Florida Network for Youth and Family Services
Compliance Monitoring Report for

Family Resources, Inc. (St. Petersburg)
Safe Place 2B
3761 5th Ave., North
St. Petersburg, FL 33713

January 31, 2024 – February 1, 2024

Compliance Monitoring Services Provided by

EXECUTIVE SUMMARY

Forefront LLC conducted a Quality Improvement (QI) monitoring visit on behalf of the Florida Network of Youth and Family Services (FNYFS) for Family Resources, Inc. (St. Petersburg) for the FY 2023-2024 at its program office located at 3761 5th Ave. North St. Petersburg 33713. Forefront LLC (Forefront) is an independent compliance monitoring firm that is contracted by FNYFS to perform onsite program reviews to assess the agency's adherence to fiscal, programmatic and overall contract requirements. Family Resources. Inc. 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 Andrea Haugabook, Consultant for Forefront LLC and Gus Mazorra, Samuel Laguerre, Amy Loomis, and Claude-Doris Gillette. Agency representatives from Family Resources Inc. (St. Petersburg) present for the entrance interview were Andy Coble, Nicole Leslie, McKenzie Tomasik, Whitney Harris, Kelli Yeazell. The last onsite QI visit was conducted May 24-25, 2023.

In general, the Reviewer found that Family Resources, Inc. (St. Petersburg) follows specific contract requirements. **Family Resources, Inc. (St. Petersburg) received an overall compliance rating of 100% for achieving full compliance with 11 indicators** of the CINS/FINS Monitoring Tool. There were no corrective actions from the monitoring visit.

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

2023-2024 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 1-31-2-1-2023-2024

Agency Name: Family Resources, Inc. (Safe Place 2 B - St. Petersburg)	**Monitor Name: Andrea Haugabook, Lead Reviewer**
Contract Type: CINS/FINS	**Region/Office: 3761 5th Ave. North St. Petersburg, FL 33713**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): January 31, 2024 – 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**		
I. Administrative and Fiscal							
DJJ (Department of Juvenile Justice) Quality Improvement Peer Reviewer A. Provider shall demonstrate that at least two staff members have been trained to be certified as DJJ QI Peer reviewers. Providers 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 agency has five peer reviewers. Two of the five need to complete a refresher before being put into the review schedule.	
Additional Contracts a. Provider shall provide a listing of all current federal, state, or local government contracts, as well as other contracts entered with for profit and not-for-profit organizations. Such a listing shall identify the awarding entity and contract start & end dates. **PTV**	☐	☐	☒	☐	☐	The agency received continued funding from the Juvenile Welfare Board and the community counseling program is only funded by the Florida Network of Youth and Family Services.	
Limits of Coverage a. Provider shall provide and maintain during this contract, the following minimum kinds of insurance: Worker's Compensation and Employer's liability insurance as required by Chapter 440, F.S. with a minimum of $100,000 per accident, $100,000 per person and $500,000 policy aggregate. Commercial General Liability	☐	☐	☒	☐	☐	The agency has a certificate of insurance with Wallace Welch & Willingham, Inc., which covers the following minimum kinds of insurance: Worker's Compensation and Employer's liability insurance (06/01/2023-06/01/2024) with a	

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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**						minimum of $200,000 per accident, $200,000 per person and $200,000 policy aggregate. Commercial General Liability (06/01/2023-06/01/2024) with a limit of $1,000,000 per occurrence, and $3,000,000 policy aggregate, $500,000 damage to rented premises. Automobile Liability Insurance (06/01/2023-06/01/2024), with a combined single limit for each accident of $1,000,000. The Florida Network of Youth and Family Services is listed as a certificate holder on the certificate of insurance reviewed on-site.	
External/Outside Contract Compliance a. Provider has corrective action item(s) cited by an external funding source (Fiscal or Non-Fiscal). **ON SITE**	☐	☐	☐	☐	☒	This item is not applicable due to the Chief Operating Officer reporting that there are no corrective action items cited by any external funders.	
Fiscal Practice a. Agency must have employee and fiscal policy/procedures manuals that follow GAAP and provide sound internal controls. Agency maintains fiscal files that are audit ready. **PTV**	☐	☐	☒	☐	☐	The agency has employee and fiscal policy/procedures manuals that comply with GAAP and provide sound internal controls. Various policies were reviewed that cover the agency's budget process, capital assts, general	

