Florida Network for Youth and Family Services Compliance Monitoring Report for

CDS Family & Behavioral Health, Inc.
(Interface Youth Program - Central)

1400 Northwest 29th Road
Gainesville, FL 32605

January 17-18, 2024

Compliance Monitoring Services Provided by

EXECUTIVE SUMMARY

Forefront LLC conducted a Quality Improvement (QI) monitoring visit on behalf of the Florida Network of Youth and Family Services (FNYFS) for the CDS Family & Behavioral Health, Inc. - Interface Youth Program (IYP) – Central (CDS Central) for the FY 2023-2024 at its program office located at 1400 Northwest 29th Road, Gainesville, Florida 32605. Forefront LLC (Forefront) is an independent compliance monitoring firm that is contracted by FNYFS to perform onsite program reviews to assess the agency's adherence to fiscal, programmatic and overall contract requirements. CDS Central is contracted with the Florida Network of Youth and Family Services (FNYFS) to provide direct services to Children/Families in Need of Services (CINS/FINS). The services to be provided are identified in Contract Section A - Descriptions and Specifications and Section B - Delivery and Performance, and are funded with General Revenue Funds effective from July 2023 through June 30, 2024.

The review was conducted by Nitara LaTouche Consultant for Forefront LLC and Tara Gilligan, Lisa Navarez, Fatima Rogers, and Erica Summerall. Agency representatives from CDS Central present for the entrance interview were: Phil Kabler, CEO; Jessica Bechtold, Regional Director; Brian Smith, Residential Supervisor; Gonzellas Whitter, Regional Director; Belinda Ross, Residential Counselor; Vincent Lipford, Admin Assistant; D Thompson, Residential Counselor; and Evelitza Soto, SNAP Supervisor. The last onsite QI visit was conducted June 1, 2023

In general, the Reviewer found that CDS Central is in compliance with specific contract requirements. **CDS Central received an overall compliance rating of 100% for achieving full compliance with 12 indicators** of the CINS/FINS Monitoring Tool. There were no corrective actions as a result of the monitoring visit.

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

2023-2024 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 1-17-18-20232024

Agency Name: CDS Family & Behavioral Health, Inc. – IYP Central	Monitor Name: Nitara LaTouche, Lead Reviewer
Contract Type : CINS/FINS	Region/Office: 1400 Northwest 29th Road, Gainesville
Service Description: Comprehensive Onsite Compliance Monitoring	Site Visit Date(s): January 17-18, 2024

Major Programmatic Requirements	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable	Ratings Based Upon: I = Interview, O = Observation, D = Documentation, PTV = Submitted Prior To Visit (List Who and What)	Notes: Explain Unacceptable or Conditionally Acceptable:
	Explain Rating						
I. Administrative and Fiscal							
DJJ Quality Improvement Peer Reviewer a. Provider shall demonstrate that a minimum of two (2) staff members have been trained to be certified as DJJ QI Peer reviewers. Provider shall participate in a minimum of one (1) on-site quality assurance review of a similar type of program in another judicial circuit during each 12-month period of the contract, if requested.	☐	☐	☒	☐	☐	I,D: The program has three staff members that are certified as peer reviewers for this location. The agency has seven certified peers across all three program locations: Phil Kabler, Alex Culbreth, LaToya Robinson, Sabriena Williams. Naomi Thompson, Brian Smith, Kevin Lee.	**No recommendation or corrective action identified at this time.**
Additional Contracts a. Provider shall provide a listing of all current federal, state, or local government contracts, as well as other contracts entered into with for profit and not-for-profit organizations. Such a listing shall identify the awarding entity and contract start & end dates. **PTV**	☐	☐	☒	☐	☐	D,PTV: The agency provided a list of all current contracts for the FY2023-2024 including the grantees name and grant amount awarded for the fiscal term. The list included the Florida Network contracts and the 4 additional contracts through other funding sources.	**No recommendation or corrective action identified at this time.**
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	☐	☐	☐	☒	☐	D,PTV: General Liability through Berkshire Hathaway Specialty Insurance Company, for limits of coverage $1,000,000 each $3,000,000 aggregate, $20,000 individual medical, $1,000,000 personal & adv injury, and	**No recommendation or corrective action identified at this time.**

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$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**						$1,000,000 employee benefits, effective 1/10/24 – 1/10/2025. Automobile insurance through Berkshire Hathaway Specialty Insurance Company, for combined single limits of $1,000,000, and PIP Basic for $10,000. Policy effective for 1/10/24 – 1/10/2025. An umbrella liability policy through Berkshire Hathaway Specialty Insurance Company, for $1,000,000 each/aggregate. Policy effective for 1/10/24 – 1/10/2025. Workers Compensation through Bridgefield Casualty Insurance Company for $500,000 each accident. Effective 5/1/2023 – 5/1/2024. Abuse and Molestation coverage through Berkshire Hathaway Specialty Insurance Company for $1,000,000	

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						each and $3,000,000 aggregate. Effective 1/10/24 – 1/10/2025 Professional Liability Coverage through Berkshire Hathaway Specialty Insurance Company for $1,000,000 each and $3,000,000 aggregate. Effective 1/10/24 – 1/10/2025. Management Liability through the Travelers Casualty and Surety Company of America Company for $1,000,000 for D&O/EPLI, fiduciary liability and/or employee theft that is effective 4/6/2023-4/6/2024. 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**	☐	☐	☐	☐	☒	I: 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 identified at this time.**

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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**	☐	☐	☒	☐	☐	I,PTV: Agency reports that they have fiscal Policies and Procedures which are contained in the CDS and Behavioral Health Services' Financial Management Policy. The P-1257 Petty Cash Policy reviewed. The most recent update and revision is related to Fiscal policies and procedures January 2022.	**No recommendation or corrective action identified at this time.**
b. Agency maintains a general ledger and the corresponding source documents. A general ledger must be set up to track the activity of the grant separately (standard account numbers / separate funds for each revenue source, etc.). **PTV**	☐	☐	☒	☐	☐	D: Detailed General Ledger for the current FY July 2023 through December 2023 was provided and reviewed. Agency maintains a detailed general ledger that is structured to track all funding sources as well as activities for the shelter and each program separately.	**No recommendation or corrective action identified at this time.**
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**	☐	☐	☒	☐	☐	O/D: The agency reported no change in petty cash practice was reported for the agency since the last onsite program review. The petty cash is reconciled on a consistent basis (monthly/quarterly) by the Residential Supervisor and reviewed by the	**No recommendation or corrective action identified at this time.**

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	Unacceptable	**Conditionally Unacceptable**	**Fully Met**	**Exceeded**	**Not Applicable**		
						Regional Director, Comptroller/Chief Financial Officer and Chief Operations Officer. Disbursements and invoices are approved by the Regional Director.	
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**	☐	☐	☒	☐	☐	PTV,D: Agency provided Bank Statements and Bank Reconciliations for the past six months, 5/2023 – 12/2023, for one accounts held with SouthState. Financial Statements are reported on a monthly basis and were found to be current. Bank reconciliations are conducted each month for the activities and bank statements for the preceding month. Each reconciliation report includes who completed the reconciliation e.g. ProActive Tax & Accounting or Olga Rivera. Invoices are submitted on a monthly basis with supporting documentation.	**No recommendation or corrective action identified at this time.**
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	☐	☐	☐	☐	☒	I/D: The agency has not purchased any property with FNYFS funds for the current fiscal year.	**No recommendation or corrective action identified at this time.**

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equipment an Informational Resources Request (IRR) has been submitted to DJJ. **PTV/ON SITE**							
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**	☐	☐	☒	☐	☐	PTV,D: Agency provided documentation in bank statements that payroll taxes are paid each payroll period to the IRS, for the last six months.	**No recommendation or corrective action identified at this time.**
g. Budget to actual reports prepared and reviewed by appropriate management. Variance from the budget are investigated and explained. **PTV/ON SITE**	☐	☐	☒	☐	☐	PTV,D: Agency provided a year-to-date report for the current fiscal year July 2023-current. The report shows Actual, Budget, and Variance with Total Revenue Over Expense with each program having designated codes. Variances in budget are monitored on a regular basis and are discussed with the Board by the Budget and Financial Committee. If changes need to be made to the budget, then the individual shelter is notified.	**No recommendation or corrective action identified at this time.**
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	☐	☐	☒	☐	☐	D,PTV: Financial audit conducted for year ending June 30, 2022, and 2021 was completed by James Moore, C.P.A. and Consultants and dated	**No recommendation or corrective action identified at this time.**

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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**						December 6, 2022. Per the audit report, a separate Management Letter requiring a Corrective Action Plan is not required and was not issued by the auditor. The most recent audit was still in process during the time of this audit. A copy of the completed audit was submitted to the FNYFS.	
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**	☐	☐	☒	☐	☐	D: Policies and procedures for IT Confidentiality, HIPAA, Personnel Policies and Personnel Records, Record Elimination, Security, and Loss Prevention was provided for review. Accounting data files are backed-up every night. Other critical servers, microcomputers and laptops complete scheduled back-ups on a secured portable hard drive. Obsolete fiscal record documents may be shredded after six years, participant records follow the funders timeframes and personnel files for a period of not less than seven years.	**No recommendation or corrective action identified at this time.**

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j. Agency provided evidence that every direct care staff employee, as of October 1, 2023, is being paid at least $19.00 per hour. This also includes funding for additional staff as approved by the Department. **PTV/ON SITE**	☐	☐	☒	☐	☐	PTV, D: The agency provided an employee listing for all Shelter, Family Action and SNAP staff that evidences the minimum wage was increased to $19 per hour effective October 1, 2023.	**No recommendation or corrective action identified at this time.**

CONCLUSION

CDS Family & Behavioral Health, Inc. (IYP – Central) has met the requirements for the CINS/FINS contract as a result of full compliance with 12 applicable indicators of the Administrative and Fiscal Contract Monitoring Tool. Two of the twelve indicators were not applicable because 1) The agency has not purchased any property with FNYFS funds for the current fiscal year and 2) the provider indicated that there are no outstanding corrective action item(s) cited by an external funding source. Consequently, **the overall compliance rate for this contract monitoring visit is 100%.** There are no corrective actions cited 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 CDS Family & Behavioral Health Services, Inc.
Interface Youth Program (Central)
CINS/FINS Program

Date: January 17-18, 2024

FOREFRONT

CINS/FINS Rating Profile

Standard 1: Management Accountability

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

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

Standard 2: Intervention and Case Management

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

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

Standard 3: Shelter Care & Special Populations

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

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

Standard 4: Mental Health/Health Services

4.01 Healthcare Admission Screening	**Satisfactory**
4.02 Suicide Prevention	**Satisfactory**
4.03 Medications	**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: 100 %
Percent of indicators rated Limited: 0 %
Percent of indicators rated Failed: 0 %

Rating Definitions

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

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

Reviewers

Members

Nitara LaTouche - Lead Reviewer Consultant-Forefront LLC/Florida Network of Youth and Family Services
Tara Gilligan – Regional Monitor, Department of Juvenile Justice
Lisa Nevarez – Orange County Youth and Family Services
Erica Summerall – SMA Healthcare
Fatima Rodgers – Thaise Educational & Exposure Tours

Methodology

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

Persons Interviewed

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

Documents Reviewed

	Accreditation Reports	X	Table of Organization		Visitation Logs
X	Affidavit of Good Moral Character		Fire Prevention Plan	X	Youth Handbook
X	CCC Reports	X	Grievance Process/Records	8	# Health Records
X	Logbooks		Key Control Log	7	# MH/SA Records
	Continuity of Operation Plan	X	Fire Drill Log	13	# Personnel /Volunteer Records
	Contract Monitoring Reports	X	Medical and Mental Health Alerts	9	# Training Records
	Contract Scope of Services	X	Precautionary Observation Logs	13	# Youth Records (Closed)
X	Egress Plans	X	Program Schedules	19	# Youth Records (Open)
X	Fire Inspection Report	X	List of Supplemental Contracts	3	# Other: SNAP in Schools
X	Exposure Control Plan	X	Vehicle Inspection Reports		

Observations During Review

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

Surveys

6	# of Youth	17	# 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

CDS Family and Behavioral Health Services, Inc. is a private non-profit social services agency that is contracted through the Florida Network of Youth and Family Services (FNYFS) to provide Children in Need Services and Families in Need Services (CINS/FINS). The agency has offices across 3 locations in Florida; Central (Gainesville), Northwest (Lake City), and East (Palatka). The main headquarter is located in Gainesville. The CDS Family and Behavioral Health Services, Inc. - Central (CDS Central) location serves youth and families in Alachua, Gilchrist, and Levy counties. CDS Interface Youth Program Central (IYP-C) was established in 1970 and the shelter has been in existence since the agency opened. The agency held a successful groundbreaking ceremony in May 2023 to celebrate the construction of a brand new program facility to serve their at-risk youth. The new 9700 square feet facility is planned to open at the end of May/beginning of June 2024. The old shelter is planned to be used by another non-profit agency that provides services for individuals experiencing homelessness.

The following programmatic updates were provided by the agency:

Staffing:

During the past year CDS' management structure has remained stable, with the addition of a CPA as Chief Financial Officer. There is currently 2 vacancies and the agency reports not having a nurse for the past year but are continuing recruiting efforts on a nurse for this location.

