Florida Network for Youth and Family Services
Compliance Monitoring Report for

Florida Keys Children's Shelter

73 High Point Road
Tavernier, FL 33070

January 31 - February 1, 2024

Compliance Monitoring Services Provided by

FOREFRONT

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 Florida Keys Children's Shelter (FKCS) for the FY 2023-2024 at its program office located at 73 Highpoint Road, Tavernier, Florida. Forefront LLC (Forefront) is an independent compliance monitoring firm that is contracted by the FNYFS to perform onsite program reviews to assess the agency's adherence to fiscal, programmatic and overall contract requirements. Florida Keys Children's Shelter is contracted with the Florida Network of Youth and Family Services (FNYFS) to provide direct services to Children/Families in Need of Services (CINS/FINS). The services to be provided are identified in Contract Section A - Descriptions and Specifications and Section B - Delivery and Performance, and are funded with General Revenue Funds effective from July 2023 through June 30, 2024.

The review was conducted by Marcia Tavares, Consultant for Forefront LLC and Peer Reviewers Paula Friedrich, Teresa Clove, and Scoundrel Oliver. Agency representatives from FKCS present for the entrance interview were: Ben Kemmer, CEO; Alvin Bentley, COO; Nathaly Milla, Quality Compliance Manager; Maile Horn, Residential Coordinator; Karen Martinez, Residential Specialist; and Katya Andrade, Office Manager. Also in attendance were three counseling staff from the shelter and community counseling program. The last onsite QI visit was conducted November 16, 2022.

In general, the Reviewer found that Florida Keys Children's Shelter is in compliance with specific contract requirements. **FKCS received an overall compliance rating of 100% for achieving full compliance with all 12 applicable indicators** of the CINS/FINS Monitoring Tool. There were no corrective actions or recommendations made as a result of the monitoring visit.

The following report represents the results of the 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 01-31-2023-2024

Agency Name: Florida Keys Children's Shelter	**Monitor Name: Marcia Tavares**
Contract Type : CINS/FINS	**Region/Office: 73 High Point Rd., Tavernier, FL 33070**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): January 31 – February 1, 2024**

Major Programmatic Requirements	Explain Rating: Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable	Ratings Based Upon: I = Interview; O = Observation; D = Documentation; PTV = Submitted Prior To Visit (List Who and What)	Notes: Explain Unacceptable or Conditionally Acceptable:
I. Administrative and Fiscal							
DJJ Quality Improvement Peer Reviewer a. Provider shall demonstrate that a minimum of two (2) staff members have been trained to be certified as DJJ QI Peer reviewers. Provider shall participate in a minimum of one (1) on-site quality assurance review of a similar type of program in another judicial circuit during each 12-month period of the contract, if requested.	☐	☐	☒	☐	☐	The provider currently has three certified DJJ-QI Peer Reviewers, Kayla Clark, Karen Martinez, and Nathaly Milla. Both Ms. Martinez and Ms. Milla have participated in QI reviews this fiscal year.	

2023-2024 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 01-31-2023-2024

Agency Name: Florida Keys Children's Shelter	**Monitor Name: Marcia Tavares**
Contract Type : CINS/FINS	**Region/Office: 73 High Point Rd., Tavernier, FL 33070**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): January 31 – February 1, 2024**

Major Programmatic Requirements	**Explain Rating**					**Ratings Based Upon:** **I = Interview** **O = Observation** **D = Documentation** **PTV = Submitted Prior To Visit** **(List Who and What)**	**Notes** **Explain Unacceptable or Conditionally Acceptable:**
	Unacceptable	**Conditionally Unacceptable**	**Fully Met**	**Exceeded**	**Not Applicable**		
Additional Contracts a. Provider shall provide a listing of all current federal, state, or local government contracts, as well as other contracts entered into with for profit and not-for-profit organizations. Such a listing shall identify the awarding entity and contract start & end dates. **PTV**	☐	☐	☒	☐	☐	Documentation: A list of 14 additional contracts for FY200 was provided for funding from federal, state, and county government. The provider receives funding from DCF (for residential/group home services), DHHS-Basic Center, outreach, and transitional living grant, DHHS-Street Outreach grant, Monroe County, State of Florida Nutrition, All Stars Program, Guidance Clinic, United Way, Keys Children's Foundation, Katherine Wells Foundation, and Helen's Hope Foundation. The listing includes name of program, description of services, awarding entity, amount, and term.	
Limits of Coverage a. Provider shall provide and maintain during this contract, the following minimum kinds of insurance: Worker's Compensation and Employer's liability insurance as required by Chapter 440, F.S. with a minimum of $100,000 per accident, $100,000 per person and $500,000 policy aggregate. Commercial General Liability	☐	☐	☒	☐	☐	Documentation: General Liability through Harleysville Insurance Company, for limits of coverage $1,000,000 each $3,000,000 aggregate, effective 3/1/2023-3/1/2024 Workers Compensation through Ascendant Commercial Insurance	

2023-2024 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 01-31-2023-2024

Agency Name: Florida Keys Children's Shelter	**Monitor Name: Marcia Tavares**
Contract Type : CINS/FINS	**Region/Office: 73 High Point Rd., Tavernier, FL 33070**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): January 31 – February 1, 2024**

Major Programmatic Requirements	Explain Rating: Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable	Ratings Based Upon: I = Interview; O = Observation; D = Documentation; PTV = Submitted Prior To Visit (List Who and What)	Notes: Explain Unacceptable or Conditionally Acceptable:
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**						Company with limits of $1,000,000 each and policy limit, effective for 4/30/2023 through 4/30/2024. Automobile insurance through Harleysville Insurance Company, for combined single limits of $1,000,000 and medical payments of $5000. Policy effective for 3/1/2023-3/1/2024. Florida Network is listed on the Insurance 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**	☐	☐	☐	☐	☒	During the Entrance Conference, the provider indicated that there are no outstanding corrective action item(s) cited by any external funding sources.	
Fiscal Practice a. Agency must have employee and fiscal policy/procedures manuals that are in compliance with GAAP and provide sound internal controls. Agency maintains fiscal files that are audit ready. **PTV**	☐	☐	☒	☐	☐	Documentation: Fiscal Policies and Procedures are contained in the agency's Accounting Policy and Procedures Manual with a review date of May 2, 2022. The procedures reviewed appear to be consistent with	

2023-2024 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 01-31-2023-2024

Agency Name: Florida Keys Children's Shelter	**Monitor Name: Marcia Tavares**
Contract Type : CINS/FINS	**Region/Office: 73 High Point Rd., Tavernier, FL 33070**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): January 31 – February 1, 2024**

Major Programmatic Requirements	**Explain Rating**					**Ratings Based Upon:** **I = Interview** **O = Observation** **D = Documentation** **PTV = Submitted Prior To Visit** **(List Who and What)**	**Notes** **Explain Unacceptable or Conditionally Acceptable:**
	Unacceptable	**Conditionally Unacceptable**	**Fully Met**	**Exceeded**	**Not Applicable**		
						GAAP and provide for limited internal controls. Procedures are included for: general accounting procedures including general ledger and computer back-up; cash management procedures: accounts receivable; payroll; property, plant, and equipment procedures; accounts payable; procedures for liability; and management reporting.	
b. Agency maintains a general ledger and the corresponding source documents. A general ledger must be set up to track the activity of the grant separately (standard account numbers / separate funds for each revenue source, etc.). **PTV**	☐	☐	☒	☐	☐	Documentation: Detailed General Ledger for the current FY, for the period July 1, 2023 – February 1, 2024. The agency maintains a detailed general ledger that is structured to track all funding sources as well as activities for the CINS/FINS program. The GL includes the following items: type of transaction, date, account number, name, memo, split, amount, and balance.	
c. Petty cash ledger system is balanced and all cash disbursements are compliant with financial policies and	☐	☐	☒	☐	☐	Observation/Documentation:	

2023-2024 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 01-31-2023-2024

Agency Name: Florida Keys Children's Shelter	**Monitor Name: Marcia Tavares**
Contract Type : CINS/FINS	**Region/Office: 73 High Point Rd., Tavernier, FL 33070**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): January 31 – February 1, 2024**

Major Programmatic Requirements	**Explain Rating**					**Ratings Based Upon:** **I = Interview** **O = Observation** **D = Documentation** **PTV = Submitted Prior To Visit** **(List Who and What)**	**Notes** **Explain Unacceptable or Conditionally Acceptable:**
	Unacceptable	**Conditionally Unacceptable**	**Fully Met**	**Exceeded**	**Not Applicable**		
allowable under the contract. (Disbursements/invoices are approved & monitored by management.) –**ON SITE**						Reviewed petty cash Policy and Procedure 2.03 which is included in the Fiscal Policies and Procedures manual. The fund which does not exceed $500 is utilized for purchases under $50, unless approval is granted by Management. Petty cash is stored in a safe in the Residential Coordinator's office. The fund is reconciled weekly and submitted to the Executive Administrative Assistant/Human Resources for a refund. Disbursements and invoices are approved by the residential program coordinator.	
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**	☐	☐	☒	☐	☐	Reviewed Bank Statements and Bank Reconciliations for August-December 2023 for the program's Operating account and Cash/Bank Savings account held with Centennial Bank. Bank reconciliations are conducted by the Finance Manager each month for the activities and bank statements for the preceding month. The bank statements were all found to be	

2023-2024 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 01-31-2023-2024

Agency Name: Florida Keys Children's Shelter	**Monitor Name: Marcia Tavares**
Contract Type : CINS/FINS	**Region/Office: 73 High Point Rd., Tavernier, FL 33070**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): January 31 – February 1, 2024**

Major Programmatic Requirements	Explain Rating: Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable	Ratings Based Upon: I = Interview; O = Observation; D = Documentation; PTV = Submitted Prior To Visit (List Who and What)	Notes: Explain Unacceptable or Conditionally Acceptable:
						reconciled consistently within six weeks of receipt. Invoices are submitted on a monthly basis with supporting documentation. The agency maintains individual vendor files which are kept in secure file cabinets in the Executive Admin Assistant's office.	
e. Agency maintains inventory in accordance with a written policy and FNYFS contractual requirements. If over $1,000 inventory has DJJ Property Inventory Number/Tag. In the event the provider has purchased computer equipment an Informational Resources Request (IRR) has been submitted to DJJ. **PTV/ON SITE**	☐	☐	☐	☐	☒	The program has not purchased any equipment with Florida Network funds.	
f. Agency submits payroll taxes and deposits (and retirement deposits as applicable), Employee IRS Form W-2 and Independent Contractors IRS Form 1099 forms prior to federal requirements. **ON SITE**	☐	☐	☒	☐	☐	Documentation: Provider contracts with ADP for its payroll services. Electronic filings of the 1099 Tax Return and 941s are conducted by ADP. The most recent 941 filings for the 2nd and 3rd quarters of 2023 were reviewed. The 941 reports demonstrate that the provider is submitting its payroll taxes as	

2023-2024 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 01-31-2023-2024

Agency Name: Florida Keys Children's Shelter	**Monitor Name: Marcia Tavares**
Contract Type : CINS/FINS	**Region/Office: 73 High Point Rd., Tavernier, FL 33070**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): January 31 – February 1, 2024**

Major Programmatic Requirements	Explain Rating: Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable	Ratings Based Upon: I = Interview; O = Observation; D = Documentation; PTV = Submitted Prior To Visit; (List Who and What)	Notes: Explain Unacceptable or Conditionally Acceptable:
						required in a timely manner with no balances due indicated on the returns.	
g. Budget to actual reports prepared and reviewed by appropriate management. Variance from the budget are investigated and explained. **PTV/ON SITE**	☐	☐	☒	☐	☐	Documentation: Agency's Budget vs Actual report for the period July 1, 2023 – January 2024 was reviewed. The report demonstrates that the provider tracks budget variances for the CINS/FINS program separately on a monthly basis. Financial reports are sent to the Board Treasurer monthly for review and the CEO/Finance Manager presents the same at the agency's Board meetings. Meeting minutes and agendas demonstrate this practice.	
h. A Single Audit is performed as part of the annual audit if expenses are greater than $750,000. The agency must submit a Corrective Action Plan for findings cited in the management letter and single audit. An annual financial audit was completed within 120 days after the previous fiscal year/calendar year and that a copy was provided to the Network unless and extension has been requested and approved in writing. Copy of Audit is submitted to the FNYFS by December 31st. **Can obtain from FNYFS**	☐	☐	☒	☐	☐	The most recent completed Financial Audit was reviewed. Accounting firm, Verdeja, DeArmas, Trujillo issued a letter on 12/18/2023 stating they reviewed the provider's accounting policies and found them to be adequate. The financial audit was completed for the year ending 6/30/2022 and 2021. No management	

2023-2024 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 01-31-2023-2024

Agency Name: Florida Keys Children's Shelter	**Monitor Name: Marcia Tavares**
Contract Type : CINS/FINS	**Region/Office: 73 High Point Rd., Tavernier, FL 33070**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): January 31 – February 1, 2024**

Major Programmatic Requirements	Explain Rating: Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable	Ratings Based Upon: I = Interview; O = Observation; D = Documentation; PTV = Submitted Prior To Visit; (List Who and What)	Notes: Explain Unacceptable or Conditionally Acceptable:
						letter was issued because the audit did not disclose any matters that are reportable for the current year. A copy of the financial audit is on file with the Reviewer.	
i. Agency maintains confidentiality policy with written policies and procedures to ensure the security and privacy of all employee and client data. Personal information is not easily accessible. Agency maintains a backup system in case of accidental loss of financial information. Security procedures are in place to protect laptops. Obsolete documents are shredded and computer hard drives are wiped prior to discarding. **ON SITE**	☐	☐	☒	☐	☐	Documentation: Policy and Procedure number: 1.04 (Computer Back-up), 1.16 (Confidentiality-HIPAA), E.2 (Confidentiality), 1.26 (Client Records), and 8.04 (Record Retention) were reviewed. Daily back-ups are made to keep data back-up current and monthly offsite storage of the back-up disk is maintained by the COO during ordinary circumstances.	
j. Agency provided evidence that every direct care staff employee, as of October 1, 2023, is being paid at least $19.00 per hour. This also includes funding for additional staff as approved by the Department. **ON SITE**	☐	☐	☒	☐	☐	Documentation: Provider submitted a copy of the payroll register that shows earnings for all direct care staff. Documentation support FCS offers a higher salary than required and staff's hourly rate starts at a minimum $24/hour.	

