Florida Network for Youth and Family Services Compliance Monitoring Report for

Lutheran Services Florida Southeast - Lippman Youth Shelter

221 NW 43rd Court
Oakland Park, Florida 33309

October 11-12, 2023

Compliance Monitoring Services Provided by

EXECUTIVE SUMMARY

Forefront LLC conducted a Quality Improvement (QI) monitoring visit on behalf of the Florida Network of Youth and Family Services (FNYFS) for Lutheran Services Florida Southeast (LSF Southeast), for the FY 2023-2024. The agency has two program locations: 1) Lippman Youth Shelter located at 221 NW 43rd Court, Oakland Park, Florida, and 2) Administrative and Community Counseling office located at 2700 W. Cypress Creek Road, Suite D131, Fort Lauderdale Florida. Forefront LLC (Forefront) is an independent compliance monitoring firm that is contracted by the FNYFS to perform onsite program reviews to assess the agency's adherence to fiscal, programmatic, and overall contract requirements. LSF Southeast 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 Marcia Tavares, Consultant for Forefront LLC and Peer Reviewers. Agency representatives from LSF Southeast present for the entrance interview were Scoundrel Oliver, Shelter Director; Guillermo Arauz, Clinical Director; and Laura Saldana, Director of Compliance. The last onsite QI visit was conducted on January 18, 2023.

LSF Southeast received a performance rating of **Satisfactory** on all twelve applicable Administrative and Fiscal Contract Compliance Monitoring indicators. Specifically, LSF Southeast received an **overall compliance rating of 100% for achieving full compliance** with all twelve applicable indicators of the CINS/FINS Contract Monitoring Tool. There were no corrective actions or recommendations made as a result of the monitoring visit. The following report represents the results of the review of the agency's performance. Copies of all completed tools utilized during the visit to determine these ratings will be maintained on file with the Reviewer. If any information or clarification is required, please contact Keith Carr by E-mail: keithcarr@forefrontllc.com

2023-2024 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 10-11-2023-2024

Agency Name: Lutheran Services Florida – SE Lippman	Monitor Name: Marcia Tavares, Lead Reviewer
Contract Type : CINS/FINS	Region/Office: 221 NW 43 Ct., Oakland Park, FL 33309
Service Description: Comprehensive Onsite Compliance Monitoring	Site Visit Date(s): October 11-12, 2023

Major Programmatic Requirements	Explain Rating: Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable	Ratings Based Upon: I = Interview; O = Observation; D = Documentation; PTV = Submitted Prior To Visit; (List Who and What)	Notes — Explain Unacceptable or Conditionally Acceptable:
I. Administrative and Fiscal							
DJJ Quality Improvement Peer Reviewer a. Provider shall demonstrate that a minimum of two (2) staff members have been trained to be certified as DJJ QI Peer reviewers. Provider shall participate in a minimum of one (1) on-site quality assurance review of a similar type program in another judicial circuit during each 12-month period of the contract, if requested.	☐	☐	☒	☐	☐	Interview – Director of Compliance. The provider currently has six certified DJJ-QI Peer Reviewers: Guillermo Araz; Raymond Ballinger; Diana Davila; Ivonne Fusco; Scoundrel Oliver; and Laura Saldana. To date, none of these peers have participated in a QI Peer Review but staff have been scheduled for the current FY.	
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 seven additional contracts were submitted for the LSF Southeast region including: Childcare Food Program, Department of Health and Human Services Basic Center and Street Outreach; and four contracts with ChildNet Inc. The list includes awarding entity, amount funded, and contract period. The agency maintains multiple interagency agreements held with a variety of community partners to provide a comprehensive referral	

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						process including mental health, substance abuse, truancy, safe place sites, employment services, educational, medical services, and support services.	
Limits of Coverage a. Provider shall provide and maintain during this contract, the following minimum kinds of insurance: Worker's Compensation and Employer's liability insurance as required by Chapter 440, F.S. with a minimum of $100,000 per accident, $100,000 per person and $500,000 policy aggregate. Commercial General Liability with a limit of $500,000 per occurrence, and $1,000,000 policy aggregate. Automobile Liability Insurance shall be required and shall provide bodily injury and property damage liability covering the operation of all vehicles used in conjunction with performance of this contract, with a minimum limit for bodily injury of $250,000 per person; with a minimum limit for bodily injury of $500,000 per accident; with a minimum limit for property damage of $100,000 per accident and with a minimum limit for medical payments or $5,000-$10,000 per person. Florida Network is listed as payee or co-payee. **PTV**	☐	☐	☐	☒	☐	Documentation – Certificate of Insurance (COI). General Liability through Markel Global Insurance Company, for limits of coverage of $1,000,000 each $3,000,000 aggregate, and medical expense for $10,000, effective 6/01/2023 – 6/01/2024. Automobile insurance through Florida Insurance Trust for combined limits of liability/property damage for $1,000,000. Policy effective date 6/01/2023 – 6/01/2024. Workers Compensation through Accident Fund Insurance Company of America with limits of $1,000,000 each/aggregate, effective 6/01/2023 – 6/01/2024.	

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	Unacceptable	**Conditionally Unacceptable**	**Fully Met**	**Exceeded**	**Not Applicable**		
						Umbrella liability through Century Surety Company with limits of $1,000,000 each/aggregate, effective 6/01/2023 – 6/01/2024. Professional Liability/Abuse Molestation through Markel Global Insurance Company for $1,000,000 each and $3,000,000 aggregate, effective through 6/01/2023 – 6/01/2024. Florida Network is listed as certificate holder on the COI.	
External/Outside Contract Compliance a. Provider has corrective action item(s) cited by an external funding source (Fiscal or Non-Fiscal). **ON SITE**	☐	☐	☐	☐	☒	Interview: During the entrance conference, the provider indicated that there are no outstanding corrective action item(s) cited by any external funding source.	

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Major Programmatic Requirements	**Explain Rating** **Unacceptable**	**Conditionally Unacceptable**	**Fully Met**	**Exceeded**	**Not Applicable**	**Ratings Based Upon:** **I = Interview** **O = Observation** **D = Documentation** **PTV = Submitted Prior To Visit** **(List Who and What)**	**Notes** **Explain Unacceptable or Conditionally Acceptable:**
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: Fiscal policies and procedures. Agency maintains a Finance Policies and Procedures Manual that is consistent with GAAP and provides for limited internal controls. Policies and procedures were last approved 11/13/14 by the Executive Vice President/Chief Financial Officer and Vice President of Finance. The procedures are updated as necessary with revised policies showing a revision/approval date.	
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: Expanded General Ledger (GL) for July 1, 2023 – August 31, 2023. The agency maintains a detailed general ledger with corresponding source documents. The general ledger is structured to track all funding sources and there is a separate GL for the Lutheran Services Florida Southeast CINS/FINS program.	

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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: Reviewed Petty Cash 4.32 Policy and Procedure included in the Fiscal Manual. There are two separate funds, one for the community counseling program ($500) and the other for the shelter which does not exceed $1000. Petty cash is maintained by the Administrative Assistant (community counseling) and the Residential Director (Shelter) and are stored in secured cash boxes. Petty cash is reconciled at least monthly by the custodians, approved by management, and submitted to the corporate office for refunding as needed. Disbursements and invoices are approved by the program director/ designee.	
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 Ameris Bank operating account and the corresponding bank reconciliations for the period March-August 2023. Bank reconciliations are processed by the	

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	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable		
						finance department in the Tampa Corporate office. Successful bank reconciliations were conducted within 2 weeks of receipt of bank statements. All of the reconciliation worksheets were reviewed by a second party in addition to the preparer. Vendor payments are distributed through the corporate office in Tampa, Florida through check requisitions by the Broward office. Vendor files are maintained locally with copies of the invoices and check requisitions.	
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: Provider maintains an inventory for computer and periphery equipment purchased from 12/2002. Inventory was last updated on 9/28/23 and no additional items were purchased with FN funds within the last year.	
f. Agency submits payroll taxes and deposits (and retirement deposits as applicable), Employee IRS Form W-2 and	☐	☐	☒	☐	☐	Documentation: ADP is contracted by LSF to process payroll. ADP is responsible for	

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Independent Contractors IRS Form 1099 forms prior to federal requirements. **ON SITE**						submitting information for W2s, Quarterly 941 reports, and payroll taxes. ADP Tax Ledger Deposit Details for the first and second quarters of 2023 were reviewed. These reports demonstrate submission of payroll taxes and deposits biweekly.	
g. Budget to actual reports prepared and reviewed by appropriate management. Variance from the budget are investigated and explained. **PTV/ON SITE**	☐	☐	☒	☐	☐	Documentation: Statement of Revenues and Expenditures for June 30 to August 31, 2023 for the CINS/FINS Program was reviewed. A net deficit of $88, 934 was observed per the report. The provider has a monthly process for reviewing and explaining variances.	
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	☐	☐	☒	☐	☐	Documentation: The provider submitted a copy of the Financial audit conducted for year ending June 30, 2022 for the review. The audit was completed by RSM US, LLP and was dated December 22, 2022. Per the auditors, there was no management letter or deficiency control letter issued	

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	Explain Rating						
submitted to the FNYFS by December 31st. **Can obtain from FNYFS**						as there were no matters required to be reported in these letters.	
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 reviewed included policy and procedures regarding the following: data back-up contained in the Agency's Policy and Procedure Section 2.10, on Information Management; Section 1, 1.09 Confidentiality of Client Information; Section 12, 12.01 Access to Case Records; and 12.02 Case Record Keeping. Laptops are not furnished to case workers.	

CONCLUSION

Following the review of Administrative and Fiscal Contract Compliance Monitoring requirements, the agency's performance results were deemed **Satisfactory** for full compliance with all twelve applicable Administrative and Fiscal Contract Compliance Monitoring indicators. One of the 13 indicators was not applicable because the provider does not have any corrective action item(s) cited by an external funding source. Consequently, **the overall compliance rating for this contract monitoring visit is 100%.** There are no corrective actions cited or recommendations 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.

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

Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Lutheran Services Florida - Southeast
Residential Program

October 11-12, 2023

Compliance Monitoring Services Provided by

CINS/FINS Rating Profile

Standard 1: Management Accountability

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

Percent of indicators rated Satisfactory: 71.43 %
Percent of indicators rated Limited: 28.57 %
Percent of indicators rated Failed: 0 %

Standard 2: Intervention and Case Management

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

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

Standard 3: Shelter Care & Special Populations

Indicator	Rating
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	**Failed**
3.07 Video Survelliance System	**Limited**

Percent of indicators rated Satisfactory: 71.43 %
Percent of indicators rated Limited: 14.29 %
Percent of indicators rated Failed: 14.29 %

Standard 4: Mental Health/Health Services

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

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

Overall Rating Summary

Percent of indicators rated Satisfactory: 79.31 %
Percent of indicators rated Limited: 13.79 %
Percent of indicators rated Failed: 3.45 %

Rating Definitions

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

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

Reviewers

Members

Marcia Tavares - Lead Reviewer Consultant-Forefront LLC/Florida Network of Youth and Family Services
Paula Friedrich – Regional Monitor, Department of Juvenile Justice
Nathaly Milla - Florida Keys Children Shelter
Wanda Rivera - Children's Home Society West Palm
Myiah White - Urban League of Palm Beach

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

Documents Reviewed

	Accreditation Reports	X	Table of Organization		Visitation Logs
X	Affidavit of Good Moral Character	X	Fire Prevention Plan	X	Youth Handbook
X	CCC Reports	X	Grievance Process/Records	5	# Health Records
X	Logbooks	X	Key Control Log	5	# MH/SA Records
	Continuity of Operation Plan	X	Fire Drill Log	9	# Personnel /Volunteer Records
X	Contract Monitoring Reports	X	Medical and Mental Health Alerts	8	# Training Records
	Contract Scope of Services	X	Precautionary Observation Logs	7	# Youth Records (Closed)
X	Egress Plans	X	Program Schedules	6	# Youth Records (Open)
X	Fire Inspection Report	X	List of Supplemental Contracts		# Other: ___
X	Exposure Control Plan		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)
	Searches		Discharge		Group
X	Security Video Tapes		Treatment Team Meetings	X	Meals
X	Social Skill Modeling by Staff		Youth Movement and Counts	X	Signage that all youth welcome
	Medication Administration	X	Staff Interactions with Youth	X	Census Board

Surveys

0	# of Youth	2	# 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 (LSF) is a statewide, non-profit, human services agency with its headquarters located in Tampa, Florida. LSF Southeast (LSF SE) 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 Broward County. The program operates out of two locations: 1) Lippman Youth Shelter, located in the City of Oakland Park, Florida, and 2) its administrative office and community counseling program (also known as Broward Family Center), located at 2700 W. Cypress Creek Rd., Suite D131, Fort Lauderdale, Florida. Funding through CINS/FINS allows the agency to serve both male and female youth up to seventeen years old that are locked out, runaway, ungovernable, truant, homeless, abused, neglected, or at-risk. The agency provides services to special populations who meet the criteria for Staff Secure shelter, Domestic Minor Sex Trafficking (DMST), and youth referred by the Juvenile Justice Court System for domestic violence (DV) respite, probation (PR) respite, as well as DV and PR Family and Youth Respite Aftercare services (FYRAC). The census during the Quality Improvement (QI) visit was 12 CINS/FINS youth. Lippman is licensed to serve twenty (20) youth and the program's license was renewed by the Department of Children and Families (DCF) and is valid until June 27, 2024. In March of 2022, the agency was informed that the Council on Accreditation (COA) approved the accreditation of LSF through February 28, 2026. LSF SE programs were monitored during the visit for accreditation and met the standards set forth by COA.

