not include the location of where services were provided.

Indicator 2.09 - Limited: One applicable file was missing the post CBCL from the file. There was no evidence of a completed Teacher Report Form (TRF) or any attempts or request noted for any of the files reviewed. There was no evidence of the SNAP Discharge Report in one applicable file. There was no evidence of SNAP Child and Parent Group Evaluation Form in the files reviewed and staff had no knowledge of this requirement.

Standard 3:

Indicator 3.07 - Limited: Evidence of supervisory reviews being completed every 14 days could not be located for the 6 month period of review. There was no evidence presented to confirm when reviews were being completed and which activities are being assessed.

CINS/FINS QUALITY IMPROVEMENT TOOL

Quality Improvement Indicators and Results: Please select the appropriate outcome for each indicator for each item within the indicator.	**Summary/Narrative Findings:** The narrative write-up is a thorough summary of each assigned QI indicator worksheet, explain how you came to your finding(s).	**Deficiencies/Exceptions:** Please add additional detailed explanations for any items that have any deficiencies or exceptions.
Standard One – Management Accountability		
1.01: Background Screening of Employees, Contractors and Volunteers		**Limited**
Provider has a written policy and procedure that meets the requirement for Indicator 1.01	**NO**	
	If NO, explain here: The policy does not include the rating that is required to be considered as passing the suitability assessment. Policy also does not state that any staff not passing the suitability on initial attempt will not be considered as verbally explained by program staff.	
	The agency has a policy titled1.01 DCF FAC 65C, FDJJ-1800PC, FN YFS PPM 2020- 5.03, 5.04 that was reviewed by the Regional Director in October 2023.	

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

Total number of New Hire Employee/Intern/Volunteer Files: 13 employee records and 1 volunteer
Total number of 5 Year Re-screen Employee Files: 1 employee record was reviewed for this indicator
Staff Position(s) Interviewed *(No Staff Names)* **: Human Resources and Regional Director**
Type of Documentation(s) Reviewed: DJJ Eligibility Screening forms, predictive index summaries, employee roster and clearinghouse roster was reviewed for this indicator.
Describe any Observations: The items were provided electronically and the agency was transparent about any issues observed.

All positions providing direct services to youth has successfully passed pre-employment suitability assessment on the initial attempt.	**Exception**	The agency utilizes the Predictive Index for screening all possible candidates prior to hire. Nine staff files reviewed contained the suitability assessment as required prior to date of hire.	Three staff and one volunteer, who provide direct services to youth, did not have evidence of the suitability assessment being on file prior to the date of hire.
For any applicant that did not pass the initial suitability assessment, there was evidence that the applicant retook the assessment and passed within five (5) business days of the initial attempt, not exceeding three (3) attempts within thirty (30) days.	**No eligible items for review**	The agency reported they did not have any applicants that were hired that did not pass the suitability assessment on the first attempt. During an interview with Regional Director, it was explained that any staff not passing the suitability on initial attempt will not be considered for the position.	

Agency has evidence for employees who have had a break in service for 18 months or more, and/or when the agency had a change or update in the suitability assessment tool used was different from the employee's original assessment, that a new suitability assessment and background screening was completed as required.	**No eligible items for review**	The agency did not have any employees with a break in service for 18 months or more during this review period.	
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**	All 13 files reviewed contained the DJJ background screening prior to start date and all were deemed 'eligible' on the screening form.	
Five-year re-screening is completed every 5 years from initial date of hire or prior to retained fingerprints expiration date.	**Exception**	Only one file was applicable and reviewed for rescreen prior to retained fingerprint dates.	One employee file was found to have an expired retained fingerprint date 5/14/22 on the background screening at the time of the review. The HR staff explained this appeared to be due to an oversight with not submitting all of the required paperwork at the time of the request initially. The agency was able to submit the screening to the BSU and requested this be expedited on 11/8/23. Due to the expiration of the screen and the employee having worked shifts, the agency reported this CCC (report # 202305374) at the time of the review.
Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?	**Compliance**	The agency completed the Annual Affidavit of Compliance with Level 2 Screening prior to January 31st as required. Evidence of the email sent to the Background Screening Unit (BSU) was provided and dated January 10, 2023.	
Proof of E-Verify for all new employees obtained from the Department of Homeland Security	**Compliance**	12 files contained evidence the E-Verify was verified from the Department of Homeland Security.	
Additional Comments: **There are no additional comments for this indicator.**			

1.02: Provision of an Abuse Free Environment			Satisfactory with Exception
Provider has a written policy and procedure that meets the requirement for Indicator 1.02		**YES**	
		If NO, explain here:	
		The agency has policy number 1.02 titled Provision of an Abuse Free Environment that was reviewed/ approved by the Regional Director 11/7/23.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Staff Position(s) Interviewed *(No Staff Names)* **: The Youth Care Supervisor from the shelter and a Counselor in the Community Counseling program** **Type of Documentation(s) Reviewed: The written policy and procedure were reviewed, along with completed grievance forms.** **Describe any Observations: Grievance forms and secure Dropbox were seen in the shelter. The Client Grievance Form was observed to have a place for the " YCS/Counselor" to sign , rather than a supervisor. However, the signed grievance forms were signed by the supervisor. A note was left in the grievance box by the review team at the time of the review but follow-up was not able to demonstrate the box was checked daily.**			
Agency has a code of conduct of policy and there is evidence that staff are aware of agency's code of conduct.	**Compliance**	Agency has a code of conduct that is outlined in the Lutheran Services Florida Personnel Policies and Procedures Manual, Section 1.0 - Statements of Mission and Philosophy. Employees sign forms acknowledging they will comply with the expectations. The signed forms are kept tin the employee personnel file.	
The agency has a process in place for reporting and documenting child abuse hotline calls.	**Compliance**	Staff are trained to report allegations of child abuse or suspected abuse to the Florida Abuse Hotline. Abuse reports are documented in the electronic logbook and client files. An interview was conducted with a Community Counseling Counselor who explained that she has filed approximately ten abuse reports in the past six months and articulated the process of completing the Abuse Registry Report form.	
Youth were informed of the Abuse and Contact Number	**Compliance**	The Florida Abuse Hotline Number was observed as posted and being visible to youth in the facility.	
Grievance			
Grievances are maintained on file at minimum for 1 year.	**Compliance**	Grievances are maintained as required and were observed for the 6 month review period.	
There are formal grievance procedures for youth, including grievance forms, and a locked box which are easily accessible to youth in a common area.	**Compliance**	The secure grievance box and blank forms were observed in the common/living area of the shelter. The grievance box and forms are accessible to youth and the grievance procedures are posted for client view.	

There is evidence that grievance boxes are checked by management or a designated supervisor at least daily as evidenced in the program logbook.	**Exception**	A review of the past 6 months documentation from the electronic logbook revealed notations of some checks for grievances being documented during the required timeframe (as allowed per policy and the indicator).	Documentation revealed that there is a process is in place to check the box, but it is inconsistent. Missed dates included seven days in May, ten days in June, eight days in July seven days in September, and eight days in October.
All grievances are resolved within 72 hours and documented by program director/supervisor or escalated to higher leadership if grievance involves them directly.	**Exception**	There were 12 grievances provided for review from the past six months. Three were dated by both the client and the staff. The dates did not consistently designate date grievance was filed or resolved. During discussion of the process and observation of the forms, the Youth Care Supervisor explained that sometimes youth submit grievance forms that are not actually bona fide grievances, but rather simple commentary or other communication.	Five out of the 12 grievances reviewed had no dates at all, and were not dated by the supervisor who signed as having addressed the grievance. Three were dated by both the client and the staff but dates did not specifically designate clearly the date filed and/or resolved.
1.03: Incident Reporting			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 1.03		**YES** If NO, explain here: Agency policy 1.03 Incident Reporting /Risk Management was reviewed/approved by the Regional Director in November 2023.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Staff Position(s) Interviewed *(No Staff Names)* **: Regional Director** **Type of Documentation(s) Reviewed: For the period reviewed, a file of 12 internal CCC reports from the agency was reviewed, along with 16 reports provided by the DJJ and email correspondence between the CCC and the program.** **Describe any Observations: The time zone difference between the location of the program and the CCC requires special attention. CCC generated reports time and date stamp have a one hour time difference due to being located in the Eastern time zone, while the program is located in and reports in the Central time zone. Most reports generated from the CCC note the times in the program's time zone in the narrative of the report. The DJJ hotline number was posted in the facility.**			
During the past 6 months, the program notified the Department's CCC (Central Communication Center) no later than two hours after any reportable incident occurred or within two hours of the program learning of the incident	**Exception**	There were 12 CCC reports provided by the agency for Review. The incidents were recorded on the Contract Provider Incident Report Form and contained information related to situation, the name of the reporting employee, the date and time of the incident, and notification made both internally and externally. Of the 12 reports, 11 were determined to have been reported within 2 hours of the program learning of the incident.	One CCC report (report 20230279) was determined not reported within the two hour time frame. Corrective action for the employee responsible was completed according to follow-up updates to CCC.
The program completes follow-up communication tasks/special instructions as required by the CCC	**Compliance**	A series of emails between the CCC and the program's management staff reflected that the program completes follow-up communication / special tasks as required by the CCC.	

Agency internal incidents are documented on incident reporting forms and all CCC reportable incidents were consistently reported to CCC as required.	**Compliance**	Incidents were recorded on the Contract Provider Incident Report Form and were consistently reported to the CCC.	
Incidents are documented in the program logs and on incident reporting forms	**Compliance**	Incidents were noted to be documented in the NoteActive electronic logbook and all CCC reports were noted on the agency's Contract Provider Incident Report Forms.	
All incident reports are reviewed and signed by program supervisors/ directors	**Compliance**	During the review period, the program had five Program Disruption Incidents reported, one Escape /Abscond incident, nine medical incidents, six complaints against staff incidents and one Youth Behavior incident. Some incidents were classified in multiple of the noted categories. All incident reports observed were signed by a supervisor/director. One incident report appeared to have a typo where staff incorrectly noted AM vs. PM so that it indicated the supervisor was informed of the incident before it occurred. The Regional Director was interviewed and all supporting documentation confirmed that the program did report the incident to the CCC timely.	
1.04: Training Requirements (*Staff receives training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions*)			**Limited**
Provider has a written policy and procedure that meets the requirement for Indicator 1.04		**YES**	
		If NO, explain here:	
		Agency policy 1.04 Training was reviewed/approved by the Regional Director 11/7/23.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			

Total number of New Hire Staff Files: Five employee and one intern who were hired within the past year were reviewed. One of those was still within the first 90 days.
Total number of Annual In-Service Staff Files: Five employees Total number of Non-Licensed Mental Health Clinical Shelter Staff Files: One Non-licensed Mental Health clinical Shelter staff (Counselor) file was reviewed.
Annual Training Plan Timeframe (*Program timeframe for annual trainings*)**: The agency uses the calendar year to calculate annual in-service training hours. At the time of this review, there was almost two months remaining in the year and the last completed annual in-service cycle was calendar year 2022.**
Staff Position(s) Interviewed *(No Staff Names)* **: The Manager responsible for training was interviewed.**
Type of Documentation(s) Reviewed: Eleven training files were reviewed. Those included samples of first year, ongoing, direct care, and non-licensed clinical staff as well as an intern.
Describe any Observations: Staff training files were similarly arranged in two sided file fastener folders with the left side holding CPR /First Aid, MAB, and other similar specific certifications. The right side of the files contained a listing of the employees' completed trainings on top. The format of the training list met the requirements of the FNYFS training log as they included the name of employee, date of hire, title or topic of training and date trainings were completed. Certificates of completion, outlines, checklists and other similar supporting documents were located on the right side of the file behind the training list / logs.