CONCLUSION

Florida Keys Children's Shelter 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 14 indicators were not applicable because: 1) there are no outstanding corrective action item(s) cited by any external funding sources, and 2) the program does not have any current inventory purchased with DJJ/FN Funds. Consequently, **the overall compliance rate for this contract monitoring visit is 100%.** There are no corrective actions cited or recommendations made as a result of the contract monitoring visit. Overall, the provider is performing satisfactorily in meeting the fiscal and administrative terms of its contract. 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 Florida Keys Children's Shelter, Inc. - Tavernier, Florida
CINS/FINS Program

January 31-February 1, 2024

Compliance Monitoring Services Provided by

FOREFRONT

CINS/FINS Rating Profile

Standard 1: Management Accountability

1.01 Background Screening of Employees/Volunteers	Satisfactory
1.02 Provision of an Abuse Free Environment	Satisfactory
1.03 Incident Reporting	Satisfactory
1.04 Training Requirements	Satisfactory
1.05 Analyzing and Reporting Information	Satisfactory
1.06 Client Transportation	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)	Not Applicable

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

Standard 3: Shelter Care & Special Populations

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

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

Standard 4: Mental Health/Health Services

4.01 Healthcare Admission Screening	Satisfactory
4.02 Suicide Prevention	Satisfactory
4.03 Medications	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:

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

Reviewers

Members

Marcia Tavares - Lead Reviewer Consultant-Forefront LLC/Florida Network of Youth and Family Services
Paula Friedrich– Regional Monitor, Department of Juvenile Justice
Teresa Clove – Thaise Educational Tours
Scoundrel Oliver– Lutheran Services Florida Southeast

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	X	Nurse – Part time
X	Chief Operating Officer		Advocate	4	# Case Managers
	Executive Director	X	Direct – Care Full time	1	# Program Supervisors
	Program Director		Direct – Part time		# Food Service Personnel
	Program Manager		Direct – Care On-Call	1	# Healthcare Staff
X	Program Coordinator		Intern		# Maintenance Personnel
	Clinical Director		Volunteer	1	# Other (listed by title): CLEO
	Counselor Licensed	X	Human Resources		

Documents Reviewed

	Accreditation Reports	X	Table of Organization		Visitation Logs
X	Affidavit of Good Moral Character	X	Fire Prevention Plan	X	Youth Handbook
X	CCC Reports	X	Grievance Process/Records	5	# Health Records
X	Logbooks		Key Control Log	5	# MH/SA Records
	Continuity of Operation Plan	X	Fire Drill Log	15	# Personnel /Volunteer Records
X	Contract Monitoring Reports	X	Medical and Mental Health Alerts	7	# Training Records
	Contract Scope of Services	X	Precautionary Observation Logs	9	# Youth Records (Closed)
X	Egress Plans	X	Program Schedules	3	# Youth Records (Open)
X	Fire Inspection Report	X	List of Supplemental Contracts		# Other: ___
	Exposure Control Plan		Vehicle Inspection Reports		

Observations During Review

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

Surveys

5	# of Youth	6	# 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

The Florida Keys Children's Shelter (FKCS) contracts with the Florida Network to operate the Child in Need of Services and Family in Need of Services (CINS/FINS) program in Monroe County, Florida. The program is located at the Tavernier's Jelsema Center, at the north-end of the county next to the Tavernier Government Center. Funding through CINS/FINS allows the agency to serve both male and female youth up to seventeen years old who are locked out, runaway, ungovernable and/or truant, homeless, abused, neglected, or at-risk. The agency provides services to special populations who meet the criteria for Staff Secure shelter, Domestic Minor Sex Trafficking, and youth referred by the Juvenile Justice Court System for domestic violence, probation respite, and Family/Youth Respite Aftercare Services (FYRAC). FKCS is not contracted to provide Intensive Case Management (ICM) services or SNAP. In addition to the CINS/FINS Program, the agency operates the Poinciana Emergency Shelter (birth through 10 years) and Poinciana Group Home (11-17 years old) in Key West, for children who have been removed from their families/homes as a result of abuse or neglect. It also provides street outreach through Project Lighthouse where staff conducts outreach in areas where homeless youth congregate with the goal of getting these youth help and providing a safe shelter. The youth census during the Quality Improvement (QI) visit was six CINS/FINS and three DCF (Department of Children & Families) youth. FKCS is currently accredited by the Council of Accreditation (COA) through July 31, 2024. The Council on Accreditation (COA) partners with human service organizations worldwide to improve service delivery outcomes by developing, applying, and promoting accreditation standards.

The following programmatic updates were provided by the agency:

Florida Keys Children's Shelter has once again experienced several positive changes and modifications in its residential and community outreach teams this year:

Staffing

Counseling Coordinator, Kayla Clark, received her Master's in Social Work from Florida International University. With a host of professional training, certifications, and skills in her background, along with her commitment and dedication to helping at risk youth. Ms. Clark proves to be an excellent professional and a welcome addition to the team.

Residential Coordinator, Maile Horn, has a Masters of Arts in Psychology from Pepperdine University and is also an adjunct instructor with the College of the Florida Keys. Among her many certifications, recognitions, and achievements, Ms. Horn utilizes her knowledge of youth psychology and counseling to inform and direct the case management and support systems.

TLP (Transitional Living Program) Outreach Specialist, Christopher McNulty, was awarded his Masters of Arts in Philosophy and Religion from the California Institute of Integral Studies. Mr. McNulty is driven to utilize his training and experience to enhance the outreach efforts of the TLP. He also manages specific communications of the program through social media, collaborating with partner agencies and community resources as advocates for transitional/homeless/street-dependent youth.

On an extremely sad note, FKCS lost one of its most crucial and beloved team members, Paivi Johnson (Chief Learning and Evaluation Officer). Her devotion to the children she served at FKCS is her lasting legacy. Nathaly Milla has been transitioned from her role as Residential Coordinator to Quality Compliance Manager in efforts to fill the void left in Paivi's passing.

Program Updates

FKCS residential coaching program, now in its fifth year, continues to provide critical services of three coaching positions - life skills, education, and recreation. All coaches have college degrees and specific expertise that empower the organization to better support the youth served. With the recent increase of a higher pay scale, the agency has recruited these qualified professionals long-term with the support of one of our largest funders, the Ocean Reef Community Foundation, who once again granted $50,000 to aid this program.

The Jelsema Journey school break camp program, that includes last years' newly introduced Jelsema Mini-Camps, once again operated at capacity, receiving tremendous community support. The camps were held as free week-long or mini, overnight programs for at-risk youth ages 11-17 and offered field trips, group counseling, academic tutoring, counseling on conflict resolution and decision-making, during spring, summer and winter school holidays. Transportation, meals and incentives were all provided free of charge. This program provides a free, safe and educational alternative to at-risk youth who would otherwise lack adult supervision. It is the agency's goal to continue with the Jelsema Journey camp program in 2024.

FKCS also welcomed a new partnership with "Pawsitive Beginnings", a local nonprofit organization that provides a safe and happy home to foxes that have been saved from fur farms. This animal-assisted therapy program was born out of an idea that sharing stories of survival from the fox's perspective has the power to help heal those that may be struggling with trauma. Pawsitive Beginnings serves the entire county, visiting FKCS Jelsema, Project Lighthouse, and TLP locations monthly. Individual or small group therapy visits to Pawsitive Beginnings' location in the Upper Keys occurs on a weekly basis.

The agency is once again grateful to be in a position to provide qualifying team members end-of-year bonuses. FKCS hosted a fishing charter trip for its team members this past fall in Islamorada. The outing was an appreciated experience for all and resulted in creating tighter team bonds amongst the employees. The agency also held a holiday party for staff and board members at a local restaurant with games and prizes. FKCS continues to publish monthly employee newsletters, offered one month of free mental health services, and promotes the Employee of the Month program with gift card incentives. Presently, the agency is researching affordable healthcare benefits for all FKCS team members.

Facility

FKCS implemented additional improvements to its facilities and equipment this year, that included the following at our Tavernier/Jelsema Location:

- New outdoor climate-controlled storage units
- New bedroom, reception, and common room furniture (made possible with a supplemental grant from the Keys Children's Foundation – who, incidentally, assisted FKCS with purchasing that replaced furniture 17 years ago)
- New bicycles of varying sizes and helmets

In addition to the regularly-scheduled maintenance of all our locations and vehicles, the agency is planning to replace the signage for the outside of our Tavernier/Jelsema facility as well as replacing the bathroom vanities and towel racks.

Funding/Finance

In addition to securing various local, state, and federal government grants and contracts, FKCS continues to locate and successfully apply for more private funding. The agency currently contracted with Elemental Group to seek out additional funding sources with their fundraising and grant strategies. The expectation is that this nonprofit leadership development company will help the agency identify new funding opportunities, develop compelling grant proposals, and establish sustainable fundraising strategies. FKCS is also doing a website refresh in efforts to support overall communications and to assist in securing new sources of revenue.

Governance and Community

The Florida Keys Children's Shelter added three new members to its Executive Board, rounding out all open positions with highly-qualified and dedicated people: 1) Captain Spenser Bryan – With over 14 years of service in the Monroe County Sheriff's Office, as well as volunteering with a variety of local agencies, Captain Bryan offers a wealth of knowledge and experience to our board; 2) Jessica Blass – A Key West resident, MIT graduate, real estate agent with Oceans Sotheby, and office manager of her husband's surgical practice. Ms. Blass, also a mother to three young children in school, brings an insightful perspective to all of our board meetings and endeavors; and 3) Theresa Java – Ms. Java's 20 year career in the communications field, her talents in writing (a contributor to local papers like "Keys Weekly",) photography, and social media, as well as her compassion to help those most vulnerable in our Keys community is a very welcome addition to our board. Victoria Pena serves as the FKCS student representative during her senior year in high school. Ms. Pena provides a much needed and informative voice for youth.

The Florida Keys Children's Shelter has been a member in good standing for many years with the following chambers of commerce: South Dade, Ocean Reef, Key Largo, Islamorada, Marathon, Key West, and Key West Business Guild.

The agency also holds individual memberships and board positions through its leadership team with the following organizations: Leadership Monroe, Key Largo Sunset Rotary, Upper Keys Business and Professional Women, First Key in Paradise (FKIP) with the Key Largo Chamber of Commerce, and Upper Keys Sailing Club.

With the opening of the Transitional Living Program (TLP), the agency's partnerships with College of the Florida Keys and the Monroe County School District for continuing education benefit the clients as well as with employment possibilities. FKCS was once again awarded a grant from the Community Foundation of the Florida Keys to be used in conjunction with another nonprofit – Marine Lab – as a primary outing venue for its camp programs. The FKCS was recently selected to be the beneficiary charity for the following events in 2023 and 2024:

- Keys Weekly's "Best of the Upper Keys" contest
- YPN/Florida Keys Board of Realtors "Bingo Night"
- Key Largo Moose Lodge Steak Dinner Fundraiser
- Elks Lodge #1872 Dinner Fundraiser
- Key Largo Rotary Pasta Dinner Fundraiser
- Thrivent Action Team Valentines Day Party for FKCS clients

Other

Recruitment and retention of employees has continued to be one of the agency's biggest challenge. During this past year, FKCS was able to maintain increased pay to all employees, but have experienced obstacles in recruiting qualified employees, chief among them is an increased demand for a sustainable living wage and incentives that reflect the rising cost of living and inflation in the Florida Keys. Recent reduction in funding makes it difficult to sustain these higher payroll levels. It is vital to the momentum of the entire program and its continued success to increase the pay level of its youth support staff. As such, the agency strives to pursue new levels of private foundation funding to further transition these higher salaries into its annual budget indefinitely.

