Florida Network for Youth and Family Services
Compliance Monitoring Report for

SMA Healthcare (Beach House)

3875 Tiger Bay Road
Daytona Beach, FL 32124

Compliance Monitoring Services Provided by

EXECUTIVE SUMMARY

Forefront LLC conducted a joint Quality Improvement (QI) and Florida Network of Youth and Family Services (FNYFS) monitoring visit for SMA Healthcare Beach House (SMA Beach House) for the FY 2023-2024 at its program office located at 3875 Tiger Bay Road Daytona Beach, 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. SMA Beach House is contracted with the Florida Network of Youth and Family Services (FNYFS) to provide direct services to Children/Families in Need of Services (CINS/FINS). The services to be provided are identified in Contract Section A - Descriptions and Specifications and Section B - Delivery and Performance and are funded with General Revenue Funds effective from July 2023 through June 30, 2024.

The review was conducted by Marcia Tavares, Consultant for Forefront LLC and Peer Reviewer(s). Agency representatives from SMA Beach House present for the entrance interview were: Pam Palmer, Director of Residential Adolescent Services; Kim Stone, Operation Supervisor Beach House; and Erica Summerall, Operation Supervisor RAP House. The last onsite QI visit was conducted on May 7, 2023.

In general, the Reviewer found that SMA Beach House is in compliance with specific contract requirements. **SMA Beach House received an overall compliance rating of 100% for achieving full compliance with nine applicable indicators** of the CINS/FINS Monitoring Tool. There were no corrective actions as a result of the monitoring visit or recommendation made for an indicator rated as conditionally acceptable.

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

2023-2024 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 11-08-2023-2024

Agency Name: SMA Beach House	**Monitor Name: Marcia Tavares, Lead Reviewer**
Contract Type : CINS/FINS	**Region/Office: 3875 Tiger Bay Road, Daytona Beach, FL**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): November 8-9, 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.	☐	☐	☒	☐	☐	The program currently has at least four staff members certified as DJJ QI Peer reviewers: Pam Palmer, Jeffrey Honaker, Kim Stone, and Erica Summerall. To date, one of the staff, Ms. Palmer, has participated as a peer reviewer.	**No recommendation or Corrective Action.**
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**	☐	☐	☒	☐	☐	The agency provided a list of sixteen additional contracts for FY2023-2024. The list includes: the Name of Contract, Contract Period, and Contract Amount. The program also maintains interagency agreements and Memorandums of Agreement (MOUs) with schools, mental health, and substance abuse providers. All of the agreements reviewed had current contract/agreement dates.	**No recommendation or Corrective Action.**

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	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable		
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**	☐	☐	☐	☒	☐	General Liability through Alliance of Nonprofits for Insurance for limits of coverage $1,000,000 each $3,000,000 aggregate, and $20,000 medical expense, effective 6/30/23-6/30/24. Automobile insurance through Alliance of Nonprofits for Insurance for combined limits of liability/property damage for $1,000,000 each and aggregate. Policy effective for 6/30/23-6/30/24. Workers Comp insurance through Accident Fund Insurance Company of America for limits of coverage $1,000,000 each accident, effective 4/1/2023 – 4/1/2024. Professional Liability Insurance through Scottsdale Insurance Company for limits of coverage of $1,000,000 each/aggregate effective 6/30/2023-6/30/2024.	**No recommendation or Corrective Action.**

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						Florida Network is listed on the Worker's Compensation certificate as certificate holder.	
External/Outside Contract Compliance a. Provider has corrective action item(s) cited by an external funding source (Fiscal or Non-Fiscal). **ON SITE**	☐	☐	☐	☐	☒	Interview: During the Entrance Conference, the provider indicated that there are no outstanding corrective action item(s) cited by an external funding source.	**No recommendation or Corrective Action.**
Fiscal Practice a. Agency must have employee and fiscal policy/procedures manuals that are in compliance with GAAP and provide sound internal controls. Agency maintains fiscal files that are audit ready. **PTV**	☐	☐	☒	☐	☐	Documentation: Fiscal Policies and Procedures are contained in the Financial Services Policy and Procedures Manual. The manual is divided into eight sections with subsections in each one. The procedures reviewed appear to be consistent with GAAP and provide for sound internal controls.	**No recommendation or Corrective Action.**
b. Agency maintains a general ledger and the corresponding source documents. General ledger must be set up to track the activity of the grant separately (standard account numbers / separate funds for each revenue source, etc.). **PTV**	☐	☐	☒	☐	☐	Documentation: Detailed General Ledger for the current year-to-date. Agency maintains a detailed general ledger that is structured to track all funding sources as well as activities for the CINS/FINS program.	**No recommendation or Corrective Action.**

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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**	☐	☐	☒	☐	☐	Interview: No change in practice was reported for the agency since the last onsite program review in May 2023. Reviewed petty cash Policy and Procedure was conducted. The Petty Cash fund does not exceed the established minimum of $500. Requests for money greater than $75 requires a check request. Cash is stored in a secure locked location in the building. Petty cash is reconciled on a consistent basis (monthly/quarterly) by designated staff and reviewed by the Supervisor. Disbursements and invoices are approved by the Program Supervisor as required.	**No recommendation or Corrective Action.**
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 and Observation: Reviewed Bank Statements and Bank Reconciliations for the past six months for one account held with Wells Fargo. Financial Statements are reported on a monthly basis and were found to be reconciled each month. Bank	**No recommendation or Corrective Action.**

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						reconciliations are conducted each month for the activities and bank statements for the preceding month. Invoices are approved by the director and submitted on a monthly basis with supporting documentation. The agency maintains individual vendor files.	
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**	☐	☐	☐	☐	☒	N/A – The agency has not purchased any items with FNYFS monies since the last time on-site.	**No recommendation or Corrective Action.**
f. Agency submits payroll taxes and deposits (and retirement deposits as applicable), Employee IRS Form W-2 and Independent Contractors IRS Form 1099 forms prior to federal requirements. **ON SITE**	☐	☐	☒	☐	☐	Documentation: Agency Provided copy of Form 941 for 1st quarter FY 23-24. Form 941 shows payroll taxes were paid each pay period during the period.	**No recommendation or Corrective Action.**

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g. Budget to actual reports prepared and reviewed by appropriate management. Variance from the budget are investigated and explained. **PTV/ON SITE**	☐	☐	☒	☐	☐	Documentation: Agency provided a Budget to Actual statement, as of September 30, 2023, with budget comparison for the current FY. A review of these documents was conducted. Report shows program budget and variances with YTD Total Budget. Variances in budget are monitored on a regular basis and approved by management.	**No recommendation or Corrective Action.**
h. A Single Audit is performed as part of the annual audit if expenses are greater than $750,000. The agency must submit a Corrective Action Plan for findings cited in the management letter and single audit. An annual financial audit was completed within 120 days after the previous fiscal year/calendar year and that a copy was provided to the Network unless and extension has been requested and approved in writing. Copy of Audit is submitted to the FNYFS by December 31st. **Can obtain from FNYFS**	☐	☐	☒	☐	☐	Documentation: The financial audit conducted for year ending June 30, 2022 and 2021 was completed by James Moore, C.P.A. and Consultants. A separate Management Letter requiring a Corrective Action Plan was not issued by the auditor as there were no items required to be reported. A copy of the audit was submitted to the FNYFS.	**No recommendation or Corrective Action.**

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	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable		
I. Agency maintains confidentiality policy with written policies and procedures to ensure the security and privacy of all employee and client data. Personal information is not easily accessible. Agency maintains a backup system in case of accidental loss of financial information. Security procedures are in place to protect laptops. Obsolete documents are shredded and computer hard drives are wiped prior to discarding. **ON SITE**	☐	☐	☒	☐	☐	Documentation: Procedures relating to confidentiality and data backup are found in the Health Information Management Manual last approved February 2023. The policies were reviewed and appear to provide for sound internal control. The agency has an IT department that maintains strict control over the security of all computers and laptops. All documents are shredded after seven years.	**No recommendation or Corrective Action.**

CONCLUSION

SMA Beach House has met the requirements for the CINS/FINS contract as a result of full compliance with nine applicable indicators of the Administrative and Fiscal Contract Monitoring Tool. Two of the 13 indicators were not applicable because, 1) the provider did not have any corrective action item(s) cited by an external funding source, and 2) The agency has not purchased any items with FNYFS monies since the last time on-site. Consequently, **the overall compliance rate for this contract monitoring visit is 100%.** There are no corrective actions cited or recommendation made as a result of the contract monitoring visit. Overall, the provider is performing satisfactorily in meeting the fiscal and administrative terms of its contract. In addition, the majority of indicators reviewed were carried out in a manner which meets the standard described in the report findings.

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

Florida Network of Youth and Family Services Quality Improvement Program Report

Review of SMA Healthcare - Beach House
Residential Program

Date: November 8-9, 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	**Satisfactory**
1.04 Training Requirements	**Satisfactory**
1.05 Analyzing and Reporting Information	**Satisfactory**
1.06 Client Transportation	**Satisfactory**
1.07 Outreach Services	**Satisfactory**

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

Standard 2: Intervention and Case Management

Indicator	Rating
2.01 Screening and Intake	**Satisfactory**
2.02 Needs Assessment	**Limited**
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: 80 %
Percent of indicators rated Limited: 10 %
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	**Satisfactory**
3.07 Video Surveillance System	**Satisfactory**

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

Standard 4: Mental Health/Health Services

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

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

Overall Rating Summary

Percent of indicators rated Satisfactory: 89.66 %
Percent of indicators rated Limited: 6.9 %
Percent of indicators rated Failed: 0 %

Rating Definitions

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

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

Reviewers

Members

Marcia Tavares - Lead Reviewer Consultant, Forefront LLC/Florida Network of Youth and Family Services
Andrea Haugabook – Consultant, Forefront LLC/Florida Network of Youth and Family Services
Kristine Harshaw – Regional Monitor, Department of Juvenile Justice
Vincelyn Brown – Childrens Home Society West Palm Beach
Aleundro McCray – Boys Town
LaToya Robinson - CDS Family & Behavioral Health Services, Inc.