The agency provided the following programmatic updates:

Staffing

During the current review period, the executive management structure for LSF-SE remains intact and stable under the leadership of Regional Director, Raymond Ballinger. Ivonne Fusco continues in her role as Executive Administrative Assistant. Her experience and leadership are an integral part of ensuring the program's management and accountability is not compromised. Her diligence and attention to detail supports many key functions of program operations. She has been a resource and support for onboarding with the newly acquired LSF Miami Bridge program.

Scoundrel Oliver has led the program's residential services since October 2019. She continues to provide steady and transformational leadership that enhances the quality of services for all those served in shelter. Her compassion and dedication to the youth and families served at Lippman Youth Shelter has afforded her opportunities to provide support and technical assistance to other agency programs in Pensacola and West Palm Beach. Loraine Fordhan is the program's longest tenured (13 years) direct care staff and serves in the role of Youth Care Specialist III (YCS III). Loraine provides support for shelter operations and is the program's lead for the child caring food program.

Martin Kalathungal, RN is the program's nurse. The RN works 20 hours per week and leads the programs efforts in managing the risk associated with medication management. Martin has been with the program the entire review period and has provided stability for the program. Lippman Youth Shelter received recognition at the Florida Network's Summer QIC for having no medication errors in the past year. Guillermo Arauz, LMHC remains the Clinical Director of LSF SE residential and community counseling programs. Additionally, Guillermo is a Qualified Supervisor and oversees the region's internship program. LSF SE has utilized three interns in the shelter program and one intern in the community counseling program. The interns have had a positive impact on creating additional opportunities for support and mentoring for youth and families while gaining a robust learning experience in their field of study. Diana Davila and Lisa Ellis remain tenured staff with 10 years' experience each in their roles of community counselors. Marilyn McDaniel remains with the agency as she started prior to the last review period. The newest member of the community counseling team is Marlene Reid-Brown, and she started 8/7/2023. The program is happy to report they are currently fully staffed in both community counseling and residential counseling program. Constance Rose, LSF-SE residential counselor, has been with the program for over a year. Her longevity in the program and passion for working with youth and families has led to stabilizing the lives of the youth served. Juliet Peterkin joined the LSF SE team in April 2023. Having two full-time clinicians have positively impacted the programs and contributed to the stability of clinical programming.

Program Updates

The program received $450k in funding to support the renovations at Lippman Youth Shelter. The funds were to be exhausted by June 2023 with an extension through October 2023 provided. Renovations at the facility continue to be underway. The program does not anticipate any disruption in services. However, there may be times throughout the renovation process in which the residential census is reduced.

Facility

Renovations completed since the last review period include: exterior painting, window replacements, door replacements, interior flooring. The Grants Manager and Development Team are meeting weekly to discuss the critical needs of Lippman and have made getting these critical needs met at Lippman a priority. New fundraising opportunities and community connections are being explored each week to expeditiously raise funds for additional shelter repairs. The Development team is actively engaged in a CAPITAL CAMPAIGN aimed at "Building Hope" through improvements to the program's facilities.

Funding

The program received notice of award on 9/22/2023 for Basic Center Program for 2023-2026 in the amount of 250K per year with 27.7K in LSF matching for volunteers.
The program had its filled bed day units increased from 3178 to 3378 for the current fiscal year.
The Development team is actively engaged in a CAPITAL CAMPAIGN aimed at "Building Hope" through improvements to the program's facilities.
The program was assigned a 2023 Chevy Equinox in June of 2023 for Lippman youth Shelter.

Major Challenges

The program continues to deal with challenges associated with the cooperative working agreement between DCF, DJJ, and the Broward County School Board. Currently, there is no agreement in place and community referrals through the schools have been very low. As a result, Broward County has reduced the number of youths served in our community counseling program. Additionally, the program is challenged with raising funds to make the necessary renovations to Lippman Youth Shelter.

Narrative Summary

LSF SE is under the leadership of a management team, including a regional director, a shelter director, a licensed clinical director, a director of compliance, and a senior administrative assistant. The residential program is staffed by a youth care specialist supervisor, a part-time registered nurse, one YCS II, and 10 YCS I. In addition to the clinical director, the residential clinical component includes two master's level counselor position and the community counseling program is serviced by three bachelor degreed and one master's level staff. The program has not reported any major challenges, incidents, administrative review, or current external investigations.

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

Standard 1: There are seven indicators for Standard 1. Indicator 1.05-Analyzing and Reporting Information and Indicator 1.07- Outreach Services were rated **Satisfactory with no exceptions**. Indicator 1.01- Background Screening of Employees/Volunteers, Indicator 1.04 Training Requirements, and Indicator 1.06-Client Transportation were rated **Satisfactory with exceptions**. There were two Indicators, Indicator 1.02-Provision of an Abuse Free Environment and Indicator 1.03-Incident Reporting that received **Limited** rating.

Standard 2: There are nine indicators for Standard 2. One of the indicators, Indicator 2.09 is not applicable because LSF SE is not contracted to provide SNAP services. Six Indicators were rated **Satisfactory with no exceptions**: Indicator 2.01 Screening and Intake, Indicator 2.02 Needs Assessment, Indicator 2.04 Case Management and Service Delivery, Indicator 2.05 Counseling Service, Indicator 2.06 Adjudication/Petition Process, and Indicator 2.07 Youth Records. Indicators 2.03 Case/Service Plan and Indicator 2.08 Specialized Additional Program Services were rated **Satisfactory with exceptions.**

Standard 3: There are seven indicators for Standard 3. Indicator 3.05 Behavior Management Strategies was rated **Satisfactory with no exceptions.** Indicators 3.01 Shelter Environment, Indicator 3.02 Program Orientation, Indicator 3.03 Youth Room Assignment, and Indicator 3.04 Log Books were rated **Satisfactory with exceptions.** Indicator 3.06 Staffing and Youth Supervision received a **Failed rating**, 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 and Indicator 4.03 were rated **Satisfactory with no exceptions**. Indicator 4.02 Suicide Prevention and 4.05 Episodic/Emergency Care were rated **Satisfactory with exceptions.** Indicator 4.04 Medical/Mental Health Alert Process was rated **Limited.**

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

Standard 1:

Indicator 1.02 - Limited

A review of the logbook entries for the past 6 months showed 73 of the 131 work days during that period where there was no documentation in the logbook that the grievance box was checked. In addition, two of the three grievances reported were resolved five days after they were submitted, outside of the 72 hours required.

Indicator 1.03 - Limited

One of the seven incidents (6/26/23) was not reported to the CCC within the 2-hour time frame. The caller gained knowledge at 4:50pm and it was not reported until 8:36pm.

During the QI review of offsite episodic emergency, it was observed the program documented an internal incident report for two medical emergency incidents; however, there was no CCC report made in relation to the medical transport of the youth on 2/24/23 transported to ER by the parent/guardian and another medical transport on 2/25/23. Upon notification of this discovery, the shelter director called CCC to report these incidents.

Three incidents were not documented on the program internal incident reporting form. The reviewer was provided copies of the CCC report for two of the three incidents occurring 6/26/23 and 8/2/23; however, the program was unable to locate written documentation for the third incident that occurred on 10/2/23.

Standard 3:

Indicator 3.06 - Failed

During video review of five random 2-hour overnight timeframes it was observed that 31 bed checks were missed including multiple that were falsified; 10 bed checks were done three to five minutes late; and only four were completed on time. CCC report was completed by the shelter director on 10/11/2023 at 5:51pm to report all findings.

Indicator 3.07 - Limited

Supervisory video reviews for the month of June were completed; however, both reviews done for this month are 15 and 16 days apart. For the month of July, there was a video surveillance done on time but the second review for the month of July was done 23 days later. For the month of August, only one review was done on 08/04/2023. First review in the month of September was done 49 days afterwards. The remaining reviews in September and October were done in accordance with the 3.07 Video Surveillance Policy.

Standard 4:

Indicator 4.04 - Limited

The program reported they do not utilize an alerts binder. An alerts binder was not maintained therefore documentation was not available to validate when each of the five reviewed youth was placed on alert or when an alert was discontinued.

<table>
<tr><td colspan="4">CINS/FINS QUALITY IMPROVEMENT TOOL</td></tr>
<tr><td colspan="2">Quality Improvement Indicators and Results:
Please select the appropriate outcome for each indicator for each item within the indicator.</td><td>Summary/Narrative Findings Must include Document Source:
E.g. Interview/Surveys, Observation, and/or Type of Documentation</td><td>Deficiencies/Exceptions
Please add additional detailed explanations for any items that have any deficiencies or exceptions.</td></tr>
<tr><td colspan="4">Standard One – Management Accountability</td></tr>
<tr><td colspan="3">1.01: Background Screening of Employees, Contractors and Volunteers</td><td>Exception</td></tr>
<tr><td colspan="2" rowspan="3">Provider has a written policy and procedure that meets the requirement for Indicator 1.01</td><td>NO</td><td rowspan="3"></td></tr>
<tr><td>If NO, explain here: Policy 1.01 is missing additional information provided on the requirement regarding timeframes for re-taking the pre-employment suitability assessment.</td></tr>
<tr><td>The agency's policy 1.01, Background Screening of Employees, Interns, and Volunteers, was approved on September 7, 2023 by the Regional Director.</td></tr>
<tr><td colspan="4">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.</td></tr>
<tr><td colspan="4">Total number of New Hire Employee/Intern/Volunteer Files: Five new staff hired and three interns.
Total number of 5 Year Re-screen Employee Files: One 5-year rescreened staff.
Type of Documentation(s) Reviewed: Staff roster, Department of Juvenile Justice Background Screening results, Predictive Index Suitability Screenings, E-Verify, Annual Affidavit of Compliance with Level 2 Screening Standards</td></tr>
<tr><td>All positions providing direct services to youth has successfully passed pre-employment suitability assessment on the initial attempt.</td><td>Exception</td><td>The agency uses the Predictive Index (PI) pre-employment assessment that was implemented July 2018. The tool was administered prior to the hiring of three of five new direct care staff hired during the review period. All three staff completing the assessment obtained passing scores (greater than five) on a scale of 1-10. The two staff who did not complete the assessment are master's level clinicians. One of the two did not complete a pre-employment assessment due to being hired prior to the effective date of 7/1/2023 for master's level clinicians.</td><td>One Master's level direct care staff hired 8/7/2023 did not complete a pre-employment assessment as required.</td></tr>
<tr><td>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.</td><td>No eligible items for review</td><td>All three staff who completed the suitability assessment received passing scores.</td><td></td></tr>
</table>

Agency has evidence for employees who have had a break in service for 18 months or more, and/or when the agency had a change or update in the suitability assessment tool used was different from the employee's original assessment, that a new suitability assessment and background screening was completed as required.	**No eligible items for review**	None of the new hires were prior employees.	
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**	Background screenings for all five new hires and three interns were initiated prior to hire/start dates with eligibility documented on the DJJ background screening results. There were no exemptions required.	
Five-year re-screening is completed every 5 years from initial date of hire or prior to retained fingerprints expiration date.	**Compliance**	The program had one eligible five year re-screening since the last QI visit. The re-screening was completed prior to the employee's retained fingerprints expiration date.	
Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?	**Compliance**	The program emailed its Annual Affidavit of Compliance with Level 2 Screening Standards to the Background Screening Unit on January 6, 2023 prior to the January 31st deadline.	
Proof of E-Verify for all new employees obtained from the Department of Homeland Security	**Compliance**	Proof of employment authorization from the Department of Homeland Security was obtained through E-verify and maintained on file for all five new hires.	
Additional Comments: **There are no additional comments for this indicator.**			
1.02: Provision of an Abuse Free Environment			**Limited**
Provider has a written policy and procedure that meets the requirement for Indicator 1.02		**YES** If NO, explain here: The agency has the required policy 1.02, titled Provision of an Abuse Free Environment, that was approved on September 7, 2023 by the 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)* **:** Shelter Manager **Type of Documentation(s) Reviewed:** Code of Conduct, Resident Handbook, client grievance file **Describe any Observations: Abuse Hotline postings,** Grievance box, grievance forms			
Agency has a code of conduct of policy and there is evidence that staff are aware of agency's code of conduct.	**Compliance**	The agency has a code of conduct that prohibits that use of physical abuse, profanity, threats or intimidations. All new staff are required to signs the code of conduct form during the orientation process.	