Facility:

The new 20-bed Gainesville CINS/FINS shelter, which will replace the one currently being used, is under construction. We have begun planning for the transition between the two facilities. Our Board of Directors is actively involved in the entire process.

Funding/Finance:

We were recently awarded increases in our Florida Network CINS/FINS and LSF Health Systems prevention programs contract. Our U.S. HHS/Administration for Children & Families/Family & Youth Services Bureau grants related to the Gainesville and Palatka shelters were renewed for three years. As part of its internal planning process, the Partnership for Strong Families took the Independent Living in-house.

In concert with our Board of Directors and its Development Committee, we are actively engaged in a number of funding opportunities, including public and private third-party donations and grant applications. We have received funding and other support from the Clay Electric Foundation (for the IYP-Palatka shelter), Community Foundation for NE Florida (for the IYP-Lake City), Downtown Gainesville and Sunrise Rotary Clubs (for the IYP-Gainesville shelter), U.S. FEMA – Emergency Food and Shelter Program (administered by the United Way of North Central Florida; for the IYP-Gainesville shelter), and the United Way of Suwannee Valley (for the IYP-Lake City shelter). We further participated in the Amazing Give and the U.F. Campaign for Charities. Our Board of Directors has an ongoing internal donation campaign. Towards that end, our Annual Meeting and Celebration was underwritten by several business, banking, and individual donors. It is the intent of the Board's Development Committee that this sponsored event will serve as the basis for future fundraising and development activities.

Governance and Community:

The Board has expanded to 19 Members. In furtherance of a DEI initiative to make the Board better representative of the communities we serve, the Board added a number of women, male, African-American, and Latin X Members.

The Board is in the midst of preparing a new Strategic Implementation Plan and updating its Articles of Incorporation and Bylaws.

As has been done with the funding opportunities described above, CDS has increased its partnerships, and continued its ongoing partner relationships, including with: BAYS Florida; CARE Connect + BRAVE; Circuits 3 & 8 Behavioral Consortium; Children's Trust of Alachua County; Community Foundation of North Central Florida; Community Foundation for NE Florida; Eighth Judicial Circuit Bar Association; Eighth Judicial Circuit State Attorney's Office; Florida Department of Children & Families; Florida Department of Juvenile Justice (including County Councils and Circuit Advisory Boards); Florida Juvenile Justice Association; Florida Network of Youth and Family Services; Gainesville Black-on-Black Crime Task Force; Greater Gainesville Chamber of Commerce; LSF Health Systems; National Runaway Safeline; National Safe Place Network; North Central Florida Human Trafficking Task Force; Putnam Safety Alliance; United Way of North Central Florida; United Way of St. Johns County; United Way of Suwannee Valley; U.S. HHS/Administration for Children & Families/Family & Youth Services Bureau. We continue to actively pursue new partnerships and linkages.

We are also developing an ongoing program of larger community events throughout our catchment area. Our most significant events to-date have been our 2023 Annual Meeting and Celebration (featuring Susan Frankel, the National Runaway Safeline CEO, as Keynote Speaker), National Runaway Prevention Month, National Safe Place Week, and Child Abuse Prevention Week. We also participate in other local agencies' events as a supportive partner; for example, we hosted a regional SNAP Facilitators training and Motivation Interviewing, and are under consideration to host a QI Peer Reviewer Refresher course.

We have an active public presence, including a website, active Facebook, Instagram, Threads, TikTok, and LinkedIn pages for both CDS and SNAP at CDS, and a small YouTube page.
CDS and its team have received the following awards: Florida Network of Youth and Family Services 2023 Agency of the Year - CDS; DJJ Service Excellence Award - Stephanie Douglas, MA, LHMC – Family Action Program, IYP-Lake City Supervisor); North Central Florida Human Trafficking Task Force "Rise Award" – CDS Board Treasurer Frank Williams, Esq.; and National Runaway Safeline – National Runaway Prevention Month "Greenest Team" Finalist - CDS.

Community Counseling/Family Action Updates:

Family Action-Central has been extremely active with counseling and outreach and as we continue to use schools as a resource, our referrals continue to increase. Family Action counselors continue to offer both face to face and remote counseling services and are able to provide sessions at school and within the home if appropriate.

At the beginning of 2023, Family Action began to provide groups to participants in the Teen Court program through the Alachua County Sherriff's office. The groups were so successful that we decided to also offer them within schools. We are now providing groups for the Sherriff's Office, Westwood Middle School and soon will be offering groups in Ft. Clarke middle school. Family Action continues to hold consistent Case Staffing meetings and attends SARB meetings for issues related to truancy. Family Action team members have participated in outreach with University of Florida (UF), Gainesville Police Department (GPD), Bays Florida, Department of Children and Families (DCF), Alachua County Student Services and have renewed our collaborative agreement with the University of Florida. We are currently hosting Master's internship opportunities for one University of Florida student, one Bonaventure student and one St. Leo University student. Administratively, and since last audit, we have one Administrative position open and are in the final stages of the recruiting process. The team received a rate increase in the Fall of 2023 for staff retention which has significantly improved counselor turn over rates.

Shelter/Interface Youth Program (IYP) Updates:

1. On May 10, 2023, CDS celebrated a huge milestone with the Groundbreaking Ceremony of the New Interface Youth Program Central Shelter. The completion of this exciting project will be 2024.

2. The 2023 Summer Enrichment Program at Interface Youth Program Central began on June 5, 2023 and concluded on July 28, 2023. Our participants had the opportunity to enjoy a variety of educational, community and leisure activities that promoted self-development, cooperation and exploration through tours and presentation.

3. Interface Youth Program Central purchased a New Dryer and a New Ice Machine in order to enhance our ability to satisfy the needs of our participants and create a home like environment.

4. During this reporting period, four (4) IYP-C staff were terminated / resigned and five (5) were hired. Currently, IYP-C has 21 employees, this includes: Regional Director, Residential Supervisor, 2 Full Time Residential Counselors, 1 Senior Youth Care Worker, 1 Residential Administrative Assistant, 1 Part Time Cook, 1 Part Time House Manager, 3 Full Time YCW's, 8 Part Time YCW's and 2 PRN YCW's. IYP-C will continue to focus on hiring additional Youth Care Workers in order to satisfy Program expectations.

5. Congratulations to Brian Smith, Residential Supervisor and Kevin Lee, Senior Youth Care Worker who are now Certified Peer Reviewers with FOREFRONT. They successfully completed the Certified Peer Reviewer Training on September 27-28, 2023 at the Hillsborough County Children's Services Fellowship Hall in Tampa, Florida.

6. Congratulations to Naomi Thompson, Residential Counselor who is now the Human Trafficking Train the Trainer for the Department of Children and Families and CDS. Naomi successfully completed the Human Trafficking Train the Trainer at the Department of Children and Families Auditorium in Jacksonville, Florida, on October 16-18, 2023.

7. Congratulations to Kevin Lee, Senior Youth Care Worker who received the Interface Youth Program Central Employee of the Year Award at the CDS 2023 Annual Celebration Meeting at Fairfield Inn & Suites on November 10, 2023. In addition, congratulations to Youth Care Worker, Gretchen Strickland, who received a 10 Year Longevity Recognition Award at that CDS 2023 Annual Celebration Meeting.

8. Our staff enjoyed a Christmas Day Celebration at Interface Youth Program Central on December 15, 2023 from 4pm until 6pm, which included a variety of interactive fun activities, gift exchange, delicious food and good music. Youth Care Worker - Anita McCarter, Youth Care Worker - Nadia Mathews, House Manager - Joe Mattox, and Cook - Ken Welcome facilitated this Christmas Day Celebration.

9. We are very thankful to the following Community Partners for their generous Christmas donations to our participants: (1). Planned Parenthood (2). Pastor Bill and Vickie Davenport with Ridgeview Baptist Church (3). Christmas donations from Josie Callcci.

Our goal is to continue providing Residential Services to children at risk and their families who are in crisis. We are motivated to teach our participants to become tax payers and not tax burdens and to empower their parents with behavioral strategies and community referral resources.

Narrative Summary

The services provided under the CINS/FINS contract with the FNYFS allow the agency to serve all eligible youth between the ages of ten to seventeen years old that are runaway, ungovernable and/or truant, locked out, homeless, abused, neglected, or possess other at-risk factors. The agency provides specialized services to eligible youth with other profiles such as Staff Secure shelter, Domestic Minor Sex Trafficking, Domestic Violence, Probation Respite, Family/Youth Respite Aftercare Services (FYRAC), and provides services for eligible youth through Stop Now and Plan (SNAP). The youth census during the onsite QI program review visit was three (3) CINS/FINS youth. The CDS organization is currently accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF).

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

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

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

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

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

CINS/FINS QUALITY IMPROVEMENT TOOL

Quality Improvement Indicators and Results: Please select the appropriate outcome for each indicator for each item within the indicator.		**Summary/Narrative Findings:** The narrative write-up is a thorough summary of each assigned QI indicator worksheet, explain how you came to your finding(s).	**Deficiencies/Exceptions:** Please add additional detailed explanations for any items that have any deficiencies or exceptions.
Standard One – Management Accountability			
1.01: Background Screening of Employees, Contractors and Volunteers			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 1.01		**YES** If NO, explain here: The agency has three policies for this indicator; P-1292 Pre-employment Suitability Assessment that was last revised 1/24, P-1268 E-Verify Policy that was last revised 3/14, and P-1025 Background Check, Reference Check, Fingerprinting for Personnel, Volunteers or Interns that was last revised 7/23 by the CEO.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of New Hire Employee/Intern/Volunteer Files: 10 files **Total number of 5 Year Re-screen Employee Files: 3** **Staff Position(s) Interviewed** *(No Staff Names)* **: COO, HR, Regional Director** **Type of Documentation(s) Reviewed: Staff files, clearinghouse roster** **Describe any Observations: HR staff advised that Clearinghouse roster is inaccurate and agency doesn't have access to update or correct errors so agency maintains a separate manual list to track staff background screenings timely.**			
All positions providing direct services to youth has successfully passed pre-employment suitability assessment on the initial attempt.	**Compliance**	Nine files were applicable for new hire staff. The agency utilizes the Criteria Candidate Summary screening tool for suitability assessment. The agency provided evidence that all nine staff successfully passed pre-employment suitability assessment prior to date of hire.	
For any applicant that did not pass the initial suitability assessment, there was evidence that the applicant retook the assessment and passed within five (5) business days of the initial attempt, not exceeding three (3) attempts within thirty (30) days.	**No eligible items for review**	Per interview with the COO, the agency does not consider applicants that do not pass the initial suitability assessment.	

Agency has evidence for employees who have had a break in service for 18 months or more, and/or when the agency had a change or update in the suitability assessment tool used was different from the employee's original assessment, that a new suitability assessment and background screening was completed as required.	**No eligible items for review**	The agency reported there have been no employees who have had a break in service for 18 months or more.	
Background screening completed prior to hire/start date (or exemption obtained prior to working with youth if rated ineligible) for new hires, volunteers/interns, and contractors. *(Employees who have had a break in service and are in good standing may be reemployed with the same agency without background screening if the break is less than 90 days.)*	**Compliance**	One volunteer and ten new hire files were reviewed for initial background screening and all files contained evidence the screening was completed prior to hire with an eligible rating.	
Five-year re-screening is completed every 5 years from initial date of hire or prior to retained fingerprints expiration date.	**Compliance**	Three staff files were reviewed for re-screening and all three files were completed within the required timeframe or prior to the retained fingerprints expiration date.	
Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?	**Compliance**	The agency provided email confirmation that the Annual Affidavit of Compliance with Level 2 Screening Standards was completed and sent to BSU on January 10, 2024.	
Proof of E-Verify for all new employees obtained from the Department of Homeland Security	**Compliance**	Nine new employee files reviewed contained the required proof of E-Verify from the Department of Homeland Security.	
Additional Comments: **There are no additional comments for this indicator.**			
1.02: Provision of an Abuse Free Environment			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 1.02		**NO**	
		If NO, explain here: P1105 is missing the mention of maintaining for 1 year.	
		The agency has five policies for this indicator; P1044 - Florida Abuse Reporting which was last revised 2/09, P1105 - Complaint/Grievance Process for Participants or Companions with Disabilities last revised 11/22, P1032 - Behavioral Expectations for Staff last revised 2/22, P1128 - Rule Violations last revised 1/16, and P1212 - Standards of Conduct last revised 12/17 which were all approved by the CEO.	

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

Staff Position(s) Interviewed *(No Staff Names)* **: Residential counselors, Regional Director, Program Supervisor**
Type of Documentation(s) Reviewed: Policies, grievance forms,
Describe any Observations: girls and boys living areas, tour of facility

Agency has a code of conduct of policy and there is evidence that staff are aware of agency's code of conduct.	**Compliance**	The agency has a code of conduct that informs staff of expectations of acceptable conduct. The Rule Violation policy outlines the expectations and guidelines of staff interactions with youth. None of the nine staff surveys received reported observing threats, profanity, intimidation or humiliation when interacting with youth.	
The agency has a process in place for reporting and documenting child abuse hotline calls.	**Compliance**	The agency has several policies that relate to reporting and documenting child abuse calls. The program had a total of six child abuse calls in last 6 months; four calls pertained to parent/guardians and two calls pertained to a close relative. There were no abuse calls observed, during the period of review, involving the program.	
Youth were informed of the Abuse and Contact Number	**Compliance**	The agency has signage posted including the Abuse Hotline, Rights of Youth, and the Search Policy to inform youth of their rights and how to contact the abuse hotline. All youth surveyed reported knowing about the abuse hotline and denied being stopped or delayed if needing to make a call.	
Grievance			
Grievances are maintained on file at minimum for 1 year.	**Compliance**	The agency maintains a binder for grievances.	
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 formal grievance protocol for youth which is posted and accessible in the living areas for both the girls and boys areas. Each area contains grievance forms and a locked box for youth to access.	