Methodology

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

Persons Interviewed

	Chief Executive Officer		Case Manager		Nurse – Full time
	Chief Financial Officer	X	Counselor Non-Licensed	X	Nurse – Part time
	Chief Operating Officer		Advocate		# Case Managers
	Executive Director	X	Direct – Care Full time	X	# Program Supervisors
X	Program Director		Direct – Part time		# Food Service Personnel
	Program Manager		Direct – Care On-Call		# Healthcare Staff
	Program Coordinator		Intern		# Maintenance Personnel
	Clinical Director		Volunteer	X	# Other (listed Compliance Manager
	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	X	# Health Records
X	Logbooks		Key Control Log	X	# MH/SA Records
	Continuity of Operation Plan	X	Fire Drill Log	X	# Personnel /Volunteer Records
X	Contract Monitoring Reports	X	Medical and Mental Health Alerts	X	# Training Records
	Contract Scope of Services	X	Precautionary Observation Logs	9	# Youth Records (Closed)
X	Egress Plans	X	Program Schedules	4	# Youth Records (Open)
X	Fire Inspection Report	X	List of Supplemental Contracts		# Other: ___
	Exposure Control Plan	X	Vehicle Inspection Reports		

Observations During Review

	Intake	X	Posting of Abuse Hotline	X	Staff Supervision of Youth
	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		Meals
X	Social Skill Modeling by Staff	X	Youth Movement and Counts	X	Signage that all youth welcome
	Medication Administration	X	Staff Interactions with Youth	X	Census Board

Surveys

5	# of Youth	10	# 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

SMA Healthcare Foundation is a non-profit human services organization that has provided behavioral healthcare services in Florida for more than 60 years. SMA Healthcare provides a full continuum of comprehensive services for individuals in need of mental health and substance abuse services including crisis intervention, short-term residential, and substance use treatment in-patient programs. Services are provided in the following counties: Flagler, Marion, Putnam, St. Johns, and Volusia County. BEACH House is a CINS/FINS shelter that provides short-term respite for youth ages 10-17 who are truant, ungovernable, or runaway, and/or homeless. The shelter is located at 3875 Tiger Bay Road, South Daytona Beach. The program also 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). Beach House is licensed for twenty beds but has a capacity to serve twelve youth. The program's license was renewed by the Department of Children and Families (DCF) and is valid until July 11, 2024. The census during the Quality Improvement (QI) visit was seven CINS/FINS youth. The agency is currently accredited with Commission on Accreditation of Rehabilitation Facilities (CARF) effective through April 30, 2026.

The following programmatic updates were provided by the agency:

Staffing

Due to staffing shortage in Beach House and the Residential Adolescent Program (RAP) for the past year, the program started in June 2023 to combine the youth in the RAP facility at nights and maintain a census of 10-11 youth. The program has been challenged with staff leaving and moving to other positions and currently has the following vacancies at Beach House: five full-time Residential Adolescent Specialist positions, one part-time Residential Adolescent Specialists position, two Operations Supervisor positions, and one part-time counselor position.

Due to the increase in pay to $19 an hour, the agency has changed the position title from Behavior Health Technician to Residential Adolescent Specialist (RAS). RAS, at a minimum, must have a High School diploma; Operations Supervisors must have, at minimum, a 2-year degree with two years of supervisory experience; and Counselors must have, at a minimum, a master's degree in the field of social work, psychology, or other human service fields. The Community Counselors must have, at minimum, a bachelor's degree in a related field and two years of case management experience. The program has maintained its two part time registered nurse positions who work Monday through Friday from 6:30 a.m. to 4:00 p.m.

Beach House and community counselors have been operating as usual for the past year. They continue to serve youth 10-17 and their families in the community in Volusia and Flagler County. Currently, at Beach House and in CINS/FINS, paper document are used for youth records but electronic medical records are maintained in Avatar. The goal is to get all documents into Avatar in the future.

In terms of enhanced security, the shelter added five more security cameras to continue improving campus surveillance.

Facility
This past year, the agency installed a new roof to the resident building on campus and paved the parking lot and driveway. The ROPES course, which had damage due to hurricanes and storms, is now operational for all low elements. The program plans to finish the roof, purchase the rest of the group room furniture, and convert the high elements of the ROPES course to low and moderate elements upon receipt of new funds.

Funding/Finance
The shelter received $5,000 from Jeep Beach for the Beach House furniture. It also received $2,500 from the Variety Foundation and $2,500 from the Eagles to purchase clothing and duffle bags for youth who come in with no clothes and to ensure that all youth who leave our facility leave with their belongings in a duffle bag or suitcase.

Every Christmas, the program receives gifts from Volusia County Schools transportation department, the Margaretville community residents, the HO HO HO Girls charity organization, and the TAG V Bear charity organization for Beach House and CINS/FINS families who cannot afford gifts.

Governance and Community
The Director and the Operations Supervisors have participated in monthly Crisis Intervention Training for Law enforcement/911 operators to discuss program services and availability to assist youth. Staff also attended many community events like Back-to-School drives and multiple meetings with school counselors in elementary, middle, and high school.

Beach House also hosted the Volusia County High School Futures Tomorrow Leaders seminar on campus on November 2nd to explain its services, discuss career options to work in the social service field, provide a tour, participate in a team-building activity using the ROPES course, and presented youth testimonies about how the program helped them.

The Flagler CINS/FINS Community Counselor, Sonja Bucy, received Counselor of the Year at the Florida Network's annual meeting. Two youths from our community counseling program also received the Youth Resiliency Award.

Major Challenges
Three staff were terminated since May 2023, two at BEACH house and one at RAP. The unexpected terminations and significant struggles finding appropriate candidates and getting them through the background screenings timely have made it difficult for the program to recruit staff. The background screenings are taking a long time and candidates are leaving for other positions.

<u>Narrative Summary</u>
SMA Beach House is contracted by the Florida Network of Youth and Family Services to provide CINS/FINS services to youth and families in need. The program provides residential and community counseling services over two counties, Volusia and Flagler, across Circuit 7. The program is managed by a Director of Adolescent Services who oversees a Manager of Operations. The youth shelter operates 24 hours a day, 365 days a year and is licensed for up to ten CINS/FINS shelter beds.

During the QI review it was observed that the policy manual was last approved by the director of adolescent residential services on April 1, 2023. There were reviews and/or revisions made to the policies and procedures in October 2023 however, the updated policies are still pending approval.

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

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

Standard 2: There are nine indicators for Standard 2. Indicator 2.01 Screening and Intake, Indicator 2.04 Case Management and Service Delivery, Indicator 2.05 Counseling Services, Indicator 2.06 Adjudication/Petition Process, Indicator 2.07 Youth Records, and Indicator 2.08 Specialized Additional Program Services were rated **Satisfactory with no exceptions.** Indicator 2.03 Case/Service Plan was rated **Satisfactory with exceptions**, and Indicator 2.02 Needs Assessment received a **Limited** rating**.** Indicator 2.09 Stop Now and Plan (SNAP) is not applicable because SMA is not contracted to provide SNAP services.

Standard 3: There are seven indicators for Standard 3. Indicator 3.02 Program Orientation, Indicator 3.03 Youth Room Assignment, Indicator 3.04 Log Books, Indicator 3.05 Behavior Management Strategies, and Indicator 3.06 Staffing and Youth Supervision were rated **Satisfactory with no exceptions.** Indicator 3.01 Shelter Environment and Indicator 3.07 Video Surveillance System were rated **Satisfactory with exceptions.**

Standard 4: There are five indicators for Standard 4. All five indicators, Indicator 4.01 Healthcare Admission Screening, Indicator 4.02 Suicide Prevention, Indicator 4.03 Medications, Indicator 4.04 Medical/Mental Health Alert Process, and Indicator 4.05 Episodic/Emergency Care were rated **Satisfactory with no exceptions.**

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

Standard 1:

Indicator 1.02 - Limited

There was no documentation in the logbook supporting management or a designee checked the grievance box for eight out of ten days in June, six of ten days in July, seven of ten days in August, six of ten days in September, and eight of ten days in October.

Standard 2:

Indicator 2.02 - Limited

One open and one closed residential record reviewed did not meet the requirement for initiation of NIRVANA within 72 hours of admission. The intake was completed on 10/13/2023 for one closed residential record; however, NIRVANA assessment wasn't initiated until five days later on 10/18/2023. The open record reviewed shows an intake date of 6/19/2023, but NIRVANA wasn't initiated until 6/23/2023.

All five NIRVANA Assessments for the residential files reviewed did not include the supervisor's signature on the document or a chronological note stating NIRVANA Assessment was reviewed.

One open community counseling file reviewed did not demonstrate a NIRVANA Re-Assessment was completed every 90 days during review period; case was opened on 8/8/2023 and NIRVANA Re-assessment was due by 11/5/2023 but was not completed.

CINS/FINS QUALITY IMPROVEMENT TOOL

Quality Improvement Indicators and Results: Please select the appropriate outcome for each indicator for each item within the indicator.		Summary/Narrative Findings: E.g. Interview/Surveys, Observation, and/or Type of Documentation	Deficiencies/Exceptions: Please add additional detailed explanations for any items that have any deficiencies or exceptions.
Standard One – Management Accountability			
1.01: Background Screening of Employees, Contractors and Volunteers			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 1.01		**NO** If NO, explain here: Background Screening policy is missing additional information required regarding timeframes (items a-c) for re-taking the pre-employment suitability assessment, for applicants who do not pass the initial assessment. The provider has a policy titled Background Screening of Employees/Volunteers that was revised 10/31/2023 by the Director of Adolescent Services.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
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, Impact Pre-Employment assessment tool, E-Verify, Annual Affidavit of Compliance with Level 2 Screening Standards			
All positions providing direct services to youth has successfully passed pre-employment suitability assessment on the initial attempt.	**Compliance**	The program uses the Impact pre-employment assessment tool. The tool was administered prior to hiring two new direct care staff who were hired during the review period. The two staff obtained passing scores greater than 70 on the assessment.	
For any applicant that did not pass the initial suitability assessment, there was evidence that the applicant retook the assessment and passed within five (5) business days of the initial attempt, not exceeding three (3) attempts within thirty (30) days.	**No eligible items for review**	The two staff who completed the suitability assessment received passing scores.	
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 two applicable new hires were initiated prior to hire/start dates with eligibility documented on the DJJ background screening results. There were no exemptions required. There were no new interns/volunteers utilized during the review period.	
Five-year re-screening is completed every 5 years from initial date of hire or prior to retained fingerprints expiration date.	**No eligible items for review**	The program does not have any eligible 5-year re-screens for the review period, dating back to the last QI review in May 2023.	
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 November 6, 2023 for 2024 prior to the January 31st deadline. An email from Human Resources was submitted on 11/6/23 in compliance with DJJ's policy allowing agencies to submit up to three months prior, but no later than January 31st.	
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 the two 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 provider has the required policy titled Provision of an Abuse Free Environment that was revised 10/31/2023 by the Director of Adolescent Services.	