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						ledger, internal controls and purchasing. An interview with the Director of Finance confirms the agency maintains fiscal files that are audit ready.	
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**	☐	☐	☒	☐	☐	A review of the agency's general ledger confirms that it is set up to track the activity of the Florida Network of Youth and Family Services grant separately from all other revenue sources.	
c. Petty cash ledger system is balanced, and all cash disbursements are compliant with financial policies and allowable under the contract. (Disbursements/invoices are approved & monitored by management.) –**ON SITE**	☐	☐	☐	☐	☒	The agency does not use petty cash. Interview with the director of finance indicated, the residential supervisor has an agency credit card for purchases. The policy states supervisors have a spending limit up to $500 on agency cards. Receipts for purchases are submitted to the accounting/ finance department for reconciliation with the credit card statements. Credit card statements are paid monthly by the accounting/ finance department.	

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d. financial records and reports are current. Includes bank statements reconciled within 6 weeks of receipt. Vendor invoices past 6 months. Invoices are submitted monthly with supporting documentation. (Disbursements/invoices are approved & monitored by management). **ON SITE**	☐	☐	☒	☐	☐	The Director of Finance provided bank statements for the past six months which have all been reconciled within ten days of the close of the statement. The Director of Finance indicated that checks are cut weekly to pay vendor invoices. Disbursements and invoices are reported to the CEO monthly by the Director of Finance and she reviews and signs the report.	
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**	☐	☐	☐	☐	☒	Interview with the Director of Finance indicated there are no purchases requiring an Information Resources Request to DJJ and no purchases made with funds from the Florida Network of Youth and Family Services 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**	☐	☐	☒	☐	☐	Proof of payroll tax payments was reviewed for the most recent six months, from the agency's payroll company who submits payroll reports, taxes and issues W-2's.	

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g. Budget for actual reports prepared and reviewed by appropriate management. Variance from the budget is investigated and explained. **PTV/ON SITE**	☐	☐	☒	☐	☐	The most recent six months of budget to actual reports were reviewed by the Director of Finance, Chief Executive Officer and Chief Operating Officer on a monthly basis. Additionally, reviews are conducted by the Board of Director at agency board meetings.	
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**	☐	☐	☒	☐	☐	A Single Audit was performed for the period ending June 30, 2023. Assurance Dimensions, Certified Public Accountants, conducted the audit and the agency has no deficiencies to require a corrective action plan. The annual financial audit was completed within 120 days after the previous fiscal year/calendar year and a copy was provided to the Network.	

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i. Agency maintains confidentiality policy with written policies and procedures to ensure the security and privacy of all employee and client data. Personal information is not easily accessible. Agency maintains a backup system in case of accidental loss of financial information. Security procedures are in place to protect laptops. Obsolete documents are shredded, and computer hard drives are wiped prior to discarding. **ON SITE**	☐	☐	☒	☐	☐	The agency has a confidentiality policy with written policies and procedures to ensure the security and privacy of all employee and client data. The policy on record retention was reviewed. Personal information is not easily accessible and personal information is only accessible electronically to key individuals in the agency. The agency maintains a backup system in case of accidental loss of financial information. Security procedures are in place to protect laptops. Documents are scanned and maintained in an electronic format. Computer hard drives are wiped prior to discarding.	
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**	☐	☐	☒	☐	☐	The Director of Finance provided a spreadsheet of all direct care staff which included: employee ID, name, job, cost center, location and payrate. The listing shows all direct care workers are earning a minimum of $19.00 per hour as of October 1, 2023.	

CONCLUSION

Family Resources, Inc. (St. Petersburg) has met the requirements for the CINS/FINS contract because of full compliance with 11 applicable indicators of the Administrative and Fiscal Contract Monitoring Tool. Three of the 14 indicators were not applicable. Consequently, **the overall compliance rate for this contract monitoring visit is 100%.** There are no corrective actions cited. Overall, the provider is performing satisfactorily in meeting the fiscal and administrative terms of its contract. In addition, most of the indicators reviewed were carried out in a manner which meets the standard described in the report's 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, timeframes 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 Family Resources, Inc. - St. Petersburg
CINS/FINS Program

Date: January 31, 2024 - 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)	Satisfactory