The agency has a process in place for reporting and documenting child abuse hotline calls.	Compliance	Postings of the Abuse Hotline Number was observed in each bedroom located in the binders posted on the wall. The agency has a process in place for reporting and documenting abuse hotline calls. Once an abuse call is made, staff completes a Child Abuse and Neglect form and documents the call on a log that is maintained by the program manager. A review of the log showed the agency reported four calls to the abuse hotline during the past six month. None of the four calls were institutional.	
Youth were informed of the Abuse and Contact Number	Compliance	Per the shelter manager, youth are informed of the abuse hotline during orientation. The abuse hotline number was observed to be included in the Resident handbook and posted on a wall in the main hallway.	
Grievance			
Grievances are maintained on file at minimum for 1 year.	Compliance	The shelter manager maintains records of grievances in a file for a minimum one year.	
There are formal grievance procedures for youth, including grievance forms, and a locked box which are easily accessible to youth in a common area.	Compliance	The agency has a grievance procedure in place that is reviewed with youth during intake. The grievance box was observed to be locked and is mounted on a wall in the shelter at the entry to the youth dormitory. Grievance forms are accessible next to the grievance box.	
There is evidence that grievance boxes are checked by management or a designated supervisor at least daily as evidenced in the program logbook.	Exception	The grievance box was void of any submitted grievances during the tour of the facility. Grievance box is checked by the shelter manager and/or youth care supervisor. The checks are required to be documented in the program logbook; however, during the review period, there was no documentation in the logbook to support grievance box checks were conducted at least five times per week, Monday -Friday, with the exception of holidays.	A review of the logbook entries for the past 6 months showed 73 of the 131 work days during that period where there was no documentation in the logbook that the grievance box was checked.
All grievances are resolved within 72 hours and documented by program director/supervisor or escalated to higher leadership if grievance involves them directly.	Exception	Three grievances were reported by youth during the review period. All three grievances were addressed by the shelter supervisor and were signed by the youth, supervisor, and shelter manager indicating acceptable solution.	Two of the three grievances reported were resolved five days after they were submitted, outside of the 72 hours required.

1.03: Incident Reporting			Limited
Provider has a written policy and procedure that meets the requirement for Indicator 1.03		**YES** If NO, explain here: The agency has the required policy 1.03, titled Incident Reporting, that was approved on October 6, 2023 by the 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)*: Shelter Supervisor **Type of Documentation(s) Reviewed:** Agency incident reports, and DJJ CCC incident reports for the period April - October 10, 2023 **Describe any Observations:**			
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	In the last 6 months a total of seven incidents were accepted by CCC. Two of the seven incidents were determined to be medical, one baker act, one improper sexual conduct, one visitor disruption, and two for youth who absconded. Six of the incidents were reported within the two hour time frame.	One of the seven incidents (6/26/23) was not reported to the CCC within the 2-hour time frame. The caller gained knowledge at 4:50pm and it was not reported until 8:36pm. During the QI review of offsite episodic emergency, it was observed the program documented an internal incident report for two medical emergency incidents; however, there was no CCC report made in relation to the medical transport of the youth on 2/24/23 transported to ER by the parent/guardian and another medical transport on 2/25/23. Upon notification of this discovery, the shelter director called CCC to report these incidents.
The program completes follow-up communication tasks/special instructions as required by the CCC	No eligible items for review	All of the seven incidents were closed by CCC and no further follow ups were required.	
Agency internal incidents are documented on incident reporting forms and all CCC reportable incidents were consistently reported to CCC as required.	Exception	Four of the incidents were documented on the agency's incident report form.	Three incidents were not documented on the program internal incident reporting form. The reviewer was provided copies of the CCC report for two of the three incidents occurring 6/26/23 and 8/2/23; however, the program was unable to locate written documentation for the third incident that occurred on 10/2/23.
Incidents are documented in the program logs and on incident reporting forms	Compliance	All seven incidents were documented in the program logbook.	
All incident reports are reviewed and signed by program supervisors/ directors	Exception	Out of seven incidents, one was missing a supervisor's signature.	Incident report dated 9/29/23 was not signed by the supervisor.

1.04: Training Requirements (Staff receives training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions)			**Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 1.04		**YES** If NO, explain here: The agency has the required policy 1.04, titled Training Requirements, that was approved on October 6, 2023 by the 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 New Hire Staff Files: 4 training records for two fulltime and one part time youth care staff and one shelter counselor **Total number of Annual In-Service Staff Files:** 4 training records for a fulltime youth care staff, shelter manager, and two community counseling counselors **Total number of Non-Licensed Mental Health Clinical Shelter Staff Files:** 1 **Annual Training Plan Timeframe** (*Program timeframe for annual trainings*)**:** Staff anniversary date **Staff Position(s) Interviewed** *(No Staff Names)***:** Director of Compliance **Type of Documentation(s) Reviewed:** Staff training files and FY 23-24 Training Plan			
First Year Direct Care Staff			
All direct care staff have completed new hire pre-service training requirements for safety and supervision as required.	**Compliance**	A review of four pre-service staff training records were conducted. Three of the four staff were within the first six months of hire and one was one week short of completing the first full year. All four staff completed all new hire training as required for safety and supervision.	
All staff completed the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days from date of hire.	**Compliance**	A review of the four training records verified each staff completed the United States Department of Justice Civil Rights and Federal Funds training within the required thirty 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**	As of the date of the QI review, all four staff had completed an excess of 80 training hours ranging from 110-132 .5 training hours.	
All staff receives all mandatory training during the first 90 days of employment from date of hire.	**Exception**	Two of the four staff completed all mandatory training due within the first 90 days of employment. The remaining two staff had completed all of required annual training but two training topics were not completed within the 90 day required period.	Two training topics were not completed during the first 90 days for two of the four first year. Both staff completed Cultural Diversity three months late and Fire Safety was completed one month late for one of the two staff.

Staff Required to Complete Data Entry for NIRVANA or access the Florida Department of Juvenile Justice Information System (JJIS)			
Any designated staff that is responsible for entering NIRVANA or ensuring accurate and complete data entry in the Florida Department of Juvenile Justice Information System (JJIS) have completed all of the required trainings.	Compliance	One applicable residential counselor completed the NIRVANA and JJIS training within 90 days as required.	
Staff Participating in Case Staffing & CINS Petitions (within first year of employment)			
Documentation of instructor led FL Statute 984 CINS Petition Training by a local DJJ Attorney. *Effective for staff hired after 7/1/23*	Not Applicable	None of the four first year staff members were hired after the 7/1/23 effective date of this requirement	
Non-licensed Mental Health Clinical Shelter Staff (within first year of employment)			
Documentation of non-licensed mental health clinical staff person's training in Assessment of Suicide Risk form or written confirmation by a licensed mental health professional of training (includes date, signature and license number of the licensed mental health professional supervisor).	Compliance	One applicable residential counselor completed the required Assessment of Suicide Risk training with supporting documentation confirmed by the licensed clinical supervisor.	
In-Service Direct Care Staff			
Direct care staff completes 24 hours of mandatory refresher Florida Network, SkillPro, and job-related training annually *(40 hours if the program has a DCF child caring license).*	Exception	Two residential staff training records supported one of the two residential staff had an excess of 40 hours required, and the two community counseling staff training records had an excess of 24 hours required. Three of the four in-service staff completed all mandatory annual trainings.	One residential staff (date of hire (DOH) 8/20/21) completed 37 of the 40 annual training hours required. Per the compliance director, the staff was on FMLA for part of the year from April to July 2023. One of the four in-service staff (DOH 10/8/2019) last completed Information Security Awareness 3/25/22 and Youth Suicide Prevention on 3/12/21. Both are due annually and were not completed in the 2022-2023 training year.
Required Training Documentation			
The agency has a training plan that includes all of the required training topics including the pre-service and in-service.	Compliance	A review of the agency's FY 23-23 training plan reveals there is a plan in place that includes all required training topics for pre/in-service staff. A copy of the training plan is included in each training file reviewed.	
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 Director of Compliance is responsible for managing all employees' individual training files and conducting periodic reviews to monitor and maintain the training records.	

The program maintains an individual training file or employee file AND a FLN Training Log (Or similar document) for each staff, which includes an annual employee training hours tracking form and related documentation, such as electronic record/transcript, training certificates, sign-in sheets, and agendas for each training attended.	Compliance	The program maintains individual training records for each staff. Each of the training records contained an annual training tracking form indicating the name of the training, date it was taken, and the number of training hours received. Further review of the files contained sign-in sheets, certificates and agendas of the training received.	
Additional Comments: **There are no additional comments for this indicator.**			
1.05 - Analyzing and Reporting Information			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 1.05		**YES** If NO, explain here: The agency has the required policy 1.05, titled Analyzing and Reporting Information, that was approved on October 6, 2023 by the Regional Director. In addition, there is a comprehensive agency-wide Performance Quality Improvement (PQI) plan that includes detailed procedures to collect, review, and reports various sources of information to identify patterns and trends.	
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)* **:** Director of Compliance, Shelter Manager, Community Counseling Director **Type of Documentation(s) Reviewed:** LSF PQI Plan 2023, staff meeting agendas/minutes, LSF Monthly CQI metrics, Peer Review Report, NetMIS meeting email			
Case record review reports demonstrate reviews are conducted quarterly, at a minimum	Compliance	Case record reviews are conducted at a minimum on a monthly basis by the clinical staff and documented individually for each record reviewed. A monthly cumulative Peer Review Report summarizes the finding by listing the name of youth, open/closed status, counselor, date of review, total number of records reviewed, deficiency, and reason for deficiency. Outcome of the peer reviews are reported to staff at monthly staff meetings to address deficiencies identified. Staff meeting minutes and agenda for the review period support peer record reviews are conducted and communicated to staff.	

The program conducts reviews of incidents, accidents, and grievances quarterly, at a minimum	**Compliance**	Data regarding the number of incidents/accidents and grievances is entered into the agency's PQI Monthly CQI Program Metrics Report. The spreadsheet captures a variety of data for all the programs statewide as well as regionally and monitors the numbers of incidents, accidents, and grievances. Incidents/accidents are tracked on the companion report monthly by level of severity. A review of monthly staff meeting agendas showed evidence of discussion of incidents/accidents and grievances during the review period.	
The program conducts an annual review of customer satisfaction data	**Compliance**	The programs collect customer satisfaction survey data monthly and enter the number completed each month by program into the CQI Program Metrics. A review of the staff meeting agendas/minutes demonstrated there is communication and discussion of client satisfaction surveys during the review period.	
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 provider has established program and contract outcomes and collects performance measures data monthly on the monthly CQI Program Metrics by program. Data collected includes benchmarks and performance measures such as: client satisfaction; client functioning; staff turnover; incidents/accidents; grievances; care days; data entry; service completion and status at discharge; 30 and 60-day follow-up; and exits. PQI, outcomes, and NetMIS data is reviewed and discussed at monthly staff meetings and monthly management meetings and are documented in the meeting minutes.	
The program has a process in place to review and improve accuracy of data entry & collection	**Compliance**	Weekly NetMIS meetings are held to review data entry collection, benchmark data, and deficiencies. This information is sent via email to the Regional Director and Community Counseling Director, the latter oversees quality checks of youth records.	
There is documentation that findings are regularly reviewed by management and communicated to staff and stakeholders.	**Compliance**	Findings are regularly reported on a monthly basis and documented in the agency's monthly CQI Program Metrics where reports can be generated and shared with staff at monthly staff meetings. Documentation supported findings are reviewed by management and communicated with staff during staff meetings. The agency's publishes an Annual Report to share program information with stakeholders.	