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

Staff Position(s) Interviewed (No Staff Names): Shelter Operations Supervisor
Type of Documentation(s) Reviewed: Code of Ethical Conduct, Client 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 provider has a code of ethical conduct, HR001, that prohibits the use of physical abuse, profanity, threats or intimidations. The code of ethical conduct is reviewed with staff during on the job training and documented on the training schedule completed during orientation. This practice was verified for two new staff hired during review period.	

The agency has a process in place for reporting and documenting child abuse hotline calls.	Compliance	The abuse hotline number was visibly posted on a hallway wall in the facility. The provider 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. Ten abuse hotline calls were documented on the SMA Resolver Occurrence Report for June 1 -November 6th. None of the ten hotline calls were institutional.	
Youth were informed of the Abuse and Contact Number	Compliance	Per the shelter supervisor, youth are informed of the abuse hotline during orientation. The abuse hotline number was observed to be included in the client handbook.	
Grievance			
Grievances are maintained on file at minimum for 1 year.	Compliance	Operation's supervisor maintains grievance file for more than year. The last grievance on file is dated 10/27/21.	
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 multipurpose room in the shelter. 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	There were no client grievances reported for the review period. Grievance box checks are required daily Monday-Friday each week and were reviewed for randomly selected two-week periods during each of the past six months as follows: June 11-24, July 16-29; August 6-19; September 17-30; and October 1-14.	There was no documentation in the logbook supporting management or a designee checked the grievance box for eight out of ten days in June, six of ten days in July, seven of ten days in August, six of ten days in September, and eight of ten days in October.
All grievances are resolved within 72 hours and documented by program director/supervisor or escalated to higher leadership if grievance involves them directly.	No eligible items for review	There were no client grievances reported for the review period.	

1.03: Incident Reporting			Satisfactory with Exception
Provider has a written policy and procedure that meets the requirement for Indicator 1.03		**YES** If NO, explain here: The agency has several policy's pertaining to incident reporting which are as follows: Occurrence reporting, last revised 04/01/2023; Administrator on Call and Adverse Event/ Incident Reporting, effective 03/04/2020, last revised 10/20/2023;and Notification of Key Stakeholders Regarding Major Occurrences, effective 6/30/2019, date last revised 10/31/2023. Revisions were by completed by the Director of Adolescent Services.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Staff Position(s) Interviewed *(No Staff Names)*: Residential Director and RAP Director **Type of Documentation(s) Reviewed:** Five CCC reports, Program log books and internal incident reports reviewed over the most recent six months.			
During the past 6 months, the program notified the Department's CCC (Central Communication Center) no later than two hours after any reportable incident occurred or within two hours of the program learning of the incident	**Compliance**	A total of five incident reports were reviewed for incidents that were reported to the CCC. All reportable events were reported to the CCC within the required time frames.	
The program completes follow-up communication tasks/special instructions as required by the CCC	**Compliance**	All CCC reports demonstrated follow-up communication tasks/ special instructions completed by the program, if indicated.	
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 five CCC reports reviewed were documented internally on the agency's incident reporting system.	One of the five CCC reports reviewed was not documented internally in the agency's incident reporting system. On 08/03/2023 a CCC report was filed regarding a youth leaving the facility with parent to seek medical treatment due to complaint of fever and loss of appetite. Parent informed agency that youth would require more advance medical treatment and was transported to Orlando for surgery. Youth was subsequently discharged from the program the same day. No internal incident report form was completed regarding this occurrence; however, it was noted in the program's logbook.

Incidents are documented in the program logs and on incident reporting forms	**Exception**	One of five incidents crossed referenced in the program log books was recorded accurately and documented across shifts by several staff members.	Four of the five incidents reviewed were either not recorded or not consistent with the agency's internal incident reports. Incident #1, dated 07/03/2023 was not recorded in the program's logbook. Incident #2, dated 09/03/2023, was recorded at a time (per the logbook) that was not consistent with the internal incident report. Incident #3, dated 10/25/2023 was not recorded in the program logbook. Incident #4, dated 11/06/2023 was recorded in the logbook, however, the entry had many discrepancies (i.e., date of occurrence, time of the incident, and description of the incident) when cross-referenced with the agency's internal incident report.
All incident reports are reviewed and signed by program supervisors/ directors	**Compliance**	All five incident reports recorded in the agency's internal incident report system showed electronic records of supervisor follow-up.	

1.04: Training Requirements (*Staff receives training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions*)		**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 1.04	**YES** If NO, explain here: The provider has the required policy titled Provision of an Abuse Free Environment that was revised 10/31/2023 by the Director of Adolescent Services.	

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

Total number of New Hire Staff Files: 3
Total number of Annual In-Service Staff Files: 4
Total number of Non-Licensed Mental Health Clinical Shelter Staff Files: 0
Annual Training Plan Timeframe (*Program timeframe for annual trainings*)**:** anniversary of hire date
Staff Position(s) Interviewed *(No Staff Names)***:** Supervisor, Residential Director
Type of Documentation(s) Reviewed: Training logs, training certificates, training reports from Bridge, SkillPro, My learning Pointe

First Year Direct Care Staff			
All direct care staff have completed new hire pre-service training requirements for safety and supervision as required.	**Exception**	Two of three new hire training files reviewed, dates of hire (DOH) 9/25/2023, are still within the first 90 days of employment and have adequate time to complete all required training.	One file, DOH 4/2/2022, reviewed for first-year training requirement was not compliant with the completion of all pre-service training requirements. Only five of the required 30 trainings were completed on time, ten were late, and 15 were not completed during the full training year. It was reported by the residential director that the employee was no longer with the agency as of 08/03/2023.
All staff completed the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days from date of hire.	**Exception**	Two of three new hires completed the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days from date of hire.	One file was not compliant with completion of the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days from date of hire within 30 days of hire. The employee's hire date was 04/02/22 and the training was completed 05/22/2022.
All direct care CINS/FINS staff (full time, part time, or on-call) demonstrated a minimum of 80 hours of training or more for the first full year of employment.	**Exception**	Two of three new hires are still within the first 90 days of employment. One of the two staff completed 99 hours of training, exceeding the required 80 hours, and the other staff has completed 62 hours with adequate time to complete the remaining hours required.	One staff completed 68 of the 80 hours and was not compliant with completion of the minimum required hours for the first year of employment. The staff is no longer with the agency as previously reported.
All staff receives all mandatory training during the first 90 days of employment from date of hire.	**Exception**	Two of three new hires reviewed are still within the first 90 days of employment and have adequate time to complete all required training.	One file was not compliant with the completion of pre-service training due within the first 90 days of employment . This employee is no longer with the agency as of 08/03/2023.
Staff Required to Complete Data Entry for NIRVANA or access the Florida Department of Juvenile Justice Information System (JJIS)			
Any designated staff that is responsible for entering NIRVANA or ensuring accurate and complete data entry in the Florida Department of Juvenile Justice Information System (JJIS) have completed all of the required trainings.	**No eligible items for review**	The program did not hire any new counseling staff during the review period. The three new hires reviewed are youth care staff and are not required to complete NIRVANA assessment.	

Staff Participating in Case Staffing & CINS Petitions (within first year of employment)			
Documentation of instructor led FL Statute 984 CINS Petition Training by a local DJJ Attorney. *Effective for staff hired after 7/1/23*	**No eligible items for review**	The program did not hire any new staff during the review period who are responsible for participating in case staffing and CINS petitions.	
Non-licensed Mental Health Clinical Shelter Staff (within first year of employment)			
Documentation of non-licensed mental health clinical staff person's training in Assessment of Suicide Risk form or written confirmation by a licensed mental health professional of training (includes date, signature and license number of the licensed mental health professional supervisor).	**No eligible items for review**	The program did not hire any new non-licensed mental health clinical staff during the review period.	
In-Service Direct Care Staff			
Direct care staff completes 24 hours of mandatory refresher Florida Network, SkillPro, and job-related training annually *(40 hours if the program has a DCF child caring license).*	**Compliance**	Four in-service direct care staff training files reviewed demonstrate all four staff completed more than the required 40 hours of mandatory refresher, Florida Network, SkillPro and job-related training.	
Required Training Documentation			
The agency has a training plan that includes all of the required training topics including the pre-service and in-service.	**Compliance**	The program provides training across three different platforms including DJJ Skill Pro, Florida Network Bridge, and the agency's My Learning Pointe learning management system, as well as in-person classroom sessions. The training plan for staff include all mandatory pre-service and in-service training topics required.	
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**	Human Resources completes all new hire training, including all 90-day training requirements. After 90-day training requirements have been met the staff member completes an additional 40 hours of training with the residential supervisor, including orientation before the employee is released to work in the shelter or with youth records. Each employee maintains their own training log and is responsible for recording all completed training with completion dates and uploading the certificate and log to the agency's shared drive. To ensure compliance, the program director reviews each employee's log on a regular basis and notifies the employee via email of pending, upcoming, or late trainings.	