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

Standard 3: Shelter Care & Special Populations

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

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

Standard 4: Mental Health/Health Services

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

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

Overall Rating Summary

Percent of indicators rated Satisfactory: 96.43 %
Percent of indicators rated Limited: 3.57 %
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

Andrea Haugabook, Lead Reviewer Consultant-Forefront LLC/Florida Network of Youth and Family Services
Gus Mazorra, Regional Monitor, Department of Juvenile Justice
Amy Loomis, Safe Children Coalition
Samuel Laguerre, Lutheran Services Florida Southwest
Doris Gillette, Hillsborough County Children's Services

Methodology

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

Persons Interviewed

	Chief Executive Officer		Case Manager		Nurse – Full time
	Chief Financial Officer	X	Counselor Non-Licensed	X	Nurse – Part time
X	Chief Operating Officer		Advocate		# 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		# Healthcare Staff
	Program Coordinator		Intern		# Maintenance Personnel
X	Clinical Director		Volunteer	2	# Other: Vice President of Impact, Finance Director
X	Counselor Licensed		Human Resources		

Documents Reviewed

X	Accreditation Reports	X	Table of Organization		Visitation Logs
X	Affidavit of Good Moral Character		Fire Prevention Plan	X	Youth Handbook
X	CCC Reports	X	Grievance Process/Records	2	# Health Records
X	Logbooks		Key Control Log	1	# MH/SA Records
	Continuity of Operation Plan	X	Fire Drill Log	6	# Personnel /Volunteer Records
X	Contract Monitoring Reports	X	Medical and Mental Health Alerts	7	# Training Records
	Contract Scope of Services	X	Precautionary Observation Logs	3	# Youth Records (Closed)
X	Egress Plans	X	Program Schedules	4	# Youth Records (Open)
X	Fire Inspection Report	X	List of Supplemental Contracts		# Other: Incident Reports, Menus, DCF license
	Exposure Control Plan	X	Vehicle Inspection Reports		

Observations During Review

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

Surveys

9	# of Youth	10	# of Direct Staff		# of Other		

Comments

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

Monitoring Purpose

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

Strengths and Innovative Approaches

Family Resources Inc. is sub-contracted with the Florida Network of Youth and Family Services (Florida Network) to provide temporary residential and non-residential services to youth and families through the Children In Need of Services/Families In Need of Services (CINS/FINS) program. The central office is located in Pinellas Park, Florida and CINS/FINS SafePlace2B has three shelters located in Clearwater, St. Petersburg, and Bradenton, Florida. Family Resources, Inc. Safe Place 2B (St. Petersburg) is located at 3761 5th Ave. North, St. Petersburg, FL 33713.

Family Resources, Inc. serves both male and female youth between the ages of ten to seventeen years that are locked out, runaway, ungovernable and/or truant, homeless, abuse, neglected, or at-risk. The program is also contracted to provide services for Staff Secure Shelter and is a provider for youth referred through the Juvenile Justice Court System for domestic violence, probation respite, domestic minor sex trafficking, and Family/Youth Respite Aftercare Services (FYRAC).

The program is designated by the National Safe Place Program as a Safe Place provider who is responsible for building a network of safe place sites in the community to provide help and access to run away and homeless youth. The shelter holds a license from the Department of Children and Families, which was recently renewed in January 2024. The agency is currently accredited by the Council of Accreditation (COA) effective through December 31, 2024.

The following programmatic updates were provided by the agency:

Since the date of the last audit the residential program has transitioned to electronic records. The program uses the electronic record system, Lauris, for all residential youth files. The program uses paper logbooks. The community counseling program is slated to transition to the Lauris electronic record system next month. In the meantime, all paper files are still maintained for community counseling youth served.

Staffing:

Leadership:

The shelter staff report directly to the Residential Supervisor, who is newly hired since October 2023. The Residential Supervisor reports the Chief Operating Officer (COO). The Community Counseling team is led by the Clinical Director, who also is a new hire since September of 2023. The Clinical Director also reports directly to the COO.

SafePlace2B:

The residential supervisor is new to the agency. There are also many new direct care staff. The program reports being close to full staffing.

Community Counseling:

There is a new Clinical Director as of September 2023.

Funding/Finance:

Family Resources - St. Petersburg has not received any new funding. The counseling program is 100% funded by the Florida Network of Youth and Family Services. The shelter received continued funding this fiscal year from the Juvenile Welfare Board. The agency did not seek to renew the basic center grant which ended September 30, 2023. The agency completed a financial audit and received a management letter in October 2023 for the 2022-2023 fiscal year indicating there were no findings requiring a corrective action.