There is evidence the program demonstrates that critical performance data reports are shared with the Board of Directors frequently. All final reports that include a Limited or Failed score is submitted electronically or by mail to the providers Executive Committee on the Board of Directors.	Compliance	LSF's Quality Assurance Department is responsible for data collection, data processing, analysis, and reporting of performance quality and improvement to the Executive Leadership Team and the LSF Board of Directors. Metrics that impact the agency are reviewed via LSF's cross-functional continuous quality improvement workgroups, committees, and departmental meetings. Per the agency's PQI, the Board of Directors/Executive Leadership reviews performance targets, including QI performance, on a quarterly basis.	.
There is evidence that strengths and weaknesses are identified, improvements are implemented or modified, and staff are informed and involved throughout the process.	Compliance	The agency has an Associate Vice President Quality Assurance and Compliance who leads the development, implementation, documentation, evaluation, and promotion of continuous improvement practices and systems. LSF SE also has a director of compliance who is responsible for oversight at the regional level. Processes are in place and established in the PQI plan to collect date and identify areas needing improvement. Should negative trends be observed, a corrective action will be implemented as a priority issue to be addressed and is monitored by the compliance staff as well as the program management team.	
Additional Comments: **There are no additional comments for this indicator.**			
1.06: Client Transportation			Exception
Provider has a written policy and procedure that meets the requirement for Indicator 1.06		**YES** If NO, explain here: The agency has the required policy 1.06, titled Client Transportation, that was approved on October 6, 2023 by the 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: April 1 - October 11, 2023 **Staff Position(s) Interviewed** *(No Staff Names)*: Shelter Supervisor **Type of Documentation(s) Reviewed:** Transportation logs, approved driver's list with approved driver's licenses, insurance verification of approved drivers, and phone text messages. **Describe any Observations:** Vehicle #205 and Vehicle #914			
Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	Compliance	The agency maintains a list of authorized drivers and per the shelter manager, all staff are approved. The reviewer viewed supporting documents showing the number of employees and approved drivers licenses	

Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	Compliance	Documentation supported all staff have a valid drivers licenses and are covered under the agency's automobile insurance with Florida Insurance Trust effective 6/1/2023-6/1/2024.	
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 has a transportation policy that requires staff to make arrangements to transport youth and ensure the staff member is never in a one to one situation with any youth. When another youth care staff is unavailable to assist with transportation the youth care staff may utilize interns, volunteer or may utilize other youth during transport. The agency does have in place a procedure if a 3rd party cannot be obtained for transport. All transports have been done with the required amount of personnel to transport.	
In the event that a 3rd party cannot be obtained for transport, the agency's supervisor or managerial personnel consider the clients' history, evaluation, and recent behavior	Compliance	In the event of a single transport of youth, per the transportation policy, approval is required by the Residential Supervisor who considers the client's history, evaluation, and recent behavior.	
The 3rd party is an approved volunteer, intern, agency staff, or other youth	Compliance	Transportation logs were reviewed for two agency vans for the review period April 1, 2023 through the review date. With the exception of single transports, third party present in vehicles were typically 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	During the review period, a total of 484 single transports were identified from the review of transportation logs for the two agency vans. The reviewer observed that there were a few instances where the supervisor was unable to sign and approve transportation log prior to single transport. Staff was not inputting approval information on both the transportation logs as well as the tablet.	In vehicle #205 there were 263 single transports events in which there were 10 non-approvals by supervisor. In vehicle #914 there were 221 single transports and 5 non- approvals by the supervisor.
There is documentation of use of vehicle that notes name or initials of driver, date and time, mileage, number of passengers, purpose of travel and location.	Compliance	The agency has a vehicle utilization tracking log that includes all required information to document transportation events. The logs were not always completely filled out in certain spaces such as youth name, signatures, times and number of kids in the transport. The reviewer was unable to see in the program logbook where there was a call made to a senior program lead, or designee upon departure or arrival of single transport; however, the youth care supervisor provided phone text messages where check-ins were conducted with staff during single transports that occurred after July 1st.	

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

1.07 - Outreach Services			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 1.07		**YES** If NO, explain here: The agency has the required policy 1.07, titled Outreach Services, that was approved on October 6, 2023 by the 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, Director of Compliance **Type of Documentation(s) Reviewed:** NetMIS Outreach Activity Report			
The program has a lead staff member designated to participate in local DJJ board, Circuit and Council meetings with evidence that includes minutes of the event or other verification of staff participation.	**Compliance**	The Regional Director is the designee for participation and attendance to the Circuit 17 DJJ Advisory Board meetings.	
The program maintains written agreements with other community partners which include services provided and a comprehensive referral process.	**Compliance**	The agency maintains multiple interagency agreements that meet all contractual requirements. The agreements are held with a variety of community partners to provide a comprehensive referral process including mental health, substance abuse, truancy, safe place sites, employment services, educational, medical services, and support services.	
The program will maintain documentation of outreach activities and enter into NetMIS the title, date, duration (hours), zip code, location description, estimated number of people reached, modality, target audience and topic.	**Compliance**	Outreach activities in the past six months have included attendance at Community Collaboration events, Food Distribution, participation at the McNair Park Resource Event, school resource fairs at Dillard High School and Blanche Ely, participation in parenting and family functioning classes with Boys town, establishing relationships with inter-local providers including the Department of Health, Career Source, YMCA, Fort Lauderdale Police Department, Sunserve, Pompano Beach Police Department, Goodwill, Covenant House, Handy, and Pride Center. Outreach activities are entered into NetMIS including the title, date, duration (hours), zip code, location description, estimated number of people reached, modality, target audience and topic.	
The program has designated staff that conducts outreach which is defined in their job description.	**Compliance**	The program does not have one position with position description responsibility for community outreach; however, the program has included community outreach as an added duty and responsibility for current counseling positions.	
Additional Comments: **There are no additional comments for this indicator.**			

2.01 - Screening and Intake			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 2.01		**YES** If NO, explain here: The agency has the required policy 2.01, titled Screening and Intake, that was approved on October 6, 2023 by the 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 3 open community counseling youth records **Total number of Closed (Residential & Community) Files:** 3 closed residential and 2 closed community counseling youth records **Staff Position(s) Interviewed** *(No Staff Names)*: Clinical Director **Type of Documentation(s) Reviewed:** Total of 10 youth records			
Shelter youth: Eligibility screening is completed immediately for all shelter placement inquiries.	Compliance	All five residential youth records contained screenings that had been completely prior to or immediately upon admission to shelter.	
Community counseling: Eligibility screening is completed within 3 business days of referral by a trained staff using the Florida Network screening form.	Compliance	Four of five community counseling youth records contained screenings that had been completed within 3 business days of referral and prior to intake. One file referral was made 5/2/2023 and screening/intake was not completed on 6/10/2023 due to multiple documented attempts to contact the parent/guardian who was not responding to the calls. The counselor made an earlier appointment but had to reschedule to 6-10-23 due to illness.	
There is evidence all referrals for service is screened for eligibility and is logged in NetMIS within 72 hours of screening completion.	Compliance	All ten youth records contained evidence referrals for service is screened for eligibility and is logged in NetMIS within 72 hours of screening completion	
Youth and parents/guardians receive the following in writing: a. Available service options b. Rights and responsibilities of youth and parents/guardians	Compliance	All ten records reviewed contained verification that the youth and parents/guardians were provided with information related to available service options and rights and responsibilities of youth and parents/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	Compliance	All ten youth records contained documentation to support CINS/FINS brochure was discussed by way of a form that stated the brochure and handbook were reviewed. All ten records included documentation grievance procedures were provided/reviewed with youth and parents/guardians.	
During intake, all youth were screened for suicidality and assessed as required if needed.	Compliance	A completed copy of the CINS/FINS intake was present in all ten youth records to support suicide screening was conducted and youth were referred for assessment of suicide risk for three of the ten youth.	
Additional Comments: **There are no additional comments for this indicator.**			

2.02 - Needs Assessment			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.02		**YES** If NO, explain here: The agency has the required policy 2.02, titled Network Inventory of Risks, Victories, and Needs Assessment (NIRVANA), that was approved on October 6, 2023 by the 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 3 open community counseling youth records
Total number of Closed (Residential & Community) Files: 3 closed residential and 2 closed community counseling youth records
Staff Position(s) Interviewed (No Staff Names): Clinical Director
Type of Documentation(s) Reviewed: Total of 10 youth records

Shelter Youth: NIRVANA is initiated within 72 hours of admission	**Compliance**	All five residential records reviewed had the NIRVANA Assessment initiated within 72 hours of admission.	
Non-Residential youth: NIRVANA is initiated at intake and completed within 2 to 3 face-to-face contacts after the initial intake **OR** updated, if most recent assessment is over 6 months old	**Compliance**	All five community counseling records reviewed demonstrated NIRVANA Assessments were initiated at intake and completed within 2 to 3 face-to-face contacts.	
Supervisor signatures is documented for all completed NIRVANA assessments and/or the chronological note and/or interview guide that is located in the youths' file.	**Compliance**	All 10 records had the supervisor's signatures signed on all completed NIRVANA assessments.	
(Shelter Only) NIRVANA Self-Assessment (NSR) is completed within 24 hours of youth being admitted into shelter. If unable to complete, there must be documentation in NetMIS and the youth's file explaining the barriers to completion.	**Compliance**	The five residential records reviewed included NIRVANA Self-Assessment (NSR) that were completed within 24 hours of youth being admitted into shelter.	
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 five residential youth were in shelter care for 30 days and therefore did not require a NIRVANA post-assessment.	
A NIRVANA Re-Assessment is completed every 90 days excluding files for youth receiving SNAP services.	**No eligible items for review**	None of the five residential youth were in shelter care for 90 days and therefore did not require a NIRVANA re-assessment.	
All files include the interview guide and/or printed NIRVANA.	**Compliance**	All ten youth records included a printed NIRVANA assessment.	