The program maintains an individual training file or employee file AND a FLN Training Log (or similar document that includes all requirements) for each staff, which includes an annual employee training hours tracking form and related documentation, such as electronic record/transcript, training certificates, sign-in sheets, and agendas for each training attended.	**Compliance**	The program provided training files for each employee selected for review. Each training file contained a Florida Network training log with all required information within, and several reports from additional training platforms used by the agency. Certificates of completion were attached for all trainings completed within the last 12 months or first 90 days of employment for each employee file reviewed.	
Additional Comments:			
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 provider has the required policies titled 1) Obtaining and Analyzing Client Feedback, and 2) Data Entry and Collection that were revised 10/31/2023 by the Director of Adolescent Services.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Staff Position(s) Interviewed (No Staff Names): Director of Adolescent Services **Type of Documentation(s) Reviewed:** Corporate Compliance Program Plan, Avatar reports of peer record Reviews, performance measure reports, FY 2023 Performance Dashboard, Compliance Audit Results, safety committee meeting minutes, staff meeting agendas/minutes, monthly Performance Improvement Council (PIC) meetings, Peer Review Report, and satisfactions survey results.			
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 entered individually for each record reviewed in the agency's Avatar platform. The peer review tool consists of a set of 16 indicators and includes client ID, staff being reviewed, reviewer's name, review date, program, and review summary for strengths and weaknesses. Reports can be generated in Avatar for each staff to see overall findings of case reviews over any period of time. For the current fiscal year to date, a total of 37 charts were reviewed for the CINS/FINS program. 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**	Incidents, accidents, and grievances are entered in real time into the provider's internal occurrence reporting data system. Reviews by supervisors are required and documented in the system. A monthly report is generated to track the number of occurrences and a separate Incident Category Raw Data report lists more detail information including program, type of incident, and date/time. The provider also has a safety committee that conducts safety meetings regularly. Three safety committee meetings were held in May, July, and September and the agenda includes a discussion of safety issues identified, incident occurrence reporting, and safety drill and inspection updates.	
The program conducts an annual review of customer satisfaction data	**Compliance**	The provider has supporting documentation to show surveys are completed and reviewed monthly. A report of the surveys completed for FY 2022-2023, and current FY year-to-date was reviewed. The program collects and enters client satisfaction data into an internal database. Monthly reports are sent to program directors who can view the scores and survey results collected. If the program score is highlighted yellow, the score fell below 4.00 and the text is red if the score was lower the following month. Any yellow scores with red font require the program to review the survey results and send a response as to why there is a downward trend.	
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 a performance improvement committee that meets the third Monday each month. Performance measures for predetermined metrics are sent to the clinical data manager to enter into the program's report card. Findings are reported on a performance dashboard, reviewed by the committee, and communicated to program directors. Evidence of monthly PIC meetings and performance measure reports for the past 6 months were reviewed. End of month (EOM) Florida Network reports are reviewed by the program director and emailed to key staff. Meeting minutes of monthly staff meetings held demonstrate communication with staff.	
The program has a process in place to review and improve accuracy of data entry & collection	**Compliance**	The program director and shelter supervisor review data entry collection, benchmark data, and deficiencies upon receipt from the Florida Network. Data entry deficiencies identified are corrected and communicated via email with the Florida Network Director of Data and Research.	
There is documentation that findings are regularly reviewed by management and communicated to staff and stakeholders.	**Compliance**	There was documentation through monthly all staff meeting minutes that findings are communicated to staff and stakeholders. These meeting minutes were reviewed for the last six months to confirm this practice.	

There is evidence the program demonstrates that critical performance data reports are shared with the Board of Directors frequently. All final reports that include a Limited or Failed score is submitted electronically or by mail to the providers Executive Committee on the Board of Directors.	**Compliance**	Findings are regularly reviewed by management and communicated to staff, stakeholders, and the board of directors through the Performance Improvement Committee process. Auditing and monitoring results throughout the year are compiled into a report by the compliance officer and presented to the SMA board of directors.	
There is evidence that strengths and weaknesses are identified, improvements are implemented or modified, and staff are informed and involved throughout the process.	**Compliance**	Monthly PIC meetings were reviewed, which address program compliance and ensure corrective action is taken for any issues identified. The last six months of these meetings were reviewed, and documented strengths and weaknesses and any improvements or corrective actions needed.	

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

1.06: Client Transportation	**Satisfactory with Exception**

Provider has a written policy and procedure that meets the requirement for Indicator 1.06	**YES** If NO, explain here: The provider has the required policies titled Vehicle Use, effective 10/01/2023; Driver Responsibility, effective 10/01/2023; and Transporting Clients, date last revised 10/31/2023 by the Director of Adolescent Services.	

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

Dates or Timeframe Reviewed: Transportation log for vehicle Trax #291 was reviewed from May 2023 to present and log for vehicle Escape #231 was reviewed from August 2023 to present.
Staff Position(s) Interviewed *(No Staff Names)* **:** Director of Residential Program and Director RAP program
Type of Documentation(s) Reviewed: Vehicle logs, program log books, and HR email confirmation of approved drivers from Brown and Brown Insurance Company.

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 10 drivers who were reviewed and approved to drive agency vehicles. The HR Generalist provided email documentation sent and received from the insurance company approving each employee.	
Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	**Compliance**	The agency's HR department verifies the validity of the employee's drivers license and initiates the request to add the employee as a covered driver to the agency's insurance policy.	
Agency's Transportation policy prohibit transporting a client without maintaining at least one other passenger in the vehicle during the trip and include exceptions in the event that a 3rd party is NOT present in the vehicle while transporting	**Compliance**	Agency's transportation policy prohibits single transports and includes exceptions in the event that a 3rd party is not present in the vehicle while transporting.	

In the event that a 3rd party cannot be obtained for transport, the agency's supervisor or managerial personnel consider the clients' history, evaluation, and recent behavior	**Compliance**	The agency's policy provides provision in the event a 3rd party cannot be obtained for the transport for the consideration of the client's history, evaluation and recent behavior.	
The 3rd party is an approved volunteer, intern, agency staff, or other youth	**Compliance**	The agency's policy does require the 3rd party to be an approved volunteer, intern, agency staff or other youth.	
The agency demonstrated evidence via logbook or other written verification that supervisor approval was obtained prior to all single youth transports.	**Exception**	One single transport was conducted during the review period and noted in the two transportation logs reviewed. After interviewing the residential and RAP program directors, it was stated that one single transport took place with a Beach House youth who was taken to a medical appointment.	Evidence of one single transport was confirmed in the program logbook; however there was no indication of prior supervisor approval documented in the program logbook.
There is documentation of use of vehicle that notes name or initials of driver, date and time, mileage, number of passengers, purpose of travel and location.	**Compliance**	The program maintains vehicle logs for each vehicle used for transporting youth. Logs include name of driver, date and time, mileage and number of passengers, purpose of travel and location. The program operates two vehicles and logs for both vehicles were reviewed.	

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

1.07 - Outreach Services		**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 1.07	**YES** If NO, explain here: The provider has the required policy titled Vehicle Use; Driver Responsibility; and Transporting Clients. All three policies were last revised 10/31/2023 by the Director of Adolescent Services.	

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

Staff Position(s) Interviewed *(No Staff Names)*: Director of adolescent residential services, RAP operation supervisor and Beach House operation supervisor
Type of Documentation(s) Reviewed: policy and procedure, NETMIS outreach log, emails from the director of adolescent residential services, letters of understanding, 2 letters of agreement with the Volusia County Schools and Halifax Hospital Medical Center.

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.	**Exception**	The director of adolescent residential services indicated she is the designated staff to attend the local DJJ board and council meetings. The director of adolescent residential services indicated she is the designated staff to attend the local DJJ board and council meetings for Volusia and Flagler counties. For the review period, May – November 2023, there were six DJJ board and council meetings scheduled as follows: April 14, which is listed on the NETMIS log; however no verification of attendance was provided. June 9, September 8, and October 13, meetings were scheduled, however the program did not attend due to the provider's mandatory supervisor meeting. The director of adolescent residential services did not have an email indicating a meeting scheduled for July. The Circuit 7 advisory board meeting and DJJ board and council meetings were combined on May 12, 2023. The program provided email documentation of a scheduling conflict with a mandatory supervisor meeting. On August 4, 2023, the program provided email documentation of attendance. The director of adolescent residential services did not have an email for the Circuit 7 advisory board meeting in Flagler County for August, however a meeting was scheduled on October 18 and she did not attend due to a conflict. A meeting is scheduled for November 15 and the director of adolescent residential services plans to attend. The director of adolescent residential services indicated they are informed of the meetings a day prior to the meeting, which does not allow ample time to prepare to attend. The director of adolescent residential services indicated the DJJ meetings are also scheduled the same day and time as a mandatory supervisor meeting. The director of adolescent residential services stated hiring an outreach specialist is in the strategic plan, however until the position is filled she will continue to attend or designate another supervisor to attend.	The director of adolescent residential services or another designee is not attending all of the required monthly DJJ board meetings or the quarterly Circuit 7 advisory board meetings. There was no verification provided for attendance to all of the DJJ council meetings that were scheduled.
The program maintains written agreements with other community partners which include services provided and a comprehensive referral process.	**Compliance**	The program provided two letters of agreement with the Volusia County Schools and Halifax Hospital Medical Center.	
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**	The director of adolescent residential services provided the NETMIS Outreach log for May-November, which 11 outreach activities/events including four staff members who completed some of the outreach activities. The NetMIS outreach log includes all required information.	

The program has designated staff that conducts outreach which is defined in their job description.	Compliance	The director of adolescent residential services indicated she is the primary staff to conduct outreach at the moment but hiring an outreach specialist is in the strategic plan; however, until the position is filled she will continue outreach or designate another supervisor to attend.	
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 provider has the required policy titled Screening, Eligibility, and Linkage to Services that was revised on July 31, 2023 by the Director of Adolescent Residential Services.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open (Residential & Community) Files: 2 Residential and 2 Community Counseling **Total number of Closed (Residential & Community) Files:** 3 Residential and 3 Community Counseling **Type of Documentation(s) Reviewed:** Policy and Procedure, Client Case Files			
Shelter youth: Eligibility screening is completed immediately for all shelter placement inquiries.	Compliance	All five residential files reviewed demonstrated eligibility screening is completed immediately for all shelter placement inquiries.	
Community counseling: Eligibility screening is completed within 3 business days of referral by a trained staff using the Florida Network screening form.	Compliance	All five community counseling files reviewed demonstrated eligibility screening is completed within three business days of referral by a trained staff using the Florida Network screening form.	
There is evidence all referrals for service is screened for eligibility and is logged in NetMIS within 72 hours of screening completion.	Compliance	All five residential and five community counseling files reviewed demonstrated there is evidence all 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 five residential and five community counseling files reviewed demonstrated youth and parents/guardians receive the available service options and rights and responsibilities of youth and parents/guardians in writing during intake.	