Governance and Community:
The following changes have been made to the Board of Directors in the last year; the board has added four new members, one from Manatee County Schools, one from the private business sector in Pinellas County, one from the Bank of Tampa, and one who is a former county commissioner of Pinellas County.

Other:
The Chief Operating Officer reports that Family Resources - St. Petersburg has no corrective action plans with any other funding agencies and no major challenges at this time.

Narrative Summary
Family Resources, Inc. SafePlace2B (St. Petersburg) provides both residential and non-residential CINS/FINS services for youth and their families in Pinellas County and the surrounding areas. The program is under the leadership of a CEO, a Chief Operating Officer, Vice President of Impact, and Finance Director. Other staff consist of: a Clinical Director, a residential supervisor, director of client success and community services, a shelter counselor, a case manager, several youth development specialists and a part-time nurse. The shelter is in its inaugural year of transitioning to the Lauris electronic record system and still uses paper logbooks.

The shelter is licensed for 12 beds by the Department of Children and Families effective through December 2024. The shelter environment consists of a one open great-room with four bedrooms (two on either side of the great-room). Two bedrooms are for girls and two for boys, with three beds in each room. The bedrooms have jack and jill bathrooms containing shower, toilet and a sink. The shelter had a total of ten youth in shelter at the time of the annual QI review.

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**.
Indicator 1.05 Analyzing and Reporting Information was rated **Satisfactory.**
Indicator 1.06 Client Transportation was rated **Satisfactory with Exception**.
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**.
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 with Exception**.
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**.
Indicator 2.09 Stop Now and Plan (SNAP) was rated **Satisfactory**.

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

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

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

Standard 3: Indicator 3.06 Staffing and supervision was rated Limited due to evidence of falsification was observed on the 15 minute bed check logs. Times documented on the programs bed check logs did not correspond with evidence of bed checks completed as seen on the program's video surveillance system. There were bed checks documented on the program's bed check log that did not occur at all. A CCC report was initiated by the agency's residential supervisor during the review to report the falsification of documentation and missed bed checks.

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:** Narrative guidelines: The narrative write-up is a thorough summary of each assigned QI indicator worksheet, explain how you came to your finding(s).	**Deficiencies/Exceptions:** Please add additional detailed explanations for any items that have any deficiencies or exceptions.

Standard One – Management Accountability

1.01: Background Screening of Employees, Contractors and Volunteers		**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 1.01	**YES** If NO, explain here: The agency has a policy, 1.01 Background Screening of Employees and Volunteers last updated July 2023 by the COO.	

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: A total of six (five new hire employees and one intern) files were reviewed.
Total number of 5 Year Re-screen Employee Files: None
Type of Documentation(s) Reviewed: Agency for Healthcare Administration background screening results, Department of Homeland Security

All positions providing direct services to youth has successfully passed pre-employment suitability assessment on the initial attempt.	**Compliance**	Five of six files reviewed contained evidence of successful completion of pre-employment suitability assessment on the initial attempt. One of six files was not applicable due to the fact that it was an intern file.	
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.	**Not Applicable**	Five of five employee files reviewed passed the suitability assessment on the initial attempt.	
Agency has evidence for employees who have had a break in service for 18 months or more, and/or when the agency had a change or update in the suitability assessment tool used was different from the employee's original assessment, that a new suitability assessment and background screening was completed as required.	**No eligible items for review**	The agency had no employees who had a break in service for 18 months or longer.	