First Year Direct Care Staff			
All direct care staff have completed new hire pre-service training requirements for safety and supervision as required.	**Exception**	All six new hire completed the Provider's Orientation training that included a series of topics, confidentiality and child abuse reporting. One staff was still within the 90 day requirement to complete pre-service requirements.	Five applicable staff files were not consistent for completing all pre-service training requirements within the required timeframe. One staff was missing Signs and Symptoms of Mental Health and Substance Abuse, Universal Precaution. Five staff were missing Cultural Humility and Understanding Youth/Adolescent Development as required within 90 days. Two staff were missing Fire Safety equipment.
All staff completed the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days from date of hire.	**Compliance**	All six of the first year Direct Care staff training files reviewed indicated staff had completed the Civile Rights & federal Funds training within 30 days of hire.	
All direct care CINS/FINS staff (full time, part time, or on-call) demonstrated a minimum of 80 hours of training or more for the first full year of employment.	**Compliance**	Two first year employees had completed more that 80 hours of training at the time of the review. Three first year employees and the intern were within their first year and had several months to complete their hours. They had completed 79 hours, 74.3 hours, 76.8 hours and 50 hours and all appear to be on track to meet this requirement.	

All staff receives all mandatory training during the first 90 days of employment from date of hire.	**Exception**	All new hires had completed four of the mandatory trainings that are required within the first 90 days. There was one employee who was within the first 90 days and still had time to complete mandatory training.	Four employees were missing Cultural Humility training within the first 90 days of employment. Three were missing Understanding Youth /Adolescent Development, four were missing CPR and First Aid and three were missing Managing Aggressive Behavior or other FNYFS approved crisis intervention training as required.
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**	There were two staff members who were responsible for NIRVANA training and both had completed the training.	
Staff Participating in Case Staffing & CINS Petitions (within first year of employment)			
Documentation of instructor led FL Statute 984 CINS Petition Training by a local DJJ Attorney. *Effective for staff hired after 7/1/23*	**Not Applicable**	Requirement effective July 2023 and there were no staff training files reviewed to whom this applied.	
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**	There was one counselor within the first year of employment that had documentation of training in Assessment of Suicide Risk that was confirmed in writing by the Regional Director, who is a Licensed Mental Health Counselor, (license MH4727) on 5/20/23. The counseling Intern is within the first year of hire.	
In-Service Direct Care Staff			

Direct care staff completes 24 hours of mandatory refresher Florida Network, SkillPro, and job-related training annually *(40 hours if the program has a DCF child caring license).*	**Exception**	All five files reviewed for in-service training hours showed that employees met the number of required hours but were inconsistent in completion of the required trainings. The completed training hours ranged from 40 to 78.5 hours of annual in-service. During a staff interview, the training manager explained that these omissions were residual and staff are now able to distinguish between training requirements for "residential" or "all staff having direct contact with youth" more clearly.	Though the number of hours was met, specific in-service topics were missing. Three staff member (SNAP facilitator and counselors) were missing Suicide Prevention, CPR and First Aid. Two were missing PREA, Sexual harassment, Human Trafficking, Child Abuse Recognition and Reporting, and Trauma informed Care.
Required Training Documentation			
The agency has a training plan that includes all of the required training topics including the pre-service and in-service.	**Compliance**	The agency's written policy and procedure serves as the training plan. The Training Manager, who oversees all training, was interviewed and explained in detail how new employees are onboarded and the order and timelines in which the trainings are completed, as well as how the training is tracked.	
The agency has a designated staff member responsible to manage all employee's individual training files and completes routine tracking and reviews of staff files to ensure compliance.	**Compliance**	The agency has a designated Training Manager who maintains and manages the employees' training files and tracks the training hours of each employee.	
The program maintains an individual training file or employee file AND a FLN Training Log (or similar document that includes all requirements) for each staff, which includes an annual employee training hours tracking form and related documentation, such as electronic record/transcript, training certificates, sign-in sheets, and agendas for each training attended.	**Compliance**	The agency maintains individual training files for each employee. Each training file is arranged similarly in two-sided fastener folders with the left side holding CPR/First Aid, MAB and other such major required certifications. The right side of the files contained a listing of the employees' completed training placed on top. The format of the training list met the requirements of the FNYFS training logs as they included the name of the employee, date of hire, title or topic of training, date trainings were completed, and total count of hours for the specified time period. Certificates of completion, outlines, checklists and other similar supporting documents were located on the right side of the file behind the training list /log.	

Additional Comments: **There are no additional comments for this indicator.**			
1.05 - Analyzing and Reporting Information			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 1.05		**YES** If NO, explain here: Policy 1.05 Analyzing and Reporting Information was approved on 11/7/23 by Regional Director.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Staff Position(s) Interviewed *(No Staff Names)* **: Regional Director, Lead Counselor** **Type of Documentation(s) Reviewed: PQI plan, agenda for May and June 2023, Quality Assurance Peer Review records**			
Case record review reports demonstrate reviews are conducted quarterly, at a minimum	**Compliance**	During the exit meeting the program provided record reviews dated between November 2023, August 2023, June 2023, May 2023. The forms include client name, file number, counselor assigned, open/closed cases, program type reviewed (residential vs. community counseling), compliant/ non-compliant, timely compliant/ untimely compliant, yes or no indicators for review elements, comment section, and a section for confirming when the item is corrected.	
The program conducts reviews of incidents, accidents, and grievances quarterly, at a minimum	**Exception**	The agency has a CQI Monthly Spreadsheet Companion Report that addresses incidents, accidents, grievances, performance measures, and chart reviews. Companion Report Dated for October 2023 provided data for August - September 2023 showed the program does have a process in place.	Program was unable to provide evidence for entire 6 month review period and missed reports for May - August.
The program conducts an annual review of customer satisfaction data	**Compliance**	The agency reviews customer satisfaction data on a quarterly basis as discussed in October 2023 Companion Report.	

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**	The program has a policy to report monthly outcome and performance measure data into a CQI Monthly Spreadsheet. The Quality Assurance team compiles a report based on this information provided and meetings are held to address concerns.	
The program has a process in place to review and improve accuracy of data entry & collection	**Compliance**	The agency has provided the LSF Quality Improvement Plan 2023 (PQI plan) which discusses the Quality Assurance department is responsible for data collection, processing, analysis, and reporting.	
There is documentation that findings are regularly reviewed by management and communicated to staff and stakeholders.	**Exception**	Agendas for staff meetings were provided for the months of May and June 2023. The PQI plan reports that findings are to be communicated with staff and stakeholders. Upon interview with the Regional Director, the EOM report is reviewed via email with staff and ongoing discussions are held to address areas of concern.	No documentation of meeting minutes was provided for staff meetings after June 2023.
There is evidence the program demonstrates that critical performance data reports are shared with the Board of Directors frequently. All final reports that include a Limited or Failed score is submitted electronically or by mail to the providers Executive Committee on the Board of Directors.	**Exception**	The Regional Director was able to provide correspondence with senior leadership requesting the final reports be provided to the Executive Committee. However, evidence of the Committee receiving this information was not provided to the reviewer at the time.	Unable to verify evidence that Executive Committee was provided final reports electronically or by mail.
There is evidence that strengths and weaknesses are identified, improvements are implemented or modified, and staff are informed and involved throughout the process.	**Compliance**	A quarterly meeting discusses each program's data provided and evidence provided noted that all metrics not met are discussed for root cause. The Companion Report has a section to capture items needing priority, on a current plan or issues that need to be deferred. Additionally, it has a comment section that allows for detail on progress or items needing further explanation based on the pending status. The layout of the document allows for the agency to identify both strengths and weaknesses. The comments did allow for modifications to be discussed and does list all staff in attendance with meeting and discussed if specific tasks were designated. However, it was observed the report provided was not consistent in implementation of all areas that identify concerns and/or does not document timeframes for deferred items that were identified as non-compliant in the Report.	
Additional Comments: **There are no additional comments for this indicator.**			

1.06: Client Transportation			Failed
Provider has a written policy and procedure that meets the requirement for Indicator 1.06		**YES**	
		If NO, explain here:	
		Policy 1.06 Client Transportation reviewed on 11/7/23 by Regional Director.	

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

Dates or Timeframe Reviewed: May 2023-Nov. 2023
Staff Position(s) Interviewed *(No Staff Names)* **: Regional Director and Senior Administrator**
Type of Documentation(s) Reviewed: Transportation Records Binder and Shelter Transportation Log Print Outs

Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	**Compliance**	HR provided a list of 20 drivers who are approved by administrative personnel to drive clients in agency vehicles.	
Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	**Exception**	17 out of the 20 drivers have a Florida driver's license. Senior Administrator showed company insurance policy that covered their agency. It was observed that two staff out of the 20 drivers have valid Alabama driver's licenses. One staff is in the process of getting a Florida license, however, the other staff resides in the state of Alabama and commutes to Florida for work.	One out of the 20 drivers has a suspended license as of 6/26/23. Driver is documented in Transport Record Binder as the driver transporting youth 34 times. Regional Director confirmed that staff was immediately removed from approved driver list the day the suspended license was discovered.
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 transportation policy prohibits transporting a client without at least another passenger and includes exceptions when a 3rd party is not present and is in compliance with the requirement.	
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**	Per the agency's policy, the supervisor or shelter manager consider the clients' history, evaluation, and recent behavior for single transport.	
The 3rd party is an approved volunteer, intern, agency staff, or other youth	**Compliance**	Policy is in compliance with the indicator and utilizes a 3rd party who is an approved volunteer, intern, agency staff, or other youth.	