Narrative Summary

FKCS is located at 73 High Point Rd, Tavernier, FL. The agency has an eleven-member Board of Directors/Trustees with representatives from the upper, middle, and lower keys, to oversee the agency's goals, objectives, and activities. The FKCS building houses the CINS/FINS shelter on the first floor and the agency's administrative offices on the second floor. The shelter provides separate female and male dormitories to children under 18 years of age that are locked out, runaway, ungovernable and/or truant, homeless, abused, neglected, or at risk. The program has a Senior Management team that is comprised of a Chief Executive Officer, Chief Operating Officer (COO), Financial Manager, Chief Learning & Evaluation Officer, Counseling Services Coordinator, Residential Program Coordinator, and Executive Administrative Assistant. At the time of the onsite QI review, there were no staff vacancies reported.

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 with Exception**, Indicator 1.04 Training Requirements was rated **Satisfactory with Exception**, Indicator 1.05 Analyzing and Reporting Information was rated **Satisfactory,** Indicator 1.06 Client Transportation was rated **Satisfactory with Exception**, and Indicator 1.07 Outreach Services was rated **Satisfactory.**

Standard 2: There are nine indicators for Standard 2. Indicator 2.01 Screening and Intake was rated **Satisfactory with Exception**, Indicator 2.02 Needs Assessment was rated **Satisfactory with Exception**, Indicator 2.03 Case/Service Plan was rated **Satisfactory with Exception**, Indicator 2.04 Case Management and Service Delivery was rated **Satisfactory**, 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**, and Indicator 2.09 Stop Now and Plan (SNAP) was rated **Not Applicable**.

Standard 3: There are seven indicators for Standard 3. Indicator 3.01 Shelter Environment was rated **Satisfactory with 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**, Indicator 3.05 Behavior Management Strategies was rated **Satisfactory,** Indicator 3.06 Staffing and Youth Supervision was rated **Satisfactory**, and Indicator 3.07 Video Surveillance System was rated **Satisfactory with Exception**.

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

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

None of the indicators reviewed received a Limited or Failed rating.

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 provider has the required policy and procedure, 1.12 - Background Screening and Post Hire Arrest, that was approved 10/1/23 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: 15 new hires files
Total number of 5 Year Re-screen Employee Files: 1 re-screened employee file
Staff Position(s) Interviewed (No Staff Names): Office Manager
Type of Documentation(s) Reviewed: Staff roster, Department of Juvenile Justice Background Screening results, Pre-Employment assessment tool, E-Verify, Annual Affidavit of Compliance with Level 2 Screening Standards

All positions providing direct services to youth has successfully passed pre-employment suitability assessment on the initial attempt.	**Compliance**	Since January 2019, Florida Keys Children Shelter (FKCS) has utilized a self-created pre-employment suitability questionnaire screening tool that is comprised of 11 open ended questions, one of which is a bonus question. The suitability questionnaire tool captures responses to 11 typical job related scenarios for direct-care positions and was used to evaluate the 15 new staff hired during the review period. The tool has a pass rate of 70%; all 15 staff hired met or exceeded the pass rate.	
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**	All 15 applicable staff received passing scores.	
Agency has evidence for employees who have had a break in service for 18 months or more, and/or when the agency had a change or update in the suitability assessment tool used was different from the employee's original assessment, that a new suitability assessment and background screening was completed as required.	**No eligible items for review**	None of the new staff were prior agency employees.	

Background screening completed prior to hire/start date (or exemption obtained prior to working with youth if rated ineligible) for new hires, volunteers/interns, and contractors. *(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**	Background screenings for all 15 new hires were initiated prior to hire/start dates with eligibility documented on the DJJ background screening results. There were no exemptions required. The program did not utilize any interns/volunteers during the review period who met the criteria for background screenings.	
Five-year re-screening is completed every 5 years from initial date of hire or prior to retained fingerprints expiration date.	**Compliance**	The program had one staff who met the criteria for 5-year re-screening. The staff was re-screened on time and had valid retained prints in the clearinghouse.	
Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?	**Compliance**	The provider emailed its Annual Affidavit of Compliance with Level 2 Screening Standards on December 18, 2023 prior to the January 31st deadline.	
Proof of E-Verify for all new employees obtained from the Department of Homeland Security	**Compliance**	The program provided E-Verify documentation from the Department of Homeland Security for all of the new staff, verifying authorization to work.	
Additional Comments: **There are no additional comments for this indicator.**			
1.02: Provision of an Abuse Free Environment			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 1.02		**YES** If NO, explain here: The provider has multiple policies and procedures that meet the requirement of the indicator as follows: 1.10 - Employee Behavioral Expectations/Dress Code; 1.07 - Reporting of Child Abuse, 3.09 - Shelter Program Services, and 3.10 - Grievance Process. The policies were approved 10/1/2023 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): Shelter Coordinator, Residential Specialist **Type of Documentation(s) Reviewed: client handbook, client grievance file** **Describe any Observations: abuse hotline postings, grievance box, grievance forms**			
Agency has a code of conduct of policy and there is evidence that staff are aware of agency's code of conduct.	**Compliance**	The program has a behavioral expectation policy that prohibits the use of physical abuse, profanity, threats or intimidation as well as a code of conduct that is signed and dated by each employee during their initial orientation.	

The agency has a process in place for reporting and documenting child abuse hotline calls.	**Compliance**	Employees are required to report all known or suspected cases of abuse and/or neglect and youth have unimpeded access to self-report. The program documents child abuse hotline calls in a binder that is located in the staff monitoring room. A copy of the report is maintained in the youth's file. Four new direct care staff training files were reviewed all four have completed the required Child Abuse training. A total of five non-institutional abuse calls were reported during the review period.	
Youth were informed of the Abuse and Contact Number	**Compliance**	The abuse hotline number is posted in the facility and youth are given a handbook during admission that includes the hotline telephone number.	
Grievance			
Grievances are maintained on file at minimum for 1 year.	**Compliance**	The shelter coordinator maintains a record of grievances for a minimum of one year. A total six grievances were reported during the review period.	
There are formal grievance procedures for youth, including grievance forms, and a locked box which are easily accessible to youth in a common area.	**Compliance**	Youth are informed of the grievance procedures during orientation and a copy of the procedures is included in the resident handbook. Staff documents reviewing the grievance procedures with youth on the orientation checklist. There are two locked grievance boxes located outside each dorm, as well as grievance policies posted in each youth hallway. Grievance forms are located next to the grievance boxes and are accessible to youth.	
There is evidence that grievance boxes are checked by management or a designated supervisor at least daily as evidenced in the program logbook.	**Exception**	The grievance boxes are only accessed by the residential coordinator. Direct care staff do not handle the grievances. Grievance box checks, and documentation in the program logbook, for three randomly selected weeks during October-December was conducted. Evidence supported the grievance boxes were check daily during the week in all but one of the dates reviewed.	One grievance box check was missed (November 8th) out of the 15 days reviewed.
All grievances are resolved within 72 hours and documented by program director/supervisor or escalated to higher leadership if grievance involves them directly.	**Compliance**	All six grievances reviewed were resolved within 72 hours. All were resolved at either the informal level or supervisory level with the youth.	

1.03: Incident Reporting			Satisfactory with Exception
Provider has a written policy and procedure that meets the requirement for Indicator 1.03		**YES** If NO, explain here: The provider has the required policy and procedures, 1.13 - Incident Reporting, that was approved 10/1/2023 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 Specialist **Type of Documentation(s) Reviewed: DJJ CENTRAL COMMUNICATIONS CENTER (CCC) Incidents Detail Report and FKCS Internal Reports** **Describe any Observations: CCC number posted in facility**			
During the past 6 months, the program notified the Department's CCC (Central Communication Center) no later than two hours after any reportable incident occurred or within two hours of the program learning of the incident	**Exception**	Of the 29 CCC calls made in the past 6 months, 28 were called in within the 2 hours required.	One of 29 CCC incidents reported to CCC was not reported within the 2-hour timeframe. Contraband (cell phone) was discovered being used by youth in his room on 12/19/23 at 11:15pm but was not reported until the following day at 10:15am when the supervisor became aware of the incident.
The program completes follow-up communication tasks/special instructions as required by the CCC	**Compliance**	The DJJ CCC reports reviewed confirm follow-up tasks were completed by the agency when additional information or tasks were requested.	
Agency internal incidents are documented on incident reporting forms and all CCC reportable incidents were consistently reported to CCC as required.	**Exception**	The program documents internal incidents on an incident report form titled DJJ Central Communication Center Incident Report.	Failure to report a CCC reportable incident regarding a documented emergency offsite transport on 9/24/2023 was discovered while reviewing indicator 4.05. Upon notification, the provider contacted CCC and the call was accepted.
Incidents are documented in the program logs and on incident reporting forms	**Exception**	All incidents reported to CCC were found to be documented on incident reporting forms. The program logbook was reviewed for notation of five randomly selected incidents that were reported to CCC. The program's practice does not include documenting calls, or attempted calls, to the CCC in the program's logbook. Three of the CCC incidents were offsite medical transports. The medical transports were noted in the logbook; however, the reasons for the medical emergency/transport was not documented.	Two of the five CCC calls were related to contraband discovery; however, the contraband discovery incidents were not noted in the logbook.
All incident reports are reviewed and signed by program supervisors/ directors	**Compliance**	A breakdown of the types of incidents reported to CCC is as follows: medical transport = 18; contraband = 3; runaway = 5; youth arrest = 1; medication error = 1; and improper supervision = 1. All 29 incidents were reviewed and signed by the program supervisor.	

1.04: Training Requirements (*Staff receives training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions*)			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 1.04		**YES** If NO, explain here: The provider has the required policy and procedures, 5.01 - Employee Training, that was approved 10/1/2023 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: 4 **Total number of Annual In-Service Staff Files: 4** **Annual Training Plan Timeframe (Program timeframe for annual trainings): Annual training is based on the employee's anniversary date** **Type of Documentation(s) Reviewed: Training files**			
First Year Direct Care Staff			
All direct care staff have completed new hire pre-service training requirements for safety and supervision as required.	**Compliance**	Training records for four new hire staff were reviewed, three of whom are currently still completing the first year of training. All four staff have completed mandatory pre-service training required prior to working independently with youth.	
All staff completed the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days from date of hire.	**Compliance**	All four first year staff completed the DOJ Civil Rights and Federal Funds training within the 30 days required from hire.	
All direct care CINS/FINS staff (full time, part time, or on-call) demonstrated a minimum of 80 hours of training or more for the first full year of employment.	**Compliance**	All four first year staff completed the required 80 hours of required training during the first year of employment. .	
All staff receives all mandatory training during the first 90 days of employment from date of hire.	**Exception**	Two of four first year staff completed all mandatory trainings during the first 90 days of employment.	One staff (hire date 6/19/23) has not completed Motivational Interviewing training to date. A second staff (hire date 4/22/22) completed the DJJ SkillPro Mental Health Substance Abuse training in April 2022 but did not complete the required Florida Network Signs and Symptoms of Mental Health and Substance Abuse training in the first year.
Staff Required to Complete Data Entry for NIRVANA or access the Florida Department of Juvenile Justice Information System (JJIS)			
Any designated staff that is responsible for entering NIRVANA or ensuring accurate and complete data entry in the Florida Department of Juvenile Justice Information System (JJIS) have completed all of the required trainings.	**Compliance**	One applicable counseling staff was trained in NIRVANA prior to administration and data entry of the tool.	