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**	Six of six files reviewed showed evidence of completion of background screening prior to hire or start date.	
Five-year re-screening is completed every 5 years from initial date of hire or prior to retained fingerprints expiration date.	**No eligible items for review**	The agency had no employees who had a 5 year rescreen due since the date of the last review.	
Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?	**Compliance**	An annual affidavit of compliance was completed by the CEO on January 16, 2024. The Vice President of Impact shared an email confirming the submission of the annual affidavit of compliance being sent to background screening unit on January 18, 2024.	
Proof of E-Verify for all new employees obtained from the Department of Homeland Security	**Compliance**	Five of six files reviewed contained proof of E-Verify obtained from the Department of Homeland Security. This indicator is not applicable for one file due to the fact the it is an intern position and not an employee.	
Additional Comments: **There are no additional comments for this indicator.**			
1.02: Provision of an Abuse Free Environment			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 1.02		**YES** If NO, explain here: The agency has a policy numbered 1.02, Provision of an Abuse Free Environment, reviewed and approved by COO in July 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: VP of Impact, Residential Supervisor, Shelter Staff **Type of Documentation(s) Reviewed: Abuse Hotline Forms, Grievance Forms, Daily Log Book** **Describe any Observations: Poster Observed in Common Area related to Abuse Hotline Information**			
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 signage posted in the common area of the shelter related to Abuse Hotline and agency's code of conduct. Residential Supervisor was able to communicate the importance of the agency's code of conduct and show evidence of its importance to the staff through their implementation of their leadership program.	

The agency has a process in place for reporting and documenting child abuse hotline calls.	**Compliance**	The agency has a process in place for reporting and documenting child abuse hotline calls. Interview with the Vice President of Impact, reported that Abuse Hotline forms are kept in a log form for a minimum of 6 months on paper, then scanned and stored electronically for a year. Evidence of two abuse hotline forms completed in the past 6 months was reviewed.	
Youth were informed of the Abuse and Contact Number	**Compliance**	Youth are informed of the Abuse and Contact Number in their orientation into the shelter; as well as they are shown the signage which is kept in the common area. Shelter staff were able to communicate the orientation process which indicates the youth are informed of the abuse hotline and contact number.	
Grievance			
Grievances are maintained on file at minimum for 1 year.	**Compliance**	Residential Supervisor verbally communicated that grievances are kept on hand for two years and stored electronically after the first year.	
There are formal grievance procedures for youth, including grievance forms, and a locked box which are easily accessible to youth in a common area.	**Compliance**	Agency has a formal grievance system in place. Residential Supervisor was able to provide location grievance box where it was observed in the c the common area, locked with grievance forms 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 program's daily logbook was reviewed from 10/25/2023 to 11/16/2023, Eight of 23 days reviewed did show evidence of the program's grievance box being checked.	Fifteen out of 23 days did not have entries documented in the program's log book that the grievance box was checked daily.
All grievances are resolved within 72 hours and documented by program director/supervisor or escalated to higher leadership if grievance involves them directly.	**Compliance**	Seven out of seven grievances during the period of 08/01/2023 to 01/30/2024 were reviewed by Residential Supervisor within 72 hours.	
1.03: Incident Reporting			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 1.03		**YES** If NO, explain here: The agency has a policy, 1.03 Incident Reporting, last reviewed July 2023 by COO; 1.03.A. CCC Incident Reporting, last reviewed July 2023 by COO	
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 : VP of Impact and Residential Supervisor **Type of Documentation(s) Reviewed: Incident Logs and CCC-Reports** **Describe any Observations: Observed was the incident reporting electronic database.**			
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**	Seventeen CCC intakes were reviewed from 08/01/2023 to 1/30/2024. 16 out of 17 were reported to the CCC within the two hours as required.	One out of the 17 incidents were not reported to the CCC within the 2 hour timeframe of when the incident occurred or from learning about the incident.
The program completes follow-up communication tasks/special instructions as required by the CCC	**Compliance**	Nine out of nine CCC intakes were reviewed and contained follow-up communication tasks/instructions. Evidence of completion of follow-ups was reviewed.	
Agency internal incidents are documented on incident reporting forms and all CCC reportable incidents were consistently reported to CCC as required.	**Compliance**	17 out of 17 CCC incidents reported were documented on the internal incident log forms.	
Incidents are documented in the program logs and on incident reporting forms	**Compliance**	Incident reports are documented in the programs log books and on incident reporting forms. Hard copies are maintained in a log for six months and then scanned into an electronic format and stored electronically for a year. The Vice President of Impact and Residential Supervisor provided incident reports via their electronic system.	
All incident reports are reviewed and signed by program supervisors/ directors	**Compliance**	Twenty-one incident reports were provided for the past six months which were all reviewed and signed by Residential Supervisor and COO.	
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**
Provider has a written policy and procedure that meets the requirement for Indicator 1.04		**YES** If NO, explain here: The agency has a policy, 1.04, Training Requirements, last reviewed July 2023 by COO	
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: One **Total number of Annual In-Service Staff Files: Three** **Total number of Non-Licensed Mental Health Clinical Shelter Staff Files: One** **Staff Position(s) Interviewed: Vice President of Impact and Clinical Director** **Type of Documentation(s) Reviewed: Training Binders, Training Plan, Training Certificates**			