The following is also available to the youth and parents/guardians: a. Possible actions occurring through involvement with CINS/FINS services (case staffing committee, CINS petition, CINS adjudication) b. Grievance procedures	**Compliance**	All five residential and five community counseling files reviewed demonstrated the program provided the CINS/FINS parent brochure and grievance procedures during intake. An acknowledgement of review of this information is included in each youth record.	
During intake, all youth were screened for suicidality and assessed as required if needed.	**Compliance**	All five residential and five community counseling files reviewed demonstrated during intake, all youth were screened for suicidality and assessed as required if needed.	
Additional Comments: **There are no additional comments for this indicator.**			
2.02 - Needs Assessment			**Limited**
Provider has a written policy and procedure that meets the requirement for Indicator 2.02		**YES** If NO, explain here: The provider has the required policy titled Network Inventory of Risks, Victories and Needs Assessment-NIRVANA that was revised on July 31, 2023 by the Director of Adolescent Residential Services.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open (Residential & Community) Files: 2 Residential and 2 Community Counseling **Total number of Closed (Residential & Community) Files:** 3 Residential and 3 Community Counseling **Staff Position(s) Interviewed** *(No Staff Names)*: Director of Adolescent Residential and Operation Supervisor of Beach House **Type of Documentation(s) Reviewed:** Policy and Procedure, Client Case Files			
Shelter Youth: NIRVANA is initiated within 72 hours of admission	**Exception**	Three of five residential records reviewed, one open and two closed, demonstrated NIRVANA is initiated within 72 hours of admission.	One open and one closed residential record reviewed did not meet the requirement for initiation of NIRVANA within 72 hours of admission. The intake was completed on 10/13/2023 for one closed residential record; however, NIRVANA assessment wasn't initiated until five days later on 10/18/2023. The open record reviewed shows an intake date of 6/19/2023, but NIRVANA wasn't initiated until 6/23/2023.

Non-Residential youth: NIRVANA is initiated at intake and completed within 2 to 3 face-to-face contacts after the initial intake **OR** updated, if most recent assessment is over 6 months old	**Compliance**	All five community counseling files reviewed demonstrated NIRVANA was initiated at intake and completed within two to three face-to-face contacts after the initial intake.	
Supervisor signatures is documented for all completed NIRVANA assessments and/or the chronological note and/or interview guide that is located in the youths' file.	**Exception**	None of NIRVANA assessments in the five residential records reviewed were signed by a supervisor. All five community counseling files reviewed demonstrated supervisor's signature documented for completed NIRVANA assessments. However, two of five community counseling files show the NIRVANA was generated on 11/7/23 but both were back dated to 9/14/23 on one and 6/22/23 on the other.	All five NIRVANA Assessments for the residential files reviewed did not include the supervisor's signature on the document or a chronological note stating NIRVANA Assessment was reviewed. In addition, two of the community counseling records show supervisor's signatures on the NIRVANA that were backdated and not signed when they were generated. A CCC call was made to report falsification.
(Shelter Only) NIRVANA Self-Assessment (NSR) is completed within 24 hours of youth being admitted into shelter. If unable to complete, there must be documentation in NetMIS and the youth's file explaining the barriers to completion.	**Compliance**	All five residential files reviewed demonstrated NIRVANA Self-Assessment was 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.	**Compliance**	Two residential and two community counseling files reviewed were not applicable as the cases were active during the review. Three closed residential files reviewed were not applicable as the length of stay was not greater than 30 days. Three closed community counseling files reviewed demonstrated a NIRVANA Post-Assessment was completed at discharge for all youth who had a length of stay greater than 30 days.	
A NIRVANA Re-Assessment is completed every 90 days excluding files for youth receiving SNAP services.	**Exception**	Nine of the files reviewed were not applicable for NIRVANA re-assessment because the length of stay did not meet the 90 days requirement.	One open community counseling file reviewed did not demonstrate a NIRVANA Re-Assessment was completed every 90 days during review period; case was opened on 8/8/2023 and NIRVANA Re-assessment was due by 11/5/2023 but was not completed.
All files include the interview guide and/or printed NIRVANA.	**Compliance**	All ten files reviewed included the NIRVANA interview guide and/or a printed NIRVANA.	

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

2.03 - Case/Service Plan			Satisfactory with Exception
Provider has a written policy and procedure that meets the requirement for Indicator 2.03		**YES** If NO, explain here: The provider has the required policy titled Assessment and Treatment Planning that was revised on October 31, 2023 by the Director of Adolescent Residential Services.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open (Residential & Community) Files: 2 Residential and 2 Community Counseling **Total number of Closed (Residential & Community) Files:** 3 Residential and 3 Community Counseling **Type of Documentation(s) Reviewed:** Policy and Procedure, Client Case Files			
The case/service plan is developed on a local provider-approved form or through NETMIS and is based on information gathered during the initial screening, intake, and NIRVANA.	**Compliance**	All ten files reviewed demonstrated the case/service plan is developed on a local provider-approved form and is based on information gathered during the initial screening, intake, and NIRVANA.	
Case/Service plan is developed within 7 working days of NIRVANA	**Compliance**	All ten files reviewed demonstrated case/Service plan is developed within seven working days of NIRVANA	
Case plan/service plan includes: 1. Individualized and prioritized need(s) and goal(s) identified by the NIRVANA 2. Service type, frequency, location 3. Person(s) responsible 4. Target date(s) for completion and Actual completion date(s) 5. Signature of youth, parent/ guardian, counselor, and supervisor 6. Date the plan was initiated	**Exception**	All ten files reviewed demonstrated individualized and prioritized need(s) and goal(s) identified by the NIRVANA, service type, frequency, location, person(s) responsible, signature of counselor, target date(s) for completion, and date the plan was initiated. Eight applicable files reviewed (three closed residential files and all five community counseling) demonstrated actual completion date(s) of goals. All five residential, and one open and three closed community counseling files reviewed demonstrated signature of youth, parent/guardian, and supervisor.	Two open community counseling records were missing signatures. One was missing the signature of the youth and the supervisor and the other record was missing parent/guardian signature.
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**	Thirty day reviews were applicable to one open residential and all five community counseling files reviewed. All six records demonstrated case/service plans are reviewed for progress/revised by counselor and parent (if available) every 30 days for the first three months and every six months after.	
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 provider has the required policy titled Case Management Services that was revised on October 31, 2023 by the Director of Adolescent Residential Services.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open (Residential & Community) Files: 2 Residential and 2 Community Counseling **Total number of Closed (Residential & Community) Files:** 3 Residential and 3 Community Counseling **Type of Documentation(s) Reviewed:** Policy and Procedure, Client Case Files			
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 ten records reviewed demonstrated referral needs were identified and coordination of referrals to services based upon the on-going assessment of the youth's/family's problems and needs. It was also evident the case worker coordinated service plan implementation, monitored youth's/family's progress in services, provided support for families, referred the youth/family for additional services when appropriate, and provided case monitoring in all ten records. All five residential and four community counseling records reviewed were not applicable for monitoring of progress for court ordered youth in shelter as none were reported to be court ordered during the review period. One community counseling file was monitored for progress due to court order to the shelter. All files both residential and community counseling reviewed were not applicable to making referrals to the case staffing to address problems and needs of the youth/family, and accompany youth and parent/guardian to court hearings and related appointments as none were reported during the review period. All six closed records included termination notes. Five applicable records, three closed residential and two closed community counseling files, demonstrated follow-ups after 30 days of exit and two closed residential and one closed community counseling file demonstrated follow-up after 60 days of exit.	

The program maintains written agreements with other community partners that include services provided and a comprehensive referral process	**Compliance**	All ten files reviewed included a document in the case file which listed agreed community partners and services provided to ensure a comprehensive referral process.	

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

2.05 - Counseling Services		**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.05	**YES** If NO, explain here: The provider has the required policy titled Counseling Services that was revised on July 31, 2023 by the Director of Adolescent Residential Services.	

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

Total number of Open (Residential & Community) Files: 2 Residential and 2 Community Counseling
Total number of Closed (Residential & Community) Files: 3 Residential and 3 Community Counseling
Staff Position(s) Interviewed *(No Staff Names)*: Operation Supervisor of Residential Adolescent Program
Type of Documentation(s) Reviewed: Policy and Procedure, Client Case Files

Shelter Program

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**	All five residential files reviewed demonstrated group counseling session were provided to youth in care. The program's group sign in sheets for the 6-month review period was 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**	Per interview with Operation Supervisor, groups are conducted by approved individuals. All five files reviewed demonstrated groups were conducted by staff, consist of a clear leader or facilitator, relevant topic opportunity for youth participation, and a minimum of 30 minutes.	
Documentation of groups must include date and time, a list of participants, length of time, and topic.	**Compliance**	Group logs were reviewed from May through November 2023. Group counseling sessions consisted of a clear leader or facilitator, relevant topic, date and time of group, list of participants, an opportunity for youth to participate, and the length of groups was at minimum thirty minutes.	

Community Counseling			
Community counseling programs provide therapeutic community-based services designed to provide the intervention necessary to stabilize the family. Services are provided in the youth's home, a community location, the local provider's counseling office or virtually if written documentation is provided in the youth's file for reasons why it is in the best interest of the youth and family.	**Compliance**	All five community counseling records demonstrated the community counseling program providing therapeutic community-based services designed to provide the intervention necessary to stabilize the family. Services were provided in an approved location or virtually documented in the best interest of the youth and family.	
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. In addition peer record reviews are conducted monthly for a sample of case records and deficiencies are identified and addressed by management. Record reviews were evident for the past six months, May through November 2023.	
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 provider has the required policy titled Adjudication Services/Petition Process that was revised on October 31, 2023 by the Director of Adolescent Residential Services.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open (Residential & Community) Files: 0 **Total number of Closed (Residential & Community) Files:**0 **Staff Position(s) Interviewed** *(No Staff Names)*: Director of Adolescent Residential **Type of Documentation(s) Reviewed:** Policy & Procedures			
Must include: a. DJJ rep. or CINS/FINS provider b. Local school district representative	**Compliance**	Per interview with Director of Adolescent Residential, there were no adjudication/petition filed or staffing during the review period. Director of Adolescent Residential was interviewed and the agency's policy and procedure was reviewed to determine compliance. 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 will 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 provider has the required policy titled Youth Records that was revised on October 31, 2023 by the Director of Adolescent Residential Services.	