The agency demonstrated evidence via logbook or other written verification that supervisor approval was obtained prior to all single youth transports.	**Exception**	Transportation logs from May 2023- Nov 2023 were reviewed for this indicator. The program was in compliance 79% of the time by obtaining 104 supervisor approval out of 132 single transports prior to transport. For the applicable months reviewed (July 2023 - November 2023) there were two phone calls made and logged for the approved single client transports. There were 72 approved single client transports in total that were applicable from the time this policy went into effect in July 2023.	28 single transports were not approved prior to transport. 70 of the 72 applicable single transports with prior approval did not have documentation of check in calls during that transport from the time the policy was in effect from July 2023 - November 2023.
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 majority of the entries reviewed were well documented with no missing initials, date and time, mileage, number of passengers, or purpose of travel and location from May 2023 - Nov. 2023 in Transportation Records Binder.	There was a lack of evidence for 18 entries missing driver's initials and one entry was missing the Destination/Purpose for the period of review (May 2023 - Nov. 2023) in Transportation Records Binder as required.
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: Policy 1.07, Outreach Services, was reviewed and approved by the Regional Director on 11/7/23.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Staff Position(s) Interviewed *(No Staff Names)* **: Community Outreach Coordinator** **Type of Documentation(s) Reviewed: Agendas and minutes from various community meetings / outreach events and copies of interagency agreements with service providers.** **Describe any Observations: Documents mentioned above were provided and Outreach events were observed directly from NetMIS. The reviewer met with the Community Outreach Coordinator and pulled up NetMIS Outreach Reports in the live database as there was some technical difficulty with getting the report to download / print. Several leadership staff including the Community Outreach Coordinator reported the Agency / Program is in the midst of a re-branding initiative and showed new promotional materials that include a change in color scheme for their logo.**			
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 Community Outreach Coordinator designated to participate in the local Department of Juvenile Justice (DJJ) Council Meetings. She reported and showed correspondence reflecting the fact that the Circuit Advisory Board has had poor attendance/organization "since Covid". For this reason they had limited formal meeting minutes, however, the Outreach Coordinator was in attendance of the local County DJJ Council Meetings. Outreach was entered into NETMIS and documentation of attendance at various community meetings and events was observed.	

The program maintains written agreements with other community partners which include services provided and a comprehensive referral process.	**Compliance**	The agency has a collection of written interagency agreements and maintains partnerships with local organizations including schools, law enforcement, Baptist hospital, the local Continuum of Care, etc. These working collaborations enables referrals both into and from the program.	
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**	NetMIS Outreach reports reflected 64 outreach events that had been recorded during the past 6 month review period. The report contained the required elements. Some examples of meetings/ outreach events attended included the Escambia County DJJ Council, Back to School Counselors/ student Services Meeting, National Night Out, Opening Doors Continuum of Care, Homeless Reduction Task Force of NWG and the Circuit 1 Human trafficking Task Force.	
The program has designated staff that conducts outreach which is defined in their job description.	**Compliance**	Many staff members conduct outreach and the designated staff person per job description is the Community Outreach Coordinator.	
Additional Comments: **There are no additional comments for this indicator.**			
2.01 - Screening and Intake			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 2.01		**YES** If NO, explain here: Policy 2.01/Screening and Intake reviewed on 11/7/23 by Regional Director	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open (Residential & Community) Files: 2 open Residential and 2 open Community **Total number of Closed (Residential & Community) Files: 3 closed Residential and 3 closed Community** **Staff Position(s) Interviewed** *(No Staff Names)* **: Lead Community Counselor, Community Counselor Intern and Residential Case Manager.** **Type of Documentation(s) Reviewed: Client Records**			
Shelter youth: Eligibility screening is completed immediately for all shelter placement inquiries.	**Compliance**	All five files had eligibility screening completed immediately for shelter placement inquiries.	
Community counseling: Eligibility screening is completed within 3 business days of referral by a trained staff using the Florida Network screening form.	**Compliance**	All five files had eligibility screening completed within 3 business days of referral by a trained staff using the Florida Network screening form.	

There is evidence all referrals for service is screened for eligibility and is logged in NetMIS within 72 hours of screening completion.	**Exception**	Nine of the files were logged into NetMIS within 72 hours of screening completion.	One screening was logged into NetMIS on 11/7/23 but completed on 11/3/23.
Youth and parents/guardians receive the following in writing: a. Available service options b. Rights and responsibilities of youth and parents/guardians	**Compliance**	All 10 files documented that youth and parent/guardians received in writing available service options and rights and responsibilities of youth and parent/guardians.	
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	**Exception**	Seven of the 10 files did have documentation that youth and parent/guardians were informed of possible actions occurring through involvement with CINS/FINS services. 10 out of 10 files documented that youth and parent/guardians were informed of grievance procedures.	Three of the 10 files did not have documentation that youth and parent/guardians were informed of possible actions occurring through involvement with CINS/FINS services. Those files were missing CINS/FINS Voluntary Agreements.
During intake, all youth were screened for suicidality and assessed as required if needed.	**Exception**	10 out of 10 files were screened for suicidality. Seven of the 10 files had a suicide assessment completed as required.	Two of the 10 files had a suicide assessment completed but was not signed by a licensed professional. One suicide assessment, had missing documentation regarding when assessment was completed or how it was staffed with licensed professional.
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: Policy 2.02/Network Inventory of Risks, victories, and needs assessment reviewed on 11/7/23 by Regional Director.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open (Residential & Community) Files: 2 open Residential and 2 open Community Counseling. **Total number of Closed (Residential & Community) Files: 3 closed Residential and 3 closed Community Counseling** **Staff Position(s) Interviewed** *(No Staff Names)* **: Lead community counselor, Community counselor intern, and residential case manager** **Type of Documentation(s) Reviewed: client records and NetMIS**			
Shelter Youth: NIRVANA is initiated within 72 hours of admission	**Exception**	Four of the five residential files initiated the NIRVANA within 2 hours of admission.	One of the five did not initiate NIRVANA within 72 hours of admission.

Non-Residential youth: NIRVANA is initiated at intake and completed within 2 to 3 face-to-face contacts after the initial intake **OR** updated, if most recent assessment is over 6 months old	**Compliance**	All five Community Counseling files initiated NIRVANA at intake and completed within 2-3 face to face contacts after initial intake.	
Supervisor signatures is documented for all completed NIRVANA assessments and/or the chronological note and/or interview guide that is located in the youths' file.	**Exception**	Eight of the 10 files included supervisor signatures on the completed NIRVANA and/or the chronological note and/or interview guide that is located in the youths' files.	Two of the 10 files did not include supervisor signatures on the completed NIRVANA and/or the chronological note and/or interview guide that is located in the youths' files.
(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.	**Exception**	Four of the five residential files did complete the Self-report NIRVANA within 24 hours of admission.	One of the five residential files did not complete the self-report NIRVANA within 24 hours of admission and did not have documentation to explain barriers to completion.
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**	None of the files sampled met this criteria.	
A NIRVANA Re-Assessment is completed every 90 days excluding files for youth receiving SNAP services.	**Exception**	Two files were applicable for 90 day re-assessment. The remaining eight were not applicable based on dates files were open.	Two of the 10 files did not have documentation or print out that a NIRVANA Re-assessment was completed.
All files include the interview guide and/or printed NIRVANA.	**Compliance**	All 10 files included the interview and/or printed NIRVANA.	
Additional Comments: **There are no additional comments for this indicator.**			
2.03 - Case/Service Plan			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 2.03		**YES**	
		If NO, explain here:	
		Policy 2.03 Case/Service Plan was reviewed on 11/7/23 by Regional Director.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open (Residential & Community) Files: 2 open Residential and 2 open Community Counseling. **Total number of Closed (Residential & Community) Files: 3 closed Residential and 3 closed Community Counseling** **Staff Position(s) Interviewed** *(No Staff Names)* **: Lead community counselor, Community counselor intern, and residential case manager** **Type of Documentation(s) Reviewed: client records**			
The case/service plan is developed on a local provider-approved form or through NETMIS and is based on information gathered during the initial screening, intake, and NIRVANA.	**Compliance**	All 10 files had plans developed on Local provider-approved form or through NetMIS and is based on information gathered during the initial screening, intake, and NIRVANA.	

Case/Service plan is developed within 7 working days of NIRVANA	**Compliance**	All 10 files had plans developed within 7 days of NIRVANA,.	
Case plan/service plan includes: 1. Individualized and prioritized need(s) and goal(s) identified by the NIRVANA 2. Service type, frequency, location 3. Person(s) responsible 4. Target date(s) for completion and Actual completion date(s) 5. Signature of youth, parent/ guardian, counselor, and supervisor 6. Date the plan was initiated	**Exception**	All 10 files has individualized and prioritized needs and goal(s) identified by the NIRVANA. Seven files documented service type, frequency, and location. All 10 files documented person(s) responsible. Nine files documented target date(s) for completion and actual completion date(s). Six files had signatures from the youth, parent/guardian, counselor, and supervisor. All 10 files had signatures from youth and counselor. Four files have a date the plan was initiated.	Three files did not document service type, frequency, and location. One file did not document target date(s) for completion and actual completion date(s) and did not have signatures from parent/guardian. Two files did not have supervisor signatures. Six files did not have date the plan was initiated.
Case/service plans are reviewed for progress/revised by counselor and parent (if available) every 30 days for the first three months and every 6 months after	**Exception**	Eight of the 10 files were reviewed for progress/revised by counselor and parent (if available) every 30 days for the first 3 months and every 6 months after.	Two files were reviewed late for progress/revised by counselor and parent (if available) every 30 days for the first 3 months and every 6 months after.
Additional Comments: **There are no additional comments for this indicator.**			
2.04 - Case Management and Service Delivery			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 2.04		**YES** If NO, explain here: Policy 2.04 Case Management/Service Delivery was reviewed on 11/7/23 by Regional Director.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open (Residential & Community) Files: 2 open Residential and 2 open Community Counseling. **Total number of Closed (Residential & Community) Files: 3 closed Residential and 3 closed Community Counseling** **Staff Position(s) Interviewed** *(No Staff Names)* **: Lead community counselor, Community counselor intern, and residential case manager** **Type of Documentation(s) Reviewed: client records**			
Counselor/Case Manager is assigned	**Compliance**	All 10 cases had an assigned counselor/case manager.	

The Counselor/Case Manager completes the following as applicable: 1. Establishes referral needs and coordinates referrals to services based upon the on-going assessment of the youth's/family's problems and needs 2. Coordinates service plan implementation 3. Monitors youth's/family's progress in services 4. Provides support for families 5. Monitoring of progress for court ordered youth in shelter 6. Makes referrals to the case staffing to address problems and needs of the youth/family 7. Accompanies youth and parent/guardian to court hearings and related appointments 8. Refers the youth/family for additional services when appropriate 9. Provides case monitoring and reviews court orders 10. Provides case termination notes 11. Provides follow-up after 30 days of exit 12. Provides follow-up after 60 days of exit	**Exception**	Nine of the 10 cases had established referral needs and coordinated referrals to services based upon the ongoing assessment of the youth's/family's problems and needs. One file was not applicable since it was noted in the progress notes that the youth and family did not engage in services. All 10 files coordinated service plan implementation. Nine of the 10 files monitored youth's/family's progress in services. All 10 files had documentation regarding how support was provided to families. One applicable file documented a court order as required and documented the counselor/case manager who accompanied youth to their court hearing. Three of the 10 cases referred youth/family to additional services when appropriate as documented in Case Summary and the other seven were not applicable. All 10 files provided case monitoring and reviews of court orders. Of the six closed cases reviewed four had case termination notes as documented in their contact log or Case Summary Form as required.	One of the 10 files did not document youth's/family's progress in services. Two out of six applicable files did not have case termination notes. All three applicable files did not have documentation of 30 day follow-ups. Two applicable files did not have documentation of 60 day follow-ups as required.
The program maintains written agreements with other community partners that include services provided and a comprehensive referral process	**Compliance**	Lead Counselor was able to show their referral list and their referral process.	
Additional Comments: **There are no additional comments for this indicator.**			
2.05 - Counseling Services			**Limited**
Provider has a written policy and procedure that meets the requirement for Indicator 2.05		**YES** If NO, explain here: Policy 2.05 Counseling Services was reviewed on 11/7/23 by Regional Director.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open (Residential & Community) Files: 2 open Residential and 2 open Community Counseling. **Total number of Closed (Residential & Community) Files: 3 closed Residential and 3 closed Community Counseling** **Staff Position(s) Interviewed** *(No Staff Names)* **: Lead community counselor, Community counselor intern, and residential case manager** **Type of Documentation(s) Reviewed: client records and Group Log Binder**			
Shelter Program			
Shelter programs provides individual and family counseling	**Compliance**	All 5 shelter files reviewed provided individual and family counseling.	
Group counseling sessions held a minimum of five days per week	**Exception**	The program uses a group log binder to document group counseling sessions.	The group log showed that groups were not held a minimum of 5 days per week between May 2023 thru Oct. 2023.