First Year Direct Care Staff			
All direct care staff have completed new hire pre-service training requirements for safety and supervision as required.	**Compliance**	Three out of the three training files reviewed for direct care staff have completed new hire pre-service training requirements for safety and supervision as evidence by the training log and training certificates.	
All staff completed the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days from date of hire.	**Compliance**	Four out of the four training files reviewed showed all staff had completed the Civil Rights & Federal Funds training within 30 days from their date of hire as evidence by the training certificate.	
All direct care CINS/FINS staff (full time, part time, or on-call) demonstrated a minimum of 80 hours of training or more for the first full year of employment.	**Compliance**	Two of the three direct care CINS/FINS staff completed a minimum of 80 hours of training which was evident by their training certificates. One out of the three has ten hours remaining of training; however the staff member has eight more months until his one year due date.	
All staff receives all mandatory training during the first 90 days of employment from date of hire.	**Compliance**	Three out of the four staff training files completed all of their mandatory training during the first 90 days of employment. One of the four staff files reviewed was an intern's training file and the inter completed all of the FLN required trainings.	
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 of the four applicable staff training files were reviewed who's role requires entering Nirvana. This staff completed the required training.	
Staff Participating in Case Staffing & CINS Petitions (within first year of employment)			
Documentation of instructor led FL Statute 984 CINS Petition Training by a local DJJ Attorney. *Effective for staff hired after 7/1/23*	**No eligible items for review**	Agency has been unable to attend required training due to the DJJ Attorney canceling. Request by agency has been made to reschedule this training but the DJJ Attorney has not identified a date convenient to them.	
Non-licensed Mental Health Clinical Shelter Staff (within first year of employment)			
Documentation of non-licensed mental health clinical staff person's training in Assessment of Suicide Risk form or written confirmation by a licensed mental health professional of training (includes date, signature and license number of the licensed mental health professional supervisor).	**Compliance**	Review of one (non-licensed mental health clinical) staff's training file showed evidence of completion of training in the assessment of suicide risk conducted by the licensed mental health professional supervisor on 06/20/2023.	

In-Service Direct Care Staff			
Direct care staff completes 24 hours of mandatory refresher Florida Network, Skill Pro, and job-related training annually (40 hours if the program has a DCF child caring license).	**Compliance**	Three of the three direct care staff completed 40 hours of Florida Network, Skill Pro, and job-related trainings annually.	
Required Training Documentation			
The agency has a training plan that includes all of the required training topics including the pre-service and in-service.	**Compliance**	The agency has established a training plan that includes all of the required training topics including the pre-service and in-service.	
The agency has a designated staff member responsible to manage all employee's individual training files and completes routine tracking and reviews of staff files to ensure compliance.	**Compliance**	Vice President of Impact explained that the agency has one staff member assigned that is responsible to managing all employee's individual training files and reviews 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 agency maintains individual training files and has an agency approved training log for each staff. Agency approved training log includes annual employee training hours, name, position, and hire date. Evidence of training completion was verified by training certificates and transcripts.	
Additional Comments: **There are no additional comments for this indicator.**			
1.05 - Analyzing and Reporting Information			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 1.05		**YES** If NO, explain here: The agency has a policy, 1.5, Analyzing and Reporting Information, last reviewed July 2023 by COO.	
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): VP of Impact **Type of Documentation(s) Reviewed: Quarterly Emails, SharePoint files, Spreadsheets, Meeting Notes, Board Review Meeting Notes**			
Case record review reports demonstrate reviews are conducted quarterly, at a minimum	**Compliance**	The agency provided evidence through SharePoint and email that case record reviews are being conducted at a minimum of quarterly. Per email correspondence, evidence showed monthly file reviews are conducted.	
The program conducts reviews of incidents, accidents, and grievances quarterly, at a minimum	**Compliance**	The agency discusses reviews of incidents, accidents, and grievances quarterly. This was evident by accessing SharePoint and VP of Impact's email. VP of Impact also states that VP of Impact gives quarterly presentations to Agency.	