Staff Participating in Case Staffing & CINS Petitions (within first year of employment)			
Documentation of instructor led FL Statute 984 CINS Petition Training by a local DJJ Attorney. *Effective for staff hired after 7/1/23*	**No eligible items for review**	One applicable staff hired June 2023 has time to complete the required training in the first year by June 2024.	
Non-licensed Mental Health Clinical Shelter Staff (within first year of employment)			
Documentation of non-licensed mental health clinical staff person's training in Assessment of Suicide Risk form or written confirmation by a licensed mental health professional of training (includes date, signature and license number of the licensed mental health professional supervisor).	**No eligible items for review**	The program has not hired any new non-licensed mental health clinical shelter staff person during the review period.	
In-Service Direct Care Staff			
Direct care staff completes 24 hours of mandatory refresher Florida Network, SkillPro, and job-related training annually *(40 hours if the program has a DCF child caring license).*	**Exception**	Three annual staff training records reviewed revealed all three staff completed the required 40 hours of training and two of the three completed the required mandatory annual training.	One in-service staff did not complete eight of 12 mandatory trainings by their anniversary date 11/9/23. All eight training topics were recently completed in January and will apply to the current training year.
Required Training Documentation			
The agency has a training plan that includes all of the required training topics including the pre-service and in-service.	**Compliance**	The program has a training plan that lists all of the required training topics required for both 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 Quality Compliance Manager (QCM) is the designated staff member responsible for managing all employees' individual training files and completes routine reviews of staff files to ensure compliance.	
The program maintains an individual training file or employee file AND a FLN Training Log (or similar document that includes all requirements) for each staff, which includes an annual employee training hours tracking form and related documentation, such as electronic record/transcript, training certificates, sign-in sheets, and agendas for each training attended.	**Compliance**	The program individual training files for each staff that includes a training log with cumulative hours, transcripts, certificates, sign-in sheets and/or verification of the training.	
Additional Comments: **There are no additional comments for this indicator.**			

1.05 - Analyzing and Reporting Information			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 1.05		**YES** If NO, explain here: The provider has multiple policies and procedures that meet the requirement of the indicator as follows: 1.03-Quality Improvement Initiatives, 1.19 -Data Collection, Analysis and Reporting,1.20-Risk Management/Internal Quality Monitoring, and 1.22-External Review Findings Integration. The policies were approved 0n 10/1/2023 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.*			
Describe any Observations: "Staff Position(s) Interviewed (No Staff Names): CEO, COO, and Quality Compliance Manager **Type of Documentation(s) Reviewed: Performance and Quality Improvement Plan, quarterly case record reviews, annual and quarterly risk management reports, board of director meeting minutes, program committee/staff meeting agendas/minutes, and NetMIS data reports.**			
Case record review reports demonstrate reviews are conducted quarterly, at a minimum	**Compliance**	Quarterly case record reviews are completed for each program at least once per quarter by the Quality Compliance Manager for the Residential files, and by the Community Counseling Coordinator for the Community Based Counseling Program. When an area is noted to be missing information or needing correction, staff is notified to correct the issue (when possible). A Corrective Action Plan is completed, as needed, if the case record review reveals significant deficiencies. Any trends/patterns are identified and shared with the Leadership team. Case record reviews are documented on a Quality Record Review form and were conducted for 24 residential and 38 community counseling records for the 1st and 2nd quarters of FY2023-2024.	
The program conducts reviews of incidents, accidents, and grievances quarterly, at a minimum	**Compliance**	Florida Keys Children's Shelter conducts monthly risk management reviews of all incident reports, grievances and accidents involving persons served or personnel for all program sites. The CEO or its designee will prepare monthly risk management reports compiling the information as included in the previous paragraphs. The reports are disseminated to Leadership Team members on a monthly basis for review prior to scheduled meetings. Quarterly risk reports for the 1st and 2nd quarters of FY2023-2024 were reviewed and observed to include a collection of data on incidents, accidents, grievances, abuse calls, CCC calls, and fire/emergency drills.	

The program conducts an annual review of customer satisfaction data	**Compliance**	An assigned staff member is responsible for entering the results on the Satisfaction Surveys into the data entry system and forwarding the original questionnaire to the CEO for retention. The results from questionnaires are processed annually to produce a report of satisfaction. The last annual youth survey data aggregated by the CEO was reviewed based on 183 responses with 99% of youth indicating overall satisfaction with services provided.	
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**	At least annually, Florida Keys Children's Shelter collects and reviews several sources of information and/or areas to identify patterns and trends including outcome data. Additionally, outcomes data is generated by CEO and COO and included in the provider's monthly leadership report. Data is collected on program effectiveness, client outcomes, and CQI. The outcome data incorporates all of the contract, NetMIS, and program benchmarks required by the Florida Network and DJJ. Documentation support the CEO presents program performance at Board of Director's meetings.	
The program has a process in place to review and improve accuracy of data entry & collection	**Compliance**	Florida Keys Children's Shelter (FKCS) utilizes the NETMIS (Network Management Information System) and JJIS (Juvenile Justice Information System) to track data. All youth information is entered into the NETMIS and JJIS. FKCS cooperates with the Florida Network in their efforts to collect uniform and accurate client data and inconsistencies are monitored by the CEO and resolved immediately by program manager's. End of month (EOM) NetMIS data is reviewed on a monthly basis by the program managers who correspond mainly via email to communicate areas of performance met/deficient.	
There is documentation that findings are regularly reviewed by management and communicated to staff and stakeholders.	**Compliance**	Monthly risk management reports are presented for review and discussion during Leadership Team meetings. Management reviews all findings on a regular basis and communicates them to staff and stakeholders. Strengths and weaknesses are identified, improvements are implemented or modified and staff are informed and involved throughout the process. In addition, all risk management reports are submitted to the Governance board annually.	
There is evidence the program demonstrates that critical performance data reports are shared with the Board of Directors frequently. All final reports that include a Limited or Failed score is submitted electronically or by mail to the providers Executive Committee on the Board of Directors.	**Compliance**	The COO provided minutes of board meetings held in December 2022 and January 2024 to support program performance data reports are shared with the Board of Directors.	

There is evidence that strengths and weaknesses are identified, improvements are implemented or modified, and staff are informed and involved throughout the process.	**Compliance**	Following external or internal reviews and receipt of written review findings, the Leadership Team meets and determines how the findings can best be integrated into the PQI process and what corrective actions may be required and/or advised. Areas of concern are discussed and reviewed during Leadership Team Management held at least monthly. Issues discussed and resolutions are included in the meeting minutes. Program supervisors and direct care staff are requested to provide input into the most conducive and time-effect manner changes can be facilitated. Feedback is provided to staff as to overall effectiveness of changes facilitated.	
Additional Comments: **There are no additional comments for this indicator.**			
1.06: Client Transportation			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 1.06		**YES** If NO, explain here: The provider has the required policy and procedure 8.02 Transportation of Youth, that was approved 10/1/2023 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.*			
Dates or Timeframe Reviewed: August 2023-January 2024 **Staff Position(s) Interviewed (No Staff Names): QCM** **Type of Documentation(s) Reviewed: Van transportation logs** **Describe any Observations: single transport entries were observed**			
Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	**Compliance**	The agency has implemented a transportation policy with drivers approved by the administration. A list of 32 agency approved drivers is maintained by the program. The program has two vans used to transport youth	
Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	**Compliance**	Driver's license check results were provided for all approved drivers validating they are clear to drive agency vehicles. All approved drivers were found to have valid Florida drivers' licenses and are covered under the organization's insurance policy.	
Agency's Transportation policy prohibit transporting a client without maintaining at least one other passenger in the vehicle during the trip and include exceptions in the event that a 3rd party is NOT present in the vehicle while transporting	**Compliance**	The transportation policy prohibits transporting a client without maintaining at least one other passenger in the vehicle. The 3rd party must be an approved volunteer, intern, agency staff, or other youth.	
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 program supervisor notes approval in the event that a 3rd party cannot be obtained for transport, taking into consideration the client's history, evaluation and recent behavior before giving approval prior to transport.. Notation of approval is made on the transportation log.	

The 3rd party is an approved volunteer, intern, agency staff, or other youth	**Compliance**	The 3rd party was observed to be documented on the transportation log as an agency staff or other youth.	
The agency demonstrated evidence via logbook or other written verification that supervisor approval was obtained prior to all single youth transports.	**Exception**	During the review period, the program conducted over 300 single transport. A random sample of 25 single transport events were reviewed. All were recorded on the transportation log and show supervisor's approval. All 25 randomly selected single transports were recorded in the logbook. Twenty-one of the 25 single transports evidenced prior approval by the supervisor.	Four of the 25 single transports reviewed did not show prior approval by the supervisor.
There is documentation of use of vehicle that notes name or initials of driver, date and time, mileage, number of passengers, purpose of travel and location.	**Compliance**	The agency has two vans that have two separate transportation logs. Each log notes the names/ initials of the driver and 2nd party, the date & time of the trip, mileage, number of passengers and purpose of travel along with the destination.	
Additional Comments: **There are no additional comments for this indicator.**			
1.07 - Outreach Services			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 1.07		**YES** If NO, explain here: The provider has the required policy and procedure 7.01 - Prevention/Outreach & Community Partnerships, that was approved on 10/1/2023 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)* **: CEO, COO, and Development Director / Type of Documentation(s) Reviewed: DJJ Meeting Agenda, partnership agreements, flyers, Pictures of the events, and meeting minutes.** **Describe any Observations:**			
The program has a lead staff member designated to participate in local DJJ board, Circuit and Council meetings with evidence that includes minutes of the event or other verification of staff participation.	**Compliance**	The CEO, Development Director, and COO are lead staff members designated to participate in DJJ board, Circuit and Council meetings as evidenced by their participations from the event minutes for two meetings held in August and November 2023.	
The program maintains written agreements with other community partners which include services provided and a comprehensive referral process.	**Compliance**	The provider maintains written agreements with community partners and a comprehensive referral process that allows them to refer to outside agencies and outside agencies to refer to them as evidence by their referral forms and written agreements.	

The program will maintain documentation of outreach activities and enter into NetMIS the title, date, duration (hours), zip code, location description, estimated number of people reached, modality, target audience and topic.	**Compliance**	Program staff attended a total of 43 Outreach Activities from July to January 2024. All the mandatory information for Outreach was listed in the NETMIS system with the title, date, duration, zip code, location description, number of people in attendance, modality, targeted audience, and topic as required.	
The program has designated staff that conducts outreach which is defined in their job description.	**Compliance**	The provider has designated staff that attends outreach and the responsibility is also included on their job description. The CEO, Development Director, and COO are lead staff members designated to conduct outreach but counseling/case management staff also participate in outreach activities.	
Additional Comments: **There are no additional comments for this indicator.**			
2.01 - Screening and Intake			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.01		**YES** If NO, explain here: The provider has the required policy and procedure 2.01 - Screening and Intake, that was approved on 10/1/2023 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 Residential and 2 Community Counseling open files **Total number of Closed (Residential & Community) Files: 4 Residential and 3 Community Counseling closed files** **Staff Position(s) Interviewed** *(No Staff Names)* **: 4 counselors, CEO and COO** **Type of Documentation(s) Reviewed: Case files**			
Shelter youth: Eligibility screening is completed immediately for all shelter placement inquiries.	**Compliance**	Screenings were completed immediately for all five shelter youth reviewed. One screening and one inventory form did not include the staff or supervisor's signature and date.	
Community counseling: Eligibility screening is completed within 3 business days of referral by a trained staff using the Florida Network screening form.	**Compliance**	Screenings were completed within three business days for all community counseling youth by a trained staff using Florida Network screening form, as evident by the date and time entered by the staff person on the screening form. It was also observed in NETMIS on the screening page.	
There is evidence all referrals for service is screened for eligibility and is logged in NetMIS within 72 hours of screening completion.	**Compliance**	It was evident that all referrals were screened for eligibility by review of the screening forms and then logged into NETMIS within 72 hours as evidenced on the NETMIS System Screening page as well as the screening form in the case file.	
Youth and parents/guardians receive the following in writing: a. Available service options b. Rights and responsibilities of youth and parents/guardians	**Compliance**	All youth and parent/guardians received the available service options, rights and responsibilities of youth and parents/guardian in writing as evidenced by their signatures on the forms in the case files.	

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**	Possible actions occurring through involvement with CINS/FINS services and grievance procedures were also made available to the youth and family as evidenced by the parent/guardian and youth signatures on the form in the case file.	
During intake, all youth were screened for suicidality and assessed as required if needed.	**Compliance**	During intakes, case records support all youth were screened for suicide and assessed further, if needed, as evidenced by the suicide risk screening completed by staff and signed by a supervisor and/or licensed staff.	
Additional Comments: **There are no additional comments for this indicator.**			
2.02 - Needs Assessment			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 2.02		**YES** If NO, explain here: The provider has the required policy and procedure 2.02 - NIRVANA Assessment that was approved 10/1/23 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 Open (Residential & Community) Files: 1 Residential and 2 Community Counseling open files **Total number of Closed (Residential & Community) Files: 4 Residential and 3 Community Counseling closed files** **Staff Position(s) Interviewed** *(No Staff Names)* **: 4 counselors, CEO and COO** **Type of Documentation(s) Reviewed: Case Files- NIRVANA Assessment - NETMIS System for the NIRVANA Assessment**			
Shelter Youth: NIRVANA is initiated within 72 hours of admission	**Compliance**	The NIRVANA Assessments for the five residential records reviewed were all completed within 72 hours of admission and was placed in the case file.	
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**	The Nirvana Assessments were initiated at Intake and completed within 2 to 3 face contacts for all five community counseling records reviewed. The Nirvana Assessments were observed in the NETMIS system and one was observed in the case file.	
Supervisor signatures is documented for all completed NIRVANA assessments and/or the chronological note and/or interview guide that is located in the youths' file.	**Exception**	All 5 of the Residential case records reviewed included a completed NIRVANA assessment and was in the case file. A supervisor's signature was documented on the NIRVANA assessments for the five residential records and one of the community counseling record.	Four of five community counseling records did not include the required supervisor's signature on the completed NIRVANA assessments as the four Nirvana Assessments were not in the case file. The four (4) Nirvana Assessment was observed in the NETMIS system as being completed but was not in the case file.