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	**Exception**	Based on documentation reviewed, each group held had clear documentation of who led or facilitated the group and each group held had a relevant topic that was developmental or educational. One of the five shelter files reviewed had group participation documented on contact sheets for 6/5/23 and 6/12/23. Attendance sheets were only completed for the groups held in October 2023.	Four of the five shelter files reviewed did not have any group notes documented and it was unclear that youth had the opportunity to participate in groups. Attendance sheets were not consistently completed for groups held from May 2023 - Sept.2023. The Group Log Binder did not document the end times for the groups held and it was not documented in the 5 shelter files reviewed to determine if groups were being held for 30 minutes or longer.
Documentation of groups must include date and time, a list of participants, length of time, and topic.	**Exception**	Group Log Binder documented date and start time, topic, and a list of participants for the month of Oct. 2023.	The Group Binder did not have documentation of end time or length of time of the group. May 23 - Sept. 2023 did not have a list of participants for groups 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.	**Exception**	All five community counseling files reviewed provided therapeutic community-based services designed to provide the intervention necessary to stabilize the family as evident in their individual and family session notes. Four of the five community counseling files reviewed documented services provided in the youth's home, community location, local provider's counseling office as evident in Service Plan. No files were eligible for review in regards to virtual services.	One of the five community files reviewed did not have documentation of where services were provided.
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 10 files reviewed reflected coordination between presenting problem(s), psychosocial assessments, case/service plan, case/service reviews, case management, and follow-ups.	
Maintain individual case files on all youth and adhere to all laws regarding confidentiality	**Compliance**	All 10 files reviewed maintained individual case files on all youth and adhered to all laws regarding confidentiality.	
Case notes maintained for all counseling services provided and documents youth's progress	**Compliance**	All 10 files reviewed had individual and family session notes and documented youth's progress in the note.	
On-going internal process that ensures clinical reviews of case records and staff performance	**Compliance**	All 10 files documented staffing's, openings, closures, and peer reviews.	
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:	
		Policy 2.06 Adjudication/Petition Process reviewed on 11/7/23 by Regional Director.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open or Closed (Residential & Community) Files: N/A			
Must include: a. DJJ rep. or CINS/FINS provider b. Local school district representative	**No eligible items for review**	It was reported by Lead Community Counselor they had not had any adjudicated/petitioned case in the last 6-12 months.	
Other members may include: a. State Attorney's Office b. Others requested by youth/ family c. Substance abuse representative d. Law enforcement representative e. DCF representative f. Mental health representative	**No eligible items for review**	No applicable cases eligible for review.	
The program has an established case staffing committee, and has regular communication with committee members	**Compliance**	The program has not had any adjudicated/petitioned case in the last 12 months but does have an established case staffing committee in the event one is needed.	
The program has an internal procedure for the case staffing process, including a schedule for committee meetings	**Compliance**	The program has policy 2.06 Adjudication/Petition Process in place and has a committee that meets on a regular basis.	
The youth and family are provided a new or revised plan for services	**No eligible items for review**	No applicable cases eligible for review.	
Written report is provided to the parent/guardian within 7 days of the case staffing meeting, outlining recommendations and reasons behind the recommendations	**No eligible items for review**	No applicable cases eligible for review.	
If applicable, the program works with the circuit court for judicial intervention for the youth/family	**No eligible items for review**	No applicable cases eligible for review.	
Case Manager/Counselor completes a review summary prior to the court hearing	**No eligible items for review**	No applicable cases eligible for review.	
Additional Comments: **There are no additional comments for this indicator.**			

2.07 - Youth Records			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 2.07		**YES**	
		If NO, explain here:	
		Policy 2.07 Youth Records reviewed on 11/7/23 by Regional Director.	

Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Staff Position(s) Interviewed *(No Staff Names)* **: Lead community counselor and community counselor intern.** **Type of Documentation(s) Reviewed: client records** **Describe any Observations: Locked and labeled "confidential" file cabinets observed in facility tour and file room identified on the tour.**			
All records are clearly marked 'confidential'.	**Compliance**	All 10 files reviewed were clearly marked "confidential."	
All records are kept in a secure room or locked in a file cabinet that is marked "confidential"	**Compliance**	During facility tour, they showed the file room that was locked with a sign on the door that read "confidential". Inside the room there were several locked file cabinets marked "confidential." The Community Counselor Intern showed each counselors' and case manager's office had a locked file cabinet marked "confidential" for their active files.	
When in transport, all records are locked in an opaque container marked "confidential"	**Compliance**	Lead community Counselor showed their opaque black and locked box to transport files and marked "confidential."	
All records are maintained in a neat and orderly manner so that staff can quickly and easily access information	**Compliance**	All 10 files reviewed were maintained in a neat and orderly manner.	
Additional Comments: **There are no additional comments for this indicator.**			
2.08 - Specialized Additional Program Services			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 2.08		**YES**	
		If NO, explain here:	
		Policy 2.08 Specialized Additional Program Services was approved on 11/7/2023 by the Regional Director.	
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.*			
Type of Documentation(s) Reviewed: N/A			
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**	No Staff Secure services were provided during the period under review.	
Staff Secure policy and procedure outlines the following: a. In-depth orientation on admission b. Assessment and service planning c. Enhanced supervision and security with emphasis on control and appropriate level of physical intervention d. Parental involvement e. Collaborative aftercare	**Not Applicable**		

Program only accept youth that meet legal requirements of F.S. 984 for being formally court ordered in to Staff Secure Services	**Not Applicable**		
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	**Not Applicable**		
Agency provides a written report for any court proceedings regarding the youth's progress	**Not Applicable**		
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.*			
Type of Documentation(s) Reviewed: N/A			
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**	No DMST services were provided during the period under review.	
Agency has evidence that the FNYFS was contacted for approval prior to admission for all Domestic Minor Sex Trafficking (DMST) placements.	**Not Applicable**		
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.	**Not Applicable**		
Services provided to these youth specifically designated services designed to serve DMST youth	**Not Applicable**		
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?	**Not Applicable**		
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.)	**Not Applicable**		
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	**Not Applicable**		
All other services provided to DMST youth are consistent with all other general CINS/FINS program requirements	**Not Applicable**		

Domestic Violence			
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Closed Files: 3 **Staff Position(s) Interviewed** *(No Staff Names)* **:** **Type of Documentation(s) Reviewed: Policy 2.08, Youth records and NetMIS**			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	**Yes**		
Youth admitted to DV Respite placement have evidence in the file of a pending DV charge	**Compliance**	All three files demonstrated evidence that youth had a pending DV charge. The counselor showed the process and referral used to establish eligibility and document youth status to meet criteria for DV.	
Data entry into NetMIS within (3) business days of intake and discharge	**Exception**	All three files showed evidence data entry was complete within the required timeframe. Two out of three youth files demonstrated data discharge was within three business days from discharge.	One youth file was one day late for data entry at discharge.
Youth length of stay in DV Respite placement does not exceed 21 days. If more than 21 days, documentation exists in youth file of transition to CINS/FINS or Probation Respite placement, if applicable.	**Compliance**	One youth was applicable for exceeding the 21 days and the file contained documentation of the youth transitioning to CINS/FINS as required. The counselor showed the program maintains a intake and release date spreadsheet for all youth to track length of stay in program.	
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**	All three files had case plans that reflected goals to address aggression management, family coping skills, or another intervention to reduce propensity for violence.	
All other services provided to Domestic Violence Respite youth are consistent with all other general CINS/FINS program requirements	**Compliance**	All three files showed evidence that all other services provided to youth are consistent with the general CINS/FINS program requirements.	

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: 1 **Total number of Closed Files: 2** **Staff Position(s) Interviewed** *(No Staff Names)* **: Counselor** **Type of Documentation(s) Reviewed: Policy, Youth records and NetMIS**			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	**Yes**		
All probation respite referrals are submitted to the Florida Network.	**Compliance**	All three files showed email correspondence that probation respite referrals were submitted to the Florida Network.	
All Probation Respite Referral come from DJJ Probation and there is evidence that the youth is on Probation regardless of adjudication status.	**Not Applicable**		
Data entry into NetMIS and JJIS within (3) business days of intake and discharge	**Exception**	Two out of three files had evidence that the data entry into NetMIS was within the required timeframes.	One file was late for intake data entry by 11 days per the NetMIS lag report.
Length of stay is no more than fourteen (14) to thirty (30) days. Any placement beyond thirty (30) days contains evidence in the file that the JPO was contacted in writing to request the need of an extension no later than the 25th day the youth was admitted into the program.	**Compliance**	All files were compliant with requirement and length of stay was no more than fourteen (14) to thirty (30) days.	
All case management and counseling needs have been considered and addressed	**Compliance**	All three files demonstrated evidence that case management and counseling needs have been considered and addressed.	
All other services provided to Probation Respite youth are consistent with all other general CINS/FINS program requirements	**Exception**	All three files showed that all other program services provided to youth was consistent with all general CINS/FINS program requirements with the exception of 30 day and 60 day follow-ups. One youth was not yet eligible for a 30 day or 60 day follow-up and was consistent will all other program requirements.	Two applicable files reviewed were missing evidence of the 60 day follow up as required. One file was also missing evidence of the 30 day follow up required.