There is evidence that grievance boxes are checked by management or a designated supervisor at least daily as evidenced in the program logbook.	**Exception**	Examples of logbook entries completed by residential staff on 10/24/23 and 1/7/24 was provided as evidence of completed grievance box checks during the 6 month timeframe. There was not evidence in the logbook of daily entries by management or designated supervisor as required per the current standard. On day 2, management staff provided follow-up they received a note left in the grievance box by this QI review team as observation of practice in checking the grievance box.	Missing consistent documentation of grievance boxes being checked daily in logbook. The program's residential counseling staff are currently checking grievance boxes and not management staff as required per standard.
All grievances are resolved within 72 hours and documented by program director/supervisor or escalated to higher leadership if grievance involves them directly.	**Compliance**	The past six months of grievances were reviewed. All grievances were resolved within 72 hours and initially reviewed by the residential counselor staff or Program Supervisor. Grievances are escalated to the Regional Director if necessary. Regional Director reviews and maintains grievances submitted in binder/grievance log.	

Additional Comments: **One youth reported hearing a YCW use a curse word when speaking to another youth. All six youth surveyed denied hearing adults threaten any**

1.03: Incident Reporting		**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 1.03	**YES**	
	If NO, explain here:	
	The agency has a policy P-1045 Incident Reporting Procedure that was last revised on 6/23 by the CEO.	

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

Staff Position(s) Interviewed *(No Staff Names)* **: Residential Supervisor**
Type of Documentation(s) Reviewed: Agency's Policy; Agency's Incident Report Book/Incident Reports; CCC's Follow-Up Documents/Emails & Agency's Log Book
Describe any Observations: The agency had seven CCC reports within the last six months. All CCC reports were provided and reviewed. All of the CCC reports were submitted within two hours of the incident occurring or as soon as the incident was learned about. Every follow-up that the CCC requested or required was completed as asked. It was noted that some of the CCC reports were documented on the daily log sheet as they occurred, however, some were not. All of the seven CCC calls were documented on the daily log book summary sheet, which met the requirement for Indicator 1.03. Each incident was documented using the organization's incident forms and was consistently reported to CCC. The supervisor properly signed each of the reviewed incident reports.

During the past 6 months, the program notified the Department's CCC (Central Communication Center) no later than two hours after any reportable incident occurred or within two hours of the program learning of the incident	**Compliance**	During the past 6 months, there was evidence that the agency notified the Department's CCC (Central Communication Center) of all seven applicable incidents no later than two hours after any reportable incident occurred or within two hours of the program learning of the incident.	

The program completes follow-up communication tasks/special instructions as required by the CCC	**Compliance**	The agency did complete all follow-up communication tasks/special instructions as required by the CCC for all seven incidents.	
Agency internal incidents are documented on incident reporting forms and all CCC reportable incidents were consistently reported to CCC as required.	**Compliance**	The agency's internal incidents are documented on incident reporting forms, and all CCC reportable incidents were consistently reported to CCC as required.	
Incidents are documented in the program logs and on incident reporting forms	**Compliance**	The following types of incidents were observed: 1 - program disruption incident, 3 - medical incidents, and 3 - mental health/substance abuse incidents. The agency documented all incidents in the agency's log book and on incident reporting forms.	
All incident reports are reviewed and signed by program supervisors/ directors	**Compliance**	All incident reports were reviewed and signed by the program supervisors/directors.	
Additional Comments: **There are no additional comments for this indicator.**			
1.04: Training Requirements *(Staff receives training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions)*			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 1.04		**YES** If NO, explain here: The agency has a policy P-1030 Training Policy that was last revised 6/23 by the CEO.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of New Hire Staff Files: 5 **Total number of Annual In-Service Staff Files: 4** **Total number of Non-Licensed Mental Health Clinical Shelter Staff Files: 9** **Annual Training Plan Timeframe** (*Program timeframe for annual trainings*)**: Fiscal Year (7/1/2022-6/30/2023)** **Staff Position(s) Interviewed** *(No Staff Names)*: **Non- Residential and Residential Supervisor** **Type of Documentation(s) Reviewed: Agency Staff Roster, Employee Training Files, Agency Training Policy**			
First Year Direct Care Staff			
All direct care staff have completed new hire pre-service training requirements for safety and supervision as required.	**Exception**	Five staff files were reviewed for completion of the new hire pre-service requirements. Four staff files contained evidence that all trainings were complete for safety and supervision.	One SNAP employee staff file reviewed was missing two trainings (Confidentiality and Fire Safety equipment) within the 90 days as required.

All staff completed the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days from date of hire.	**Exception**	Four out of the five new hire employees completed the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days from date of hire, as required.	One SNAP staff (DOH January 2023) file reviewed was missing the DOJ training within timeframe required.
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**	There are four of the five employees who are still within their first year timeframe to complete all required training, however, two of these four staff have already exceeded 100 hours. One staff member has 56.7 hours so far and 12 days to complete the remaining hours.	One direct care CINS/FINS staff has obtained 42.5 hours in total, which is below the minimum of 80 training hours within the first full year of employment.
All staff receives all mandatory training during the first 90 days of employment from date of hire.	**Exception**	Out of the five new employee training files reviewed, four staff files (two residential and two community counseling staff) demonstrated staff completed the mandatory training during the first 90 days of employment from date of hire.	One staff file reviewed was missing 16 mandatory training required within the first 90 days of employment and had four completed late. The missed training include: Child Abuse: Recognition, Reporting and Prevention; Civil Rights & Federal Funds; Human Trafficking Intervention; Information Security; PREA 1 & 2; Sexual Harassment; Trauma Responsive Practices; CPR & First Aid; CINS/FINS Core; Adverse Childhood Experience; FL Network Suicide Prevention; Signs and Symptoms of Mental Health and Substance Abuse; and Universal Precaution.
Staff Required to Complete Data Entry for NIRVANA or access the Florida Department of Juvenile Justice Information System (JJIS)			
Any designated staff that is responsible for entering NIRVANA or ensuring accurate and complete data entry in the Florida Department of Juvenile Justice Information System (JJIS) have completed all of the required trainings.	**Compliance**	Three out of three applicable staff 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.	
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*	**Compliance**	The agency was able to provide proof of Documentation of instructor led FL Statute 984 CINS Petition Training by a local DJJ Attorney for the two applicable files that met this requirement on 11/7/23.	

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).	**Not Applicable**	The agency did not have any staff that met this requirement for the period reviewed.	
In-Service Direct Care Staff			
Direct care staff completes 24 hours of mandatory refresher Florida Network, SkillPro, and job-related training annually *(40 hours if the program has a DCF child caring license).*	**Exception**	All direct care staff must complete 24 hours (40 hours for shelter) of mandatory refresher Florida Network, SkillPro, and job-related training annually as required. Three of four staff files reviewed exceeded 40 hours for their annual training hours.	One shelter staff file reviewed obtained 29 of the 40 hours required.
Required Training Documentation			
The agency has a training plan that includes all of the required training topics including the pre-service and in-service.	**Compliance**	The agency has a training plan in place that includes all of the required training topics including the pre-service and in-service.	
The agency has a designated staff member responsible to manage all employee's individual training files and completes routine tracking and reviews of staff files to ensure compliance.	**Compliance**	The agency does have 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. Each respective Director is responsible for the program staff they supervise.	
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.	**Exception**	The program does maintain and individual training file for each employee with a training log and related training documentation. The majority of the training log requirements were present on the training logs being used by the program, however, it was noted that each program type uses their own form specific to the trainings required for their staff.	The standard mandates that the agency create a training log, with required fields. Two required fields were not present on all training forms. The agency amended the forms on Day 2 to include the missing fields: cumulative totals and tracking method.
Additional Comments: **There are no additional comments for this indicator.**			

1.05 - Analyzing and Reporting Information		**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 1.05	**YES** If NO, explain here: The agency has four policies that meet the requirement for this indicator; P-1049, 1077, 1079, 1180 which were all reviewed by the CEO.	

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

Staff Position(s) Interviewed *(No Staff Names)* **: COO, Regional Director, Clinical Director**

Type of Documentation(s) Reviewed: Staff Meeting Minutes, Board communication and correspondence with staff.

Case record review reports demonstrate reviews are conducted quarterly, at a minimum	**Exception**	The program has a process in place that reviews the youth records for missing information or areas that need to be addressed individually across all files. Each residential counselor reviews the other counselors' files in a peer review process. The community counseling program presented evidence of two quarters of summary reports of peer reviews for Quarter 4 and Quarter 1. The results of the peer review summary report is shared in a subsequent team meeting.	The residential program completed reviews of youth records but did not have evidence of a summary report of case record reviews, identifying compliance with the CINS/FINS requirements that is reviewed by management and communicated with staff on a quarterly basis.
The program conducts reviews of incidents, accidents, and grievances quarterly, at a minimum	**Compliance**	The agency has a robust quality improvement initiative that includes the COO, Regional Directors and CINS/FINS Managers across all three locations. A sample of monthly meeting minutes was provided for review. The program demonstrated the program conducts reviews of incidents, accidents, and grievances on a monthly basis. The program has an established meeting minute template to address these issues with the following topic categories: Health & safety, Quality Improvement and Risk Management. Leadership will communicate incidents, trends or other relevant information in subsequent staff meetings as required.	
The program conducts an annual review of customer satisfaction data	**Compliance**	The program demonstrated evidence that the program conducts a review of customer satisfaction on an annual basis. Annual review of outcome data and customer satisfaction was discussed under Business Operations and Quality Improvement categories in the Nov 2023 staff meeting minutes.	
The program conducts an annual review of outcome data and (if applicable) there is evidence of annual reconciliation that occurs through communication from the Florida Network via email or phone call when corrections are needed and the information is corrected and submitted within the requested timeframes.	**Compliance**	The program provided staff meeting minutes to demonstrate they conduct a review of outcome data on a monthly basis which exceeds the annual requirement. The data reconciliation on an ongoing basis between staff and leadership each month or when issues are identified.	

The program has a process in place to review and improve accuracy of data entry & collection	**Compliance**	The program has a process in place to review and improve accuracy of data entry & collection. Senior leadership was interviewed about this process and shared how staff are involved to address any areas needed.	
There is documentation that findings are regularly reviewed by management and communicated to staff and stakeholders.	**Compliance**	Staff meeting minutes demonstrate that findings are regularly reviewed by management and communicated to staff and stakeholders. The agency has different meetings by type of program and includes the leadership necessary for that meeting type. Executive Management Team (EMT) will regularly review performance measures and outcomes and communicate next steps to leadership staff across all three locations.	
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**	There was email correspondence provided that demonstrated the final report was provided to the Board of Directors electronically. Board Meeting Minutes demonstrated ongoing discussion of performance and communication regarding the service delivery and programmatic outcomes are discussed. Email correspondence provided for January 2024 as evidence of communication with the Board.	
There is evidence that strengths and weaknesses are identified, improvements are implemented or modified, and staff are informed and involved throughout the process.	**Compliance**	The program has a Quality Improvement Committee that identifies internal strengths and weaknesses. The program's internal process includes the UER Committee which includes both the CEO and COO. The agency's utilizes meeting minutes and internal reports to monitor and track the status of any improvements implemented or modified, and staff meeting minutes demonstrate that staff are informed and involved throughout the process.	
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		**NO** If NO, explain here: Program policy will need to be updated to include requirement of check ins when single youth transports occur. The agency has a Transportation policy P-1013 which was revised by the CEO in January 2024.	

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: Past 6 months **Type of Documentation(s) Reviewed: Program logbook, Transportation records, Employee's Drivers Licenses**			
Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	**Compliance**	The agency's policies and procedures were reviewed and found to be compliant with all requirements pertaining to driver eligibility. The agency produced a list of approved drivers for this service region.	
Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	**Compliance**	The agency produced a list of approved driver's for this service region. Ten staff are authorized to transport clients, and all ten had a valid drivers license.	
Agency's Transportation policy prohibit transporting a client without maintaining at least one other passenger in the vehicle during the trip and include exceptions in the event that a 3rd party is NOT present in the vehicle while transporting	**Compliance**	The agency policy does not allow a transport in a single transport situation with the exception of an approved third party not being available.	
In the event that a 3rd party cannot be obtained for transport, the agency's supervisor or managerial personnel consider the clients' history, evaluation, and recent behavior	**Compliance**	The agency policy required the agency's supervisor or managerial personnel consider the clients' history, evaluation, and recent behavior if a third party cannot be obtained.	
The 3rd party is an approved volunteer, intern, agency staff, or other youth	**Compliance**	The agency policy requires the third party 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.	**Compliance**	The agency had policy which requires the regional director be made aware and grant approval for single transport events. The agency had six total single youth transports for the review period. All six demonstrated the agency maintained written verification that supervisor approval was obtained prior to all single youth transports. The program did demonstrate the practice of transporting employee completing a check-in for return which was documented in five of six events with the senior management leader but only one noted it was by phone.	