(Shelter Only) NIRVANA Self-Assessment (NSR) is completed within 24 hours of youth being admitted into shelter. If unable to complete, there must be documentation in NetMIS and the youth's file explaining the barriers to completion.	**Compliance**	The NIRVANA Self Assessments were completed within 24 hours of the youth being admitted to the shelter as evidence of the Self-Assessment in the case files completed and dated.	
A NIRVANA Post-Assessment is completed at discharge for all youth who have a length of stay that is greater than 30 days.	**Compliance**	All seven youth who had a stay greater than 30 days had a Post NIRVANA Assessment completed which was placed in the case file and was entered into the NETMIS system.	
A NIRVANA Re-Assessment is completed every 90 days excluding files for youth receiving SNAP services.	**Compliance**	There were only two community counseling youth that were required to have a NIRVANA Re-Assessment completed and they were completed and placed in the case file and were entered into the NETMIS system.	
All files include the interview guide and/or printed NIRVANA.	**Compliance**	All ten case files reviewed included a printed NIRVANA .	
Additional Comments: **There are no additional comments for this indicator.**			
2.03 - Case/Service Plan			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 2.03		**YES** If NO, explain here: The provider has the required policy and procedure 2.03 -Case/ Service Plan that was approved 10/1/23 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 Open (Residential & Community) Files: 1 Residential and 2 Community Counseling open files **Total number of Closed (Residential & Community) Files: 4 Residential and 3 Community Counseling closed files** **Staff Position(s) Interviewed** *(No Staff Names)* **: 4 counselors, CEO and COO** **Type of Documentation(s) Reviewed: Case file**			
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**	The service plans are developed on a local provider-approved form and is based on information gathered during the screening, intake and Nirvana as evidence by the screening and intake form and NIRVANA assessment evaluations in the case files.	
Case/Service plan is developed within 7 working days of NIRVANA	**Exception**	Nine of ten case plans reviewed were developed within 7 working days of the NIRVANA as indicated on the service plan date.	One of ten service plans was developed within 14 days of the NIRVANA Assessment. The NIRVANA was completed on 9/13/23 and the service plan was not developed until 9/27/23.

Case plan/service plan includes: 1. Individualized and prioritized need(s) and goal(s) identified by the NIRVANA 2. Service type, frequency, location 3. Person(s) responsible 4. Target date(s) for completion and Actual completion date(s) 5. Signature of youth, parent/ guardian, counselor, and supervisor 6. Date the plan was initiated	**Exception**	Eight of the ten service plans reviewed included individualized and prioritized needs and goals identified by the NIRVANA, service type, frequency, location; persons responsible; target dates for completion and actual completion dates; signature of youth, parent/ guardian, counselor, and supervisor; and date the plan was initiated. Another service plan did not include the parent, youth, staff and supervisor signatures; however, the counselor wrote in the case notes that the client was not seen after the initial intake.	One of the ten service plans was missing the target date for completion of goals.
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**	Seven (7) out of ten (10) case files were applicable for 30 day reviews and was completed as evidenced by the review dates listed on the service plan along with the initials of the staff, client and parents.	
Additional Comments: **There are no additional comments for this indicator.**			
2.04 - Case Management and Service Delivery			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.04		**YES** If NO, explain here: The provider has the required policy and procedures 1.02 - Program Description, Mission, Vision and Values that was approved on 10/1/23 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 Open (Residential & Community) Files: 1 Residential and 2 Community Counseling open files **Total number of Closed (Residential & Community) Files: 4 Residential and 3 Community Counseling closed files** **Staff Position(s) Interviewed** *(No Staff Names)* **: 4 counselors** **Type of Documentation(s) Reviewed: Case Files, Follow-up book**			
Counselor/Case Manager is assigned	**Compliance**	All 10 records reviewed included evidence of the counselors name and credentials assigned to the case.	

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**	As observed in the case files, the counselors established referrals and coordinated referrals based on the needs of the family, implemented and coordinated the service plans, provided support for the families, monitored the youth and family progress and documented it in the case notes, and provided case termination notes in the discharge summary and in the case notes for the clients that were terminated. One (1) client was referred for additional service and it was evidence by a referral form in the case file. There were no applicable court ordered cases reviewed. Six (6) cases out of the 10 reviewed were due for a 30 day follow-up and they were completed as evidenced by the follow-ups in the Follow-Up Book and documentations in the case notes. Three (3) out of the ten (10) were due for a 60-day follow-up and they were completed and were observed in the Follow-Up Book as well as the documentation in the case file.	
The program maintains written agreements with other community partners that include services provided and a comprehensive referral process	**Compliance**	Florida Keys maintains written agreements with community partners that allows them to refer their youth for additional services. They have a written process that allows them to refer to the 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 provider has the required policy and procedures 1.02 - Program Description, Mission, Vision and Values, and 3.09 - Shelter Services, that were approved on 10/1/23 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 Open (Residential & Community) Files: 1 Residential and 2 Community Counseling open files **Total number of Closed (Residential & Community) Files: 4 Residential and 3 Community Counseling closed files** **Staff Position(s) Interviewed** *(No Staff Names)* **: 4 counselors** **Type of Documentation(s) Reviewed: Case files**			
Shelter Program			
Shelter programs provides individual and family counseling	**Compliance**	Individual and family counseling was observed in the case file notes for applicable shelter youth.	
Group counseling sessions held a minimum of five days per week	**Compliance**	The shelter provided group counseling sessions five days a week as evidenced by group sessions logged in the shelter log book and the group log book.	

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**	It was observed that group sessions were documented in the group log book and that the group sessions consisted of a leader/facilitator, relevant topic, opportunity for youth to participate and that the groups sessions lasted 30 minutes are longer.	
Documentation of groups must include date and time, a list of participants, length of time, and topic.	**Compliance**	It was observed in the group log that documentation of groups included the date, time, a list of client participants, the length of time and the topic.	
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**	The community counseling program provides therapeutic services designed to provide intervention needed to stabilize the family in the office, in the school or in the community and is documented in the case file notes. The case files reflected where the services were provided and the progress of the client and 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 of the files reviewed reflected coordination between presenting problem(s), psychosocial assessment, case/service plans, case/service plan reviews, case management, and follow-up when applicable.	
Maintain individual case files on all youth and adhere to all laws regarding confidentiality	**Compliance**	Florida Keys program maintains individual case files on each youth and adheres to the law regarding confidentiality. Each case file had confidential on the front and back and was secured in a locked case file mark confidential.	
Case notes maintained for all counseling services provided and documents youth's progress	**Compliance**	The case files notes were observed in each case file and were observed to document the client's progress or lack of progress.	
On-going internal process that ensures clinical reviews of case records and staff performance	**Compliance**	The program has an internal process that ensures clinical reviews of case records and staff performance. The supervisor or the clinical staff meets with the counselors for supervision on a regular basis and documents the supervision in the case file.	
Additional Comments: **There are no additional comments for this indicator.**			

2.06 - Adjudication/Petition Process			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 2.06		**YES** If NO, explain here: The provider has the required policy and procedures 3.04- Staffing Committee that was approved on 10/1/23 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 Open (Residential & Community) Files: 1 Residential and 2 Community Counseling open files **Total number of Closed (Residential & Community) Files: 4 Residential and 3 Community Counseling closed files** **Staff Position(s) Interviewed** *(No Staff Names)* **: counselor** **Type of Documentation(s) Reviewed: Case File**			
Must include: a. DJJ rep. or CINS/FINS provider b. Local school district representative	**Compliance**	The provider had only one case staffing that was held this year on April 17, 2023. A DJJ Representative, the CINS/FINS provider, and the school district representative were present as evidenced by their signatures of the sign-in form.	
Other members may include: a. State Attorney's Office b. Others requested by youth/ family c. Substance abuse representative d. Law enforcement representative e. DCF representative f. Mental health representative	**Compliance**	Per the program's policy and procedure, other members of the committee may include: State Attorney's Office; others requested by youth/ family; substance abuse representative; law enforcement representative; DCF representative; and mental health representative.	
The program has an established case staffing committee, and has regular communication with committee members	**Compliance**	The program has a case staffing committee that meets when they have a youth to staff. Only one request for staffing occurred this year on April 17, 2023.	
The program has an internal procedure for the case staffing process, including a schedule for committee meetings	**Compliance**	The case staffing has an internal process for the case staffing which includes a schedule of meetings. It is decided in the supervision meeting with the counselor and supervisor whether a client will need to be assigned for case staffing. If a case is recommended for case staffing, then the parents are notified along with the case staffing team, and a meeting would be scheduled.	
The youth and family are provided a new or revised plan for services	**Compliance**	As a result of the case staffing the client and family were provided a new case plan for services. The plan was signed by the client and the parent which ensured that they received it.	
Written report is provided to the parent/guardian within 7 days of the case staffing meeting, outlining recommendations and reasons behind the recommendations	**Compliance**	A written report was provided to the parent/guardian within seven days of the case staffing as evidenced in the case file documentation.	
If applicable, the program works with the circuit court for judicial intervention for the youth/family	**Not Applicable**	No judicial intervention was required.	

Case Manager/Counselor completes a review summary prior to the court hearing	**Not Applicable**		
Additional Comments: **There are no additional comments for this indicator.**			
2.07 - Youth Records			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.07		**YES** If NO, explain here: The provider has the required policy and procedures 2.07- Youth Records, that was approved on 10/1/23 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)* **: 4 Counselors** **Type of Documentation(s) Reviewed: Client Case Files** **Describe any Observations: Case files, transportation container, and file cabinet were labeled confidential, opaque, and secured**			
All records are clearly marked 'confidential'.	**Compliance**	All 10 case files reviewed were marked confidential on the front and back of the folders.	
All records are kept in a secure room or locked in a file cabinet that is marked "confidential"	**Compliance**	A tour of the facility was conducted to observe where the case files are kept. The files are kept in a secure room in a locked file cabinet with confidential marked on the file cabinet.	
When in transport, all records are locked in an opaque container marked "confidential"	**Compliance**	The program uses a locked opaque container that is marked confidential and used to transport client records.	
All records are maintained in a neat and orderly manner so that staff can quickly and easily access information	**Compliance**	All the case files were observed to be well maintained, neat and in an orderly manner.	
Additional Comments: **There are no additional comments for this indicator.**			
2.08 - Specialized Additional Program Services			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.08		**YES** If NO, explain here: The provider has the required policy and procedures 3.08 - Specialized Additional Program Services, that was approved 10/1/23 by the 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.*			
Staff Position(s) Interviewed: Quality Compliance Manager, Residential Specialist			

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**	FKCS has not served any youth who meet the criteria for Staff Secure services 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.*

Staff Position(s) Interviewed: Quality Compliance Manager, Residential Specialist

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**	FKCS has not served any youth who meet the criteria for Domestic Minor Sex Trafficking (DMST) services 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 Closed Files: Two (2) Domestic Violence closed files **Staff Position(s) Interviewed** *(No Staff Names)* **: 2 counselors** **Type of Documentation(s) Reviewed: Case Files**			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	**Yes**	A total of two DV youth were served since the last onsite review and both records were reviewed.	
Youth admitted to DV Respite placement have evidence in the file of a pending DV charge	**Compliance**	The domestic violence charges were observed on the client's face sheet in the two case files.	
Data entry into NetMIS within (3) business days of intake and discharge	**Compliance**	The data was entered into NETMIS within 3 days of intake as indicated in the NETMIS system and in the case file.	
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.	**Not Applicable**	Neither youth had a length of stay over 21 days. Both were in the shelter for less than 10 days as indicated on the discharge forms.	