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

2.03 - Case/Service Plan			**Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 2.03		**YES** If NO, explain here: The agency has the required policy 2.03, titled Case/Service Plans, that was approved on October 6, 2023 by the 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 3 open community counseling youth records **Total number of Closed (Residential & Community) Files:** 3 closed residential and 2 closed community counseling youth records **Staff Position(s) Interviewed (No Staff Names):** Clinical Director **Type of Documentation(s) Reviewed:** Total of 10 youth records			
The case/service plan is developed on a local provider-approved form or through NETMIS and is based on information gathered during the initial screening, intake, and NIRVANA.	**Compliance**	All ten case/service plans reviewed were documented on a local provider-approved form and are based on information gathered during the initial screening, intake, and NIRVANA	
Case/Service plan is developed within 7 working days of NIRVANA	**Compliance**	All ten case/service plans reviewed were developed within 7 working days of completion of the NIRVANA.	
Case plan/service plan includes: 1. Individualized and prioritized need(s) and goal(s) identified by the NIRVANA 2. Service type, frequency, location 3. Person(s) responsible 4. Target date(s) for completion and Actual completion date(s) 5. Signature of youth, parent/ guardian, counselor, and supervisor 6. Date the plan was initiated	**Exception**	All ten case/service plans reviewed contained individualized and prioritized need(s) and goal(s) identified by the NIRVANA and date plan was initiated; service type, frequency, location; person(s) responsible for completing goals; and target date(s) for completion of goals. Seven of the ten case plans reviewed included actual goal completion dates. Signatures of youth, parent/ guardian, counselor, and supervisor were observed on all ten case plans.	Three of the residential case plans, including one for a closed record, did not include actual completion dates.
Case/service plans are reviewed for progress/revised by counselor and parent (if available) every 30 days for the first three months and every 6 months after	**Compliance**	All five community counseling records reviewed demonstrated timely reviews for progress by the counselor during the required timeframes. None of the five residential youth were in shelter care for at least 30 days and therefore did not require 30-day reviews.	
Additional Comments: **There are no additional comments for this indicator.**			

2.04 - Case Management and Service Delivery			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 2.04		YES If NO, explain here: The agency has the required policy 2.04, titled Case Management and Service Delivery, that was approved on October 6, 2023 by the 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 3 open community counseling youth records **Total number of Closed (Residential & Community) Files:** 3 closed residential and 2 closed community counseling youth records **Staff Position(s) Interviewed (No Staff Names):** Clinical Director **Type of Documentation(s) Reviewed:** Total of 10 youth records, Interagency agreements			
Counselor/Case Manager is assigned	Compliance	Each of the ten files demonstrated a counselor/case manager was assigned to work with the youth/family from case assignment to termination.	
The Counselor/Case Manager completes the following as applicable: 1. Establishes referral needs and coordinates referrals to services based upon the on-going assessment of the youth's/family's problems and needs 2. Coordinates service plan implementation 3. Monitors youth's/family's progress in services 4. Provides support for families 5. Monitoring of progress for court ordered youth in shelter 6. Makes referrals to the case staffing to address problems and needs of the youth/family 7. Accompanies youth and parent/guardian to court hearings and related appointments 8. Refers the youth/family for additional services when appropriate 9. Provides case monitoring and reviews court orders 10. Provides case termination notes 11. Provides follow-up after 30 days of exit 12. Provides follow-up after 60 days of exit	Compliance	All 10 records were observed to demonstrate identification of referral needs, coordination of service plans, provision of various types of support, referrals for needed services, and provision of case management and overall support and follow up. None of the ten records reviewed were court ordered or referred to the case staffing committee, thereby requiring any court related/adjudication services. Case termination notes were completed for five applicable closed cases. Thirty-day follow ups were conducted for four applicable closed cases as well as one applicable 60-day follow up.	
The program maintains written agreements with other community partners that include services provided and a comprehensive referral process	Compliance	Provider has agreements with two Mental Health Services, three Substance Abuse Centers, one Truancy provider, two Safe Place agencies, one Employment Services, seven Educational Facilities, three Medical Treatment Facilities, and seven support agencies.	

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

2.05 - Counseling Services			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.05		**YES** If NO, explain here: The agency has the required policy 2.05, titled Counseling Services, that was approved on October 6, 2023 by the 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 3 open community counseling youth records
Total number of Closed (Residential & Community) Files: 3 closed residential and 2 closed community counseling youth records
Staff Position(s) Interviewed (No Staff Names): Clinical Director
Type of Documentation(s) Reviewed: Total of 10 youth records**,** group schedule and group sign In sheets

Standard	Rating	Finding	
Shelter programs provides individual and family counseling	**Compliance**	Residential youth received individual and family counseling as evident by the counseling notes in the five residential youth records.	
Group counseling sessions held a minimum of five days per week	**Compliance**	The program's group sign in sheets for the 6-month review period were reviewed. It was evident from the documents presented the program is conducting groups five days per week consistently.	
Groups are conducted by staff, youth, or guests and group counseling sessions consist of : 1. A clear leader or facilitator 2.Relevant topic - educational/informational or developmental 3. Opportunity for youth to participate 4. 30 minutes or longer	**Compliance**	The clinical groups reviewed met the criteria with minimal errors but not all house meetings conducted met the criteria for groups. Group documentation reviewed included: a clear leader or facilitator, relevant topic - educational/informational or developmental, opportunity for youth to participate, and duration of 30 minutes or longer.	
Documentation of groups must include date and time, a list of participants, length of time, and topic.	**Compliance**	The group sign-in sheets reviewed included the date and time of the group, names of all participating youth, length of time, and topic discussed.	

Community Counseling			
Community counseling programs provide therapeutic community-based services designed to provide the intervention necessary to stabilize the family. Services are provided in the youth's home, a community location, the local provider's counseling office or virtually if written documentation is provided in the youth's file for reasons why it is in the best interest of the youth and family.	**Compliance**	Counseling services that address the needs identified during the assessment process were established in all applicable records reviewed in accordance with the youth's case/service plan. All five applicable community counseling files reviewed showed youth received counseling services as evident with attached case notes.	
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 ten files reviewed reflected coordination between presenting problem(s), psychosocial assessment, case/service plans, case/service plan reviews, case management, and follow-up when applicable.	
Maintain individual case files on all youth and adhere to all laws regarding confidentiality	**Compliance**	All ten youth records were maintained in individual case files with adherence to all laws regarding confidentiality.	
Case notes maintained for all counseling services provided and documents youth's progress	**Compliance**	Case notes were maintained in all ten files indicating the youth's progress as well as case notes for all services provided.	
On-going internal process that ensures clinical reviews of case records and staff performance	**Compliance**	All ten files reviewed received ongoing clinical reviews of case records and staff performance. Case reviews are conducted by the supervisor and the review form is maintained in each case file.	
Additional Comments: **There are no additional comments for this indicator.**			

2.06 - Adjudication/Petition Process		**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.06	**YES** If NO, explain here: The agency has the required policy 2.06, titled Adjudication/Petition Process, that was approved on October 6, 2023 by the 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: 0
Total number of Closed (Residential & Community) Files: 0
Staff Position(s) Interviewed *(No Staff Names)* **: Clinical Director**

Must include: a. DJJ rep. or CINS/FINS provider b. Local school district representative	**Compliance**	Since the last onsite review, there's been no request for case staffing. If requested, at a minimum, the committee is comprised of a DJJ representative or CINS/FINS provider and a local school district representative.	

Other members may include: a. State Attorney's Office b. Others requested by youth/ family c. Substance abuse representative d. Law enforcement representative e. DCF representative f. Mental health representative	**Compliance**	Per the program's policy and procedure, other members of the committee may include: State Attorney's Office; others requested by youth/ family; substance abuse representative; law enforcement representative; DCF representative; and mental health representative.	
The program has an established case staffing committee, and has regular communication with committee members	**Compliance**	The agency has established a case staffing committee in the event the youth/family is not in agreement with services or treatment; the youth/family will not participate in the services selected; or the program receives a written request from a parent/guardian or any other member of the committee.	
The program has an internal procedure for the case staffing process, including a schedule for committee meetings	**Compliance**	The case staffing meetings occur monthly and additional meetings may be held if, requested, including emergency case staffing. Members of the committee are notified via email when a case staffing is scheduled to be convened.	
The youth and family are provided a new or revised plan for services	**No eligible items for review**	No case staffings were held since the last QI 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 case staffings were held since the last QI review.	
If applicable, the program works with the circuit court for judicial intervention for the youth/family	**No eligible items for review**	No case staffings were held since the last QI review.	
Case Manager/Counselor completes a review summary prior to the court hearing	**No eligible items for review**	No case staffings were held since the last QI review.	

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

2.07 - Youth Records		**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.07	**YES** If NO, explain here: The agency has the required policy 2.07, titled Youth Records that was approved on October 6, 2023 by the 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)***:** Clinical Director
Type of Documentation(s) Reviewed: 5 residential and 5 community counseling youth records
Describe any Observations: File storage room/cabinets**,** container for transporting youth records

All records are clearly marked 'confidential'.	**Compliance**	All ten case records reviewed were marked confidential.	
All records are kept in a secure room or locked in a file cabinet that is marked "confidential"	**Compliance**	All records were kept in a secure locked room in a locked file cabinet marked as confidential as observed during onsite tour.	
When in transport, all records are locked in an opaque container marked "confidential"	**Compliance**	Staff provided evidence showing they have locked opaque containers marked "confidential" to use for the transportation of records.	
All records are maintained in a neat and orderly manner so that staff can quickly and easily access information	**Compliance**	All files were observed to be clearly divided into sections which were consistent in their organization among residential and community counseling files. Each client case record includes: chronological sheet and youth demographic data, program information, correspondence, service/treatment plans, needs information, case management information and other materials relevant to the case.	
Additional Comments: **There are no additional comments for this indicator.**			
2.08 - Specialized Additional Program Services			**Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 2.08		**YES** If NO, explain here: The agency has the required policy 2.09, titled Special Populations, that was approved on October 6, 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.*			
Staff Position(s) Interviewed (No Staff Names): Clinical Director			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? **(If no, select rating "No eligible items for review")**	**No eligible items for review**	The agency has not served any youth who met the criteria for staff secure in the last 6 months or since the last onsite QI 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	**Compliance**	A review of the current staff secure policy and procedures indicate protocols are in place to provide the following as required: In-depth orientation on admission; assessment and service planning; enhanced supervision and security with emphasis on control and appropriate level of physical intervention; parental involvement; and collaborative aftercare.	

Program only accept youth that meet legal requirements of F.S. 984 for being formally court ordered in to Staff Secure Services	**No eligible items for review**	The agency has not served any youth who met the criteria for staff secure in the last 6 months or since the last onsite QI review.	
Staff Assigned: a. One staff secure bed and assigned staff supervision to one staff secure youth at any given time b. Program assign specific staff during each shift to monitor location/ movement of staff secure youth c. Agency clearly documents the specific staff person assigned to the staff secure youth in the logbook or any other means on each shift	**No eligible items for review**	The agency has not served any youth who met the criteria for staff secure in the last 6 months or since the last onsite QI review.	
Agency provides a written report for any court proceedings regarding the youth's progress	**No eligible items for review**	The agency has not served any youth who met the criteria for staff secure in the last 6 months or since the last onsite QI review.	
Domestic Minor Sex Trafficking (DMST)			
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Staff Position(s) Interviewed (No Staff Names): Clinical Director			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	**No eligible items for review**	The agency has not served any youth who met the criteria for Domestic Minor Sex Trafficking (DMST) in the last 6 months or since the last onsite QI review.	
Agency has evidence that the FNYFS was contacted for approval prior to admission for all Domestic Minor Sex Trafficking (DMST) placements.	**No eligible items for review**		
There is evidence the youth was entered into NetMIS as a Special Populations youth at admission and a Human Trafficking Screening Tool (HTST) was completed.	**No eligible items for review**		
Services provided to these youth specifically designated services designed to serve DMST youth	**No eligible items for review**		
Did the placement of DMST youth require additional supervision for the safety of the youth or the program? If so, did the agency provide the appropriate level of supervision and safety measures?	**No eligible items for review**		

Length of Stay: a. Youth in program do not have length of stay in DMST placement that exceeds seven (7) days b. Agency has approval for stays and support beyond seven (7) days for DMST placements that are obtained on a case-by-case basis? (If applicable.)	**No eligible items for review**		
Agency has evidence that staff assigned to DMST youth under this provision are to enhance the regular services available through direct engagement in positive activities designed to encourage the youth to remain in shelter	**No eligible items for review**		
All other services provided to DMST youth are consistent with all other general CINS/FINS program requirements	**No eligible items for review**		

Domestic Violence

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

Total number of Open Files: 1 open residential DV record
Total number of Closed Files: 2 closed residential DV records
Type of Documentation(s) Reviewed: 3 total youth records, NetMIS special populations report
Staff Position(s) Interviewed (No Staff Names): Clinical Director

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**	A total of three residential DV youth records (one open and two closed) were reviewed.	
Youth admitted to DV Respite placement have evidence in the file of a pending DV charge	**Compliance**	All three records reviewed have face sheets in their files with documentation to show the three youth have pending DV charge and were referred to the shelter for DV respite.	
Data entry into NetMIS within (3) business days of intake and discharge	**Compliance**	The three youth records were reviewed in NetMIS and data entry was verified to be completed within three business days of intake and discharge.	
Youth length of stay in DV Respite placement does not exceed 21 days. If more than 21 days, documentation exists in youth file of transition to CINS/FINS or Probation Respite placement, if applicable.	**No eligible items for review**	None of the three youth placements exceeded 21 days.	