There is documentation of use of vehicle that notes name or initials of driver, date and time, mileage, number of passengers, purpose of travel and location.	**Compliance**	The agency utilizes a Travel Log form which was reviewed and documented the name or initials of the driver, date and time the vehicle is in use, mileage, number of passengers, purpose of travel and location.	

Additional Comments: Two separate youth transports on September 15, 2023, at 8am and 2pm showed the authorization and departure, but no logbook entry of return, on September 18, 2023, at 7:47am, the transport shows authorization and departure, but not return. September 19, 2023 was authorized at 7:43 am, but there was no indication the phone call was made for departure or arrival, September 20, 2023, was authorized at 7:52am and shows the departure, but not the return, on September 21, 2023, the authorization, departure and return were all recorded as required, but did not expressly state the information was provided by phone call.

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: P-1050; Outreach Plan for Targeting Youth For Program Services was reviewed and approved by the CEO.	

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

Staff Position(s) Interviewed *(No Staff Names)*: Non Residential and Residential Supervisor
Describe any Observations: The organization maintains an Outreach Binder that documents all of the outreach activities that were carried out all year long. Three non-residential and two residential outreach forms, totaling five outreach forms/activities were reviewed. Program access and education were included in the outreach activity forms. Staff participation and minutes were included in the outreach activity forms. Two of the five outreach activities (residential) were not recorded in Netmis, while three of the five outreach activities (non-residential) were recorded in Netmis. The Agency's Outreach Form served as a record of every outreach activity. The agency did, however, enter the previously noted outreach forms into Netmis as required on day two of the review.

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.	**No eligible items for review**	COO interviewed regarding DJJ meetings and provided email documentation to verify postponed CAB and DJJ meetings for their circuit. There was no eligible items to review for the review period. Email communication demonstrated the program's engagement with DJJ board is ongoing.	
The program maintains written agreements with other community partners which include services provided and a comprehensive referral process.	**Compliance**	The agency had and produces written agreements with other community partners, which include services provided and a comprehensive referral process.	

The program will maintain documentation of outreach activities and enter into NetMIS the title, date, duration (hours), zip code, location description, estimated number of people reached, modality, target audience and topic.	**Exception**	The program did maintain documentation of outreach activities and entered three of the five outreach services into NetMIS, which listed the title, date, duration (hours), zip code, location description, estimated number of people reached, modality, target audience and topic. All five outreach efforts that were assessed had and evidence of individual meetings, presentations, and the distribution of program material. Three of the five outreach activities (non-residential) were recorded in Netmis.	Two of the five outreach activities were not recorded in Netmis. The Agency's Outreach Form served as a record of every outreach activity.
The program has designated staff that conducts outreach which is defined in their job description.	**Compliance**	The program utilizes two positions to primarily conduct outreach; the Clinical Director for Community Counseling and the House Manager for the Shelter.	
Additional Comments: **There are no additional comments for this indicator.**			
2.01 - Screening and Intake			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 2.01		**YES** If NO, explain here: The agency has two policies that meet the indicator; policy #1112/Screening Process (1/24) and policy #1151/Intake Assessment (7/23) were both approved by the CEO.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open (Residential & Community) Files: 4 Open Files - All Community Counseling **Total number of Closed (Residential & Community) Files: 6 Closed Files- 2 Community Counseling, 4 Residential** **Type of Documentation(s) Reviewed: Youth Records, Agency Policy**			
Shelter youth: Eligibility screening is completed immediately for all shelter placement inquiries.	**Compliance**	The agency policy requires eligibility screenings of youth for all shelter placements. Four residential records were reviewed which contained required screenings.	
Community counseling: Eligibility screening is completed within 3 business days of referral by a trained staff using the Florida Network screening form.	**Exception**	The agency has a policy which requires eligibility screening of youth within 3 business days. Six youth records were reviewed (4 open and 2 closed). Four files had evidence the screening was completed within the required timeframes.	One community counseling file received a referral on 10/23/23 and the screening was not completed until 10/31/23. A second community counseling file received a referral on 12/5/23 and the screening was not completed until 12/11/23.

There is evidence all referrals for service is screened for eligibility and is logged in NetMIS within 72 hours of screening completion.	**Compliance**	The agency requires that all eligible youth are logged into Netmis within 72 hours. 10 youth records were reviewed and all 10 were entered within the required time period.	
Youth and parents/guardians receive the following in writing: a. Available service options b. Rights and responsibilities of youth and parents/guardians	**Compliance**	The program has procedures which require the youth and parents receive documentation about the program in writing of available service options and rights and responsibilities of the youth and parent. 10 youth records were reviewed and all had verification the information was provided to both the youth and the parents.	
The following is also available to the youth and parents/guardians: a. Possible actions occurring through involvement with CINS/FINS services (case staffing committee, CINS petition, CINS adjudication) b. Grievance procedures	**Compliance**	The program has a policy which requires information about possible additional actions and grievance procedures be provided to the youth and the parent. 10 youth files were reviewed and all provided documentation this information was provided to the youth and the parents.	
During intake, all youth were screened for suicidality and assessed as required if needed.	**Compliance**	The program has a policy which requires all youth are screened for suicidality at intake in a location where the youth can feel safe and heard. Nine of 10 were conducted in the program office and one was conducted virtually. 10 youth files were reviewed and all provided documentation that the youth were screened. Four of the records indicated the youth responded "yes" and all Four records include documentation that additional screening and assessment was completed in a timely manner by a qualified staff member.	

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

2.02 - Needs Assessment			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 2.02		**YES** If NO, explain here: The agency has a policy P-1019/Needs Assessment last revised on 7/23 by CEO.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open (Residential & Community) Files: 4 Open Files - All Community Counseling **Total number of Closed (Residential & Community) Files: 6 Closed Files- 2 Community Counseling, 4 Residential** **Type of Documentation(s) Reviewed: Youth Records, Agency Policy**			
Shelter Youth: NIRVANA is initiated within 72 hours of admission	**Compliance**	Six youth records were reviewed for residential youth and all files had a NIRVANA initiated within 72 hours of admission.	
Non-Residential youth: NIRVANA is initiated at intake and completed within 2 to 3 face-to-face contacts after the initial intake **OR** updated, if most recent assessment is over 6 months old	**Compliance**	Four youth records were reviewed for residential youth. All records indicate a NIRVANA was initiated at intake. All were completed within 2-3 face-to-face contacts.	
Supervisor signatures is documented for all completed NIRVANA assessments and/or the chronological note and/or interview guide that is located in the youths' file.	**Compliance**	10 youth records were reviewed and all were signed by the Supervisor, and has the assessments included in the files.	
(Shelter Only) NIRVANA Self-Assessment (NSR) is completed within 24 hours of youth being admitted into shelter. If unable to complete, there must be documentation in NetMIS and the youth's file explaining the barriers to completion.	**Compliance**	Four youth records were reviewed for residential youth. All included a NIRVANA Self Assessment and was completed within 24 hours of the youth being admitted.	
A NIRVANA Post-Assessment is completed at discharge for all youth who have a length of stay that is greater than 30 days.	**Compliance**	10 youth records were reviewed. Four had a NIRVANA Post Assessment completed and the remaining 6 files it was not applicable.	
A NIRVANA Re-Assessment is completed every 90 days excluding files for youth receiving SNAP services.	**Compliance**	10 youth records were reviewed. Three records were applicable and had the NIRVANA Re-Assessment completed every 90 days.	
All files include the interview guide and/or printed NIRVANA.	**Compliance**	10 youth records were reviewed and all included the required documentation.	
Additional Comments: **There are no additional comments for this indicator.**			

2.03 - Case/Service Plan			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.03		**YES** If NO, explain here: The agency has a policy P-1162 Individual Plan DJJ/QA last reviewed on 7/23 by CEO.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open (Residential & Community) Files: 4 Open Community Counseling **Total number of Closed (Residential & Community) Files: 6 Closed(2 Community Counseling, 4 Residential)** **Type of Documentation(s) Reviewed: Youth Records, Agency Policy**			
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**	10 youth records were reviewed (four open community counseling, two closed community counseling, and four open residential). All files included a case plan based on information received from the Nirvana assessment.	
Case/Service plan is developed within 7 working days of NIRVANA	**Compliance**	10 youth records were reviewed. All files included a case/service plan developed within 7 days of the completed 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	**Compliance**	10 youth records were reviewed and all files included the required elements for a complete case/service plan.	
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**	10 youth records were reviewed. Of these files, six files had the case/service plan reviewed by the counselor and parent. Four files were not applicable due to youth discharge occurred prior to 30 days.	
Additional Comments: **There are no additional comments for this indicator.**			

2.04 - Case Management and Service Delivery			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 2.04		**YES** If NO, explain here: The agency has a Policy P-1163 Case Management, Counseling & Service Delivery and was last reviewed 1/24 by CEO.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open (Residential & Community) Files: 4 Open Files - All Community Counseling **Total number of Closed (Residential & Community) Files: 6 Closed Files- 2 Community Counseling, 4 Residential** **Type of Documentation(s) Reviewed: Youth records, agency policy**			
Counselor/Case Manager is assigned	**Compliance**	All 10 files reviewed had a counselor/case manager assigned.	
The Counselor/Case Manager completes the following as applicable: 1. Establishes referral needs and coordinates referrals to services based upon the on-going assessment of the youth's/family's problems and needs 2. Coordinates service plan implementation 3. Monitors youth's/family's progress in services 4. Provides support for families 5. Monitoring of progress for court ordered youth in shelter 6. Makes referrals to the case staffing to address problems and needs of the youth/family 7. Accompanies youth and parent/guardian to court hearings and related appointments 8. Refers the youth/family for additional services when appropriate 9. Provides case monitoring and reviews court orders 10. Provides case termination notes 11. Provides follow-up after 30 days of exit 12. Provides follow-up after 60 days of exit	**Compliance**	All 10 youth records were reviewed and demonstrated evidence that each file included documentation that the counselor/case manager assigned completed all of the applicable requirements: Establishes referral needs and coordinates referrals to services based upon the on-going assessment of the youth's/family's problems and needs, Coordinates service plan implementation, Monitors youth's/family's progress in services, Provides support for families, Provides ongoing case monitoring, and Refers the youth/family for additional services when appropriate. All three applicable cases demonstrated the monitoring of progress for court ordered youth in shelter. Two applicable cases demonstrated the case manager makes referrals to the case staffing to address problems and needs of the youth/family as needed. One applicable case demonstrated the case manager accompanies youth and parent/guardian to court hearings and related appointments. All four applicable cases had evidence of the case termination summary as required. All eight applicable cases had evidence of the 30 and 60 day follow-ups completed as required.	

The program maintains written agreements with other community partners that include services provided and a comprehensive referral process	**Compliance**	The agency provided written agreements with other community partners. Upon review, the program has agreements with several other community partners.	
Additional Comments: **There are no additional comments for this indicator.**			
2.05 - Counseling Services			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.05		**YES** If NO, explain here: The agency has 2 policies that meet this indicator; P-1163/ Case Management & Service Delivery & P-1135 30/60 day Follow up was approved by CEO.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open (Residential & Community) 4 Open Files - All Community Counseling **Total number of Closed (Residential & Community) Files: 6 Closed Files- 2 Community Counseling, 4 Residential** **Type of Documentation(s) Reviewed: Youth records, agency policy**			
Shelter Program			
Shelter programs provides individual and family counseling	**Compliance**	The shelter does provide individual and family counseling as evident by the four residential files reviewed.	
Group counseling sessions held a minimum of five days per week	**Compliance**	Group counseling sessions reviewed included documentation that group sessions are held at minimum of 5 days per week.	
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**	Groups were reviewed and demonstrated that each group had a clear facilitator, relevant topics, opportunities for youth to participate, and each session was 30 minutes or longer.	
Documentation of groups must include date and time, a list of participants, length of time, and topic.	**Compliance**	Four residential youth records were reviewed and included all of the required documentation.	

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**	Six community counseling youth records were reviewed. All records included required documentation that evidence services provide the necessary intervention to stabilize the 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 10 youth records reviewed indicated coordination between presenting issue, assessment, case/service plan, case management are receiving services in accordance with service plan.	
Maintain individual case files on all youth and adhere to all laws regarding confidentiality	**Compliance**	All10 youth records reviewed were in compliance with all laws pertaining to confidentiality.	
Case notes maintained for all counseling services provided and documents youth's progress	**Compliance**	All 10 youth records reviewed included case notes documenting the youth's progress.	
On-going internal process that ensures clinical reviews of case records and staff performance	**Compliance**	All 10 youth records reviewed included documentation of an internal review of case records.	
Additional Comments: **There are no additional comments for this indicator.**			

2.06 - Adjudication/Petition Process		**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.06	**YES**	
	If NO, explain here:	
	The agency had 2 policies for this indicator; #P-1159/Case Staffing Committee :Parent(2/08) #P-1160/Case Staffing: Plan of Service (2/08), both were approved by the CEO.	