Intensive Case Management (ICM)			
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Type of Documentation(s) Reviewed: N/A			
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**	No eligible ICM files served for period under review.	
Youth receiving services were deemed chronically truant and/or runaway and require more intensive and lengthy services. The youth was determined to be eligible because they have gone through petition and/or case staffing and was in need of case management services.	**Not Applicable**		
Services for youth and family include: a. Two (2) direct contacts per month b. Two (2) collateral contacts per week c. Direct and collateral contacts not obtained must have documentation to support attempts made to obtain them. All reasonable attempts (at minimum of three) must be made to reach all contacts (direct and collateral) and documented in the case file and NetMIS.	**Not Applicable**		
Assessments include a. NIRVANA at intake b. NIRVANA Re-Assessment every 90 days c. Post NIRVANA at discharge as aligned with timeframe requirements	**Not Applicable**		
Service/case plan demonstrates a strength-based, trauma-informed focus	**Not Applicable**		
For any virtual services provided, there is written documentation in the youths' file as to why virtual contact is in the best interest of the youth and family	**Not Applicable**		

Family and Youth Respite Aftercare Services (FYRAC)			
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: 1 **Total number of Closed Files: 1** **Staff Position(s) Interviewed** *(No Staff Names)* **: Counselor** **Type of Documentation(s) Reviewed: Policy, Youth records and NetMIS**			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	**Yes**		
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.	**Compliance**	File review demonstrated evidence of youth on probation. Face sheet in file 3/22/23. Unit 102 means probation is assigned and adjudicated.	
Agency has evidence that all FYRAC referrals have documented approval from the Florida Network office	**Compliance**	Two files showed evidence that all FYRAC referrals had documented approval from the Florida Network office via email correspondence maintained within the file.	
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.	**Compliance**	All files showed evidence that the intake and initial assessment sessions met all of the required criteria. Services were well documented and there was evidence of the youth and the parent signature for orientation into the program. The sessions were conducted face-to-face and focused on gathering family history and demographic information to develop the service plan.	
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.	**Compliance**	Life management sessions for all files reviewed demonstrated that sessions were face-to-face, sixty (60) minutes in length and focus on strengthening the family unit. Services were highly supportive, individualized, and focused on the "whole family" approach.	

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.	**Compliance**	The files contained evidence of progress and all counselor activity maintained with youth and family. One file specified the concerns the youth and caregiver had that was a potential barrier to receiving services. The counselor would have open conversations during early sessions to address concerns with clients about cultural or racial issues and offered options or alternatives to ensure the family would remain engaged throughout the process.	
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	**Not Applicable**		
There is evidence of completed 30 and/or 60 day follow-ups and is documented in NetMIS following case discharge.	**Compliance**	One file was applicable for 30 day follow-up and demonstrated the attempts made in NetMIS.	
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	**Exception**	Two files met the criteria for this review item. One file was open between 3/31/23-9/29/23; 2nd file was open from 7/24/23-11/1/23, however, the counselor was unable to make contact with the family since September. The staff misunderstood the requirement for clients that were not consistently receiving 13 sessions or requested a break from services and didn't take into account the 90 day requirement.	Two files were missing evidence of an extension granted by DJJ circuit probation staff when days of service exceeded 90 days.
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**	No services were provided virtually.	
All data entry in NetMIS is completed within 3 business days as required.	**Compliance**	All data entry in NetMIS was completed within 3 business days as required for all three files.	
Additional Comments: **There are no additional comments for this indicator.**			

2.09- Stop Now and Plan (SNAP)			Limited
Provider has a written policy and procedure that meets the requirement for Indicator 2.09	**YES**		
	If NO, explain here:		
	Policy 2.09 Stop Now and Plan (SNAP) was last approved by the Regional Director on 11/7/23.		
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: 2 **Total number of Closed Files: 1** **Staff Position(s) Interviewed** *(No Staff Names)* **: SNAP Facilitator** **Type of Documentation(s) Reviewed: Youth records and SNAP documentation, NetMIS** **Describe any Observations: SNAP Facilitator staff are fairly new to the program and still learning about the SNAP program. Completed training with the FN recently.**			
SNAP Clinical Groups Under 12			
Youth are screened to determine eligibility of services.	**Compliance**	Three files showed evidence that all youth are screened for eligibility of services.	
The NIRVANA was completed at initial intake, or within two sessions.	**Compliance**	All three youth records contained a completed NIRVANA that was done on the same day as the intake.	
There is evidence of the completed Child Behavior Checklist (CBCL) by the caregiver (pre and post) and is located within the file.	**Exception**	All three files contained the Child Behavior Checklist (CBCL) that was completed by the caregiver. Two files were not applicable for a post CBCL.	One applicable file was missing the post CBCL from the file.
There is evidence of the completed Teacher Report Form (TRF) is completed by the teacher (pre and post) and is located within the file.	**Exception**	All three files were applicable to have the pre Teacher Report Form (TRF). The post Teacher Report Form (TRF) is only applicable in two of the three files. During an interview, SNAP staff shared TRF was not initially obtained due to the sessions commencing in the summer but they were not familiar with actual form.	There was no evidence of a completed Teacher Report Form (TRF) or any attempts or request noted for any of the files reviewed.
There is evidence of the completed SNAP Discharge Report located within the file for any discharged youth.	**Exception**	The SNAP Discharge Report is applicable in one of three files.	There was no evidence of the SNAP Discharge Report in the applicable file.
There is evidence of the SNAP Boys/SNAP Girls Child Group Evaluation Form located in the file.	**Exception**	Upon interview with staff, it was explained that they were not familiar with SNAP Child Group Eval Form and no attempts were documented to obtain.	There was no evidence of SNAP Child Group Evaluation Form in the files reviewed and staff had no knowledge of this requirement.
There is evidence of the SNAP Boys/SNAP Girls Parent Group Evaluation Form located in the file.	**Exception**	Upon interview with staff, it was explained that they were not familiar with SNAP Parent Group Eval Form.	There was no evidence of SNAP Parent Group Evaluation Form in the files reviewed and staff had no knowledge of this requirement.
SNAP Clinical Groups for Youth 12-17			

Youth are screened to determine eligibility of services.	**Not Applicable**	The program does not provide services to this age group.	
The Consent to Treatment and Participation in Research Form is completed and located within the file.	**Not Applicable**		
The NIRVANA was completed at initial intake, or within two sessions.	**Not Applicable**		
There is evidence of the completed 'How I Think Questionnaire' (HIT) form located within the file or evidence of at least three (3) documented attempts in the youths' file to obtain this information.	**Not Applicable**		
There is evidence of the completed Social Skills Improvement System (SSIS) Student form located within the file or evidence of at least three (3) documented attempts in the youths' file to obtain this information.	**Not Applicable**		
There is evidence of the completed Social Skills Improvement System (SSIS) Teacher/Adult form located within the file or evidence of at least three (3) documented attempts in the youths' file to obtain this information.	**Not Applicable**		
SNAP for Schools & Communities			
The program demonstrated all of the required weekly attendance sheets that included youth names and/or identifying numbers completed with the teacher and trained SNAP Facilitator signatures. (*This must include a total of 13 attendance sheets for a full cycle*)	**Compliance**	One full cycle was available for review which was completed on 12/14/2022. All of the required weekly attendance sheets included the names of youth with teacher and SNAP Facilitator signatures.	
The program maintained evidence of a completed "Class Goal" Document for the class reviewed.	**Compliance**	There was a completed Class Goal sheet in the file dated 9/14/22.	
The program maintained evidence of both pre AND post Measure of Classroom Environment (MoCE) completed documents for the class reviewed.	**Compliance**	The program demonstrated evidence that MoCE pre and post evaluations were completed and maintained on file.	
The program maintained evidence of completed pre and post evaluation documents for the class reviewed.	**Compliance**	There was evidence of pre and post evaluation documents for each youth that stayed in the program the full 13 weeks.	
There is evidence of the fidelity adherence checklist maintained in the file for each class reviewed.	**Compliance**	There was evidence of the Fidelity Adherence Checklist for the classroom dated 11/30/22.	
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:		
	Policy 3.01 Shelter Environment. Approved 11/7/2023 by Regional Director		

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

Staff Position(s) Interviewed *(No Staff Names)* **: Youth Care Specialist Lead, Shelter Manager**
Type of Documentation(s) Reviewed: Fire and Mock drills, MSDS, Perpetual Inventory, Daily Programming Schedule, Food Service Inspection Report, Fire Safety Equipment Report, Fire Inspection Report, DCF Child Care License, Residential Group Care License
Describe any Observations: The Residential Group Care License is expired. There is email communication from DOH stating the Group Care Inspector position is vacant and it may be some time before the facility can be inspected.

Facility Inspection: a. Furnishings are in good repair. b. The program is free of insect infestation. c. Bathrooms and shower areas are clean and functional, free of foul odors, leaks, dust, and mildew and in good working order. d. There is no graffiti on walls, doors, or windows. e. Lighting is adequate for tasks performed there. f. Exterior areas are free of debris; grounds are free of hazards. g. Dumpster and garbage can(s) are covered. h. All doors are secure, in and out access is limited to staff members and key control is in compliance. i. Detailed map and egress plans of the facility, general client rules, grievance forms, abuse hotline information, DJJ Incident Reporting Number and other related notices are posted. j. Interior areas (bedrooms, bathrooms, common areas) do not contain contraband and are free from hazardous unauthorized metal/foreign objects.	**Exception**	Upon the walkthrough of the facility, it was noted the lighting was bright. The furniture was adequate and in good repair. The day room contains enough seats for 12 children and staff. A bulletin board in the hall maintained postings that included: the staff schedule, client rights, daily programming schedule, DJJ Reporting number, Florida Abuse Hotline, facility rules and expectations. The grievance box is wall mounted in the day room and easily accessible with blank forms to use. Cords on blinds in the bedrooms were not exposed. The toilets, shower/tubs and sinks have running hot and cold water. All doors were secure, and staff present had keys to enter other areas of the building that youth were not permitted in without an escort. The egress plans are posted on a wall across from the staff station. All cameras were visible and located in areas where staff and children spent time. There were no cameras in the bedrooms or bathrooms. The grounds and exterior of the facility were free of debris. Trees, shrubs, bushes, and lawn were maintained and not overgrown. There were no signs of insect infestations inside or outside the facility. The dumpster was covered, and trash was not overflowing on the ground around the dumpster. Signage of video surveillance was posted on each entrance door.	Some interior areas were found to be in need of repair, unclean or had graffiti inside the facility. There was damage to a bedroom door near the door handle impacting it's ability to be properly secured on Day 1 but the program had the door repaired and freshly painted by Day 2. On Day 1, bathrooms were observed to be unclean with dust and mildew. On Day 2, the 2 restrooms were clean and odor and mildew free. The blinds in the day room were broken, the bench table contained markings from paint, markers, pens etc. The wood frame on the couches and dressers has graffiti.