Case plan in file reflects goals for aggression management, family coping skills, or other intervention designed to reduce propensity for violence in the home	**Exception**	Two of the three DV youth records included case plans that were developed and included goals for reducing violence in the home, anger management, and family coping skills.	One of three DV youth with intake date 9/26/23 does not have evidence a case plan has been developed since admission. Per the counselor, the youth refused to cooperate; however, no plan of services was developed to identify services provided to reduce violent behavior and other issues identified from the NIRVANA assessment.
All other services provided to Domestic Violence Respite youth are consistent with all other general CINS/FINS program requirements	**Compliance**	All three files reviewed demonstrated youth participated in services consistent with other general CINS/FINS population such as individual counseling, education services, groups, and recreation.	
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.*			
Staff Position(s) Interviewed (No Staff Names): Clinical Director			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	**No eligible items for review**	The agency has not served any youth who met the criteria for Probation Respite in the last 6 months or since the last onsite QI review.	
All probation respite referrals are submitted to the Florida Network.	**No eligible items for review**		
All Probation Respite Referral come from DJJ Probation and there is evidence that the youth is on Probation regardless of adjudication status.	**No eligible items for review**		
Data entry into NetMIS and JJIS within (3) business days of intake and discharge	**No eligible items for review**		
Length of stay is no more than fourteen (14) to thirty (30) days. Any placement beyond thirty (30) days contains evidence in the file that the JPO was contacted in writing to request the need of an extension no later than the 25th day the youth was admitted into the program.	**No eligible items for review**		
All case management and counseling needs have been considered and addressed	**No eligible items for review**		
All other services provided to Probation Respite youth are consistent with all other general CINS/FINS program requirements	**No eligible items for review**		
Intensive Case Management (ICM)			
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			

Staff Position(s) Interviewed (No Staff Names): Clinical Director			
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”)	Not Applicable	Lutheran Services Florida Southeast is not contracted to provide ICM services.	
Youth receiving services were deemed chronically truant and/or runaway and require more intensive and lengthy services. The youth was determined to be eligible because they have gone through petition and/or case staffing and was in need of case management services.	Not Applicable		
Services for youth and family include: 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.*			
Staff Position(s) Interviewed (No Staff Names): Clinical Director			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating “No eligible items for review”)	No eligible items for review	The agency has not served any youth who met the criteria for Family and Youth Respite Aftercare Services (FYRAC) in the last 6 months or since the last onsite QI review.	

Youth is referred by DJJ for a domestic violence arrest on a household member, and/or the youth is on probation regardless of adjudication status and at risk of violating.	**No eligible items for review**		
Agency has evidence that all FYRAC referrals have documented approval from the Florida Network office	**No eligible items for review**		
Intake and initial assessment sessions meets the following criteria: a. Services shall be documented through the signature of the youth and his/her parent/guardian as well as orientation to the program which is kept in the youths file. b. The initial assessment shall be face-to-face, in person or through virtual means, to include a gathering of all family history and demographic information, as well as the development of the service plan. c. For youth on probation, a copy of the youths Community Assessment Tool (CAT) to assist with development of the family service plan.	**No eligible items for review**		
Life Management Sessions meets the following criteria: a. Sessions are face-to-face, sixty (60) minutes in length and focus on strengthening the family unit b. Services are highly supportive, individualized, and flexible and require a “whole family” approach to dealing with the problems affecting the youth and family.	**No eligible items for review**		
Individual Sessions: a.The program conducted sessions with the youth and family to focus on work to engage the parties and identify strengths and needs of each member that help to improve family functioning. b. Issues to be covered through each session include but are not limited to: Identifying emotional triggers; body cues; healthy coping strategies through individual, group and family counseling; understanding the cycle of violence and the physical and emotional symptoms of anger; developing safety plans; and educating families on the legal process and rights	**No eligible items for review**		

Group Sessions: a. Focus on the same issues as individual/family sessions with application to youth pulling on similar experiences with other group members with the overall goal of strengthening relationships and prevention of domestic violence. b. Shall be no more than eight (8) youth at one (1) time and shall be for a minimum of sixty (60) minutes per session	No eligible items for review		
There is evidence of completed 30 and/or 60 day follow-ups and is documented in NetMIS following case discharge.	No eligible items for review		
Youth and family participate in services for thirteen (13) sessions or ninety (90) consecutive days of services, or there is evidence in the youth's file that an extension is granted by DJJ circuit Probation staff	No eligible items for review		
Any service that is offered virtually, is documented in the youth's file why it was in the youth and families best interest.	No eligible items for review		
All data entry in NetMIS is completed within 3 business days as required.	No eligible items for review		
Additional Comments: **There are no additional comments for this indicator.**			
2.09- Stop Now and Plan (SNAP)			**Not Applicable**
Provider has a written policy and procedure that meets the requirement for Indicator 2.09		**N/A** If NO, explain here: Lutheran Services Florida Southeast is not a SNAP provider.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Staff Position(s) Interviewed (No Staff Names): Clinical Director			
SNAP Clinical Groups Under 12			
Youth are screened to determine eligibility of services.	Not Applicable	Lutheran Services Florida Southeast is not a SNAP provider.	
The NIRVANA was completed at initial intake, or within two sessions.	Not Applicable		
There is evidence of the completed Child Behavior Checklist (CBCL) by the caregiver (pre and post) and is located within the file.	Not Applicable		

There is evidence of the completed Teacher Report Form (TRF) is completed by the teacher (pre and post) and is located within the file.	Not Applicable		
SNAP Clinical Groups Under 12 - Discharge			
There is evidence of the completed SNAP Discharge Report located within the file for any discharged youth.	Not Applicable		
There is evidence of the completed SNAP Discharge Report located within the file for any discharged youth.	Not Applicable		
There is evidence of the SNAP Boys/SNAP Girls Child Group Evaluation Form located in the file.	Not Applicable		
There is evidence of the SNAP Boys/SNAP Girls Parent Group Evaluation Form located in the file.	Not Applicable		
SNAP Clinical Groups for Youth 12-17			
Youth are screened to determine eligibility of services.	Not Applicable		
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*)	Not Applicable		
The program maintained evidence of a completed "Class Goal" Document for the class reviewed.	Not Applicable		
The program maintained evidence of both pre AND post Measure of Classroom Environment (MoCE) completed documents for the class reviewed.	Not Applicable		
The program maintained evidence of completed pre and post evaluation documents for the class reviewed.	Not Applicable		
There is evidence of the fidelity adherence checklist maintained in the file for each class reviewed.	Not Applicable		
Additional Comments: **There are no additional comments for this indicator.**			

3.01 - Shelter Environment		Exception
Provider has a written policy and procedure that meets the requirement for Indicator 3.01	**YES** If NO, explain here: The program has a policy in place 3.01 Shelter Environment, which was reviewed and approved on 09/20/2023 by the 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): Shelter Director and Shelter Supervisor.
Type of Documentation(s) Reviewed: MSDS binder, Perpetual and weekly chemical inventory, and observation notes.
Describe any Observations: Tour of the shelter facility, shelter vehicle inspection, chemical storage, grievance box and forms, postings,

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**	Reviewer toured facility with Shelter Director. Although facility was under renovation, reviewer did not observe any problems with furniture in the common area or inside bedrooms. All youth and staff bathrooms were found clean and in great working condition. Facility was recently painted so there was no graffiti on walls, doors or windows. Lighting seemed adequate in all common areas and bedrooms. Reviewer did not notice any problems with exterior areas. Facility is provided with one trash bin located near dinning room, which has a lid and was found closed at all times during review. There is strict key control by program director and staff. Detailed map and egress plan of the facility can be found in lobby area and different areas of the shelter. Shelter has a box for grievances and grievances forms can be found below grievance box. Reviewer found all rooms, bathrooms and common areas free of contraband.	Reviewer did not observe DJJ incident reporting number posted anywhere around the facility.
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.	**Exception**	Reviewer inspected both agency vehicles: a Silver Toyota Sienna 2018 and a Silver Ford Transit 2018. Both agency vehicles were found with all safety equipment needed, which included first aid kit, extinguisher, flashlight, glass breaker and seatbelt cutter.	Three vehicles were found unlocked during the tour. Two vehicles found were from staff and a third vehicle belonged to a service contractor.

Standard	Rating	Findings	Corrective Action
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	A review of the chemical inventory was conducted with the shelter director. The program has MSDS sheets for most of their chemical products with the exception of three. All chemicals are secured in a locked storage container, which is kept outside facility. A perpetual inventory is kept and maintained in a binder, which is located in the supervisor's office. Weekly chemical inventory was reviewed and found to be conducted and filed by month in a binder.	MSDS sheets were missing for the following products in use: hand sanitizer, Zep, toilet cleaner, Lysol, and Betco, lice cleaner aerosol.
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	Facility's laundry room has two washers and two dryers which were observed to be in perfect condition. No lint was found in any of the dryers. Agency has a current DCF Child Care License, which is display in the lobby area. DCF License was renewed on June 28th, 2023 and is valid until June 27th, 2024. All bedrooms were clean, and with all bedroom necessities. Each youth has a closet which remains locked and is opened upon request.	
Additional Facility Inspection Narrative (if applicable)			

Fire and Safety Health Hazards: a. Annual facility fire inspection was conducted, and the facility is in compliance with local fire marshal and fire safety code within jurisdiction. b. Agency completes a minimum of 1 fire drill per month within 2 minutes or less. c. Completes 1 mock emergency drill per shift per quarter. d. All annual fire safety equipment inspections are valid and up to date (extinguishers, sprinklers, alarm system and kitchen overhead hood, including fire extinguishers in all vehicles).	**Compliance**	Facility's annual fire inspection was conducted and is in compliance with the City of Oakland as of 03/02/2023. The program completes a fire drill per month within 2 minutes or less. A mock emergency drill is also completed on each shift quarterly. All fire safety equipment inspection are valid and up to date until February, 2014.	
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**	Agency has a current satisfactory Residential Group Care inspection from the Department of Health, which expires on 09/30/2024. Agency also has a satisfactory Food Service Inspection provided on 08/11/2023. Reviewer found all food stored properly inside fridge, freezer and both pantries. The refrigerator and freezer are clean and maintained at required temperatures.	
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	According to the program schedule provided by shelter director, facility keeps youth active throughout the week and weekend. Youth have group sessions which promotes life and social skills in addition to recreational activities. Schedule times are very specific for different activities throughout the week and weekend. Faith-based and community participation is also encouraged for all residents. The schedule is publicly posted in the dayroom and allows ample time for youth to complete homework and have reading time.	

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

3.02 - Program Orientation		Exception
Provider has a written policy and procedure that meets the requirement for Indicator 3.02	**YES** If NO, explain here: Provider has a written policy 3.02 Program Orientation, which was reviewed and approved by the Regional Director on 12/20/2020	

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
Type of Documentation(s) Reviewed: A total of 5 youth records, Intake Packets

Youth received a comprehensive orientation and handbook provided within 24 hours	**Compliance**	All five youth received a comprehensive orientation and handbook provided upon youth's arrival.	
Orientation includes the following: a. Youth is given a list of contraband items b. Disciplinary action is explained c. Dress code explained d. Review of access to medical and mental health services e. Procedures for visitation, mail and telephone f. Grievance procedure g. Disaster preparedness instructions h. Physical layout of the facility i. Sleeping room assignment and introductions j. Suicide prevention- alerting staff of feelings or awareness of others having suicidal thoughts	**Compliance**	The handbook is provided within 24 hours of youth's arrival and includes information about contraband items, disciplinary action, dress code, visitation procedure, mail and telephone usage. Grievance procedure is also explained during the orientation process at the facility and a tour is given to youth which includes the layout of the facility, disaster preparedness instructions, and room assignment. Suicide prevention alerts are posted on youth's intake folder and noted in the electronic logbook.	Two of the five files reviewed files had no room assigned documented on the intake packets.
Documentation of each component of orientation, including orientation topics and dates of presentation, as well as signatures of the youth and staff involved is maintained in the individual youth record	**Compliance**	Reviewer went through six closed files; all files reviewed contained orientation topics, including dates and all required staff and youths' signatured.	
Additional Comments: **There are no additional comments for this indicator.**			
			Exception
Provider has a written policy and procedure that meets the requirement for Indicator 3.03		**YES** If NO, explain here: Provider has a written policy 3.03 Youth Room Assignment which was approved by Regional on 12/29/2020.	