The program conducts an annual review of customer satisfaction data	**Compliance**	The Vice President of Impact was able to provide meeting notes from the last Board of Directors meeting which contained evidence of the annual review of customer satisfaction data; as well as quarterly presentations shared on the SharePoint platform.	
The program conducts an annual review of outcome data and (if applicable) there is evidence of annual reconciliation that occurs through communication from the Florida Network via email or phone call when corrections are needed and the information is corrected and submitted within the requested timeframes.	**Compliance**	The Vice President of Impact provided evidence via SharePoint and email that annual review outcomes are reviewed and discussed. Reviews are conducted at the Board of Directors meetings; as well as monthly program management meetings with staff. Documentation of meeting minutes was provided which showed corrective actions follow-ups and compliance standards being talked about monthly at the program's team meetings.	
The program has a process in place to review and improve accuracy of data entry & collection	**Compliance**	Vice President of Impact explained the quality improvement process which entails monthly meetings with staff and leadership to discuss compliance and improvements needed, as well as follow-ups. Meeting minutes showed evidence of the collection, data entry, and distribution of information. The Vice President of Impact reports findings for all benchmarks and CINS/ FINS compliance at each meeting.	
There is documentation that findings are regularly reviewed by management and communicated to staff and stakeholders.	**Compliance**	Emails, Spreadsheets, and Meeting Minute notes were provided as evidence by the Vice President of Impact that findings are regularly reviewed by management and communicated to the staff and stakeholders.	
There is evidence the program demonstrates that critical performance data reports are shared with the Board of Directors frequently. All final reports that include a Limited or Failed score is submitted electronically or by mail to the providers Executive Committee on the Board of Directors.	**Compliance**	Additional documentation for the Agency was reviewed and communication was documented regarding Limited and Failed reports which go to the Board and Stakeholders (Juvenile Welfare Board, Department of Children and Families, and Council On Accreditation). Reviewer was able to see the last President/CEO Report from last QA review which was August 2023. Reviewed Final QA Report, corrective action plan, and follow-ups which were sent to SharePoint, Stakeholders, Leadership, and Supervisors.	
There is evidence that strengths and weaknesses are identified, improvements are implemented or modified, and staff are informed and involved throughout the process.	**Compliance**	Vice President of Impact provided documentation of monthly meeting minutes and quarterly meeting notes which discusses the agencies strengths and weaknesses are identified, improvements or modifications.	
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 agency has a policy, 1.10 Transportation Policy, Reviewed and Approved 7/2023 by COO	
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: 08/09/2023 to 1/24/2024 **Staff Position(s) Interviewed: Residential Supervisor, Vice President of Impact, and COO** **Type of Documentation(s) Reviewed: Transportation Log/Mileage Van Log, Daily Log Book**			
Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	**Compliance**	The agency provided an approved list of agency staff approved by administrative personnel to drive clients in agency or approved private vehicle.	
Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	**Compliance**	Per interview with the COO, approved drivers are confirmed by Human Resources and are covered under the agency's insurance policy. The agency maintains a valid automobile insurance policy. Proof of covered drivers was provided via email from the agency's insurance company.	
Agency's Transportation policy prohibit transporting a client without maintaining at least one other passenger in the vehicle during the trip and include exceptions in the event that a 3rd party is NOT present in the vehicle while transporting	**Compliance**	The agency's policy prohibits transporting a youth without another passenger in the vehicle. There are provisions in place in case a third party is not present in the vehicle. The policy notes they can have an open call system, when 1:1 transport is conducted, and the driver will call the onsite staff and leave the phone open for the duration of the journey. This was confirmed verbally by Residential Supervisor and evidence of open call lines were documented in the program's logbook as well.	
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**	Residential Supervisor and Vice President of Impact communicated prior to single transport the agency's supervisor and COO take into consideration the client's history, evaluation, and their recent behaviors.	
The 3rd party is an approved volunteer, intern, agency staff, or other youth	**Compliance**	Residential Supervisor and VP of Impact where able to communicate that all 3rd parties are an approved volunteer, intern, and agency staff.	