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 facility has two vehicles: 2016 Collins Bus and 2016 Honda Odessey. The Collins Bus is the only vehicle being inspected as the other bus was offsite. The Collins Bus was locked as evidenced by engaging door handles. The safety equipment was put together to ensure it was operational. The flashlight is in working order, first aid kits are stocked with band aids, bandages, scissors, and alcohol wipes. The kit and its contents are up to date. The glass breaker and seat belt cutter were present.	
Facility Inspection: All chemicals are listed, approved for use, inventoried weekly and perpetually, stored securely and Material Safety Data Sheets (MSDS) are maintained on each item (minimum 1 time per week or per agency policy). A perpetual inventory will be the primary means of maintaining a current and real-time inventory. The weekly inventory will be conducted weekly at a minimum to ensure that a perpetual inventory is being maintained consistently and accurately. If more than one location is used to store chemicals, there is an inventory wherever chemicals are stored that is current and well maintained unless previously approved by the Network.	**Exception**	The chemicals stored in the laundry room were listed in the Material Safety Data Sheet (MSDS) binder. The perpetual inventory was present to show each use of chemicals in real time. The perpetual inventory and MSDS is located in the laundry room.	There is no evidence of a weekly chemical inventory.
Facility Inspection: Washer/dryer are operational & general area/lint collectors are clean. Agency has a current DCF Child Care License which is displayed in the facility. Each youth has own individual bed with clean covered mattress, pillow, sufficient linens and blanket. Youth have a safe, lockable place to keep personal belongings, if requested.	**Compliance**	The washer and dryers were in use during the inspection. The dryer was lint free. These appliances are in good working condition. The facility has a current DCF license dated 9/28/2023. This license is posted in the kitchen, staff office and front desk. At a minimum, each youth bed has 1 blanket, 1 sheet, 1 pillow and 1 pillowcase. The rooms have dressers, lockers, and shelves to store shoes, clothing, or other personal items. Other personal or valuable items can be stored or locked in the staff office.	

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).	**Exception**	The annual fire inspection was completed 1/24/2023. The agency is in compliance as no violations were found. The following fire drills were completed this review period. All drills below were completed in less than 2 minutes: 1st Shift: 5/28, 7/19, 8/31, 9/19 2nd Shift: 5/23, 6/1, 6/28, 7/11, 8/13, 9/18, 10/10, 10/25 3rd Shift: 7/22, 8/26, 10/10 The following mock emergency drills were completed this review period: 1st shift: 7/19 2nd Shift: 6/18, 8/25, 10/26, 10/11 3rd Shift: None completed. The annual fire extinguisher inspection was completed by The Hiller Companies, LLC on 7/10/2023. A total of 9 Fire extinguishers were inspected. This inspection did not note any defects of the fire extinguishers. Escambia County Fire-Rescue Office of Fire Prevention inspected the facility on 1/24/2023. A report of No Violations was issued.	There are several months fire drills have not been completed by 1st and 3rd shift. Below are the months each shift is missing: 1st Shift: June, October 3rd Shift: May, June, September Below are the shifts that did not complete these mock drills: 1st Shift: Did not complete any for the 2nd quarter (April, May, June) 3rd Shift: Did not complete mock drills this review period or any quarter within the review period. Neither report from 1/24/2023 and 7/10/2023 indicate inspecting facility sprinkler systems, alarm systems or kitchen overhead hood.
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 DOH issued a satisfactory Food Service Inspection Report on 9/26/2023. This report is posted on the board located in the kitchen. Signed and approved menus by the dietician are also located on this board. This facility has two refrigerators and one freezer. The refrigerator temperatures are 40 degrees F and the freezer is -22 degrees F. All food in the refrigerator and freezer are sealed in appropriate storage containers or baggies. Any used or opened food is labeled with expiration dates for disposal. The refrigerators and freezer are clean, organized with no expired food odors. The kitchen sink has running hot and cold water. The stove, oven, microwave, and toaster are in good working condition. The dishwasher is out of order. The last Group Care Inspection received from DOH was 10/1/2022. Currently the facility is holding an expired Residential Group Care Inspection report, however, the DOH emailed this facility on 11/7/2023 to inform them the Group Care Inspector position is vacant, and it may be a while before this facility is inspected.	

Additional Fire and Safety Health Hazards Narrative (if applicable)			
Youth Engagement			
a. Youth are engaged in meaningful, structured activities (e.g., education, recreation, counseling services, life and social skill training) seven days a week during awake hours. Idle time is minimal. b. At least one hour of physical activity is provided daily. c. Youth are provided the opportunity to participate in a variety of faith-based activities. Non-punitive structured activities are offered to youth who do not choose to participate in faith-based activities. d. Daily programming includes opportunities for youth to complete homework and access a variety of age appropriate, program approved books for reading. Youth are allowed quiet time to read. e. Daily programming schedule is publicly posted and accessible to both staff and youth.	**Compliance**	During the walkthrough of the facility, staff were engaged with youth playing educational games and conducting a life skills group in the day room. Youth are permitted to complete homework, study, or read in this area. Age-appropriate books can also be found in this area. Per the programming calendar posted in the day room, structured activities are held 7 days a week. If staffing permits, youth could attend off-site faith-based services. Religious/spiritual services are not mandatory to attend and youth that do not choose to attend services are given an alternate structed, non-punitive, activity to participate in during the time of services. This peer reviewer spoke with 2 youth. One arrived just a couple of days ago. She's excited about being in a place where she can receive encouragement to help with goals like finishing school early. The other youth will be discharged in the next week and is dreading going home because the staff has shown an incredible amount of support that she feels she will not get at home. Both youth expressed appreciation of the staff involvement and program support. During the review, staff allowed the youth to share a song they created that day and performed the song for the QI team while on-site expressing that they enjoyed living in the facility.	
Additional Comments: **There are no additional comments for this indicator.**			

3.02 - Program Orientation			Satisfactory with Exception
Provider has a written policy and procedure that meets the requirement for Indicator 3.02		**YES**	
		If NO, explain here:	
		Policy #3.02 Program Orientation was approved on 11/7/2023 by Regional Director.	

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

Total number of Open Files: 1
Total number of Closed Files: 2
Staff Position(s) Interviewed *(No Staff Names)* **: Program Manager**
Type of Documentation(s) Reviewed: Intake Forms, Orientation Forms, Classification Forms
Describe any Observations: Youth

Youth received a comprehensive orientation and handbook provided within 24 hours	**Exception**	Three youth records were reviewed. One open and two closed. One closed record demonstrated the youth received comprehensive orientation handbook on the day of admission. The youth signed this form acknowledging expectations and rules. The staff initialed by each category indicating they reviewed each category with the youth.	One youth record did not have the form indicating the orientation was completed on file.
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	**Exception**	One youth record clearly demonstrated that youth received orientation on contraband, disciplinary action, dress code, access to medical and mental health, contact procedures, grievance procedures, room assignments, disaster procedures and suicide prevention.	Two youth records did not contain evidence that youth received orientation on all of the specified requirements. None of the youth records clearly indicate youth received information on the physical layout of the facility at orientation, however, egress plans were observed throughout the facility.
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	**Exception**	Three records were reviewed. One open and two closed. One closed youth record received the comprehensive orientation handbook on the day of admission. The youth signed this form acknowledging expectations and rules. The staff initialed by each category indicating they reviewed each category with the youth.	Two records were not complete as required. In one file the parent signature was missing and in the 2nd file youth signature was present but was missing the staff initials and parent signature.

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

3.03 - Youth Room Assignment			Satisfactory with Exception
Provider has a written policy and procedure that meets the requirement for Indicator 3.03	**YES**		
	If NO, explain here:		
	Policy 3.03, Authorized Signer: Sherri Kirkpatrick, Regional Director. Reviewed/Approved: 11/7/2023.		

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

Total number of Open Files: 1
Total number of Closed Files: 2
Staff Position(s) Interviewed *(No Staff Names)* **: Shelter Manager**
Type of Documentation(s) Reviewed: Initial Classification (Snap Shot)

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	**Exception**	A process is in place that includes the initial classification of youth. This facility form is named "Snapshot." Three youth records were reviewed, one open and two closed. One of three records (open file) completed the snapshot form. Although the snapshot form was not completed for two of the charts, the following information is still documented in various places throughout their chart: Physical size and strength, trauma, age, gender, disabilities, suicide risk, possible acute health symptoms requiring quarantine and collateral contacts. Only the closed charts documented in the "acute symptoms requiring quarantine" section.	Two of the three files did not document the following: gang affiliation, possible/potential sexually aggressive/predatory behavior, or history of violence. One file did not document possible disabilities.
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**	An alert system is in place to capture special needs. The facility has an alert board in the kitchen for youth that have dietary concerns. An alert binder is in the medication room for youth that take medication and may have allergies. Suicide assessment forms are in the youth's file to assess suicide risk. Any health issues or other concerns can be documented in the file on the intake form. The three records reviewed did not indicate any physical, mental health, or health alerts.	

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

3.04 - Log Books			Satisfactory with Exception
Provider has a written policy and procedure that meets the requirement for Indicator 3.04	**YES**		
	If NO, explain here:		
	Policy 3.04, Authorized Signer: Sherri Kirkpatrick, Regional Director. Reviewed/Approved: 11/7/2023		

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

Dates or Timeframe Reviewed: 11/6/2023, 10/16/2023, 10/31/2023, 11/2/2023
Staff Position(s) Interviewed *(No Staff Names)* **: Shelter Manager**
Type of Documentation(s) Reviewed: Note Active Tablet
Describe any Observations: Note Active Icons were not developed for certain categories making it difficult to refine searches.

Log book entries that could impact the security and safety of the youth and/or program are highlighted	**Compliance**	Client searches, drills and incidents are highlighted in yellow. There are no logbook entries that indicate any immediate threats or risk to the facility, staff, youth, or visitors. This facility conducts contraband checks on all youth entering the facility to minimize the risk of weapons entering the facility. Drills are conducted to prepare the staff and youth in case of emergencies or natural disasters.	
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**	All entries in the tablet include brief descriptions of activities, movements or reports that include staff, visitors, or youth. Time and date stamps are generated once the note is initiated. The signature is captured once the note is saved.	
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**	This facility uses the electronic tablet, Note Active. If errors are discovered after the note is saved, the note cannot be deleted. Note Active has the strike through function to address errors. When this function is used, the staff initials date and time of strike through is saved.	
The program director or designee reviews the facility logbook(s) every week and makes a note chronologically in the logbook indicating the dates reviewed and if any correction, recommendations and follow-up are required and sign/date the entry	**Exception**	The program utilizes an electronic tablet for all note entries. There are supervisor log entries noting the logbook was reviewed and the client count only.	There is no evidence of the logbook being reviewed weekly, or if any correction or recommendations and follow-up required of dates reviewed.

All staff review the logbook of the previous two shifts and makes an entry signed and dated into the logbook indicating the dates reviewed	**Compliance**	Staff sign in indicating they have reviewed the two previous 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.	**Exception**	Shift supervisors review and sign the logbook upon starting their shift. Notes are basic and general indicating the logbook was reviewed and the client count.	The supervisor log entries does not include the dates reviewed from their last log entry.
Logbook entries include: a. Supervision and resident counts b. Visitation and home visits	**Compliance**	Logbook entries indicate when youth go offsite and the number of youth present onsite. Youth that have visitation and when they return is captured. Home visit entries have not been observed.	
Additional Comments: **There are no additional comments for this indicator.**			
3.05 - Behavior Management Strategies			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 3.05		**YES** If NO, explain here: Policy# 3.05 Behavior Management Strategies was approved by Regional Director on 11/7/23.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Staff Position(s) Interviewed *(No Staff Names)* **: Shelter Manager** **Type of Documentation(s) Reviewed: Policy, training records** **Describe any Observations: Staff and youth interactions were observed during the review.**			
The program has a detailed written description of the BMS and it is explained during program orientation	**Exception**	This facility has a detailed policy to address engagement, safety, rights and follow when dealing with a youth in crisis. This policy is designed to gain compliance and encourage youth to make positive choices. Three youth records were reviewed, one open and two closed. Of the three records, one youth received information about the BMS.	As evidenced by lack of documentation and missing documentation, two youth records did not address the BMS.