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: 5
Staff Position(s) Interviewed *(No Staff Names)***:** Shelter Director and Shelter supervisor.
Type of Documentation(s) Reviewed: Youth files and electronic logbook.

A process is in place that includes an initial classification of the youths, to include:			
a. Review of available information about the youth's history, status and exposure to trauma b. Initial collateral contacts, c. Initial interactions with and observations or the youth d. Separation of younger youth from older youth, e. Separation of violent youth from non-violent youth f. Identification of youth susceptible to victimization g. Presence of medical, mental or physical disabilities h. Suicide risk i. Sexual aggression and predatory behavior j. Acute health symptoms requiring quarantine or isolation	**Compliance**	All five closed records reviewed included a set of forms used during intake that captures all of the information required for initial interactions with and observations of the youth, alerts, physical health screening, medical history, medication, identification of youth susceptible to victimization contacts, presence of medical, mental or physical disabilities, suicide risk, sexual aggression and predatory behavior, and acute health symptoms requiring quarantine or isolation.	
An alert is immediately entered into the program's alert system when a youth is admitted with special needs and risks such as risk of suicide, mental health, substance abuse, physical health or security risk factors	**Compliance**	Admission forms for the five residential files were reviewed. Alerts for the youth are posted as colored dots on the cover of the binder for each youth file. Alerts are also added in the electronic logbook; suicide alerts are highlighted.	
Additional Comments: **There are no additional comments for this indicator.**			

3.04 - Log Books		**Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 3.04	**YES** If NO, explain here: Provider has a written policy 3.04 Log Books, which was approved by Regional Director on 12/29/2020.	

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: April 3rd to 23rd, May 8th to 21st, June 5th to the 18th, July 3rd to 16th, August 16th to 22th, and September 11th to 24th.
Staff Position(s) Interviewed *(No Staff Names)***:** Shelter Director
Type of Documentation(s) Reviewed: Electronic Log Book

Log book entries that could impact the security and safety of the youth and/or program are highlighted	**Compliance**	All log book entries that could impact security and safety of the youth or program are highlighted.	

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	Facility uses electronic logbook; all entries were brief and legible, included the date and time of the event, included names of youth and staff involved, provided a brief statement, and included the name and signature of the person making the entry.	
Recording errors are struck through with a single line. The staff person must initial and date the correction. The use of whiteout and erasures is prohibited.	Compliance	Electronic logbook errors were stricken through with a single line and had initials from staff making correction.	
The program director or designee reviews the facility logbook(s) every week and makes a note chronologically in the logbook indicating the dates reviewed and if any correction, recommendations and follow-up are required and sign/date the entry	Exception	Shelter director or shelter supervisor conducts reviews of the logbook weekly and notate dates reviewed with any recommendations. Weekly reviews of the logbook by the director or supervisor were not completed consistently as required with the exception of the months of August and September.	Weekly reviews were not done for the month of April during the weeks between April 3rd to 23rd. For the month of May only one weekly review was found. No Weekly reviews were found for the month of June between June 5th to the 18th or for the month of July between July 3rd to 16th.
All staff review the logbook of the previous two shifts and makes an entry signed and dated into the logbook indicating the dates reviewed	Compliance	All staff reviewed logbook for the previous two shifts and all entries were dated and signed.	
At the beginning of their shift, oncoming supervisor and shelter counselor reviews the logbook of all shifts since their last log entry and makes a signed and dated entry and into log book indicating the dates reviewed.	Compliance	Clinical Director and counselors reviewed log book indicating dates log book was reviewed since their last shift. All entries reviewed were dated and had staff signatures.	
Logbook entries include: a. Supervision and resident counts b. Visitation and home visits	Compliance	All staff document supervision, visits, and resident counts.	

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

3.05 - Behavior Management Strategies		Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 3.05	**YES** If NO, explain here: Provider has a written policy 3.05 Behavior Management Strategies, which was approved by Regional Director on 10/6/2023.	

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)*: Shelter supervisor
Total number of Files: 5 residential youth records, 2 open and 3 closed
Type of Documentation(s) Reviewed: Resident handbook, 4 new staff training records, point charts, behavioral notes

The program has a detailed written description of the BMS and it is explained during program orientation	**Compliance**	Program has a detailed written description of BMS in their policy and procedure. The Behavioral Management System is outlined in the parent and resident orientation handbook and in the intake paperwork. A review of five youth records support program's BMS is included on the orientation checklist and staff reviews it with youth during admission.	
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**	BMS created by the program is designed to create positive reinforcement and accountability for children behavior. The shelter is a hands-off facility and staff is trained in (MAB) behavioral intervention to utilize the least amount of force necessary to address the situation and basic rights of youth are not violated. The program has a variety of rewards (recreational outings, extra privileges on a daily and weekly basis), appropriate consequences and behavioral management system which is based on a token economy of phase level work. The (BMS) phases is used to teach youth new behaviors and help youth to understand the positive accountability for their actions. During the interview with the shelter supervisor, (BMS) procedure that is in place was described. It was confirmed that staff does explain the (BMS) during program orientation. In addition, staff document the behavioral notes daily. All consequences appear fair in respect to the behavior management plan. The system does not allow for group discipline or room restriction and does not deny the youth of basic rights.	
Program's use of the BMS			
All staff are trained in the theory and practice of administering BMS rewards and consequences	**Compliance**	All program staff are trained in theory and practice of administering BMS rewards and consequences. A review of four first year training records demonstrate all four staff received BMS training during orientation.	
There is a protocol for providing feedback and evaluation of staff regarding their use of BMS rewards and consequences	**Compliance**	Shelter's Director was interviewed and indicated program manager/supervisor reviews youth behavioral sheets and provides feedback to staff on the usage of positive and negative consequences.	
Supervisors are trained to monitor the use of rewards and consequences by their staff	**Compliance**	Supervisors are trained annually on the BMS and are trained to monitor the use of rewards and consequences by their staff.	
Additional Comments: **There are no additional comments for this indicator.**			

3.06 - Staffing and Youth Supervision			**Failed**
Provider has a written policy and procedure that meets the requirement for Indicator 3.06		**YES** If NO, explain here: Provider has a written policy 3.06 Staffing and Youth Supervision approved by Regional and Clinical Director on 10/6/2023.	
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: Bed checks September 16th (12AM-2:00AM); September 20th (2:00 AM-4:00 AM); September 24th (4:00 AM-6:AM); September 29th (1:00 AM-3:00 AM) and October 3rd (3:00 AM-5:00 AM). **Staff Position(s) Interviewed** *(No Staff Names)* **:** Shelter's Director and shelter supervisor. **Type of Documentation(s) Reviewed:** Staff schedule, electronic log book. **Observation**: Posting of staff schedule			
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	Compliance	A review of staff schedules, and logbook entries for the review period documented the required staffing ratios were met for the awake hours one staff to six youth and during sleeping hours, at least two staff on the overnight shift.	
All shifts must always provide a minimum of two direct care staff present that have met the minimum training requirements	Compliance	Schedules provided by shelter director shows all shifts have a minimum of two direct care staff on each shift.	
Program staff included in staff-to-youth ratio includes only staff that are background screened and properly trained youth care workers, supervision staff, and treatment staff	Compliance	All new staff hired were background screened and property trained youth care workers. A review of eligible re-screened staff indicate continued eligible screening results for the applicable staff.	
The staff schedule is provided to staff or posted in a place visible to staff	Compliance	Staff schedule is available to all staff and 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	The program has not been able to recruit per diem staff to support an overtime roster. Consequently, the shelter director and shelter supervisor are the ones who offer any additional coverage if needed.	

Staff observe youth at least every 15 minutes while they are in their sleeping room, either during the sleep period or at other times, such as during illness or room restriction	**Exception**	A review of random video surveillance samples listed above was conducted with the shelter director. Reviewer observed that staff checked on the youth at least every 15 minutes during the overnight sleeping hours on some of the dates and times reviewed. Not all 15-minute bed checks were conducted in real time in the electronic logbook and verified. All days combined between the hours mentioned, staff should have done a total of 45 bed checks. However, 31 bed checks were missed and in multiple cases staff did not complete the bed check but noted it as completed, 10 were done late (3-5 minutes late), and four were completed on time. The shelter manager was advised to contact CCC to report falsification of bed check documentation by two separate staff on the five dates reviewed.	During video review of five random 2-hour overnight timeframes it was observed that 31 bed checks were missed including multiple that were falsified; 10 bed checks were done three to five minutes late; and only four were completed on time. CCC report was completed by the shelter director on 10/11/2023 at 5:51pm to report all findings.

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: The Program has a policy in place 3.07 Video Surveillance System, which was approved by Regional Director on 10/6/2023.	

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: April, 2023 through October, 2023.
Staff Position(s) Interviewed *(No Staff Names)*: Shelter Director
Type of Documentation(s) Reviewed: Video Surveillance
Describe any Observations: Posting of video notice

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**	Facility has a written notice in lobby area for purpose of security and notifying visitors. The video system can store video footage for a minimum of 30 days. A review of random samples of overnight video surveillance revealed the system records date, time, location and enables facial recognition. Cameras have back-up capabilities in case of power outage. All cameras were visible and no cameras were located in sleeping quarters or restrooms.	
A list of designated personnel who can access the video surveillance system is maintained (includes off-site capability per personnel)?	**Compliance**	Director and Shelter supervisor are the only authorized staff who have access to video surveillance.	
Supervisory review of video is conducted a minimum of once every 14 days and timeframes reviewed are noted in the logbook.	**Exception**	The shelter director and supervisor are responsible for supervisory review of videos once every fourteen days. Timeframes reviewed should be noted in the program logbook. Supporting documents presented by the shelter supervisor were reviewed and showed inconsistency on camera reviews in accordance with the shelter's policy. Reviewer found no issues for supervisory video reviews for the month of May.	Supervisory video reviews for the month of June were completed; however, both reviews done for this month are 15 and 16 days apart. For the month of July, there was a video surveillance done on time but the second review for the month of July was done 23 days later. For the month of August, only one review was done on 08/04/2023. First review in the month of September was done 49 days afterwards. The remaining reviews in September and October were done in accordance with the 3.07 Video Surveillance Policy.
The reviews assess the activities of the facility and include a review of random sample of overnight shifts	**Compliance**	All cameras are directed in locations that allow observation of activities in the facility for 24 hours a day, seven days a week. The video reviews conducted by shelter director and supervisor included random samples of overnight shifts and other times of youth movement to adequately assess activities of the facility.	
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**	Recordings are available for any follow ups in regards to incident reporting. Reviewer went through Camera Review log and found two video reviews done due to incident reporting. Incident video reviews were done on 05/12/23 and 05/22/23.	

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	Camera service requests are made within 24 hours of discovery of camera malfunctioning or being inoperable. No service order requests were made during the review period.	
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 program has the required policy in place, 4.01 Healthcare Admission Screening, which was approved by Regional Director on 10/6/2023.	
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 residential youth record **Total number of Closed Files:** 4 residential youth records **Type of Documentation(s) Reviewed:** total of 5 youth records			
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	Reviewed documentation validated each of the five reviewed youth had a healthcare screening completed on the youth's date of admission. One record had the healthcare screening dated one day prior to the youth's admission; however, this was attributed to a typographical error as all other admission documents were accurately dated with the youth's actual admission date. The healthcare screening included screening for current medications, existing acute and/or chronic medical conditions, allergies, recent injuries and/or illnesses, the presence of pain or any other physical distress, noted observations of illness, injury, pain, physical distress, movement difficulty, scars, tattoos and any other skin markings, as well as whether any acute health symptoms required quarantine or isolation.	