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

Total number of Open (Residential & Community) Files: 1 Community
Total number of Closed (Residential & Community) Files: 2 Community
Type of Documentation(s) Reviewed: Youth Records, Agency Policy

Must include: a. DJJ rep. or CINS/FINS provider b. Local school district representative	**Compliance**	All three youth records reviewed included documentation required of CINS FINS or DJJ provider and 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**	All three youth records reviewed included evidence of other members involved in the case staffing committee.	
The program has an established case staffing committee, and has regular communication with committee members	**Compliance**	The program provided verification of an established case staffing committee.	
The program has an internal procedure for the case staffing process, including a schedule for committee meetings	**Compliance**	The agency's internal procedures for case staffing were provided for review and supporting evidence included a schedule of committee meetings.	
The youth and family are provided a new or revised plan for services	**Compliance**	All three youth records reviewed indicated that the youth and families were provided with new and/ or revised plan for services.	
Written report is provided to the parent/guardian within 7 days of the case staffing meeting, outlining recommendations and reasons behind the recommendations	**Compliance**	All three youth records included documentation that a written report was provided to the parent/guardian within 7 days of the case staffing.	
If applicable, the program works with the circuit court for judicial intervention for the youth/family	**Compliance**	All three youth records included documentation that the program works with the circuit court for judicial intervention for the youth and or family.	

Case Manager/Counselor completes a review summary prior to the court hearing	**Compliance**	All three youth records reviewed included documentation that a case manager/counselor completed a review summary prior to the court hearing.	
Additional Comments: **There are no additional comments for this indicator.**			
2.07 - Youth Records			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.07		**YES**	
		If NO, explain here:	
		The agency has a policy P-1046 Youth Case Record which was last revised 7/23 and approved by the CEO.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Staff Position(s) Interviewed *(No Staff Names)*: **Type of Documentation(s) Reviewed: Location of youth files** **Describe any Observations: The agency maintains a locked cabinet marked CONFIDENTIAL which is located in a locked room. 2 large suitcases equipped with keyed locks marked CONFIDENTIAL were observed.**			
All records are clearly marked 'confidential'.	**Compliance**	All records were marked "confidential".	
All records are kept in a secure room or locked in a file cabinet that is marked "confidential"	**Compliance**	All records are kept in a secure room and are maintained in a locked cabinet marked "confidential".	
When in transport, all records are locked in an opaque container marked "confidential"	**Compliance**	When records are transported, they are locked in and opaque container marked "confidential" or transported in a locked suitcase marked "confidential".	
All records are maintained in a neat and orderly manner so that staff can quickly and easily access information	**Compliance**	All records are maintained in a neat and orderly manner.	
Additional Comments: **There are no additional comments for this indicator.**			

2.08 - Specialized Additional Program Services			Satisfactory with Exception
Provider has a written policy and procedure that meets the requirement for Indicator 2.08		YES If NO, explain here: The agency has several policies that apply to this indicator; P-1301 Specialized Additional Program Services last revised 7/23, P-1279 Probation Respite was last revised 1/23, P-1283 Family/Youth Respite Aftercare Services (FYRAC) Non-Residential Services was last revised 7/23, P-1267 Domestic Violence Respite was last revised 7/23, P-1282 Domestic Minor Sex Trafficking was last revised 1/23, P-1249 Staff Secure Shelter Overview was last revised 1/23, and P-1248 Staff Secure Shelter Services was last revised 6/21 approved by CEO.	
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.*			
N/A			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? **(If no, select rating "No eligible items for review")**	No eligible items for review	The program has not served this program type since the last QI review.	
Staff Secure policy and procedure outlines the following: a. In-depth orientation on admission b. Assessment and service planning c. Enhanced supervision and security with emphasis on control and appropriate level of physical intervention d. Parental involvement e. Collaborative aftercare	No eligible items for review		
Program only accept youth that meet legal requirements of F.S. 984 for being formally court ordered in to Staff Secure Services	No eligible items for review		
Staff Assigned: a. One staff secure bed and assigned staff supervision to one staff secure youth at any given time b. Program assign specific staff during each shift to monitor location/ movement of staff secure youth c. Agency clearly documents the specific staff person assigned to the staff secure youth in the logbook or any other means on each shift	No eligible items for review		
Agency provides a written report for any court proceedings regarding the youth's progress	No eligible items for review		

Domestic Minor Sex Trafficking (DMST)			
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
N/A			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	**No eligible items for review**	The program has not served this program type since the last QI review.	
Agency has evidence that the FNYFS was contacted for approval prior to admission for all Domestic Minor Sex Trafficking (DMST) placements.	**No eligible items for review**		
There is evidence the youth was entered into NetMIS as a Special Populations youth at admission and a Human Trafficking Screening Tool (HTST) was completed.	**No eligible items for review**		
Services provided to these youth specifically designated services designed to serve DMST youth	**No eligible items for review**		
Did the placement of DMST youth require additional supervision for the safety of the youth or the program? If so, did the agency provide the appropriate level of supervision and safety measures?	**No eligible items for review**		
Length of Stay: a. Youth in program do not have length of stay in DMST placement that exceeds seven (7) days b. Agency has approval for stays and support beyond seven (7) days for DMST placements that are obtained on a case-by-case basis? (If applicable.)	**No eligible items for review**		
Agency has evidence that staff assigned to DMST youth under this provision are to enhance the regular services available through direct engagement in positive activities designed to encourage the youth to remain in shelter	**No eligible items for review**		
All other services provided to DMST youth are consistent with all other general CINS/FINS program requirements	**No eligible items for review**		
Domestic Violence			
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			

Total number of Open Files: 1
Total number of Closed Files: 2
Staff Position(s) Interviewed *(No Staff Names)*: **Regional Director**
Type of Documentation(s) Reviewed: Youth records

Indicator	Rating	Findings	Comments
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	Yes	Three randomly selected files were reviewed for this program service. Two closed files and one open file was selected during the 6 month review cycle.	
Youth admitted to DV Respite placement have evidence in the file of a pending DV charge	Compliance	All files reviewed contained a completed DV referral in file from Juvenile Court Rules Committee (JCRC) and court document in file.	
Data entry into NetMIS within (3) business days of intake and discharge	Compliance	All three files demonstrated intake and discharge were successfully entered into NetMIS within the 3 day requirement.	
Youth length of stay in DV Respite placement does not exceed 21 days. If more than 21 days, documentation exists in youth file of transition to CINS/FINS or Probation Respite placement, if applicable.	Compliance	All files reviewed were discharged prior to the length of stay exceeding 21 days.	
Case plan in file reflects goals for aggression management, family coping skills, or other intervention designed to reduce propensity for violence in the home	Exception	Two out of three files demonstrated the case plan goals focused on aggression management, family coping skills or other intervention designed to reduce reoccurrence of violence in the home.	One youth's case plan lacked aggression management being addressed in the service plan as needed.
All other services provided to Domestic Violence Respite youth are consistent with all other general CINS/FINS program requirements	Compliance	All three files demonstrated that services provided to youth was consistent with all other general CINS FINS program requirements.	

Probation Respite

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

N/A

Indicator	Rating	Findings	Comments
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	No eligible items for review	The program has not served this program type since the last 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.*			
N/A - Not contracted to provide ICM.			
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 reports they are not contracted to provide ICM services.	
Youth receiving services were deemed chronically truant and/or runaway and require more intensive and lengthy services. The youth was determined to be eligible because they have gone through petition and/or case staffing and was in need of case management services.	**No eligible items for review**		
Services for youth and family include: a. Two (2) direct contacts per month b. Two (2) collateral contacts per week c. Direct and collateral contacts not obtained must have documentation to support attempts made to obtain them. All reasonable attempts (at minimum of three) must be made to reach all contacts (direct and collateral) and documented in the case file and NetMIS.	**No eligible items for review**		

Assessments include a. NIRVANA at intake b. NIRVANA Re-Assessment every 90 days c. Post NIRVANA at discharge as aligned with timeframe requirements	**No eligible items for review**		
Service/case plan demonstrates a strength-based, trauma-informed focus	**No eligible items for review**		
For any virtual services provided, there is written documentation in the youths' file as to why virtual contact is in the best interest of the youth and family	**No eligible items for review**		
Family and Youth Respite Aftercare Services (FYRAC)			
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
N/A			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	**No eligible items for review**	The program has not served this program type since the last QI review.	
Youth is referred by DJJ for a domestic violence arrest on a household member, and/or the youth is on probation regardless of adjudication status and at risk of violating.	**No eligible items for review**		
Agency has evidence that all FYRAC referrals have documented approval from the Florida Network office	**No eligible items for review**		
Intake and initial assessment sessions meets the following criteria: a. Services shall be documented through the signature of the youth and his/her parent/guardian as well as orientation to the program which is kept in the youths file. b. The initial assessment shall be face-to-face, in person or through virtual means, to include a gathering of all family history and demographic information, as well as the development of the service plan. c. For youth on probation, a copy of the youths Community Assessment Tool (CAT) to assist with development of the family service plan.	**No eligible items for review**		

Life Management Sessions meets the following criteria: a. Sessions are face-to-face, sixty (60) minutes in length and focus on strengthening the family unit b. Services are highly supportive, individualized, and flexible and require a "whole family" approach to dealing with the problems affecting the youth and family.	**No eligible items for review**		
Individual Sessions: a. The program conducted sessions with the youth and family to focus on work to engage the parties and identify strengths and needs of each member that help to improve family functioning. b. Issues to be covered through each session include but are not limited to: Identifying emotional triggers; body cues; healthy coping strategies through individual, group and family counseling; understanding the cycle of violence and the physical and emotional symptoms of anger; developing safety plans; and educating families on the legal process and rights.	**No eligible items for review**		
Group Sessions: a. Focus on the same issues as individual/family sessions with application to youth pulling on similar experiences with other group members with the overall goal of strengthening relationships and prevention of domestic violence. b. Shall be no more than eight (8) youth at one (1) time and shall be for a minimum of sixty (60) minutes per session	**No eligible items for review**		

There is evidence of completed 30 and/or 60 day follow-ups and is documented in NetMIS following case discharge.	**No eligible items for review**		
Youth and family participate in services for thirteen (13) sessions or ninety (90) consecutive days of services, or there is evidence in the youth's file that an extension is granted by DJJ circuit Probation staff	**No eligible items for review**		
Any service that is offered virtually, is documented in the youth's file why it was in the youth and families best interest.	**No eligible items for review**		
All data entry in NetMIS is completed within 3 business days as required.	**No eligible items for review**		
Additional Comments: **There are no additional comments for this indicator.**			
2.09- Stop Now and Plan (SNAP)			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 2.09		**YES** If NO, explain here: SNAP Screening and Intake P-1299 6/2023 and Snap Discharge Requirements P-1300 7/2023 were last reviewed by CEO.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: 2 **Total number of Closed Files: 1 youth file and 3 SNAP in School closed files** **Type of Documentation(s) Reviewed: SNAP agency policy, SNAP files**			
SNAP Clinical Groups Under 12			
Youth are screened to determine eligibility of services.	**Compliance**	Youth are screened to determine eligibility of services.	
The NIRVANA was completed at initial intake, or within two sessions.	**Compliance**	The NIRVANA was completed at initial intake, or within two sessions.	
There is evidence of the completed Child Behavior Checklist (CBCL) by the caregiver (pre and post) and is located within the file.	**Compliance**	There is evidence of the completed Child Behavior Checklist (CBCL) by the caregiver (pre and post) and is located within the file. One of the applicable files contained the post-CBCL as required.	

There is evidence of the completed Teacher Report Form (TRF) is completed by the teacher (pre and post) and is located within the file.	**Exception**	One of the three files reviewed had evidence that the pre -Teacher Report Form (TRF) is completed by the teacher and is located within the file. Two of the three files were not applicable to have the post -TRF forms in the file due to remaining open. Two files were missing the completed Teacher Report Form (pre), however, the 1st file had documentation in the file that there were three attempts made by the agency with no response. The 2nd file had documentation of two attempts made as indicated in progress notes with no response at the time of the review.	Teacher Report Form (post) was not completed. Program noted it was not received, but there was no indication the agency attempted to obtain the TRF from the teacher.
There is evidence of the completed TOPSE is completed by the caregiver (pre and post) and is located within the file.	**Compliance**	There is evidence of the completed TOPSE by the caregiver (pre and post) located within all three files as applicable. The post TOPSE is only applicable for one file.	
SNAP Clinical Groups Under 12 - Discharge			
There is evidence of the completed SNAP Discharge Report located within the file for any discharged youth.	**Compliance**	There is evidence of the completed SNAP Discharge Report located within the file for the one applicable closed file reviewed.	
There is evidence of the SNAP Boys/SNAP Girls Child Group Evaluation Form located in the file.	**Compliance**	There is evidence of the SNAP Boys/SNAP Girls Child Group Evaluation Form located in the one applicable closed file.	
There is evidence of the SNAP Boys/SNAP Girls Parent Group Evaluation Form located in the file.	**Compliance**	There is evidence of the SNAP Boys/SNAP Girls Parent Group Evaluation Form located in the one closed file.	
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*)	**Compliance**	Three SNAP in School files were reviewed and all files demonstrated evidence that all 13 weekly sessions were completed and maintained within the class file.	
The program maintained evidence of a completed "Class Goal" Document for the class reviewed.	**Compliance**	All three SNAP in School files reviewed contained evidence of a completed "Class Goal" Document for the class was maintained in the file.	
The program maintained evidence of both pre AND post Measure of Classroom Environment (MoCE) completed documents for the class reviewed.	**Compliance**	All three files contained evidence of both pre and post Measure of Classroom Environment (MoCE) completed documents for the class reviewed.	
The program maintained evidence of completed pre and post evaluation documents for the class reviewed.	**Exception**	One class had 14 youth but not all youth were present for the final class. The 2nd class had 22 youth and not all youth were present for the first or last class. The third class had 17 youth and not all youth were present for the first or last class. The program did not have evidence or documentation that demonstrated youth not present for the first class were given the opportunity to complete the pre-evaluation on their 1st day in the class.	Pre and post evaluations for the youth are not being completed consistently. Two of the classes were missing the pre evaluations of youth.