Case plan in file reflects goals for aggression management, family coping skills, or other intervention designed to reduce propensity for violence in the home	**Not Applicable**	The two youth were not in the shelter long enough to have a formalized case plan.	
All other services provided to Domestic Violence Respite youth are consistent with all other general CINS/FINS program requirements	**Compliance**	All services provided to domestic violence youth are consistent with all other CINS/FINS services as evidenced in the case files. The youth case files have the same case file forms and require the same services as other youth in the CIN/FINS program.	
Probation Respite			
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Staff Position(s) Interviewed: Quality Compliance Manager, Residential Specialist			
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**	FKCS has not served any youth who meet the criteria for Probation Respite 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.*			
Staff Position(s) Interviewed: Quality Compliance Manager, Residential Specialist			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	**Not Applicable**	FKCS is not contracted to provide ICM services.	
Youth receiving services were deemed chronically truant and/or runaway and require more intensive and lengthy services. The youth was determined to be eligible because they have gone through petition and/or case staffing and was in need of case management services.	**Not Applicable**		
Services for youth and family include: a. Two (2) direct contacts per month b. Two (2) collateral contacts per week c. Direct and collateral contacts not obtained must have documentation to support attempts made to obtain them. All reasonable attempts (at minimum of three) must be made to reach all contacts (direct and collateral) and documented in the case file and NetMIS.	**Not Applicable**		
Assessments include a. NIRVANA at intake b. NIRVANA Re-Assessment every 90 days c. Post NIRVANA at discharge as aligned with timeframe requirements	**Not Applicable**		
Service/case plan demonstrates a strength-based, trauma-informed focus	**Not Applicable**		
For any virtual services provided, there is written documentation in the youths' file as to why virtual contact is in the best interest of the youth and family	**Not Applicable**		
Family and Youth Respite Aftercare Services (FYRAC)			
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Staff Position(s) Interviewed: Quality Compliance Manager, Residential Specialist			
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 any youth who met the criteria for FYRAC in the last six months or since the last onsite QI review.	

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

There is evidence of completed 30 and/or 60 day follow-ups and is documented in NetMIS following case discharge.	**No eligible items for review**		
Youth and family participate in services for thirteen (13) sessions or ninety (90) consecutive days of services, or there is evidence in the youth's file that an extension is granted by DJJ circuit Probation staff	**No eligible items for review**		
Any service that is offered virtually, is documented in the youth's file why it was in the youth and families best interest.	**No eligible items for review**		
All data entry in NetMIS is completed within 3 business days as required.	**No eligible items for review**		
Additional Comments: **There are no additional comments for this indicator.**			
2.09- Stop Now and Plan (SNAP)			**Not Applicable**
Provider has a written policy and procedure that meets the requirement for Indicator 2.09		**N/A** If NO, explain here: FKCS is not contracted to provide SNAP services	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Staff Position(s) Interviewed: Quality Compliance Manager, Residential Specialist			
SNAP Clinical Groups Under 12			
Youth are screened to determine eligibility of services.	**Not Applicable**		
The NIRVANA was completed at initial intake, or within two sessions.	**Not Applicable**		
There is evidence of the completed Child Behavior Checklist (CBCL) by the caregiver (pre and post) and is located within the file.	**Not Applicable**		
There is evidence of the completed Teacher Report Form (TRF) is completed by the teacher (pre and post) and is located within the file.	**Not Applicable**		
SNAP Clinical Groups Under 12 - Discharge			
There is evidence of the completed SNAP Discharge Report located within the file for any discharged youth.	**Not Applicable**		
There is evidence of the SNAP Boys/SNAP Girls Child Group Evaluation Form located in the file.	**Not Applicable**		
There is evidence of the SNAP Boys/SNAP Girls Parent Group Evaluation Form located in the file.	**Not Applicable**		
SNAP Clinical Groups for Youth 12-17			
Youth are screened to determine eligibility of services.	**Not Applicable**		
The Consent to Treatment and Participation in Research Form is completed and located within the file.	**Not Applicable**		

The NIRVANA was completed at initial intake, or within two sessions.	Not Applicable		
There is evidence of the completed 'How I Think Questionnaire' (HIT) form located within the file or evidence of at least three (3) documented attempts in the youths' file to obtain this information.	Not Applicable		
There is evidence of the completed Social Skills Improvement System (SSIS) Student form located within the file or evidence of at least three (3) documented attempts in the youths' file to obtain this information.	Not Applicable		
There is evidence of the completed Social Skills Improvement System (SSIS) Teacher/Adult form located within the file or evidence of at least three (3) documented attempts in the youths' file to obtain this information.	Not Applicable		
SNAP for Schools & Communities			
The program demonstrated all of the required weekly attendance sheets that included youth names and/or identifying numbers completed with the teacher and trained SNAP Facilitator signatures. (*This must include a total of 13 attendance sheets for a full cycle*)	Not Applicable		
The program maintained evidence of a completed "Class Goal" Document for the class reviewed.	Not Applicable		
The program maintained evidence of both pre AND post Measure of Classroom Environment (MoCE) completed documents for the class reviewed.	Not Applicable		
The program maintained evidence of completed pre and post evaluation documents for the class reviewed.	Not Applicable		
There is evidence of the fidelity adherence checklist maintained in the file for each class reviewed.	Not Applicable		
Additional Comments: **There are no additional comments for this indicator.**			
3.01 - Shelter Environment			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 3.01		**YES** If NO, explain here: The provider has the required policy and procedures 3.09 - Shelter Program Services that was approved 10/1/23 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 Coordinator
Type of Documentation(s) Reviewed: Weekly and perpetual chemical inventory, MSDS, Fire Drills, Emergency Drills, County Fire Inspection, Fire equipment inspection, Department of Health Inspections, activity and program schedule.
Describe any Observations: Tour of facility, postings, inspection of agency vehicle, chemical storage

Facility Inspection: a. Furnishings are in good repair. b. The program is free of insect infestation. c. Bathrooms and shower areas are clean and functional, free of foul odors, leaks, dust, and mildew and in good working order. d. There is no graffiti on walls, doors, or windows. e. Lighting is adequate for tasks performed there. f. Exterior areas are free of debris; grounds are free of hazards. g. Dumpster and garbage can(s) are covered. h. All doors are secure, in and out access is limited to staff members and key control is in compliance. i. Detailed map and egress plans of the facility, general client rules, grievance forms, abuse hotline information, DJJ Incident Reporting Number and other related notices are posted. j. Interior areas (bedrooms, bathrooms, common areas) do not contain contraband and are free from hazardous unauthorized metal/foreign objects.	**Compliance**	The agency recently replaced all of the furnishings in the shelter to include seating and bedding; all furnishings are in great condition and free from damage. Youth bedrooms, shared and common areas where free from insects or infestations. Walls, doors were clean and free from damage and graffiti throughout the facility. The interior of the shelter had adequate lighting and was well lit. All of the garbage cans and dumpster located on the grounds of the facility were covered and in good condition. There were no visible hazards identified around the exterior of the grounds nor were there any identifiable hazards found in the interior of the building. Detailed egress plans were observed and are located in the administrative hallway, common areas, female & male bedroom corridors, youth bedrooms as well as the rear kitchen and main entrances, and included in the program's handbook. Abuse hotline, grievance forms and boxes were also located in three separate locations throughout the shelter to include both male and female residential wings and the common area or tv room of the shelter.	
Facility Inspection: a. All agency and staff vehicles are locked. b. Agency vehicles are equipped with major safety equipment including first aid kit, (all items in the first aid kit are current and do not have expired items; all expired items should be replaced regularly), fire extinguisher, flashlight, glass breaker and, seat belt cutter.	**Exception**	The agency has a total of three program vehicles to include a white 2019 Honda Odyssey, a grey Honda Odyssey, as well as a 2018 Grey 12 passenger transport van. All three passenger vans were locked and secured, were equipped with flashlights, glass breakers & seat belt cutters and first aid kits. A total of six employee vehicles were also checked, four of the six staff vehicles were locked.	Two staff vehicles were found to be unlocked when checked during the tour of the facility.

Facility Inspection: All chemicals are listed, approved for use, inventoried weekly and perpetually, stored securely and Material Safety Data Sheets (MSDS) are maintained on each item (minimum 1 time per week or per agency policy). A perpetual inventory will be the primary means of maintaining a current and real-time inventory. The weekly inventory will be conducted weekly at a minimum to ensure that a perpetual inventory is being maintained consistently and accurately. If more than one location is used to store chemicals, there is an inventory wherever chemicals are stored that is current and well maintained unless previously approved by the Network.	**Exception**	Chemicals are stored in a locked cabinet in a small locked room adjacent to the kitchen area. All chemicals are approved for use, inventoried daily or immediately upon usage. Perpetual inventory logs includes chemical description, preferred use of measurements, date of use, amount used (measured in ounces) time in and out, beginning stock quantities /end of stock inventory counts and staff names.	During the tour, four chemicals, Off Bug Repellent Spray, Buggie Soap Pads, Hand Soap utilized to prefill the dispensers in the bathrooms, and Purell hand sanitizer, were found to be missing MSDS sheets. The program coordinator immediately removed items until MSDS was updated.
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 facility's washers, dryers and surrounding areas were clean, free from debris, lint and potential fire hazards. Each youth's bed was made, had clean linens and pillows, and were in good condition. Each youth's bedroom has an individually assigned dresser for clothing storage. Valuables are inventoried, labeled, and stored in a locked secured area.	
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).	**Compliance**	The program had a satisfactory annual fire and safety inspection on 07/11/23. A copy of the Islamorada Fire Rescue Fire & Life Annual Inspection Compliance Certificate with date of inspection 07/11/2023 was reviewed. Monthly fire drills with evacuation times within 2 minutes were conducted on each shift between June2023 and January 2024. Emergency mock drills were also conducted monthly, exceeding the quarterly requirements for each shift. All of the annual safety equipment inspections were satisfactory - evidenced by documentation provided by the program's leadership. Compliance of annual inspection of the Fire Suppression System was also provided and evident in the report dated 12/4/2023. Also provided was a satisfactory Sprinkler and Alarm Inspection Report, facilitated 12/11/2023.	

Fire and Safety Health Hazards: a. Agency has a current Satisfactory Residential Group Care inspection report from the Department of Health. b. Agency has a current Satisfactory Food Service inspection report from the Department of Health and food menus are posted, current and signed by Licensed Dietician annually. c. All cold food is properly stored, marked and labeled and dry storage/pantry area is clean and food is properly stored. d. Refrigerators/Freezers are clean and maintained at required temperatures and all small and medium sized appliances are operable and clean for use as needed.	**Compliance**	The agency provided copies of the satisfactory Department of Health Group Care Inspection Report (facilitated on 05/17/2023) with no violations or recommendations cited. The agency provided a copy of the Food Service Report (facilitated on 08/18/2023). The program's food menu was observed posted in the dining hall adjacent to the common area and the menu was signed by a licensed Dietician; however, it was not current with an expiration year of 2019. The program Coordinator did provide a written, signed and recently dated (07/19/2023) document from the registered dietician which gives approval for continued use of the food service menu. There was an expired can of Nesquik identified with an expiration date of December 2023 and it was immediately removed. An inspection of the program's kitchen, refrigerator ,and freezers provided evidence that all cold foods were properly stored, labeled and dated with no signs of rotting or spoiled food; nor was there any signs of threats of contamination. Fridge Temperature: 38- Degrees Fahrenheit. Freezer Temperature: 4- Degrees Fahrenheit	
Additional Fire and Safety Health Hazards Narrative (if applicable)			

Youth Engagement			
a. Youth are engaged in meaningful, structured activities (e.g., education, recreation, counseling services, life and social skill training) seven days a week during awake hours. Idle time is minimal. b. At least one hour of physical activity is provided daily. c. Youth are provided the opportunity to participate in a variety of faith-based activities. Non-punitive structured activities are offered to youth who do not choose to participate in faith-based activities. d. Daily programming includes opportunities for youth to complete homework and access a variety of age appropriate, program approved books for reading. Youth are allowed quiet time to read. e. Daily programming schedule is publicly posted and accessible to both staff and youth.	**Compliance**	The agency engages the youth in meaningful activities to include groups, outings, literacy and social skill development evident by the program's daily activity log. The facility is equipped with a health and wellness workout area, fully shaded outdoor activity area with table tennis and other games, has a fully functional and well-kept basketball area that are fully accessible for use for multiple hours daily as long as weather conditions permit. Faith based activities are available, frequently scheduled, yet optional for youth participation. Alternative activities are identified and available for youth who wish not to participate. Daily programming schedules were observed posted in the common and frequented areas of the facility and includes an hour-to-hour schedule for daily activities for both weekdays and weekends.	
Additional Comments: **There are no additional comments for this indicator.**			
3.02 - Program Orientation			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 3.02		**YES** If NO, explain here: The provider has the required policy and procedures, 2.05 - Orientation to the Program, that was approved by the CEO on 10/1/2023.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: 1 open residential youth record **Total number of Closed Files: 4 closed residential youth records** **Staff Position(s) Interviewed** *(No Staff Names)* **: Residential Coordinator** **Type of Documentation(s) Reviewed: youth records** **Observation: Electronic Alert LCD TV Monitor**			
Youth received a comprehensive orientation and handbook provided within 24 hours	**Compliance**	Reviewed documentation validated each youth received a comprehensive orientation within twenty-four hours of admission and each youth was provided a copy of the program handbook.	