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

Staff Position(s) Interviewed *(No Staff Names)***:** Operation Supervisor of Beach House and Operation Supervisor Residential Adolescent Program
Type of Documentation(s) Reviewed: Policy and Procedure, Client Case Files
Describe any Observations: File cabinet, record storage/transport container, and file room

All records are clearly marked 'confidential'.	**Compliance**	Per the observation of ten case records reviewed, all records were clearly marked confidential	
All records are kept in a secure room or locked in a file cabinet that is marked "confidential"	**Compliance**	Per interview with the Operation's Supervisor and observation, all records were kept in an office in a secure locked cabinet that is marked with confidential.	
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			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 2.08		**YES** If NO, explain here: The provider has the required policy titled Special Populations Served that was revised on October 31, 2023 by the Director of Adolescent Residential Services. Per the policies and procedures, Beach House does not have contracts to provide Domestic Minor Sex Trafficking (DMST), Staff Secure, Intensive Case Management (ICM), Physically Secure, or Family/Youth Respite Aftercare Services (FYRAC).	
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)* **:** Director of Adolescent Residential Services.			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? **(If no, select rating "No eligible items for review")**	**Not Applicable**	Beach House does not have a contract to provide Staff Secure services.	
Staff Secure policy and procedure outlines the following: a. In-depth orientation on admission b. Assessment and service planning c. Enhanced supervision and security with emphasis on control and appropriate level of physical intervention d. Parental involvement e. Collaborative aftercare	**Not Applicable**		
Program only accept youth that meet legal requirements of F.S. 984 for being formally court ordered in to Staff Secure Services	**Not Applicable**		

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

Length of Stay: a. Youth in program do not have length of stay in DMST placement that exceeds seven (7) days b. Agency has approval for stays and support beyond seven (7) days for DMST placements that are obtained on a case-by-case basis? (If applicable.)	**Not Applicable**		
Agency has evidence that staff assigned to DMST youth under this provision are to enhance the regular services available through direct engagement in positive activities designed to encourage the youth to remain in shelter	**Not Applicable**		
All other services provided to DMST youth are consistent with all other general CINS/FINS program requirements	**Not Applicable**		

Domestic Violence

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

Total number of Closed Files: 3 closed records
Staff Position(s) Interviewed *(No Staff Names)*: Operations Supervisor
Type of Documentation(s) Reviewed: Youth records

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	**Compliance**	All 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.	

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)* **:** Operations Supervisor			
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.*			

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	Beach House does not have a contract 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.*			
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	Beach House does not have a contract to provide FYRAC services.	

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.	**Not Applicable**		
Agency has evidence that all FYRAC referrals have documented approval from the Florida Network office	**Not Applicable**		
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.	**Not Applicable**		
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.	**Not Applicable**		
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.	**Not Applicable**		

Group Sessions: a. Focus on the same issues as individual/family sessions with application to youth pulling on similar experiences with other group members with the overall goal of strengthening relationships and prevention of domestic violence. b. Shall be no more than eight (8) youth at one (1) time and shall be for a minimum of sixty (60) minutes per session	**Not Applicable**		
There is evidence of completed 30 and/or 60 day follow-ups and is documented in NetMIS following case discharge.	**Not Applicable**		
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	**Not Applicable**		
Any service that is offered virtually, is documented in the youth's file why it was in the youth and families best interest.	**Not Applicable**		
All data entry in NetMIS is completed within 3 business days as required.	**Not Applicable**		
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: Beach House does not have a contract to provide SNAP services.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
SNAP Clinical Groups Under 12			
Youth are screened to determine eligibility of services.	Not Applicable		
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		Satisfactory with Exception
Provider has a written policy and procedure that meets the requirement for Indicator 3.01	**YES**	
	If NO, explain here:	
	The provider has the required policy titled Shelter Environment that was revised on October 31, 2023 by the Director of Adolescent Residential Services.	

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

Staff Position(s) Interviewed: Shelter Operation's Supervisor
Type of Documentation(s) Reviewed: Chemical weekly and perpetual inventory/checklist, MSDS, Fire Drills, Emergency Drills, Volusia County Fire Inspection, Fire equipment inspections from Pye Barker Fire and Safety LLC, and Health Department Inspections, activity and program schedule.
Describe any Observations: Tour of facility, postings, inspection of vehicle # 291, 2019 Chevy Trax, and vehicle # 231, a 2014 Ford Escape, chemical storage,

Facility Inspection: a. Furnishings are in good repair. b. The program is free of insect infestation. c. Bathrooms and shower areas are clean and functional, free of foul odors, leaks, dust, and mildew and in good working order. d. There is no graffiti on walls, doors, or windows. e. Lighting is adequate for tasks performed there. f. Exterior areas are free of debris; grounds are free of hazards. g. Dumpster and garbage can(s) are covered. h. All doors are secure, in and out access is limited to staff members and key control is in compliance. i. Detailed map and egress plans of the facility, general client rules, grievance forms, abuse hotline information, DJJ Incident Reporting Number and other related notices are posted. j. Interior areas (bedrooms, bathrooms, common areas) do not contain contraband and are free from hazardous unauthorized metal/foreign objects.	**Compliance**	A tour of the facility was conducted with the Director of Adolescent Residential Services. All furnishings appear to be in order. The facility was clean throughout with no observed contraband or hazardous objects and appeared to be free of insect infestations. The bathrooms and showers were also found to be clean and fully functional. No graffiti was observed on the walls, doors, windows, or furniture. Appropriate lighting was observed throughout the shelter. The shelter sits on a large campus that was maintained well and the yard was free of hazard. The doors to the facility are kept locked, requiring key access. Staff and visitors are required to use one entry/exit area. All others areas were secured with the alarm on. Egress plans of the facility were observed in common areas and hallways throughout the building. They were also located in different rooms where the youth reside. A encased board is mounted on the main hallway wall between the dorms that displays important program information such as general client rules, grievance procedures, abuse hotline information, and other related notices.	
Facility Inspection: a.All agency and staff vehicles are locked. b. Agency vehicles are equipped with major safety equipment including first aid kit, (all items in the first aid kit are current and do not have expired items; all expired items should be replaced regularly), fire extinguisher, flashlight, glass breaker and, seat belt cutter.	**Compliance**	Reviewer inspected both agency vehicles: vehicle # 291, 2019 Chevy Trax, and vehicle # 231, a 2014 Ford Escape. Both agency vehicles were found with all safety equipment needed, which included first aid kit, extinguisher, flashlight, glass breaker and seatbelt cutter.	

Facility Inspection: All chemicals are listed, approved for use, inventoried weekly and perpetually, stored securely and Material Safety Data Sheets (MSDS) are maintained on each item (minimum 1 time per week or per agency policy). A perpetual inventory will be the primary means of maintaining a current and real-time inventory. The weekly inventory will be conducted weekly at a minimum to ensure that a perpetual inventory is being maintained consistently and accurately. If more than one location is used to store chemicals, there is an inventory wherever chemicals are stored that is current and well maintained unless previously approved by the Network.	**Exception**	The agency has a detailed daily and weekly checklist for chemicals. The checklist was reviewed and it shows that the supervisor reviewed and signed off the weekly checklist on a consistent basis. The perpetual checklist is being completed on a consistent basis. Chemicals are stored in two different closets with an inventory checklist for each storage location. When one closet was observed, Blue Foam cleaner was not in the right area nor was it on the chemical checklist. There was a MSDS sheet for each chemical stored. The primary chemical checklist appears to be perpetual and in real time. The weekly checklist was reviewed and appears to be maintained accurately.	One of the chemicals (Blue Foam) was found in a chemical closet for which it is not listed on the inventory. It was listed on the other chemical closet's inventory where it should have been stored.
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**	Washer/dryer appeared operational. The lint trap was checked and there was no lint in the lint collector. The facility is licensed for 20 beds and the current DCF Child Care License was displayed in the front office and is effective through 7/11/2024. None of the beds were covered during the tour due to youth sleeping at the RAP House facility instead of Beach House due to current staff shortages. There are lockers in place for youth to keep all private belongings.	

Additional Facility Inspection Narrative (if applicable)			
Fire and Safety Health Hazards: a. Annual facility fire inspection was conducted, and the facility is in compliance with local fire marshal and fire safety code within jurisdiction. b. Agency completes a minimum of 1 fire drill per month within 2 minutes or less. c. Completes 1 mock emergency drill per shift per quarter. d. All annual fire safety equipment inspections are valid and up to date (extinguishers, sprinklers, alarm system and kitchen overhead hood, including fire extinguishers in all vehicles).	**Exception**	Facility's annual fire inspection was conducted and is in compliance after the reinspection was conducted by Volusia County Fire Rescue on 6/22/2022. The program completed fire drills monthly on each shift with evacuation time within 2 minutes or less in the months of May, June, and July, and October. There is record of the monthly disaster drills located in the information binder. One mock emergency drill is completed per shift. Invoices and service records for four fire extinguisher, alarm testing, smoke detectors, sprinklers, and kitchen overhead hood inspection appears to be up to date. Fire extinguisher inspection was completed on 1.27.23 by Pye Barker Fire and Safety LLC. All fire extinguishers appeared to meet requirements and were accessible to the staff. All inspections appeared to be up to date and valid.	The fire drills for August and September were not completed. Fire drills completed on May 28th, June 30th, and July 21st on the 3rd shift were all over a 2 minute time span.
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**	This agency has satisfactory certificates/receipts for its Residential Group Care and food inspection conducted by the State of Florida Department of Health. Group care inspection was completed by the State of Florida Department of Health on 1/1/2023 and the Food inspection was completed on 10/01/2023. The food menus are posted on the wall and signed by a Licensed Dietician. The youth have food catered into them throughout the day so the program does not store meals long term. Menus are posted and current with no concerns.	
Additional Fire and Safety Health Hazards Narrative (if applicable)			

Youth Engagement			
a. Youth are engaged in meaningful, structured activities (e.g., education, recreation, counseling services, life and social skill training) seven days a week during awake hours. Idle time is minimal. b. At least one hour of physical activity is provided daily. c. Youth are provided the opportunity to participate in a variety of faith-based activities. Non-punitive structured activities are offered to youth who do not choose to participate in faith-based activities. d. Daily programming includes opportunities for youth to complete homework and access a variety of age appropriate, program approved books for reading. Youth are allowed quiet time to read. e. Daily programming schedule is publicly posted and accessible to both staff and youth.	**Compliance**	The program has a facilities activity coordinator that schedules upcoming events for the youth daily. The activity calendar shows different activities ranging from education to faith based, counseling and social skills trainings. The activities coordinator also has a detailed schedule that outlines what the youth participate in throughout the day. The schedule is visibly posted and includes educational activities and time needed to complete educational assignments. Youth also have access to a room that gives them time to themselves if needed. Reviewer did not observe any punitive activities during the review.	
Additional Comments: **There are no additional comments for this indicator.**			

3.02 - Program Orientation		Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 3.02	**YES** If NO, explain here: The provider has the required policy titled Program Orientation that was revised on October 31, 2023 by the Director of Adolescent Residential Services.	