There is evidence of the fidelity adherence checklist maintained in the file for each class reviewed.	**Compliance**	All three SNAP files demonstrated evidence the fidelity adherence checklist was completed for each class reviewed. The dates of completion varied but all were documented in the file prior to the final session.	
Additional Comments: **There are no additional comments for this indicator.**			
3.01 - Shelter Environment			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 3.01		**YES** If NO, explain here: The agency has a policy P-1264 approved by the CEO last revised 1/16.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Staff Position(s) Interviewed *(No Staff Names)*: **Program Supervisor, Regional Director, YCW** **Type of Documentation(s) Reviewed: logs, MSDS** **Describe any Observations: Facility, laundry area, chemical logs, fire drills, vehicles**			
Facility Inspection: a. Furnishings are in good repair. b. The program is free of insect infestation. c. Bathrooms and shower areas are clean and functional, free of foul odors, leaks, dust, and mildew and in good working order. d. There is no graffiti on walls, doors, or windows. e. Lighting is adequate for tasks performed there. f. Exterior areas are free of debris; grounds are free of hazards. g. Dumpster and garbage can(s) are covered. h. All doors are secure, in and out access is limited to staff members and key control is in compliance. i. Detailed map and egress plans of the facility, general client rules, grievance forms, abuse hotline information, DJJ Incident Reporting Number and other related notices are posted. j. Interior areas (bedrooms, bathrooms, common areas) do not contain contraband and are free from hazardous unauthorized metal/foreign objects.	**Exception**	On the day of arrival to CDS-IYP, the Lead YCW assisted with a facility tour both internal and external. Furnishings are in good repair, program is free of insect infestation, no graffiti identified, the exterior was free of debris/hazards, dumpster and garbage cans were covered. All door and access is permitted to staff members and key controls are appropriate. Detailed map and egress plans for the facility were observed in every room of the facility (except the restrooms). General client rules, grievance forms, abuse hotline information, DJJ Incident Reporting number and other related notices are posted and the facility does not appear to contain contraband in the interior areas including hazardous unauthorized metal/ foreign objects. The facility appears to have some challenges with the cooling and heating in the building but the agency is under construction to replace the shelter by the summer of 2024.	The following exceptions were observed at the time of the review: Mold/mildew was observed in four client restroom shower walls, with mild odor (two female showers and two male shower areas). Day 2 the mildew and mold was cleaned and addressed by staff and youth. A ceiling light near the R & R area, had a cracked cover on day 1 of the review, which was repaired on day 2. The male shower stall was observed with a crack between the wall, window air conditionings were not securely affixed to window, and an opening was observed on the left side of each unit in the client sleeping areas.

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**	The findings observed and reviewed indicate the practice is aligned with the requirement(s) for the review item at the time of the review on 1/17/24 and 1/18/24. There are two facility cars utilized on the property. A blue, 2023 Ford van and a white 2016 Ford van. YCW facilitating the tour stated that the program's primary source of transportation for clients and program needs is the 2016 Ford vehicle. According to a YCW, the 2023 vehicle was designated as a backup vehicle. Non-expired first aid kits, fire extinguishers, flashlights, glass breakers, and seat cutters were included in each of the vehicles and were in working condition.	
Facility Inspection: All chemicals are listed, approved for use, inventoried weekly and perpetually, stored securely and Material Safety Data Sheets (MSDS) are maintained on each item (minimum 1 time per week or per agency policy). A perpetual inventory will be the primary means of maintaining a current and real-time inventory. The weekly inventory will be conducted weekly at a minimum to ensure that a perpetual inventory is being maintained consistently and accurately. If more than one location is used to store chemicals, there is an inventory wherever chemicals are stored that is current and well maintained unless previously approved by the Network.	**Compliance**	A review of the facility's MSDS inventory logs provide sufficient evidence that the practice is aligned with the requirement(s). The logs were inventoried weekly and perpetually. An inventory log was located in the laundry room, and one additional location, both were in compliance.	
Facility Inspection: Washer/dryer are operational & general area/lint collectors are clean. Agency has a current DCF Child Care License which is displayed in the facility. Each youth has own individual bed with clean covered mattress, pillow, sufficient linens and blanket. Youth have a safe, lockable place to keep personal belongings, if requested.	**Compliance**	The washer/dry are within compliance and are operational and free of lint. Every youth is supplied separate beds and required contents. It was observed that each youth had access to a storage bin that was identified at the foot of each client's bed for personal belongings. The agency's current DCF Child Care License was observed to be on display in the general area. Upon reviewing the agency's DCF Child Care License, it was found that it was granted on May 1st, 2023, and would be valid until March 31st, 2024, unless it was canceled, withdrawn, or renewed for special circumstances.	

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 on each shift monthly (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**	A review of the facility's fire drill logs provide sufficient evidence that the practice is aligned with the requirement. A review of fire drill logs was conducted from June 2023 through January 2024. During the month of December it was discovered that a drill was not completed for the 2nd shift. However consistent and compliant drills were conducted as follows: 1st Shift: 6/4/23, completed in 1 minute, 7/12/23, noted as successful, 8/29/23, 4 youth and 6 adults present, 9/19/23, 1 youth and 5 staff, 10/10/31/23, no youth and 5 staff, 11/9/23, no youth and 4 staff, 12/28, 8 youth 6 staff and 1/14/24 1 youth and 3 staff. 2nd Shift: 6/4/23, completed 1 minute, 7/27/24, drill noted successful, with 6 youth and 2 staff-no follow-up needed, 8/6/23, 1 youth and 2 adults present, 9/5/23, 3 youth and 2 staff, 10/7/23, drill noted as successful, 11/18/23, 7 youth and 2 staff, and 1/11/24, 2 youth and 2 staff, 3rd Shift: 6/4/23, drill noted as successful, 7/18/23, 6 youth and 3 staff present, 8/22/23, 2 youth and 3 staff present, 9/11/24, 1 youth and 5 staff, 10/31/23, drill completed 6 youth and 3 staff, 11/7/23, 6 youth and 3 staff, 12/12/23, 6 youth 4 staff, 01/11/24, and 1 youth and 3 staff. The facility completes mock emergency drills on a monthly basis. Eight samples for mock drills was completed, the drills reflected: May 26th 2023-Medical Emergency at 3:30pm, June 23, 2023-Safety for Violent/Threatening Situation at 1:00om, July 10th 2023-Safety for Violent/Threatening Situation at 8:15pm, August 30th 2023-Utility Failure at 8:15pm, September 8th 2023-Bomb Threat at 9:00am, October 19th 2023-Natural Disaster at 3:30 pm, November 28th 2023-Medical Emergency at 3:07 pm, December 29th 2023-Safety for Violent/Threatening Situation at 3:45pm. The annual facility fire inspection was completed by Gainesville Fire and Rescue. The most recent inspection occurred on January 16th 2024. Inspection comments: "No violations found at time of reinspection". The fire extinguishers are not hidden away and are immediately and easily accessible.	12/23: Missing 2nd shift fire drills for 2nd shift

Fire and Safety Health Hazards: a. Agency has a current Satisfactory Residential Group Care inspection report from the Department of Health. b. Agency has a current Satisfactory Food Service inspection report from the Department of Health and food menus are posted, current and signed by Licensed Dietician annually. c. All cold food is properly stored, marked and labeled and dry storage/pantry area is clean and food is properly stored. d. Refrigerators/Freezers are clean and maintained at required temperatures and all small and medium sized appliances are operable and clean for use as needed.	**Exception**	The facility has a Satisfactory Food Service reports with most recent inspection date 11/16/23. The food menus are posted and signed by a licensed dietician. All cold food is properly stored. The refrigerators and freezers were clean and well-maintained.	There were some items observed that did not consistently demonstrate labeling of dates, as required.
Additional Fire and Safety Health Hazards Narrative (if applicable)			
Youth Engagement			
a. Youth are engaged in meaningful, structured activities (e.g., education, recreation, counseling services, life and social skill training) seven days a week during awake hours. Idle time is minimal. b. At least one hour of physical activity is provided daily. c. Youth are provided the opportunity to participate in a variety of faith-based activities. Non-punitive structured activities are offered to youth who do not choose to participate in faith-based activities. d. Daily programming includes opportunities for youth to complete homework and access a variety of age appropriate, program approved books for reading. Youth are allowed quiet time to read. e. Daily programming schedule is publicly posted and accessible to both staff and youth.	**Compliance**	Observation of youth engagement is meaningful, activities are structured, and at least one hour physical activity are posted daily over seven days. Faith based opportunities are offered without negative consequences for those that do not engage, Opportunities to complete homework and age appropriate books are available. Youth have access to a quiet room area, and daily programming schedule is visible to client/staff.	
Additional Comments: **There are no additional comments for this indicator.**			

3.02 - Program Orientation			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 3.02		**YES** If NO, explain here: The agency has a policy P-114, Admission/Intake and Participant Orientation that was approved/reviewed by the CEO on 7/14.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: 3 **Total number of Closed Files:2** **Staff Position(s) Interviewed** *(No Staff Names)*: **Program Administrators, Kitchen Staff, Regional Manager, Counselors, Lead YCW, and YCW's** **Type of Documentation(s) Reviewed: Client charts** **Describe any Observations: Observations were compliant as required**			
Youth received a comprehensive orientation and handbook provided within 24 hours	**Compliance**	The results of the observation or review show that, at the time of the review, the practice complies with the requirement or requirements for the review item. Three open and two closed client charts were reviewed.	
Orientation includes the following: a. Youth is given a list of contraband items b. Disciplinary action is explained c. Dress code explained d. Review of access to medical and mental health services e. Procedures for visitation, mail and telephone f. Grievance procedure g. Disaster preparedness instructions h. Physical layout of the facility i. Sleeping room assignment and introductions j. Suicide prevention- alerting staff of feelings or awareness of others having suicidal thoughts	**Compliance**	The results of the observation or review show that, at the time of the review, the practice complies with the requirement or requirements for the review item. The following are Included in orientation: Youth receive a list of prohibited goods, disciplinary action is described, the dress code is explained, the availability of medical and mental health services is reviewed, visitation, mail, and phone procedures, grievance procedure, instructions for disaster preparedness, facility layout, assigning sleeping rooms and introductions suicide prevention: notifying personnel of one's own sentiments or knowledge of others' thoughts of suicide	
Documentation of each component of orientation, including orientation topics and dates of presentation, as well as signatures of the youth and staff involved is maintained in the individual youth record	**Compliance**	The results of the observation or review show that, at the time of the review, the practice complies with the requirement or requirements for the review item. Each aspect of orientation is recorded in the individual youth record, along with the topics covered, presentation dates, and signatures from the youth and staff.	
Additional Comments: **There are no additional comments for this indicator.**			

3.03 - Youth Room Assignment			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 3.03		**YES** If NO, explain here: The agency has a policy P-1116/Residential Admission, Sleeping Arrangements which was last reviewed/approved by the CEO on 1/21.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: Three open charts were reviewed **Total number of Closed Files: Two closed charts were reviewed** **Staff Position(s) Interviewed** *(No Staff Names)*: **Program administrators, Lead YCW, YCW's, Counselors, Kitchen staff, and** **Type of Documentation(s) Reviewed: Client charts**			
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**	At the time of the review, the three files reviewed demonstrate the practice complies with the requirements. A staff member gets information from a young person about the aforementioned topics when they arrive at the shelter. The Intake Assessment Form has a record of this information. When filling out the form, the staff member should indicate any areas of concern. Before the young person is assigned to a room, the supervisor or shift leader who is on duty at the time of admission will study the youth's file and intake packet and evaluate any apparent risk (medical, suicide, run, etc.). Youth should be segregated or given more stringent supervision if there is a suspicion that their safety may be jeopardized. Every program activity that is based on a youth's classification needs to be recorded in the participant file and, if necessary, acknowledged by starting the Medical/Mental Health Alert system into operation and using the relevant code to make an entry on the participant board.	
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**	Based on the review of three files, all three files demonstrate that 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.	
Additional Comments: **There are no additional comments for this indicator.**			
3.04 - Log Books			**Satisfactory with Exception**

Provider has a written policy and procedure that meets the requirement for Indicator 3.04		**YES** If NO, explain here: The agency has a policy P-1149/Program Logbook that was last reviewed/approved by the CEO on 3/23.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Dates or Timeframe Reviewed: Past 6 months **Type of Documentation(s) Reviewed: Logbooks, Policy**			
Log book entries that could impact the security and safety of the youth and/or program are highlighted	**Compliance**	Entries that could impact security/safety of clients and/or program are compliant.	
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**	Entries are brief, and legible and written in ink. Dates, and times of incidents are recorded, client names and staff involved are noted, brief notation of vital information including name and signature of the staff making the entry.	
Recording errors are struck through with a single line. The staff person must initial and date the correction. The use of whiteout and erasures is prohibited.	**Exception**	The program utilizes a paper logbook for all entries. The observations of the logbook occurred by reviewing four random samples were reviewed for the following months: October 2023, November 2023, December 2023, and January 2024. Recording errors were not consistently observed to be struck with a single line and staff initials.	Several occurrences of errors were observed where staff corrected a pre-existing entry by writing over it which does not align with policy requirements. E.g. As evidenced in logbook entries on 12/28/23, 12/29/23, 1/2/24, 1/2/24/24 & 1/3/24. Additional practice was observed in a review of two additional logbooks, dated for 11/28/23-12/13/23 and 10/18/23-10/31/23 and similar practice was observed.
The program director or designee reviews the facility logbook(s) every week and makes a note chronologically in the logbook indicating the dates reviewed and if any correction, recommendations and follow-up are required and sign/date the entry	**Compliance**	The findings observed or reviewed indicate the practice is aligned with the requirement(s) for the review item at the time of the review. The program manager reviews the logbook consistently throughout the review dates.	