Referral and Follow-Up			
Youth with chronic medical conditions have a referral to ensure medical care (e.g. diabetes, pregnancy, seizure disorder, cardiac disorders, asthma, tuberculosis, hemophilia, head injuries, etc.)	**No eligible items for review**	A referral for medical care is required for any youth with a chronic medical condition including diabetes, current pregnancy, seizure or cardiac disorders, asthma, tuberculosis, hemophilia, or any head injury in the preceding two weeks. Reviewed documentation indicated none of the reviewed records were applicable for a youth with a chronic condition since the last annual compliance review.	
When needed, the parent is involved with the coordination and scheduling of follow-up medical appointments	**No eligible items for review**	No eligible medical referrals applicable to the sample records reviewed.	
All medical referrals are documented on a daily log.	**No eligible items for review**	No eligible medical referrals applicable to the sample records reviewed.	
The program has a thorough referral process and a mechanism for necessary follow-up medical care as required and/or needed	**Compliance**	The program does have a policy and procedures in place for referral of youth and notification of parent/guardian and mechanism for necessary follow up as required and/or needed.	
Additional Comments: **There are no additional comments for this indicator.**			

4.02 - Suicide Prevention		**Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 4.02	**YES** If NO, explain here: The program has the required policy in place, 4.02 Suicide Assessment, which was approved by Regional Director on 10/6/2023.	

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: 0
Total number of Closed (Residential & Community) Files: 4
Staff Position(s) Interviewed *(No Staff Names)* **:** Clinical Director
Type of Documentation(s) Reviewed: total 4 residential youth records, no applicable community counseling records

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.	**Exception**	Four youth records were reviewed, and documentation in each indicated a suicide risk screening was conducted during the initial intake and screening. Suicide screening results are to be reviewed and signed by the supervisor and documented in each youth's case record. Two of four reviewed records included a supervisor's signature showing the screening results were reviewed by the supervisor. However, exceptions were noted in two of four reviewed records.	One reviewed record did not include the supervisors signature indicating the assessment had been reviewed and one record included a Suicide/Self-Harm Risk Assessment with only two pages stapled together and page two of three of the assessment was missing; therefore, there was no documentation to show who completed the assessment, there were no clinician signatures, and no date to show when the assessment was completed. Another reviewed youth record included initial suicide screening results which were not signed by the supervisor, as required.
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 not been changed since approved by the Florida Network of Youth and Family Services.	
Supervision of Youth with Suicide Risk *(Shelter Only)*			
Youth are placed on the appropriate level of supervision based on the results of the suicide risk assessment.	**Compliance**	All four reviewed records had the youth placed on sight-and-sound supervision until the youth was assessed by a licensed mental health clinician. Three of four records documented the youth was assessed by a licensed professional within twenty-four hours or on the morning of the first business day after the youth was admitted and one did not include the page indicating who completed the assessment, had no signatures, and did not indicate the date the assessment was completed; however, the youth was placed on precautionary observation (PO) on the day of intake day.	
Staff person assigned to monitor youth maintained one-to-one supervision or constant supervision and documented his/her observations of the youth's behavior at 30 minute or less intervals	**Compliance**	All four youth were placed on an appropriate level of supervision based upon the results of the suicide risk assessment, and each documented the direct care staff assigned to monitor the youth documented the youth's behavior every thirty minutes or less.	
Documentation includes the time of day, behavioral observations, any warning signs observed, and the observers' initials and was maintained in either an observation log or in the shelter daily log.	**Compliance**	The staff maintained PO on an observation log for all four youth records reviewed that documented the time of day, behavioral observations, any warning signs observed, and the observers' initials.	
Supervision level was not changed/reduced until a licensed professional or a non-licensed mental health professional under the supervision of a licensed professional completed a further assessment OR Baker Act by local law enforcement	**Exception**	Three of four youth records documented the supervision level was not changed until a licensed professional or a non-licensed mental health professional under the supervision of a licensed professional completed a further assessment.	There was no documentation of the Clinician stepping down one youth and the youth was inadvertently continued on PO for at least an additional 24 hours. All observed precautionary observation (PO) logs did not document the time at which PO was discontinued; rather, the checks were simply stopped.

There was evidence that documentation was reviewed by supervisory staff each shift. If program uses an observation log, completed logs are maintained in the youth's file.	**Compliance**	All of the PO logs reviewed provided evidence they were reviewed by supervisory staff each shift and copies of the PO logs are maintained in the youth's file.	
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**	Per the Clinical Director, there were no community counseling youth served since the last QI review who were identified for suicide risk.	
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**		
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**		
If the parent/guardian cannot be contacted, all efforts to contact them are documented in the case file.	**No eligible items for review**		
When the screening was completed during school hours on school property, the appropriate school authorities were notified.	**No eligible items for review**		
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 program has the required policy in place, 4.03 Medications, which was approved by Regional Director on 10/6/2023.	
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)* **: contracted registered nurse** **Type of Documentation(s) Reviewed: Medication Distribution records,** **Describe any Observations:** Medication room, Pyxis Machine			
The agency has a Registered Nurse (RN) and/or a Licensed Practical Nurse (LPN) that is being supervised by RN and all of their credentials have been verified.	**Compliance**	The agency has a part time registered nurse (RN) with valid credentials effective through 7/31/2024.	
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**	Observations and an informal interview with the program's part-time registered nurse (RN) validated the program stores medications in the Pyxis Med-Station 4000 Medication Cabinet which is inaccessible to youth. The Pyxis machine is stored in the locked medical office and in accordance with Florida Statute 499.0121. All oral medications including narcotics, controlled and over the counter medications are stored in the Pyxis cabinet and stored separately from topical medication. Medications requiring refrigeration is maintained in a refrigerator designed for medication only. Counts are conducted and documented as required. The shelter maintains emergency keys to the Pyxis which are kept in the Shelter Manager's office.	

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 has more than two trained Super Users of the Pyxis Med-Station. The program maintains a list of designated staff who have access to the secured medication. Reviewed documentation validated that all non-healthcare staff who have access to secured medication completed training with the RN to assist in the delivery of medication when the RN is not on-site. When the nurse is on duty at the program, all medication processes are conducted by the RN. The medication delivery process was found to be consistent with the FNYFS medication management and distribution policy. The program maintains a Medication Distribution Log which is used for the distribution of medication by trained non-healthcare staff and the RN. The program does not currently accept youth who are prescribed injectable medications, other than epinephrine auto-injectors.	
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 program utilizes the standard Department Medication Distribution Log (MDL) to document administration of all medication, and the log clearly indicates the time of medication administration, evidence of youth initials that the dosage was given, and evidence of staff initials that the dosage was given.	
There is evidence that staff provide youth with medications within one hour of the scheduled time of delivery as ordered by the medication. Documentation is provided for instances this does not occur within the required timeframe.	**Compliance**	All of the MDLs reviewed provided evidence the nurse or staff assisted youth with medications within one hour of the scheduled time of delivery as ordered by the medication.	
During the review period, there were no instances where youth missed their medication due to failure to open the pyxis machine.	**Compliance**	None of the CCC calls made during the review period were a result of youth missing 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**	Perpetual inventories with running balances are maintained for all controlled substances. Shift-to-shift counts were reviewed and found to be conducted and verified by a witness. Over-the-counter medications are brought in by the youth's guardian and are kept in the Pyxis machine. Evidence of a perpetual and weekly inventory of OTC medication was observed.	
There are monthly reviews of the Pyxis reports to monitor medication management practice.	**Compliance**	The agency has more than two trained Super Users of the Pyxis Med-Station and reports are typically run by the program's RN more frequently than monthly. Copies of the reports are maintained in the medication room.	
Medication discrepancies are cleared after each shift.	**Compliance**	Any medication discrepancies are to be cleared after each shift; however, an informal interview with the RN indicated the Pyxis Med-Station prevents discrepancies with red error messages on the screen and the user must enter correct counts before the Med-Station will allow access to the medications.	
The agency has an internal quality assurance process to ensure appropriate medication management and distribution methods.	**Compliance**	Medication errors, incidents, or issues identified are reviewed and discussed with staff during monthly staff meetings. Incidents are tracked on the agency's monthly CQI metrics and monitored by the program's compliance director.	
Additional Comments: **There are no additional comments for this indicator.**			

4.04 - Medical/Mental Health Alert Process		**Limited**
Provider has a written policy and procedure that meets the requirement for Indicator 4.04	**YES** If NO, explain here: The program has the required policy in place, 4.04 Medical/Mental Health Alert Process, which was approved by Regional Director on 10/6/2023.	

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 residential youth record
Total number of Closed Files: 4 residential youth records
Staff Position(s) Interviewed *(No Staff Names)***:** Shelter Director
Type of Documentation(s) Reviewed: Total 5 youth records
Describe any Observations: Alert board

Youth with a medical, mental health, or food allergy was appropriately placed on the program's alert system	Exception	A review of five youth records (1 open, 4 closed) found each youth was appropriately screened. The program's written policy and procedures require alerts to be noted on the alert clipboard located in the intake office, documented on the outside spine of the youth's case record, and in the Alerts Binder.	The program reported they do not utilize an alerts binder. An alerts binder was not maintained, therefore, real-time documentation was not available to validate or communicate when each of the five reviewed youth was placed on alert or when an alert was discontinued. E.g. It was observed that youth with a mental health alert may not be updated from the time of the initial alert.
Alert system includes precautions concerning prescribed medications, medical/mental health conditions	Compliance	The alert system is in place to ensure information concerning the youth's medical condition, allergies, common side effects of prescribed medications, foods and medications that are contraindicated, or other pertinent mental health treatment is communicated to all staff.	
Staff are provided sufficient training, information and instructions to recognize/respond to the need for emergency care for medical/mental health problems	Compliance	All the program's direct care staff training records reviewed received training in first aid, cardiopulmonary resuscitation, and emergency procedures prior to direct contact with youth in the shelter and staff is retrained as needed.	
A medical and mental health alert system is in place that ensures information concerning a youth's medical condition, allergies, common side effects of prescribed medications, foods and medications that are contraindicated, or other pertinent mental health treatment information, is communicated to all staff	Compliance	The program maintained in the intake office a color-code alert board that was observed, and it is utilized to document alerts. The alert board is inaccessible to youth and includes different types of alert status for the youth, including medical, sight & sound, allergies, medication, substance abuse, mental health, physical aggression and chronic runaway. Youth on medication or with open sight and sound and medication alerts are noted on the shift report.	

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

4.05 - Episodic/Emergency Care		Exception
Provider has a written policy and procedure that meets the requirement for Indicator 4.05	**YES** If NO, explain here: The program has the required policy in place, 4.05 Episodic/Emergency Care, which was approved by Regional Director on 10/6/2023.	

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 Closed Files: 3 residential youth records
Staff Position(s) Interviewed *(No Staff Names)***:** Shelter supervisor
Describe any Observations: First Aid Kit and Knife for Life

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	Exception	Three closed records for youth applicable for off-site emergency care were reviewed. The program maintains an electronic log which is to be utilized to document the transport of each youth for off-site medical care. Each of the three reviewed records included hospital discharge instructions with recommendations for follow up care. Two of the three reviewed youth were transported for off-site care by the parent/guardian and one youth was transported by emergency medical services from the program. The program had no ability to contact the parent of the youth transported by emergency medical services as the parent/guardian had no contact information and would only appear randomly to the shelter; therefore, the parent notification was not applicable for this youth.	Two of three reviewed emergency care incidents were not reported to the Departments CCC, as required. Episodic Emergency log documented one youth was transported to hospital on 2/24/23 by the parent and hospital discharge paper work validated the youth was in the ER on 2/24/23. The program documented an internal incident report for the incident; however, there was no CCC report made in relation to the medical transport of the youth on 2/24 to the ER by the Parent/guardian. The same youth was transported by ambulance to the hospital on 2/25/23; however, the transport for off-site care was not documented on the Episodic/Emergency Log. An internal incident report was created for the transport on 2/25; however the CCC was not notified of the transport. Upon notification, the shelter director called CCC to report the findings of the Reviewer.
All staff are trained on emergency medical procedures	Compliance	All 8 training records reviewed show the staff received training in first aid, cardiopulmonary resuscitation, and emergency procedures. Interview with the program's manager indicated the program has one automated external defibrillator (AED) that is checked monthly and is in the supervisor's office.	
The program has a Knife-for-life and wire cutters accessible to staff in a secure location(s)	Compliance	The program also maintains a knife for life and wire cutters within a secured wall-mounted box in the program's day room.	
First aid kit/supplies are fully equipped and inventoried	Compliance	Observations confirmed the program maintains two first aid kids within the shelter building, one located in the common area and the other located within the dining area. Additionally, the program maintains first-aid kits within each of the two transportation vans. The kits are inventoried weekly.	
Additional Comments: **There are no additional comments for this indicator.**			