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

Total number of Open Files: 1
Total number of Closed Files: 2
Type of Documentation(s) Reviewed: documents in the file, orientation checklist, observation logs, and introduction to services document.

Youth received a comprehensive orientation and handbook provided within 24 hours	**Compliance**	All files have a checklist indicating the youth received a comprehensive orientation within 24 hours.	

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**	All files have a checklist with the staff and youth's signature indicating the youth received a comprehensive orientation explaining the disciplinary action, program rules, grievance procedure and emergency procedures, the contraband policy, suicide prevention, tour, room assignment and how to contact the abuse hotline were explained.	
Documentation of each component of orientation, including orientation topics and dates of presentation, as well as signatures of the youth and staff involved is maintained in the individual youth record	**Compliance**	All files have a checklist that includes each component of orientation that is reviewed by staff and has youth's signature indicating the youth received a comprehensive orientation.	

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

3.03 - Youth Room Assignment		**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 3.03	**YES** If NO, explain here: The provider has the required policy titled Room Assignment that was revised on October 31, 2023 by the Director of Adolescent Residential Services.	

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

Total number of Open Files: 1
Total number of Closed Files: 2
Type of Documentation(s) Reviewed: client files, intake documentation

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 files show documentation of staff gathering information of the youth's history and exposure to trauma, age, and gender, history of violence, disability, physical size and gang affiliation. All files show documentation of the youth's sexual behavior, suicide risk and if isolation is necessary.	
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**	All files show documentation of noted alerts, collateral contacts and the youth's initial interactions and observations.	

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

3.04 - Log Books		Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 3.04	**YES** If NO, explain here: The provider has the required policy titled Log Books that was reviewed October 31, 2023 by the Director of Adolescent Residential Services.	

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

Dates or Timeframe Reviewed: Six, two-week periods for each month between May and October 2023
Staff Position(s) Interviewed *(No Staff Names)*: Operation Supervisor
Type of Documentation(s) Reviewed: Three hardcover Logbooks

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**	Three logbooks were reviewed during the audit. The entries appeared to be written legibly in ink. The dates, times and incidents were documented in the logbooks. The names of the staff and youth were documented consistently.	
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**	It was observed on several pages during the review of the logbooks that the staff crossed out the error appropriately and made the needed corrections. Whiteout is not used in the logbook.	
The program director or designee reviews the facility logbook(s) every week and makes a note chronologically in the logbook indicating the dates reviewed and if any correction, recommendations and follow-up are required and sign/date the entry	**Compliance**	It was observed during the review of the logbook that the program director reviewed the logbook on a weekly basis.	
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 appeared to review the logbook and document they had done so when they came on shift.	
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**	Documentation shows the shift supervisor reviewing the logbook on a consistent basis.	
Logbook entries include: a. Supervision and resident counts b. Visitation and home visits	**Compliance**	When the logbooks were reviewed, it showed staff consistently documenting the number of youth in the building and when youth were off campus for different situations.	

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		**NO** If NO, explain here: The provider has the required policy titled Behavior Management Strategies that was reviewed July 31, 2023 by the Director of Adolescent Residential Services.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Staff Position(s) Interviewed *(No Staff Names)*: RAP operation supervisor and Beach House operation supervisor **Type of Documentation(s) Reviewed:** Policy and procedure, BMS protocol and on the job training log, three youth records			
The program has a detailed written description of the BMS and it is explained during program orientation	**Compliance**	The program has a detailed written description of the Behavior Management System (BMS). Three youth records reviewed verified the BMS is explained during the orientation process.	
Behavior Management Strategies must include:			
a.BMS is designed to teach youth new behaviors and help youth understand the natural consequences for their actions b.Behavioral interventions are applied immediately, with certainty, and reflect the severity of the behavior c.BMS uses a wide variety of awards/incentives to encourage participation and completion of the program d.Appropriate consequences and sanctions are used by the program and consequences for behavior are logical and designed to promote skill-building for the youth e.Counseling, verbal intervention and de-escalation techniques are used prior to physical intervention (Only techniques approved by the Florida Network and DJJ are used if physical intervention is required) f.Only staff discipline youth. Group discipline is not imposed g.Room restriction is not used as part of the system or for youth who are physically and/or emotionally out of control h.Youth should never be denied basic rights such as meals, clothing, sleep, services, exercise, or correspondence privileges	**Compliance**	The Behavioral Management System is named the VIP (Very Important Person) Program which is based on the advancing youth development model and is designed to provide a reward system for adaptive behaviors based on behavior modification and communication techniques. These methods are incorporated in family therapy and in educational groups in order to prepare the youth and family for discharge from the program. The program consists of three levels: Orientation, VIP, and Super VIP. The system uses a variety of rewards and positive incentives. Behavioral interventions and consequences are applied immediately and appropriately. The BMS protocol appears to promote safety, fairness, intent to encourage positive reinforcement and behavior modification with privileges/incentives and consequences. Disciplinary actions do not deny the youth of any of their basic rights. Three (3) youth files were reviewed. All files had documentation of completed point sheets and progress notes indicating the youth negative behavior which justified the daily points.	

Program's use of the BMS			
All staff are trained in the theory and practice of administering BMS rewards and consequences	Compliance	Three new employee training files were reviewed and all three completed BMS training.	
There is a protocol for providing feedback and evaluation of staff regarding their use of BMS rewards and consequences	Compliance	Interview with the operation's supervisor indicated feedback is provided to the staff in "real time", if applicable, as well as during the monthly one on one supervisions to discuss staff's level of understanding and use of the BMS.	
Supervisors are trained to monitor the use of rewards and consequences by their staff	Compliance	Two supervisors were interviewed. One supervisor has been in her position for 18 years and the other for six years. Neither needed additional training regarding the BMS. One supervisor was trained by a previous overnight supervisor and the other supervisor was trained by the supervisor of 18 years.	
Additional Comments: **There are no additional comments for this indicator.**			

3.06 - Staffing and Youth Supervision		**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 3.06	**YES** If NO, explain here: The provider has the required policy titled Staffing and Supervision that was reviewed October 31, 2023 by the Director of Adolescent Residential Services.	

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

Dates or Timeframe Reviewed: video footage on the following dates: October 13th 12am to 2am, October 18 2am to 4am, October 22nd 4am to 6am, October 28th 1am to 3am, November 6th 3am to 5am.
Staff Position(s) Interviewed *(No Staff Names)*: Shift Supervisor
Type of Documentation(s) Reviewed: Staff Schedule, logbook
Describe any Observations: Video Surveillance System

The program maintains minimum staffing ratios as required by Florida Administrative Code and contract. • 1 staff to 6 youth during awake hours and community activities • 1 staff to 12 youth during the sleep period	Compliance	A review of staff schedules, 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 reviewed show 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 schedules are visible for the staff and are posted in a front 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 operation supervisor offers any additional coverage if needed and the program combines Beach House and RAP house youth during the overnight hours.	
Staff observe youth at least every 15 minutes while they are in their sleeping room, either during the sleep period or at other times, such as during illness or room restriction	**Compliance**	The staff logbooks and video surveillance dates reviewed demonstrated staff complete bed checks and document them in a timely manner.	

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

3.07 - Video Surveillance System		**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 3.07	**YES**	
	If NO, explain here:	
	The provider has the required policy titled Video Surveillance that was reviewed October 31, 2023 by the Director of Adolescent Residential Services.	

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

Dates or Timeframe Reviewed: video footage on the following dates: October 13th 12am to 2am, October 18 2am to 4am, October 22nd 4am to 6am, October 28th 1am to 3am, November 6th 3am to 5am.
Staff Position(s) Interviewed *(No Staff Names)*: Operation Supervisor
Type of Documentation(s) Reviewed: Program Logbooks, Video Camera Review Documentation
Describe any Observations: Video Surveillance System

Surveillance System			
The agency, at a minimum, shall demonstrate: a. A written notice that is conspicuously posted on the premises for the purpose of security b. System can capture and retain video photographic images which must be stored for a minimum of 30 days c. System can record date, time, and location; maintain resolution that enables facial recognition d. Back-up capabilities consist of cameras' ability to operate during a power outage e. Have cameras placed in interior and exterior general locations of the shelter where youth and staff congregate and where visitors enter and exit. Cameras are never placed in bathrooms or sleeping quarters. f. All cameras are visible	**Compliance**	A sign alerting video surveillance is located on the entrance building door. System can capture and retain video images for up to thirty days. A review of random samples of overnight video surveillance revealed system records date, time, and 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 the bathrooms or sleeping rooms.	
A list of designated personnel who can access the video surveillance system is maintained (includes off-site capability per personnel)?	**Compliance**	A list of the designated personnel was provided to show who has access to review video footage.	
Supervisory review of video is conducted a minimum of once every 14 days and timeframes reviewed are noted in the logbook.	**Exception**	Video footage review by the supervisor was consistent up until 10/17/23. The footage review after that time up to 11/1/23 was not documented.	Supervisory video footage review was missed for the dates between 10/18/23 and 11/1/23
The reviews assess the activities of the facility and include a review of random sample of overnight shifts	**Compliance**	The documentation of video footage reviewed by the supervisor shows random times were reviewed throughout the day.	
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**	If video footage is requested, the program contacts the IT Help Desk Department and request the needed footage. From there the IT Department pulls the footage and sends the organization who requested the footage	
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**	The IT Department is responsible for repairing malfunctions once informed by the program. If the IT Department is unable to repair another party is called in (VALDATA) to troubleshoot.	
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 provider has the required policy titled Healthcare Screenings that was reviewed October 1, 2023 by the Director of Adolescent Residential Services.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: two **Total number of Closed Files:** three **Staff Position(s) Interviewed** *(No Staff Names)*: part time nursing staff **Type of Documentation(s) Reviewed:** youth records **Describe any Observations:** Observations of medical office and med cart station/chart room were made			
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**	Each of the five youth primary healthcare screenings and observations contained current medications, existing medical conditions, allergies, recent injuries or illnesses, the presence of pain or physical distress, an observation for evidence of illness, injury, pain or physical distress, or difficulty moving, the presence of scars, tattoos, or other sin markings and acute health symptoms requiring isolation/quarantine.	
Referral and Follow-Up			
Youth with chronic medical conditions have a referral to ensure medical care (e.g. diabetes, pregnancy, seizure disorder, cardiac disorders, asthma, tuberculosis, hemophilia, head injuries, etc.)	**Compliance**	Two of the five reviewed youth files reflect chronic conditions and each had a documented referral to ensure medical care is received.	
When needed, the parent is involved with the coordination and scheduling of follow-up medical appointments	**Compliance**	In both files, parent/guardian coordination for medical treatments or follow up was confirmed by documented parent/guardian involvement. In the remaining three files, coordination with parents or guardians concerning medical care was observed.	
All medical referrals are documented on a daily log.	**Compliance**	In all five records, referrals were documented in the daily logs.	