All staff review the logbook of the previous two shifts and makes an entry signed and dated into the logbook indicating the dates reviewed	**Compliance**	The findings observed or reviewed indicate the practice is aligned with the requirement(s) for the review item at the time of the review. The logbook reflects programs staff review the logbook, and signs/date entry by notation of the date.	
At the beginning of their shift, oncoming supervisor and shelter counselor reviews the logbook of all shifts since their last log entry and makes a signed and dated entry and into log book indicating the dates reviewed.	**Compliance**	The findings observed or reviewed indicate the practice is aligned with the requirement(s) for the review item at the time of the review. The logbook reflects that oncoming supervisors/shelter counselors review the logbook, and signs/date entry by notation of the date.	
Logbook entries include: a. Supervision and resident counts b. Visitation and home visits	**Compliance**	The findings observed or reviewed indicate the practice is aligned with the requirement(s) for the review item at the time of the review.	
Additional Comments: **There are no additional comments for this indicator.**			
3.05 - Behavior Management Strategies			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 3.05		**YES** If NO, explain here: The agency has a policy P-1125 FACE (Facilitating Activity & Communication Effectively) System that was last reviewed/approved by the CEO. Additional subsequent policies that address behavior are listed below.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Type of Documentation(s) Reviewed: Participant "Facebook", Polices # P-1222 (Seclusion and Restraint) & Aggression Control; P-1123 (Behavior Management System), P-1125 FACE (Facilitating Activity & Communication Effectively) System, P#1126 (Participant/Staff Interactions & Interventions), P-1128 (Rule Violation), P-1032 (Behavioral Expectations for Staff)			
The program has a detailed written description of the BMS and it is explained during program orientation	**Compliance**	The program's policy was reviewed which includes a detailed description of the Behavior Management System (BMS) and there is documentation that the BMS is explained during the program orientation.	
Behavior Management Strategies must include:			

a.BMS is designed to teach youth new behaviors and help youth understand the natural consequences for their actions b.Behavioral interventions are applied immediately, with certainty, and reflect the severity of the behavior c.BMS uses a wide variety of awards/incentives to encourage participation and completion of the program d.Appropriate consequences and sanctions are used by the program and consequences for behavior are logical and designed to promote skill-building for the youth e.Counseling, verbal intervention and de-escalation techniques are used prior to physical intervention (Only techniques approved by the Florida Network and DJJ are used if physical intervention is required) f.Only staff discipline youth. Group discipline is not imposed g.Room restriction is not used as part of the system or for youth who are physically and/or emotionally out of control h.Youth should never be denied basic rights such as meals, clothing, sleep, services, exercise, or correspondence privileges	**Compliance**	The agency's BMS offers a wide range of rewards and incentives to motivate young people. The main goal is to teach them new behaviors and help them comprehend the natural consequences of their actions. Behavioral interventions are delivered instantly, with certainty, and reflect the severity of the behavior. The program uses appropriate sanctions and consequences, and the latter are rational and intended to help the young people develop new skills. Adolescents are only disciplined by staff members. Verbal intervention, counseling, and de-escalation tactics are employed. No room limitation is utilized as part of the system or for adolescents who are either mentally or physically out of control. Adolescents are not denied fundamental rights like food, clothing, sleep, services, exercise, and correspondence privileges. Group discipline is not practiced.	
Program's use of the BMS			
All staff are trained in the theory and practice of administering BMS rewards and consequences	**Exception**	Four residential staff training files were randomly reviewed for BMS. One staff file contained evidence that they received the training as required.	Three files were missing documentation of the BMS training in theory and practice of administering rewards and consequences.
There is a protocol for providing feedback and evaluation of staff regarding their use of BMS rewards and consequences	**Compliance**	The agency has a procedure in place for giving staff members feedback and assessing how they employ BMS rewards and penalties.	
Supervisors are trained to monitor the use of rewards and consequences by their staff	**Compliance**	Supervisors are taught to keep an eye on how their employees are using both advantages and disadvantages.	
Additional Comments: **There are no additional comments for this indicator.**			

3.06 - Staffing and Youth Supervision			Satisfactory with Exception
Provider has a written policy and procedure that meets the requirement for Indicator 3.06		**YES** If NO, explain here: The agency has the following policies: P-1133/P-1121: Supervision and Staffing Ratios/Scheduling -Bed Time Supervision & Bed Checks was reviewed/approved by CEO.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Dates or Timeframe Reviewed: Past 6 months **Type of Documentation(s) Reviewed: Staff Schedules**			
The program maintains minimum staffing ratios as required by Florida Administrative Code and contract. • 1 staff to 6 youth during awake hours and community activities • 1 staff to 12 youth during the sleep period	**Compliance**	The findings observed or reviewed indicate the practice is aligned with the requirement(s) for the review item at the time of the review. The program keeps staffing levels at the contractually specified levels. Six weeks or more of scheduling ensures that the program maintains the necessary workforce numbers.	
All shifts must always provide a minimum of two direct care staff present that have met the minimum training requirements	**Compliance**	The program employs at least two direct care employees who have completed the required minimal training, according to observation of six weeks of scheduling.	
Program staff included in staff-to-youth ratio includes only staff that are background screened and properly trained youth care workers, supervision staff, and treatment staff	**Compliance**	The findings observed or reviewed indicate the practice is aligned with the requirement(s) for the review item at the time of the review. The program staff included in the ratios are screened and trained accordingly.	
The staff schedule is provided to staff or posted in a place visible to staff	**Compliance**	The findings observed or reviewed indicate the practice is aligned with the requirement(s) for the review item at the time of the review. The staff schedule is posted in an area accessible by staff.	
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 findings observed or reviewed indicate the practice is aligned with the requirement(s) for the review item at the time of the review. The holdover/overtime rotation roster includes staff phone numbers for contact in the event coverage is required.	

Staff observe youth at least every 15 minutes while they are in their sleeping room, either during the sleep period or at other times, such as during illness or room restriction	**Exception**	A review of the indicator was observed of four samples 10/17/23, 12/20/23, 12/25/23, and 12/16/23. Staff observed conducting checks every 15 minutes during sleep periods and at other times.	One occurrence was observed on 12/25/23, during the 3rd shift between 12am - 4am, one check was noted as exceeding the 15 minute required interval by 24 minutes.
Additional Comments: **There are no additional comments for this indicator.**			
3.07 - Video Surveillance System			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 3.07		**YES** If NO, explain here: The agency has a P-1280 - Video Surveillance System P-1280 approved by the CEO on 7/23.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Dates or Timeframe Reviewed: 12/25/23, 12/31/23, 1/5/23, 1/7/23, and 1/13/23. **Staff Position(s) Interviewed** *(No Staff Names)*: **Youth Care Workers** **Type of Documentation(s) Reviewed: Video Surveillance** **Describe any Observations: Reviewed camera footage with Supervisor.**			
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**	Samples reviewed for the following dates: 12/25/23, 12/31/23, 1/5/23, 1/7/23, and 1/13/23 the observations were of Youth Care Workers. Examining the surveillance mechanism of the organization reveals a notice in writing that is prominently displayed on the property for security purposes , system that is capable of capturing and storing video photographs that need to be kept for a minimum of thirty days, the system can maintain a resolution that allows for facial identification while recording the date, time, and location, among the backup features are cameras that can continue to function in the event of a power failure, cameras in the shelter's common areas, both inside and outside, where young people and staff gather and where guests come and go, bathrooms and bedrooms are never equipped with cameras and every camera is visible.	
A list of designated personnel who can access the video surveillance system is maintained (includes off-site capability per personnel)?	**Compliance**	All cameras are visible, and a list of authorized persons with access to the video surveillance system is kept up to date. Each designated employee has the ability to work remotely.	

Supervisory review of video is conducted a minimum of once every 14 days and timeframes reviewed are noted in the logbook.	**Compliance**	At least once every 14 days, a supervisor reviews a video, and the timeframes for each review are recorded in the logbook.	
The reviews assess the activities of the facility and include a review of random sample of overnight shifts	**Compliance**	A evaluation of a random sample of nightly shifts is included in the assessments of the facility's operations.	
Grant the requesting of video recordings to yield a result within 24-72 hours from program quality improvement visits and when an investigation is pursued after an allegation of an incident	**Compliance**	The video equipment has the capability to record as needed. In the event video recordings are requested, the agency would submit the request to IT.	.
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**	Within 24 hours of the discovery of a defective or unusable camera, a camera service order or request will be made. Every attempt to get repairs is kept track of and documented. Email correspondence was provided to demonstrate the program's practice of camera malfunctions. The email request showed IT was notified of the camera malfunction where footage appeared to reflect inconsistencies with review of physical bed checks and the electronic monitoring system.	

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 agency has a policy P-1117. Preliminary Physical Health Screening, approved by the CEO, January 2024.	

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

Total number of Open Files: 2
Total number of Closed Files:3
Type of Documentation(s) Reviewed: Youth Records

Preliminary Healthcare Screening

Screening includes : a. Current medications b. Existing (acute and chronic) medical conditions c. Allergies d. Recent injuries or illnesses e. Presence of pain or other physical distress f. Observation for evidence of illness, injury, physical distress, difficulty moving, etc. g. Observation for presence of scars, tattoos, or other skin markings h. Acute health symptoms requiring quarantine or isolation	**Compliance**	The agency has policy regarding primary healthcare screening requirements. Five youth records were reviewed for primary healthcare screenings and observations recorded included current medications, existing medical conditions, allergies, recent injuries and illnesses, presence of pain or other physical distress, observations for evidence of illness, injury, pain or physical distress, difficulty moving, presence of scars, tattoos, or other skin markings and acute healthcare symptoms requiring quarantine or isolation.	
Referral and Follow-Up			
Youth with chronic medical conditions have a referral to ensure medical care (e.g. diabetes, pregnancy, seizure disorder, cardiac disorders, asthma, tuberculosis, hemophilia, head injuries, etc.)	**Compliance**	None of the youth reviewed were applicable to requiring a referral for medical care for chronic conditions. However, the program has policy and procedures to ensures youth with chronic medication conditions have a referral for medical care, as required.	
When needed, the parent is involved with the coordination and scheduling of follow-up medical appointments	**No eligible items for review**	The agency policy requires the parent be involved with the coordination and scheduling of follow-up medical appointments when necessary. None of the records reviewed were applicable to requiring follow-up.	
All medical referrals are documented on a daily log.	**No eligible items for review**	Five youth records were reviewed and none were applicable for medical referrals.	
The program has a thorough referral process and a mechanism for necessary follow-up medical care as required and/or needed	**Compliance**	The agency has procedures that include a thorough referral process and a mechanism for necessary follow-up medical care for youth admitted with chronic medical conditions which includes a consultation with the parent/guardian, youth's physician if the parent/guardian is unavailable, or 9-1-1 if an emergency, and documented on the Medical Health Follow-Up Form. When warranted, the agency initiates Medical/Mental Health Alerts.	
Additional Comments: **There are no additional comments for this indicator.**			
4.02 - Suicide Prevention			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 4.02		**YES** If NO, explain here: The agency has a policy P-1247. Suicide Prevention which was approved by the CEO, October 2022.	