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**	Staff are trained periodically and, on the spot, to manage youth behavior. Therapeutic approaches are always encouraged, and staff are to engage with youth immediately when negative behaviors arise. Incentives can range from additional points, snack of choice, preferred activity, longer phone call time or extra time to stay up not to exceed an hour. Youth are encouraged to use their coping skill to help deescalate their behavior or ask for assistance immediately from a preferred staff onsite. Approved physical interventions are used as a last resort and only when youth are bringing harm to themselves or someone else. Youth rights are not denied during the time of crisis but may be delayed if the youth behavior is not safe.	
Program's use of the BMS			
All staff are trained in the theory and practice of administering BMS rewards and consequences	**Compliance**	Four applicable training records have been reviewed for this item. Behavior management (BM) training was provided for all four staff. Theory and practice of interventions, rewards and consequences is addressed in the training.	
There is a protocol for providing feedback and evaluation of staff regarding their use of BMS rewards and consequences	**Compliance**	Supervisors can address the use of BM techniques informally or formally. During evaluation periods, during disciplinary action or verbally once the situation has deescalated.	

Supervisors are trained to monitor the use of rewards and consequences by their staff	**Compliance**	Supervisors monitor the use of rewards and consequences to ensure youth are treated fairly, to ensure youth rights are not violated and to ensure the safety of you and staff.	
Additional Comments: **There are no additional comments for this indicator.**			
3.06 - Staffing and Youth Supervision			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 3.06		**YES**	
		If NO, explain here:	
		Policy #3.06 Staffing and Youth Supervision was approved by Regional Director on 11/7/23.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Dates or Timeframe Reviewed: 10/20, 10/15, 10/28, 10/29, 11/2, 11/8. **Staff Position(s) Interviewed** *(No Staff Names)* **: Shelter Manager** **Type of Documentation(s) Reviewed: Staff schedule, roster** **Describe any Observations: Video surveillance and program logbook**			
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**	This facility has a maximum capacity of 12 youth. They operate across three shifts daily and have at least two staff on every shift every day. The staff schedule is posted on the bulletin board. This schedule indicates at least two staff are present on every shift to maintain ratio.	
All shifts must always provide a minimum of two direct care staff present that have met the minimum training requirements	**Exception**	The schedule indicates at least two staff are present on every shift to maintain ratio. One staff record completed all minimum training requirements: Universal Precautions, Confidentiality, First Aid, CPR, Child Abuse Reporting, Understanding Youth/Adolescent Development, Behavior Management, Cultural Humility, Provider Orientation Training and Managing Aggressive Behavior.	Five out the six staff have not completed the minimum training requirements.
Program staff included in staff-to-youth ratio includes only staff that are background screened and properly trained youth care workers, supervision staff, and treatment staff	**Exception**	A sample of staff files reviewed demonstrated that all staff completed Program Orientation, Child Abuse reporting, FN Suicide Prevention, CINS FINS Core Trainings.	One staff background screening was observed to be past retained fingerprint date for re-screening. Program immediately addressed the oversight and submitted the correct documentation to the BSU to obtain eligible screening at discovery. Regional Director removed staff from future shifts pending approved background screening.
The staff schedule is provided to staff or posted in a place visible to staff	**Compliance**	The staff schedule is posted in the staff office.	

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**	This facility maintains a list of counselors, YCS, and direct care staff to provide assistance in times when additional coverage is needed for emergencies or staff shortages. This list is maintained in the pass down binder which is located in the staff office.	
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**	This facility has a maximum capacity of 12 youth. Six bedrooms with two beds in each room. During bedtime hours, the ratio changes to 1:12 and a minimum of two staff must be present. During video reviews on the following days, two staff were present during the night: 10/20, 10/15, 10/28, 10/29, 11/2, 11/8. The staff present were seen completing bed checks every 10 minutes for every youth including those on standard supervision. Each check was on time. On 11/2, one staff member on shift "swiped" the tablet indicating they completed a bed check. This was saved under their login. The physical bed check was completed by the other staff person on shift. This person walked the hallway and checked each room that had a child in it. Documentation was not completed to say a bed check was completed on behalf of another staff.	
Additional Comments: **There are no additional comments for this indicator.**			

3.07 - Video Surveillance System			Limited
Provider has a written policy and procedure that meets the requirement for Indicator 3.07		**YES**	
		If NO, explain here:	
		Policy #3.07 Video Surveillance System was approved by Regional Director on 11/7/23.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Dates or Timeframe Reviewed: 10/20/23, 10/15/23, 10/28/23, 10/29/23, 11/2/23, 11/8/23 dates reviewed **Staff Position(s) Interviewed** *(No Staff Names)* **: Regional Director, Shelter Manager** **Describe any Observations: Time frame of camera being out, was reported to IT by the Regional Director within 24 hours of finding out. Tickets and receipts show notification of call.**			
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**	Notice of camera surveillance is posted on every entrance, in the parking lot and at the front desk. The camera system can store footage for a maximum of 30 days. The system can record dates, times, and locations. Facial recognition has not been confirmed. The system can operate during a power outage. A back up battery engages when the power goes out. It has been noted, there are a total of 27 cameras inside and outside the facility. These cameras are located where staff, youth, family, and visitors are present. Cameras are visible, in plain sight and not hidden. Cameras are not in the youth restrooms or bedrooms.	
A list of designated personnel who can access the video surveillance system is maintained (includes off-site capability per personnel)?	**Compliance**	The list of authorized video surveillance operators is located in the shelter managers office.	
Supervisory review of video is conducted a minimum of once every 14 days and timeframes reviewed are noted in the logbook.	**Exception**	The program utilizes an electronic logbook for all entries. During interview with the Shelter Manager, it was explained that reviews are conducted by the supervisor during the 3rd shift, however, the Shelter Manager searched the dashboard and could not find any reviews at the time. It was discussed that the electronic logbook could be used to create active notes for video reviews.	Evidence of supervisory reviews being completed every 14 days could not be located at the time of the review.

The reviews assess the activities of the facility and include a review of random sample of overnight shifts	**Exception**	There was no available documentation of reviews conducted at time of review.	There was no evidence presented to confirm when reviews were being completed and which activities are being assessed.
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 Shelter Manager can copy the video and submit it upon request. The request for video cannot be for a recording that exceeds 30 days.	
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**	This facility has encountered several camera malfunctions. Request for service is initiated by the Regional Director within 24 hours of discovering the malfunction. An example of written documentation was provided to show initiation of service call and outcome.	
Additional Comments: **There are no additional comments for this indicator.**			
4.01 - Healthcare Admission Screening			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 4.01		**YES** If NO, explain here: The policy number is 4.01 DJJ FAC 63M.2 FL Network P & P 4.0 and is titled Healthcare Screening Admission. This policy was reviewed and approved by Sherri Kirkpatrick, LSF-NW Regional Director on November 7, 2023.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: 2 **Total number of Closed Files: 3** **Staff Position(s) Interviewed** *(No Staff Names)* **: Nurse, Residential Counselor, and Regional Director** **Type of Documentation(s) Reviewed: Residential Intake Form, Suicide Screening Assessment** **Describe any Observations: Facility tour**			
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**	Five files were reviewed for screening. Four of the five files had the healthcare screening completed on the day of admission. The remaining file had the admission completed seven days after admission. Three of the five files were applicable for current medications. Two of the five files were applicable for acute and chronic medical conditions. Three of the five youth were applicable for allergies. One of the five youth was applicable for observation for evidence of illness, injury, pain or physical distress, and/or difficulty moving. One of the five youth was applicable for observation for presence of scars, tattoos or other skin markings. One of the five youth was applicable for acute health symptoms requiring quarantine and isolation. One of the five youth was applicable for seizure disorder. All five youth had parent involved with the coordination and scheduling of follow up medical appointments. None of the youth were applicable for recent injuries, illnesses, diabetes, pregnancy, cardiac disorder, asthma, tuberculosis, hemophilia, or head injuries. The program does not keep a daily medical log for referrals. If the youth needs medical attention that is out of the program's scope, the parents are contacted to take youth to hospital. The program has procedures to include a through referral process and a mechanism for necessary follow-up medical care for youth admitted with chronic medical conditions.	
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**	An interview with the nurse, residential counselor, and Regional Director revealed parent contact is made when a youth is having medical issues. The parents are still responsible for youth in the program. A referral for services is not done. However, parent contact is documented in Note Active.	
When needed, the parent is involved with the coordination and scheduling of follow-up medical appointments	**Compliance**	All parents are involved with coordination and scheduling of all medical appointments.	
All medical referrals are documented on a daily log.	**Compliance**	Medical referrals are documented on Note Active.	
The program has a thorough referral process and a mechanism for necessary follow-up medical care as required and/or needed	**Compliance**	There is no referral process in this program. The parents are contacted for all medical needs.	
Additional Comments: **There are no additional comments for this indicator.**			

4.02 - Suicide Prevention			Satisfactory with Exception
Provider has a written policy and procedure that meets the requirement for Indicator 4.02		**YES** If NO, explain here: The policy number is 4.02 Florida Network YFS 2020 - 3.01, 3.02, 3.021 titled Suicide Prevention. This policy was reviewed and approved by Sherri Kirkpatrick, LSF-NW Regional Director on November 7, 2023.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open (Residential & Community) Files: 2 **Total number of Closed (Residential & Community) Files: 4** **Staff Position(s) Interviewed** *(No Staff Names)* **: Regional Director** **Type of Documentation(s) Reviewed: Suicide Assessment**			
Suicide Risk Screening and Approval (*Residential and Community Counseling*)			
Suicide risk screening occurred during the initial intake and screening process. Suicide screening results reviewed and signed by the supervisor and documented in the youth's case file.	**Compliance**	Six files were reviewed. Five of the six files had a suicide screening completed an initial intake process and results were signed by the supervisor and documented in youth case file. The remaining file did not have the suicide risk assessment in file at the time a review was completed. It was later found in a staff's desk and placed in file. The document was provide and all information was on document.	
The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	**Compliance**	The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services.	
Supervision of Youth with Suicide Risk *(Shelter Only)*			
Youth are placed on the appropriate level of supervision based on the results of the suicide risk assessment.	**Compliance**	Six files were reviewed. Five of the six were applicable to be placed on the appropriate level of supervision based on the results of the suicide risk assessment.	
Staff person assigned to monitor youth maintained one-to-one supervision or constant supervision and documented his/her observations of the youth's behavior at 30 minute or less intervals	**Compliance**	Six files were reviewed. Three were applicable for sight-and-sound supervision. Two of the three had pre-printed times at thirty minute intervals and one was hand written. It was observed that none of them were documented in real time. A video observation was conducted for one youth that had pre-printed times of two dates with two hour intervals and there were no issues identified.	