The program has a thorough referral process and a mechanism for necessary follow-up medical care as required and/or needed	Compliance	The program has procedures which include a thorough referral process and mechanisms for follow up medical care for youth admitted with chronic medical conditions.	
Additional Comments: **There are no additional comments for this indicator.**			
4.02 - Suicide Prevention			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 4.02		**YES** If NO, explain here: The provider has the required policy titled Suicide Prevention that was reviewed October 1, 2023 by the Director of Adolescent Residential Services.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open (Residential & Community) Files: two **Total number of Closed (Residential & Community) Files:** three **Staff Position(s) Interviewed** *(No Staff Names)*: Nursing staff, Operation Supervisor **Type of Documentation(s) Reviewed:** youth 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.	Compliance	All youth entering the facility receive an initial suicide screening by the licensed clinician. Each record reflected screening results were signed by the supervisor and documented in the youth case file.	
The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	Compliance	The program's risk assessment has been approved by the Florida Network of Youth and Family Services.	
Supervision of Youth with Suicide Risk *(Shelter Only)*			
Youth are placed on the appropriate level of supervision based on the results of the suicide risk assessment.	Compliance	None of the five youth required sight-and-sound supervision. All five youth were put on the appropriate level of supervision, and all five assessments were documented in the program logbook.	
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	No eligible items for review	No youth have required sight-and-sound supervision since the last compliance review.	
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.	No eligible items for review	No youth have required sight-and-sound supervision since the last compliance review.	

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	**No eligible items for review**	The program has had no incidents of youth being place on sight-and-sound supervision since the last annual review, however each youth entering the program is given an initial suicide risk assessment during intake and is not out of sight or sound of the licensed clinician until intake is complete and the youth is determined to be appropriate for standard supervision.	
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.	**No eligible items for review**	No youth have required sight-and-sound supervision since the last compliance review.	
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 program supervisor, 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**	No eligible youth served.	
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**	No eligible youth served.	
If the parent/guardian cannot be contacted, all efforts to contact them are documented in the case file.	**No eligible items for review**	No eligible youth served.	
When the screening was completed during school hours on school property, the appropriate school authorities were notified.	**No eligible items for review**	No eligible youth served.	
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 titled Medication Management and Distribution that was updated July 31, 2023 by the Director of Adolescent Residential Services.	

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

Total number of Open Files: two
Total number of Closed Files: three
Staff Position(s) Interviewed *(No Staff Names)* **:** nursing staff
Type of Documentation(s) Reviewed: Youth medical records, medication distribution records, Pyxis reports, policy, manual, medication and supply logs
Describe any Observations: Observations of the Pyxis medication cart, cart contents, space the cart is stored in, medication/supply logs

The agency has a Registered Nurse (RN) and/or a Licensed Practical Nurse (LPN) that is being supervised by RN and all of their credentials have been verified.	**Compliance**	The program has two registered nurses with verified credentials.	

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**	All youth medication is contained in the program's Pyxis Medication Cabinet, which is inaccessible to youth. The Pyxis cabinet is orderly and stored in the medical/chart room in the administration building, according to guidelines in Florida Statues and the medication management policy. The space is secured with a restricted key and user permissions restrict access to any medications in the cabinet. The secured room is a suitable space for cleaning, maintenance, and operation of the unit. The room also has a secured, functioning refrigerator for medications requiring it and a disposal container for outdated, damaged, deteriorated, misbranded, or adulterated medications. The room is clean and free of any kind of infestation. All oral medications are kept separate from injectable epi-pens and topical medications. Documented shift-to-shift counts, and a perpetual inventory of controlled medications are required when youth are prescribed them, however, no youth were prescribed controlled medications during the time of the review. Documentation reflects discrepancies are cleared after each shift, and sharps and syringes are secured and counted weekly when added the medical office supplies. Non-controlled and over-the-counter medications are inventoried weekly in addition to the documented perpetual count. The agency has an internal quality assurance process to ensure appropriate medication management and distribution methods. The nursing staff complete monthly reports detailing any discrepancies or drawer failures. There were no instances of a failure to distribute medication due to the Pyxis cabinet malfunction or refusal of access. There was one incident of a medication error for a missed dose. The error was discovered by the nursing staff and reported to the appropriate entities, as required. Properly labeled Pyxis keys were observed to be accessible to staff in the event of a Pyxis malfunction.	

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's two registered nurses are the Pyxis system managers. Only designated staff delineated in user permissions have access to controlled substances. A medication distribution log is utilized for all medication distribution by licensed or non-licensed staff. The program verifies medications using one of the three methods listed in the FNYFS Policies and Procedures Manual. When the nursing staff are on duty, medication process are conducted by the nurse. The delivery process of medication is consistent with The Florida Network of Youth and Family Services (FNYFS) medication management and distribution policy. The nursing staff verify medication using the approved methods listed in the FNYFS Operations Manual. The program does not accept youth requiring prescribed injectable medications, except for epi-pens. All non-licensed staff have received training from the program nurses on the use of epi-pens, with refreshers completed each time a new youth is admitted to the program with one.	
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**	All youth medication distribution records included youth and staff initials and the time of administration.	
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**	Each administration record reflects doses were given within one hour of the scheduled delivery time.	
During the review period, there were no instances where youth missed their medication due to failure to open the pyxis machine.	**Compliance**	There were no instances of a failure to distribute medication due to the Pyxis cabinet malfunction or refusal of access.	

Medication Inventory			
a. For controlled substances, a perpetual inventory with running balances is maintained as well as a shift-to shift count verified by a witness and documented b. Over-the-counter medications that are accessed regularly are inventoried weekly by maintaining a perpetual inventory c. Syringes and sharps (needles, scissors, etc.) are secured, and counted and documented weekly	**Compliance**	The program currently has no youth on narcotics or controlled medications; however, the Pyxis medication cart has a secure drawer specifically designated for these medications should a youth be admitted with them. Documented shift-to-shift counts, and a perpetual inventory of controlled medications are required when youth are prescribed them. Non-controlled and over-the-counter medications are inventoried weekly in addition to the documented perpetual count. Documentation reflects sharps and syringes are secured and counted weekly when added the medical office supplies.	
There are monthly reviews of the Pyxis reports to monitor medication management practice.	**Compliance**	The nursing staff completes monthly reports detailing any discrepancies or drawer failures.	
Medication discrepancies are cleared after each shift.	**Compliance**	Documentation reflects discrepancies are cleared after each shift.	
The agency has an internal quality assurance process to ensure appropriate medication management and distribution methods.	**Compliance**	The agency has an internal quality assurance process to ensure appropriate medication management and distribution methods.	
Additional Comments: **There are no additional comments for this indicator.**			

4.04 - Medical/Mental Health Alert Process		**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 4.04	**YES** If NO, explain here: The program has the required policy titled Medical and Mental Health Alert that was updated October 1, 2023 by the Director of Adolescent Residential Services.	

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

Total number of Open Files: two
Total number of Closed Files: three
Staff Position(s) Interviewed (No Staff Names): nursing staff
Type of Documentation(s) Reviewed: youth records, alert detail book, alert boards
Describe any Observations: Observations of youth records, staff and medical alert boards were made.

Youth with a medical, mental health, or food allergy was appropriately placed on the program's alert system	**Compliance**	All five youth required an alert for a medical or mental health condition or a food allergy. Each of the five youth were appropriately placed on the program's alert system.	
Alert system includes precautions concerning prescribed medications, medical/mental health conditions	**Compliance**	The alert system includes precautions concerning prescribed medications and mental and medical health conditions. Alert boards in the staff and medical offices provide information and instructions for staff on how to respond to the need for emergency medical and/or mental health care.	
Staff are provided sufficient training, information and instructions to recognize/respond to the need for emergency care for medical/mental health problems	**Compliance**	Staff are provided training, information, and instructions on how to recognize and respond to the need for emergency medical/mental health care.	
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**	Detailed alert documentation is available to staff containing pertinent information on youth medical conditions, allergies, common side effects of prescribed medications, food and medications contraindicated, and other important mental health treatment specifics. Closed youth files observed confirmed the program's practice.	

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

4.05 - Episodic/Emergency Care		**Satisfactory with 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 titled Medical and Mental Health Alert that was updated October 31, 2023 by the Director of Adolescent Residential Services.	

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

Total number of Open Files: none
Total number of Closed Files: two
Staff Position(s) Interviewed *(No Staff Names)* **:** nursing staff/ program director
Type of Documentation(s) Reviewed: episodic care log, notes and documentation from youth records, logbooks

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**	Two incidents of off-site emergency care have occurred since the last compliance review. An internal incident report was completed for one of the two incidents. One of the two incidents did not have an internal incident report completed; however, the incident was documented in the Department of Juvenile Justice Central Communications Center records. In one incident, documentation was provided upon the youth's return regarding discharge instructions and medical clearance. The other youth was discharged from the program after the incident and did not return. In both instances, the youth's parent or guardian was notified and each provided transportation for their child to retain emergency services. The daily log recorded each incident and any corresponding follow-up or instructions.	One of the two incidents did not have an internal incident report completed; however, the incident was documented in the Department of Juvenile Justice Central Communications Center records.
All staff are trained on emergency medical procedures	**Compliance**	Seven staff training records were reviewed. All of the selected staff have been trained on emergency medical procedures.	
The program has a Knife-for-life and wire cutters accessible to staff in a secure location(s)	**Compliance**	The program has two suicide response kits located in the medication cart/chart room and the living quarters.	
First aid kit/supplies are fully equipped and inventoried	**Compliance**	The program has a total of five first aid kits, with three additional first aid kits for the three program vehicles. Each kit is fully equipped and is inventoried and monitored monthly by the nursing staff.	
Additional Comments: **There are no additional comments for this indicator.**			