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

Total number of Open (Residential & Community) Files: 2
Total number of Closed (Residential & Community) Files:3
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**	The agency had policy and procedure which includes prevention, observation and assessment of suicide risk. Five youth records were reviewed. All five youth had a suicide risk screening occur during the initial intake and screening process. Suicide screening results were reviewed and signed by the supervisor and documented in the youth's case file in all five records reviewed.	
The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	**Compliance**	The program's suicide risk assessment has been approved by the Florida Network of youth and Family Services.	
Supervision of Youth with Suicide Risk *(Shelter Only)*			
Youth are placed on the appropriate level of supervision based on the results of the suicide risk assessment.	**Compliance**	Three residential youth records were reviewed and all three youth were assessed by a non-licensed professional under the direct supervision of a licensed professional within twenty-four hours from the suicide risk screening results, or the morning of the first business day. All three residential youth were placed on the appropriate level of supervision based on the results of the suicide risk assessment.	
Staff person assigned to monitor youth maintained one-to-one supervision or constant supervision and documented his/her observations of the youth's behavior at 30 minute or less intervals	**Compliance**	The staff person assigned to monitor the youth documented the youths' behavior at thirty minute, or less, intervals and included the time of day, behavioral observations, any warning signs observed, and the observers' initials in all three residential records.	
Documentation includes the time of day, behavioral observations, any warning signs observed, and the observers' initials and was maintained in either an observation log or in the shelter daily log.	**Compliance**	The staff person assigned to monitor the youth documented the youths' behavior at thirty minute, or less, intervals and included the time of day, behavioral observations, any warning signs observed, and the observers' initials in all three residential records.	

Supervision level was not changed/reduced until a licensed professional or a non-licensed mental health professional under the supervision of a licensed professional completed a further assessment OR Baker Act by local law enforcement	**Compliance**	The supervision level was not changed/reduced until a licensed mental health professional, or non-licensed mental health professional working under the supervision of a licensed professional, completed a further assessment or Baker Act by local law enforcement in all three applicable records.	
There was evidence that documentation was reviewed by supervisory staff each shift. If program uses an observation log, completed logs are maintained in the youth's file.	**Compliance**	There was evidence that documentation was reviewed by supervisory staff each shift, and the completed logs were maintained in the youth's file in all three records.	
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.	**Compliance**	Three youth records community counseling were reviewed. All three youth identified for suicide risk during intake were 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.	
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.	**Compliance**	The agency policy and procedure to immediately refer the youth to an appropriate provider, and make notification to the parent/guardian if the suicide risk findings if the agency does not have an appropriate staff member available.	
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.	**Compliance**	Information on resources available in the community for further assessment were provided to all three clients and the notification to the parent/guardian was documented in the youth's file and signed by the parent/guardian, if the parent/guardian was present during the screening, or the parent /guardian was notified by telephone in all three applicable records.	
If the parent/guardian cannot be contacted, all efforts to contact them are documented in the case file.	**Compliance**	When a parent/guardian is not present for the assessment, the agency had policy and procedure in place which requires them to notify the parent/guardian by telephone regarding screening results.	
When the screening was completed during school hours on school property, the appropriate school authorities were notified.	**No eligible items for review**	None of the referrals were completed on school property.	
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 agency has multiple applicable policies; P-1120 Medication Provisions, Storage, Access, Inventory, and Disposal and P-1117 which was approved by the CEO, January 2024.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Files: 5 **Staff Position(s) Interviewed** *(No Staff Names)*: **Program Director, Supervisor, YCW and youth** **Type of Documentation(s) Reviewed: Youth records** **Describe any Observations: Medpass reviewed with 3 youth for morning medication distribution which demonstrated program had good practice in place of med distribution at the time of review. Youth interviewed during process acknowledged they are aware and familiar with their medication and would advise staff if had concerns regarding medication being distributed.**			
The agency has a Registered Nurse (RN) and/or a Licensed Practical Nurse (LPN) that is being supervised by RN and all of their credentials have been verified.	**Compliance**	The agency has a Registered Nurse with verified credentials who is on-site a limited amount of time each month.	
The agency has evidence of the following for all non-nursing shelter staff designated to assist with the self-administration of medication: a. Documentation of in-person self-administration of medication distribution training provided by a Registered Nurse b. Evidence demonstrating their competency to assist with self-administration of medication distribution c. Maintenance of their annual medication training re-certification	**No eligible items for review**	The agency does not currently have a Registered Nurse on Staff. The Program Supervisor attended a Florida Network training with the previous on-staff RN and has been providing this same training to staff in lieu of having a RN at the facility. Documentation reviewed for three staff showed evidence of medication distribution training to assist with the self-administration process of medication. This item is deemed not applicable based on the time the revision of policy went into effect in December 2023.	
The agency held at least quarterly staff meetings conducted by RN and/or Shelter Manager to review and assess: a. strategies implemented to reduce medication errors shelter wide b. analyze factors that contributed to medication errors c. allow staff the opportunity to practice and role-play solutions	**No eligible items for review**	Date(s) of quarterly meetings held: The program will hold its next quarterly meeting on January 25, 2024, as the requirement for this began in December 2023.	

The agency has strategies implemented to ensure medications are provided within the 2-hour time frame.	**Compliance**	Program administration is responsible for ensuring medications are provided in the two-hour timeframe. MedPass occurs four times each day including 7am, noon, 4pm and 9pm to help ensure medications are provided within a timeframe and the program has implemented structured supervisor follow-up within the appropriate time-frame.	
All non-licensed staff members are clearly identified and designated on the staff schedule and shift change report/shift responsibility form for assisting with the self-administration of medications on each shift	**Compliance**	All non-licensed staff members are clearly identified and designated on the staff schedule and shift change report/shift responsibility form for assisting with the self-administration of medications on each shift, as required.	
The agency has clear methods of communicating which youth are on medications with the times and dosage easily discernable by all staff on each shift.	**Compliance**	The agency has clear methods of communicating which you are on medications with the time and dosage easily discernable by all staff on each shift. During shift change, staff leaving shift discuss with staff coming on-shift which youth need medications and at what time. Medication needs are also listed on the client board with the youth names, time and dosage.	
The delivery process of medications is consistent with the FNYFS Medication Management and Distribution Policy and the agency has an internal quality assurance process to include the following: a. to ensure appropriate medication management and distribution methods b. to track medication errors c. to identify systemic issues and implement mitigation strategies, as appropriate.	**Compliance**	The agency has an internal quality assurance process to ensure appropriate medication management and distribution methods to track medication errors and identify system issues and implement mitigation strategies, as appropriate.	

Admission/Intake of Youth			
a. Upon admission, the youth and parent/guardian (if available) were interviewed by the Registered Nurse (when on-site) about the youth's current medications as part of the Medical and Mental Health Assessment screening process and/or an interview was conducted by the RN within three (3) business days if the RN was not on the premise at admission. **If the agency does not have a RN, there was a medication review conducted by a certified Leadership position.* b. Upon intake/admission, there is evidence that the on-shift certified supervisor of higher level staff did review all medication forms by the next business day.	**Compliance**	Five youth records were reviewed for the admission/intake process. Upon admission, the youth and parent/guardian were interviewed by program staff about the youth's current medications and part of the Medical and Mental Health Assessment screening process in all five records. Documentation reviewed showed the on-shift certified supervisor or higher level staff reviewed all medication forms by the next business day.	
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 medications are stored in a Pyxis ES Medication Cabinet that is inaccessible to youth (when unaccompanied by authorized staff). The Pyxis machine is stored in accordance with guidelines in FS 499.0121 and policy section in Medication Management. The program had no injectable or topical medications at the time of the review, but the program has policy and procedure regarding medications which states oral medications are to stored separately from injectable epi-pen and topical medications. 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. The refrigerator is secure and located in a room which is secure and inaccessible to youth. Narcotics and controlled medications are stored in the Pyxis ES Station. Observation of Pyxis keys showed key with the following labels are accessible to staff in the event they need to access medications if there is a Pyxis malfunction: TOP COVER, BACK PANEL- LEFT TALL CABINET LOCK- LEFT, and BACK PANEL- RIGHT TALL CABINET LOCK- RIGHT.	
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 ALWAYS conducted by the nurse or when the nurse is not onsite, then the designated staff who has been trained by a licensed Registered Nurse provides the medication. f. Agency does not accept youth currently prescribed injectable medications, except for epi-pens h. Non-licensed staff have received training in the use of epinephrine auto-injectors provided by a registered nurse	**Compliance**	The program maintains a minimum of 2 site-specific System Managers for the Pyxis ES Station for each shift. Only designated staff delineated in User Permissions have access to secured medications, with limited access to controlled substances (narcotics). A Medication Distribution Log shall is used for distribution of medication by non-licensed and licensed staff. The program verifies medication using one of three methods listed in the FNYFS Policies & Procedures Manual, as required. When nurse is on duty, medication processes are ALWAYS conducted by the nurse or when the nurse is not onsite, then the designated staff who has been trained by a licensed Registered Nurse provides the medication. The program does not accept youth currently prescribed injectable medications, except for epi-pens. Non-licensed staff have received training in the use of epinephrine auto-injectors provided via Bridge Trainings.	
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 give	**Compliance**	The medication distribution log documentation included the time of medication administration, evidence of youth initials that the dosage was given, and evidence of staff initials that the dosage was given.	
There is evidence that staff provide youth with medications within one hour of the scheduled time of delivery as ordered by the medication. Documentation is provided for instances this does not occur within the required timeframe.	**Compliance**	Documentation reviewed showed 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.	
During the review period, there were no instances where youth missed their medication due to failure to open the pyxis machine.	**Compliance**	A review of monthly pyxis logs confirmed there were no instances where youth missed their medication due to failure to open the pyxis machine, during the review period.	

If applicable: Any staff member deemed responsible for a medication error, there was evidence that the staff member received refresher training from an RN and demonstrated competency prior to being assigned future medication administration responsibilities. There is evidence that any staff member deemed responsible for 3 errors within a 1-year time frame, had their certification suspended and was not recertified until the completion of the full **in-person** medication administration training, demonstrating competency and re-certification from an RN.	**No eligible items for review**	The program had no staff responsible for medication errors during the review period.	
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 and inventoried weekly c. Syringes and sharps (needles, scissors, etc.) are secured, and counted and documented weekly	**Compliance**	The program demonstrated 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. Over-the-counter medications are inventoried weekly for medications accessed regularly. The program does not have syringes or sharps on the premises, as it relates to medications so this was not applicable.	

There are monthly reviews of the Pyxis reports to monitor medication management practice.	**Compliance**	Documentation showed monthly reviews of the Pyxis reports to monitor medication management practice.	
Medication discrepancies are cleared after each shift.	**Compliance**	Medication discrepancies are cleared after each shift.	
Additional Comments: **There are no additional comments for this indicator.**			
4.04 - Medical/Mental Health Alert Process			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 4.04		**YES** If NO, explain here: The agency has a policy P-1119 Medical and Mental Health Alert Process, which was approved by the CEO, Nov 2016.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: 2 **Total number of Closed Files: 3**			
Youth with a medical, mental health, or food allergy was appropriately placed on the program's alert system	**Compliance**	Two open and three closed records were reviewed for the medical and mental health alert process. All five youth reviewed had a medical or mental health condition or food allergy, and each of the youth was appropriately placed on the program's alert system.	
Alert system includes precautions concerning prescribed medications, medical/mental health conditions	**Compliance**	The agency alert system includes precautions concerning prescribed medications, medical and mental health conditions.	
Staff are provided sufficient training, information and instructions to recognize/respond to the need for emergency care for medical/mental health problems	**Compliance**	A review of documentation showed staff are provided sufficient information/instructions to recognize and respond to the need for emergency care for medical and mental health problems.	

A medical and mental health alert system is in place that ensures information concerning a youth's medical condition, allergies, common side effects of prescribed medications, foods and medications that are contraindicated, or other pertinent mental health treatment information, is communicated to all staff	**Compliance**	A medical and mental health alert system is in place that ensures information concerning a youth's medical condition, allergies, common side effects of prescription medications that are contraindicated, or other pertinent mental health treatment information is communicated to all staff.	
Additional Comments: **There are no additional comments for this indicator.**			
4.05 - Episodic/Emergency Care			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 4.05		**YES** If NO, explain here: The agency has a policy P-1166 Episodic Emergency Care, which was approved by the CEO, February 2022.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: 0 **Total number of Closed Files: 3** **Type of Documentation(s) Reviewed: Youth Records**			
Off Site Emergency Care			
a. If off-site emergency medical or dental care was provided, an incident report was submitted for the medical or dental care b. Upon youth return, there is a verification receipt of medical clearance via discharge instructions with follow-up is present in file c. Youth's parent/guardian was notified d. A daily log is maintained for emergency care provided	**Compliance**	The program had three youth records applicable to episodic or emergency care during the review period. All three records were reviewed. All three youth received off-site emergency medical care. An incident report was submitted for the medical care. Two of the youth were applicable for return upon completion of medical care. There is a verification receipt of medical clearance via discharge instructions with follow-up in both files. The parent/guardians were notified in both records, as the parent/guardians transported the youth for the medical care. Both incidents were maintained in the daily log. For the remaining record, the youth did not return to the program after leaving for emergency care. The youth's parent/guardian transported the youth for emergency care, and the youth was discharged from the program the same day.	

All staff are trained on emergency medical procedures	**Compliance**	A review of training documentation showed all staff are trained on the proper procedure for medical emergencies. The agency also completes medical emergency drills for all staff on a rotating basis with the last set of drills being conducted in November 2023.	
The program has a Knife-for-life and wire cutters accessible to staff in a secure location(s)	**Compliance**	The agency had five first aid kits and one knife-for-life. One first aid kit is kept on the medication car located in the control room. The knife-for-life is located in the control room. The agency has two vans, both of which contain two first aid kits.	
Additional Comments: **There are no additional comments for this indicator.**			