Orientation includes the following: a. Youth is given a list of contraband items b. Disciplinary action is explained c. Dress code explained d. Review of access to medical and mental health services e. Procedures for visitation, mail and telephone f. Grievance procedure g. Disaster preparedness instructions h. Physical layout of the facility i. Sleeping room assignment and introductions j. Suicide prevention- alerting staff of feelings or awareness of others having suicidal thoughts	**Compliance**	The program's orientation addresses the program rules including contraband, possible disciplinary action, the grievance procedure, emergency and disaster procedures, suicide prevention and alert notification, as well as the program's physical layout and daily activity schedule. Each youth's room assignment is documented on the Intake form which is signed by the youth.	
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**	Each reviewed youth record included the signature of the youth and parent/guardian on the Shelter Voluntary Placement Agreement to acknowledge receipt of the orientation as well as signature of the staff conducting the orientation.	
Additional Comments: **There are no additional comments for this indicator.**			
3.03 - Youth Room Assignment			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 3.03		**YES** If NO, explain here: The provider has the required policy and procedures, 2.01-Screening and Intake, that was approved by the CEO on 10/1/2023.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: 1 open residential youth record **Total number of Closed Files: 4 closed residential youth records** **Staff Position(s) Interviewed (No Staff Names): Residential Coordinator** **Type of Documentation(s) Reviewed: youth records**			

A process is in place that includes an initial classification of the youths, to include:			
a. Review of available information about the youth's history, status and exposure to trauma b. Initial collateral contacts, c. Initial interactions with and observations or the youth d. Separation of younger youth from older youth, e. Separation of violent youth from non-violent youth f. Identification of youth susceptible to victimization g. Presence of medical, mental or physical disabilities h. Suicide risk i. Sexual aggression and predatory behavior j. Acute health symptoms requiring quarantine or isolation	**Compliance**	The program has a process in place for assessing and initially classifying each youth admitted to the program. The classification process considers each youth's history, status, and exposure to trauma as well as the youth's associated contacts. The program's youth screening, youth profile, and intake forms are utilized to document the initial interactions and observations of the youth, and whether there is any indication the youth needs to be separated from other youth based upon age, presenting problems of aggression, violence, and/or assaultive behavior, susceptibility to victimization, the presence of medical, mental health, or physical disabilities, suicide risk, sexual aggression or predatory behavior, and any health symptoms requiring isolation or quarantine.	
An alert is immediately entered into the program's alert system when a youth is admitted with special needs and risks such as risk of suicide, mental health, substance abuse, physical health or security risk factors	**Compliance**	The program utilizes an electronic alert system which can be immediately updated and displayed electronically to staff in the monitoring station when a youth is admitted with special needs or risks including 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**
Provider has a written policy and procedure that meets the requirement for Indicator 3.04		**YES** If NO, explain here: The provider has the required policy and procedures, 3.17-Logbook, that was approved by the CEO on 10/1/2023.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Staff Position(s) Interviewed *(No Staff Names)* **: Residential Coordinator** **Type of Documentation(s) Reviewed: Logbooks**			
Log book entries that could impact the security and safety of the youth and/or program are highlighted	**Compliance**	A thorough review of the program's logbooks confirmed use of highlighted entries of notifications of potential or identified safety and security issues that may impact youth and staff for the six month period reviewed. Implementation of a new color coded system was evident when reviewing the logbook entries for the month of January, which now has additional colors designated for specific entries, that'll make identifying entries easier.	
All entries are brief, legibly written in ink and include: • Date and time of the incident, event or activity • Names of youth and staff involved • Brief statement providing pertinent information • Name and signature of person making the entry	**Compliance**	All reviewed entries were legible and descriptive. Dates, times, activities and other pertinent information along with the name/signature of the staff and all others involved are evidenced in the logbook.	

Recording errors are struck through with a single line. The staff person must initial and date the correction. The use of whiteout and erasures is prohibited.	**Compliance**	A review of the programs logbook validated use of correcting errors as required with staffs' use of the strike through method. Reviewer saw evidence on June 18th, August 11th, September 18th, September 23rd, and November 11th and 20th.	
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**	Program leadership's weekly review of past shifts were evidenced by written entries in the program daily logbook, including comments regarding observations and any corrective actions necessary.	
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**	A review of the programs logbooks confirmed that staff reviews past shifts at the start of their shifts. Entries verified on dates reviewed; Months of June, July, Aug , Sept, Oct, Nov, Dec & Jan for each shift.	
At the beginning of their shift, oncoming supervisor and shelter counselor reviews the logbook of all shifts since their last log entry and makes a signed and dated entry and into log book indicating the dates reviewed.	**Compliance**	It is evidenced that the program's supervisor and counselor reads the logbook since their last work shift and review notes of past shifts .	
Logbook entries include: a. Supervision and resident counts b. Visitation and home visits	**Compliance**	Logbook entries and resident counts are documented in the program's logbook at the start of every shift. Home visitations and visit are also recorded.	
Additional Comments: **There are no additional comments for this indicator.**			
3.05 - Behavior Management Strategies			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 3.05		**YES** If NO, explain here: The provider has the required policy and procedures, 3.13-Behavior Management System, that was approved by the CEO on 10/1/2023.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Staff Position(s) Interviewed *(No Staff Names)* **: Youth Support Specialist, Program Leadership** **Type of Documentation(s) Reviewed: Program Youth Handbook, surveillance reviews**			
The program has a detailed written description of the BMS and it is explained during program orientation	**Compliance**	The program's handbook galvanizes the BMS, which is very well detailed and written. Review of the program's behavior management system shows it is reviewed at intake with every youth as part of the program's orientation. All youth are also provided a copy of the program's handbook as a resource and reference.	
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 program staff utilizes appropriate interventions that are non-punitive and help the youth process and understand natural consequences. The program's BMS is structured to immediately address programmatic or behavioral infractions with the youth by staff; which allows staff to appropriately intervene, redirect and or resolve any issues within the program structure in real time. The program's incentives are point based; incentives are also tiered (two levels) based on the youth total point accumulation. Incentives vary from canteen prizes, incentivized outings, monetary incentives and bus passes. The BMS includes consequences for violations that are logical and consistent. The BMS is not designed to be punitive; however consequences for shelter rule violations will result in a youths inability to accumulate points for those infractions at that time, nor does it not negatively impact any youths rights, needs or provision of services. The BMS also delineates behavioral consequences and specifies minor and major infractions which have appropriate consequences, that are easy for the youth to understand. The BMS does not negatively impact any youths rights, needs or provision of services.	
Program's use of the BMS			
All staff are trained in the theory and practice of administering BMS rewards and consequences	**Compliance**	Youth Services Specialist receive an initial training on the programs BMS as part of the pre-service training and refreshers are provided to staff regularly. Training record for four new staff validated this practice.	
There is a protocol for providing feedback and evaluation of staff regarding their use of BMS rewards and consequences	**Compliance**	The programs leadership refreshes staff during staff meetings on the structure, intent, application and benefit of the BMS. Shelter leadership also monitors trends in issuance of consequences or potential misuse of BMS system and processes with staff.	
Supervisors are trained to monitor the use of rewards and consequences by their staff	**Compliance**	Program supervisors are trained to monitor interventions implemented by staff to ensure that there is not an issue with misuse of power, and that interventions are appropriate and align with the program's behavioral management structure.	
Additional Comments: **There are no additional comments for this indicator.**			
3.06 - Staffing and Youth Supervision			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 3.06		**YES** If NO, explain here: The provider has the required policy and procedures, 1.14 - Staffing and Youth Supervision, that was approved by the CEO on 10/1/2023.	

Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Staff Position(s) Interviewed *(No Staff Names)* **: Youth Support Specialist, Program Leadership** **Type of Documentation(s) Reviewed: Staff Schedules, Logbook, bed check logs**			
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 program has maintained adequate staffing ratios as required by the Florida Administrative Code and contract, maintaining at minimum two staff on first shift, three on second shift and two on the over nights. Evidence of staff to youth ratios of 1:6 during awake and 1:12 during sleep hours was observed.	
All shifts must always provide a minimum of two direct care staff present that have met the minimum training requirements	**Compliance**	Staffing schedules reviewed show at least 2 staff are scheduled on each shift.	
Program staff included in staff-to-youth ratio includes only staff that are background screened and properly trained youth care workers, supervision staff, and treatment staff	**Compliance**	All staff included on the scheduled were background screened and had completed the required pre-service training to work independently with youth.	
The staff schedule is provided to staff or posted in a place visible to staff	**Compliance**	Staff schedules are emailed to staff. The schedule is color coded and includes a legend that aids staff in identifying specific task. Schedules were visible in multiple areas throughout the shelter to include staff office and the program Coordinator's office.	
There is a holdover or overtime rotation roster which includes the telephone numbers of staff who may be accessed when additional coverage is needed	**Compliance**	A staffing holdover roster is maintained and updated as needed to reflect staff contact numbers, and availability to ensure shift coverages and ratios.	

Staff observe youth at least every 15 minutes while they are in their sleeping room, either during the sleep period or at other times, such as during illness or room restriction	**Compliance**	A total of five days including times were reviewed: January 05th- 12am-2am; January 10th 2am-4am; January 15th- 4am-6am; January 20th -1am-3am; and January 29th -3am-5am. All dates and times were reviewed on the surveillance videos and met compliance of 15-minute bed checks when reconciled with the program's logbook. Male youth bedrooms are separate from the female bedrooms which are located in two separate wings. Staff were observed both 10 minute (sight and sound) and regular 15 minute bed checks in accordance with requirement. Bed check logs were also utilized to reconcile the reviewed surveillance.	
Additional Comments: **There are no additional comments for this indicator.**			
3.07 - Video Surveillance System			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 3.07		**YES** If NO, explain here: The provider has the required policy and procedures, 4.11 Video Surveillance System, that was approved by the CEO on 10/1/2023.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Staff Position(s) Interviewed *(No Staff Names)* **: Program Leadership** **Type of Documentation(s) Reviewed: Surveillance Logs, policy** **Describe any Observations: Video surveillance system, cameras**			
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 (e.g. intake office, counseling office, cafeteria, day room) and exterior (e.g. entrance/exit, recreation area, parking lot) general locations of the shelter where youth and staff congregate and where visitors enter and exit; to include locations where youth searches are conducted. Cameras are never placed in bathrooms or sleeping quarters. f. All cameras are visible	**Compliance**	The facility is equipped with a total of 27 cameras throughout the exterior and interior, with the exception of youth bedrooms, bathrooms and medical facilities. The program's surveillance system provides a high quality picture which makes it easy for facial recognition and includes date and time and location of cameras. Video surveillance footage is retained for 30 days and equipped with a backup battery and cloud based storage in the event of power failure.	