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.	**Exception**	Three applicable files were reviewed. Documentation includes time of day, location, the observer's initials and was maintained in an observation log book.	All three did not document behavioral observations and warning signs.
Supervision level was not changed/reduced until a licensed professional or a non-licensed mental health professional under the supervision of a licensed professional completed a further assessment OR Baker Act by local law enforcement	**Compliance**	Three were applicable for sight-and-sound supervision. All three youth were placed on sight-and-sound supervision until assessed by a licensed professional or non-licensed professional under the direct supervision of the licensed professional. However, all three files were not assessed within 24 hours of suicide screening results or on the morning of the first business day as required.	
There was evidence that documentation was reviewed by supervisory staff each shift. If program uses an observation log, completed logs are maintained in the youth's file.	**Exception**	Suicide risk assessment had two applicable files reviewed that did contain a supervisor signature.	Suicide risk assessment for one file did not have a supervisor signature. Based on review of observation logs, no supervisor signatures were observed.
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**	None of the files reviewed met this criteria for the sample size reviewed.	
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**	None of the files reviewed met this criteria for the sample size reviewed.	
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**	None of the files reviewed met this criteria for the sample size reviewed.	
If the parent/guardian cannot be contacted, all efforts to contact them are documented in the case file.	**No eligible items for review**	None of the files reviewed met this criteria for the sample size reviewed.	
When the screening was completed during school hours on school property, the appropriate school authorities were notified.	**No eligible items for review**	None of the files reviewed met this criteria for the sample size reviewed.	
Additional Comments: **There are no additional comments for this indicator.**			

4.03 - Medications			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 4.03		**YES** If NO, explain here: The policy number is 4.03 DJJ FAC 63M-2 Florida Network YFS PPM 2020 - 5.06 and is titled Medications. This policy was reviewed and approved by Sherri Kirkpatrick, LSF-NW Regional Director on November 7, 2023.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: 2 **Total number of Closed Files: 3** **Staff Position(s) Interviewed** *(No Staff Names)* **: Nurse** **Type of Documentation(s) Reviewed: Logs, MAR** **Describe any Observations: Observed shift-to-shift medication count of controlled substance and med pass for one youth**			
The agency has a Registered Nurse (RN) and/or a Licensed Practical Nurse (LPN) that is being supervised by RN and all of their credentials have been verified.	**Compliance**	The program employs a part-time registered nurse (RN), license number RN 9474365, whose certification has an expiration date of April 30, 2025. .	
Medication Storage			
a. All medications are stored in a Pyxis ES Medication Cabinet that is inaccessible to youth (when unaccompanied by authorized staff) b. Pyxis machine is stored in accordance with guidelines in FS 499.0121 and policy section in Medication Management c. Oral medications are stored separately from injectable epi-pen and topical medications d. Medications requiring refrigeration are stored in a secure refrigerator that is used only for this purpose, at temperature range 2-8 degrees C or 36-46 degrees F. (If the refrigerator is not secure, the room is secure and inaccessible to youth.) e. Narcotics and controlled medications are stored in the Pyxis ES Station f. Pyxis keys with the following labels are accessible to staff in the event they need to access medications if there is a Pyxis malfunction: a TOP COVER b BACK PANEL-LEFT TALL CABINET LOCK- LEFT, c BACK PANEL-RIGHT TALL CABINET LOCK- RIGHT	**Compliance**	The program uses the Pyxis Med-station cabinet system and was observed to be inaccessible to youth. The Pyxis machine was observed to be stored in accordance with FS 499.0121 and policy section in medication management. The program stores controlled and over the counter separately within the Pyxis cabinet. There are currently no injectables or topical medications at the program. However, if they were they would be stored separately from oral medications. The program currently does not have medications requiring refrigeration. They do have a locked refrigerator just for medication within the required temperature of thirty-six to forty-six degrees F. The Pyxis keys were labeled and observed to be in the nurse's desk drawer. They were accessible to staff in the event the Pyxis malfunctions as required.	

Medication Distribution			
a. Agency maintains a minimum of 2 site-specific System Managers for the Pyxis ES Station b. Only designated staff delineated in User Permissions have access to secured medications, with limited access to controlled substances (narcotics) c. A Medication Distribution Log shall be used for distribution of medication by non-licensed and licensed staff d. Agency verifies medication using one of three methods listed in the FNYFS Policies & Procedures Manual e. When nurse is on duty, medication processes are conducted by the nurse f. The delivery process of medications is consistent with the FNYFS Medication Management and Distribution Policy g. Agency does not accept youth currently prescribed injectable medications, except for epi-pens h. Non-licensed staff have received training in the use of epi-pens provided by a registered nurse	**Compliance**	The agency maintains 3 site-specific system managers for the Pyxis station. The individuals are the registered nurse (RN) , the youth care specialist one, and youth care specialist three. Only designated staff in user permissions have access to secured medications. An interview with the nurse revealed she trains all direct care staff to give out medication. It is the on-duty supervisors job to assign which person on shift is responsible for giving medication to avoid missing medication when the nurse is not onsite. Otherwise the nurse distributes medication when on site. Medication is completed twice a day 7:00AM and 7:00PM. An observation was made for medication pass during the annual compliance review and no issues were noted. The nurse was observed disseminating medications. Verification was done so by the nurse verifying the youth's name, date of birth, correction medication, and dosage. Both the youth and nurse were observed signing the Medication Distribution Log (MDR). No refusals of medication by the youth were observed. An interview with the nurse revealed the program does not currently accept youth with prescribed injectable medications, except for epi-pens. An interview with the nurse revealed she conducts epi-pen training to all staff upon employment and every four months after. The nurse stated a certificate of completion is placed in the personnel files.	
The medication distribution log documentation includes: a. the time of medication administration b. evidence of youth initials that the dosage was given c. evidence of staff initials that the dosage was given	**Compliance**	The medication distribution log (MDR) was observed being used during med pass. The time of medication administration, the youth initials, and staff initials was observed being documented during the med pass. Previous days were documented.	

There is evidence that staff provide youth with medications within one hour of the scheduled time of delivery as ordered by the medication. Documentation is provided for instances this does not occur within the required timeframe.	**Compliance**	Staff provide youth with medication within one hour of scheduled time of delivery as order by the medication. This information is documented in the medications binder located in the nurse office. All medication is provided as required.	
During the review period, there were no instances where youth missed their medication due to failure to open the pyxis machine.	**Compliance**	A review of the medical distribution log revealed there were no instances where youth missed their medication due to failure to open the pyxis machine.	
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	**Compliance**	The program maintains inventories for medications and items considered sharps. Controlled medications are inventoried shift-to-shift. An observation was made during the annual compliance review and no issues were noted. Over the counter medications are inventoried using the Pyxis system. An interview with the nurse revealed she pulls inventory from the Pyxis on a weekly basis. Sharps are also inventoried weekly. An inventory of three sharps (scissors, tweezers, and nail clippers) was completed during the annual compliance review and no issues were noted.	
There are monthly reviews of the Pyxis reports to monitor medication management practice.	**Compliance**	An interview with the nurse revealed that weekly reviews of the Pyxis reports are conducted to monitor medication management practice.	
Medication discrepancies are cleared after each shift.	**Compliance**	An interview with the nurse revealed medication discrepancies are cleared after each shift. If there is a discrepancy two people need to recount and validate count. 90% of the time it is a miscount.	
The agency has an internal quality assurance process to ensure appropriate medication management and distribution methods.	**Compliance**	An interview with the nurse revealed an internal quality assurance process is in place to ensure appropriate medication management and distribution methods.	
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 policy number is 4.04 DJJ FAC 63M-2, 63N-1 and is titled Medical/Mental Health Alert Process. This policy was reviewed and approved by Sherri Kirkpatrick, LSF-NW Regional Director on November 7, 2023.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: 2 **Total number of Closed Files: 3** **Staff Position(s) Interviewed** *(No Staff Names)* **: Staff nurse and Shelter Supervisor** **Type of Documentation(s) Reviewed: Youth records**			
Youth with a medical, mental health, or food allergy was appropriately placed on the program's alert system	**Compliance**	Five files were reviewed. Three of the five files were applicable for medical or mental health condition or food allergy. All three youth were appropriately placed on the program's alert system. An interview with the nurse and shelter supervisor revealed alerts are documented four ways. Food allergies are documented on an alert board in the kitchen. All allergies are documented in the Currie House Shift Pass Down Log and on the youths files. Lastly, the alerts with medication allergies are documented in Pyxis.	
Alert system includes precautions concerning prescribed medications, medical/mental health conditions	**Compliance**	An interview with the nurse revealed the alert system includes precautions concerning prescribed medications and medical/mental health conditions.	
Staff are provided sufficient training, information and instructions to recognize/respond to the need for emergency care for medical/mental health problems	**Compliance**	An interview with the nurse revealed staff are provided sufficient training, information and instructions to recognize and respond to the need for emergency care for medical and mental health problems.	

A medical and mental health alert system is in place that ensures information concerning a youth's medical condition, allergies, common side effects of prescribed medications, foods and medications that are contraindicated, or other pertinent mental health treatment information, is communicated to all staff	**Compliance**	An interview with the nurse and Shelter supervisor revealed medical and mental health alert system is in place that ensure 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 staff. A binder with all the information was observed during the annual compliance review period.	
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 policy number is 4.05 DJJ FAC 63M - 2 titled Episodic/Emergency Care. This policy was reviewed and approved by Sherri Kirkpatrick, LSF-NW Regional Director on November 7, 2023.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: None **Total number of Closed Files: 5** **Type of Documentation(s) Reviewed: Incident reports, Program logbook**			
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**	Five files were reviewed. Four of the files were applicable for off-site emergency medical care. The remaining youth just needed a band-aid for a minor cut. An incident report was submitted for all five youth reviewed. Upon return there is verification receipt of medical clearance via discharge instructions documented in youth's file. The parent/guardian was notified in all five incidents as required. Active Note had the incidents documented.	
All staff are trained on emergency medical procedures	**Compliance**	An interview with the nurse revealed all staff are trained on emergency medical procedures.	
The program has a Knife-for-life and wire cutters accessible to staff in a secure location(s)	**Compliance**	The first aid kit locations are in counseling building kitchen, shelter kitchen, youth care specialist office, and both transport vehicles. The knife for life and wire cutters are located in the youth care specialist office.	
First aid kit/supplies are fully equipped and inventoried	**Compliance**	First aid kits are inventoried and equipped with Band-Aids, bandages, scissors and alcohol wipes. Reviewer observed the first aid kits and its contents are all up-to-date.	
Additional Comments: **There are no additional comments for this indicator.**			