A list of designated personnel who can access the video surveillance system is maintained (includes off-site capability per personnel)?	**Compliance**	The program does keep an updated list of program personnel in the program surveillance logbook of all agency staff that has access to review cameras, namely program coordinator, COO and CEO	
Supervisory review of video is conducted a minimum of once every 14 days and timeframes reviewed are noted in the logbook.	**Exception**	There were a total of 27 bi-weekly reviews that were noted by supervisory staff. Dates of verified reviews were; June 18th and 30th; July 7th, 17th, and 25th; August 7th, 16th, 28th, and 31st; September 10th, 21st, and 29th; October 8th, 18th, and 27th; November 6th, 18th, and 22nd; December 2nd and 9th; and January 15th, 25th, and 29th. However, some of those supervisory reviews noted did not indicate video reviews were conducted.	Supervisory review of video was missing from the biweekly logbook notes on the following dates: September 21st, October 27th, November 22nd, December 21st, and January 5th.
The reviews assess the activities of the facility and include a review of random sample of overnight shifts	**Compliance**	The supervisory camera reviews are conducted throughout different times of the day including overnights and weekends and assess various activities of the facility including bed checks.	
Grant the requesting of video recordings to yield a result within 24-72 hours from program quality improvement visits and when an investigation is pursued after an allegation of an incident	**Compliance**	The agency does have written policy and procedure in place surrounding third party request that allows requesters to be granted access to recordings within 24 hours but not to exceed 72 hours of request.	
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**	Although the shelter has not experienced any surveillance failures for this contract year, there is a process to include immediate notification to senior leadership, CCC and submission of a help desk ticket to the agency's surveillance support helpline as per the programs coordinator.	
Additional Comments: **There are no additional comments for this indicator.**			
4.01 - Healthcare Admission Screening			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 4.01		**YES** If NO, explain here: The provider has the required policy and procedures, 3.09 - Shelter Program Services, that was approved by the CEO on 10/1/2023.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: 1 open residential youth record **Total number of Closed Files: 4 closed residential youth records** **Staff Position(s) Interviewed (No Staff Names): Registered nurse** **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**	All five youth had a healthcare screening conducted during intake. Four of five reviewed records were for youth with current medications at the time of intake. Two of five reviewed youth were identified with an existing medical condition and one youth had diagnosed allergies. Each youth record documented the program staff's observation for evidence of illness, injury, pain, or physical distress. Staff also observed and documented any youth with scars, tattoos, or other skin markings, Two of the five reviewed records were for youth diagnosed with asthma.	
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.)	**Not Applicable**	Youth with medical conditions noted with an asterisk (*) as listed under the “Policy” section must receive medical follow-up either immediately or in a timely manner. None of the health care screening records reviewed required referrals for chronic medical condition.	
When needed, the parent is involved with the coordination and scheduling of follow-up medical appointments	**Not Applicable**	None of the records reviewed required the parent to coordinate medical appointments or follow-ups.	
All medical referrals are documented on a daily log.	**Compliance**	Four of five reviewed records were applicable for off-site medical referrals, all of which were documented on the Off-Site Care Log.	
The program has a thorough referral process and a mechanism for necessary follow-up medical care as required and/or needed	**Compliance**	The program maintains procedures detailing the referral process and mechanism for necessary follow-up medical care for any youth admitted with a chronic medical condition.	
Additional Comments: **There are no additional comments for this indicator.**			
4.02 - Suicide Prevention			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 4.02		**YES** If NO, explain here: The provider has the required policy and procedures, 4.08 - Suicide Assessment, that was approved by the CEO on 10/1/2023.	

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

Total number of Open (Residential & Community) Files: 0
Total number of Closed (Residential & Community) Files: 4 closed residential records
Staff Position(s) Interviewed (No Staff Names): Residential Specialist
Type of Documentation(s) Reviewed: youth records, precautionary observation logs,

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**	Four closed residential records were reviewed. All four were screened for suicide risk at the time of intake, with screening results reviewed by the supervisor and documented in the youth's case record.	
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 was previously approved by the Florida Network and has not changed since the last QI review.	
Supervision of Youth with Suicide Risk *(Shelter Only)*			
Youth are placed on the appropriate level of supervision based on the results of the suicide risk assessment.	**Compliance**	All four youth were placed on sight-and-sound supervision until assessed by a non-licensed professional working under the supervision of the licensed professional.	
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**	Staff monitored each youth's behavior on the observation log at least every thirty minutes or less and documented their observation of the youth's behavior.	
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**	Documentation was maintained for the duration of time each youth was placed on sight and sound. The observation log includes the observer's initial, time of day, and behavioral observations.	
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**	Supervision level was not changed/reduced for any of the four youth until the non-licensed staff, under supervision of a licensed clinician, completed a further assessment.	
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**	Documentation of supervisory staff signature was observed on the observation logs, on each shift, for each youth of the four residential youth. The observation logs were kept in the youth's case file.	
Youth with Suicide Risk *(Community Counseling Only)*			
Youth identified for suicide risk during intake was immediately assessed by a licensed professional or non-licensed professional (under the direct supervision of a licensed mental health professional) and the parents and supervisor were both notified of the results.	**No eligible items for review**	There were no community counseling youth served since the last QI review who were identified for suicide risk.	

During the intake, if the appropriate staff is unavailable, youth identified for suicide risk was immediately referred by the provider and the parent/guardian is notified of the suicide risk findings disclosed and advised that an Assessment of Suicide Risk should be completed ASAP by a licensed professional.	**No eligible items for review**		
Information on resources available in the community for further assessment was provided to the parent/guardian and is documented in the youth's file and signed by the parent/guardian OR a written follow-up notification was sent by certified mail if the parent/guardian was not present during the screening and was notified by telephone.	**No eligible items for review**		
If the parent/guardian cannot be contacted, all efforts to contact them are documented in the case file.	**No eligible items for review**		
When the screening was completed during school hours on school property, the appropriate school authorities were notified.	**No eligible items for review**		
Additional Comments: **There are no additional comments for this indicator.**			
4.03 - Medications			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 4.03		**YES** If NO, explain here: The provider has the required policy and procedures, 3.16 - Medication Management, that was approved by the CEO on 10/1/2023.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: 1 open residential youth record **Total number of Closed Files: 4 closed residential youth records** **Staff Position(s) Interviewed** *(No Staff Names)* **: Registered nurse** **Type of Documentation(s) Reviewed: youth medication distribution logs,** **Describe any Observations: medication room, pyxis med-station**			
The agency has a Registered Nurse (RN) and/or a Licensed Practical Nurse (LPN) that is being supervised by RN and all of their credentials have been verified.	**Compliance**	The program has a registered nurse with a clear and active license.	

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	**Compliance**	Reviewed documentation indicated the program has eighteen non-healthcare staff who completed medication administration training provided by the registered nurse which included each staff demonstrating competency. The program recertifies each non-healthcare staff's medication administration certification annually.	
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	**Compliance**	Reviewed documentation of monthly program staff meetings indicated medication errors, medication administration, and medication administration retraining was included on the meeting agenda in the months of July, August, September, October, November, and December.	
The agency has strategies implemented to ensure medications are provided within the 2-hour time frame.	**Compliance**	The program utilizes a posted reminder on the medical clinic door as a strategy to ensure medication is provided with the required two-hour timeframe.	
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 are clearly identified and designated on the staff schedule designating who is responsible for assisting with the self-administration of medications on each shift.	
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 program uses a computer program which is projected on a large screen notating each youth's alert including medication. Medication dosage time is documented on the medication distribution log.	
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 program has a delivery process for medications that is consistent with the FNYFS Medication Management and Distribution Policy. There is a an internal quality assurance process in place. The program identifies medication issues and discusses medication management and errors during CINS/FINS meetings.	

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**	The registered nurse signs and dates the intake form to document their review of the medication forms within one business day of each youth's admission.	
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 oral medications, including over the counter, narcotics and controlled medications are stored separately from topical or epi-pens in the Pyxis ES Medication cabinet. The medication cabinet is stored in accordance with Florida Statues in a secure room behind a locked door. There is a medical refrigerator in the medication room that stores all medications that need to be refrigerated. No medication needing to be refrigerated was stored at the time of the review. The thermometer of the refrigerator was at 40 degrees Fahrenheit. The Pyxis keys, with required labels, were observed and available to staff in the event they are needed.	

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. There are 18 trained staff who are designated and delineated User Permissions and have access to secured medications, with limited access to controlled substances. A review of youth records confirmed a Medication Distribution Log is used for distribution of medication by non-licensed and licensed staff. The program verifies medication using one of the three methods listed in the FNYFS Policies & Procedures Manual. The program confirmed when the registered nurse is on duty, medication processes are always conducted by the nurse. When the nurse is not onsite, then the designated staff who has been trained by a licensed Registered Nurse provides the medication. According to the program, they do not accept youth currently prescribed injectable medications, except for epi-pens. All non-licensed staff have received training in the use of epinephrine auto-injectors provided by a registered nurse.	
The medication distribution log documentation includes: a. the time of medication administration b. evidence of youth initials that the dosage was given c. evidence of staff initials that the dosage was given	**Compliance**	Five youth records were reviewed and all five were applicable for medications administered while at the program. All five youth records contained the Medication Distribution Log (MDL) used for distribution of medication by non-licensed and licensed staff. Reviewed documentation validated the time of the administration was noted on the MDL and both the youth and staff initialed each dose administered.	
There is evidence that staff provide youth with medications within one hour of the scheduled time of delivery as ordered by the medication. Documentation is provided for instances this does not occur within the required timeframe.	**Compliance**	All five medication records reviewed documented the delivery of medications for each youth within one hour of the scheduled time of delivery as ordered.	
During the review period, there were no instances where youth missed their medication due to failure to open the pyxis machine.	**Compliance**	During the review period, there were no instances or incidents related to failure to distribute medication to a youth due to the Pyxis machine not working.	

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.	**Compliance**	Reviewed documentation indicated the program provides refresher training to staff responsible for medication errors including each staff demonstrating competency. The program recertifies each non-healthcare staff's medication administration certification annually.	
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**	Five medication youth records were reviewed. All five had a medication distribution log for each medication they received. The medication logs confirmed shift to shift counts were conducted including a witness for controlled medication. Non- controlled and OTC medications were inventoried weekly during the review period. Sharps are secured and inventoried weekly.	
There are monthly reviews of the Pyxis reports to monitor medication management practice.	**Compliance**	Per interview with the nurse, monthly reports are generated from the knowledge portal of the pyxis machine to assist with medication management.	
Medication discrepancies are cleared after each shift.	**Compliance**	The program conducts daily clearing of medication discrepancies on each shift in which it occurs.	
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 provider has the required policy and procedures 4.12 - Medical and Mental, that was approved by the CEO on 10/01/2023.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Closed Files: 4 closed residential youth records **Staff Position(s) Interviewed (No Staff Names): Residential Specialist** **Type of Documentation(s) Reviewed: youth records**			

Youth with a medical, mental health, or food allergy was appropriately placed on the program's alert system	**Compliance**	Four applicable youth records indicating a medical or mental health condition or a food allergy were reviewed. Reviewed documentation validated each of the four youth were appropriately placed on the program's alert system.	
Alert system includes precautions concerning prescribed medications, medical/mental health conditions	**Compliance**	The program's alert system includes precautions concerning prescribed medication, medical and mental health conditions. The alerts system includes information about medical conditions, allergies, common medication side effects, foods and medications which may be contraindicated, and other pertinent mental health treatment information.	
Staff are provided sufficient training, information and instructions to recognize/respond to the need for emergency care for medical/mental health problems	**Compliance**	Program staff receive sufficient information and instructions through the alert system to recognize and respond to any needed emergency care.	
A medical and mental health alert system is in place that ensures information concerning a youth's medical condition, allergies, common side effects of prescribed medications, foods and medications that are contraindicated, or other pertinent mental health treatment information, is communicated to all staff	**Compliance**	Updates to the alert system at the program are immediately available in real time to the staff through the electronic alert notifications viewable on the electronic monitor in the which is wall mounted in the monitoring station.	
Additional Comments: **There are no additional comments for this indicator.**			
4.05 - Episodic/Emergency Care			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 4.05		**YES** If NO, explain here: The provider has the required policy and procedures 4.06-Episodic/Emergency Care, that was approved by the CEO on 10/01/2023.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: 1 open residential youth record **Total number of Closed Files: 4 closed residential youth records** **Staff Position(s) Interviewed (No Staff Names): Residential Specialist** **Type of Documentation(s) Reviewed: youth records, episodic off-site care log**			

Off Site Emergency Care			
a. If off-site emergency medical or dental care was provided, an incident report was submitted for the medical or dental care b. Upon youth return, there is a verification receipt of medical clearance via discharge instructions with follow-up is present in file c. Youth's parent/guardian was notified d. A daily log is maintained for emergency care provided	**Exception**	Five youth records were reviewed and all five were applicable for having received off-site care while admitted to the program. Four of the five reviewed off-site care incidents were reported to the Department's Central Communications Center (CCC). There was indication on the internal incident report for one of the four incidents (on 12/16/23) that the CCC was contacted, and a message left at 1:46a.m.; however, the CCC did not contact the program in response to the voicemail message, and the program did not follow-up with the CCC to report the incident the next day to generate a report. All five reviewed records included medical clearance and discharge instructions, as required. It is the program's practice to notate completed parental notification of off-site care on the Internal Incident Report form. Two of five reviewed instances documented the parent/guardian was notified on the Internal Incident Report form and three confirmation of parental notifications were documented via emails, two emails from the parent/guardian and one email between staff verifying parent was notified. All five reviewed instances of off-site care were documented on the program's Off-Site Emergency Care Log. It was observed the program's Off-Site Care Log form calls for the date and time to be documented and none of the instances on any page of the log included the time of the incident.	The Offsite Care log documented an incident on 9/24/2023 that required transport of youth to the hospital; however, there was no CCC report called in. Upon notification during the QI review, the program called in the incident to CCC and the call was accepted.
All staff are trained on emergency medical procedures	**Compliance**	A total of eight staff training records were reviewed. Documentation supported all the staff received training on emergency medical procedures.	
The program has a Knife-for-life and wire cutters accessible to staff in a secure location(s)	**Compliance**	The program maintains three Knife-for-Life tools. Two are wall mounted in a locked closet at the end of each dormitory hallway and another is located in the centrally located locked monitor station	
Additional Comments: **There are no additional comments for this indicator.**			