The agency demonstrated evidence via logbook or other written verification that supervisor approval was obtained prior to all single youth transports.	**Exception**	A review of transportation logs for the period of August 2023 - January 2024 showed a total of 88 single transports were conducted. Of 88 single transports, a sample of 30 was selected for review in the program's logbooks. Prior supervisor approval for 11 out of the 30 reviewed was evident in the program's log book.	Nineteen out of 30 (8/9/2023, 8/12/2023, 8/18/2023, 8/23/2023, 8/28/2023, 9/1/2023, 9/5/2023, 9/7/2023, 9/15/2023, 9/19/2023, 10/3/2023, 10/6/2023, 10/10/2023, 10/13/2023, 10/23/2023, 10/25/2023, 11/6/2023, 11/9/2023, 11/15/2023, 11/17/2023, 11/29/2023, 12/1/2023, 12/4/2023, 12/7/2023, 12/11/2023, 12/14/2023, 12/18/2023, 1/9/2024, 1/22/2024, and 1/23/2024) single transports selected for review did not have prior supervisor approval recorded in the program's logbook.
There is documentation of use of vehicle that notes name or initials of driver, date and time, mileage, number of passengers, purpose of travel and location.	**Compliance**	The program maintains a vehicle transportation log that documents the date, time, name of driver and initials of staff passengers, location and purpose of travel, number of passengers, initials of passengers, mileage in/out, and return time in.	
Additional Comments: **There are no additional comments for this indicator.**			
1.07 - Outreach Services			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 1.07		**YES** If NO, explain here: The agency has a policy 1.11 Outreach Services, last reviewed July 2023 by COO	
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: Vice President of Impact and COO **Type of Documentation(s) Reviewed: NetMIS, Outreach Entries, Collaborative Agreement**			
The program has a lead staff member designated to participate in local DJJ board, Circuit and Council meetings with evidence that includes minutes of the event or other verification of staff participation.	**No eligible items for review**	Per Interview with the COO and documentation provided, the Chief Probation Officer did not offer a DJJ Board, Circuit and Council Meeting for the 2023 year.	
The program maintains written agreements with other community partners which include services provided and a comprehensive referral process.	**Compliance**	Per interview with the COO, the program maintains written agreements with other community partners (Collaborative Agreement and Interagency Agreements). COO provided proof of documentation of such agreements and was able to verbally explain the referral process both internally and for other agencies.	

The program will maintain documentation of outreach activities and enter into NetMIS the title, date, duration (hours), zip code, location description, estimated number of people reached, modality, target audience and topic.	**Compliance**	The program provided documentation of outreach activities that were enter into NetMIS the title, date, duration (hours), zip code, location description, estimated number of people reached, modality, target audience and topic. During the period of August 2023 to January 2024, 41 outreach activities were captured.	
The program has designated staff that conducts outreach which is defined in their job description.	**Compliance**	Agency has designated Staff Members: Community Liaison and Supervisors enter all outreach into NetMIS and verify proof of outreach.	
Additional Comments: **There are no additional comments for this indicator.**			
2.01 - Screening and Intake			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.01		**YES** If NO, explain here: The agency has a policy 2.01/ Eligibility Screening and intake Assessment, last reviewed July 2023 by COO.	
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: Three **Total number of Closed (Residential & Community) Files: Four** **Staff Position(s) Interviewed** *(No Staff Names)* **: Clinical Supervisor, Vice President of Impact, Residential Supervisor** **Type of Documentation(s) Reviewed: Electronic Residential files in Lauris and Community Counseling files**			
Shelter youth: Eligibility screening form is completed immediately for all shelter placement inquiries.	**Compliance**	The program's four residential files provided were in compliance with the eligibility screening being completed immediately upon intake.	
Community counseling: Eligibility screening is completed within 3 business days of referral by a trained staff using the Florida Network screening form.	**Compliance**	The program's three community counseling files provided were in compliance with the eligibility screening being completed within 3 business days of the referral.	
There is evidence all referrals for service is screened for eligibility and is logged in NetMIS within 72 hours of screening completion.	**Compliance**	The seven files reviewed (four closed/ three open) were all entered into NetMIS within 72 hours of screening completion.	
Youth and parents/guardians receive the following in writing: a. Available service options b. Rights and responsibilities of youth and parents/guardians	**Compliance**	The seven files reviewed (four closed/ three open) had signatures of the parent/ guardian as an indication of having received in writing: available service options and rights and responsibilities of youth and parents/guardians.	

The following is also available to the youth and parents/guardians: a. Possible actions occurring through involvement with CINS/FINS services (case staffing committee, CINS petition, CINS adjudication) b. Grievance procedures	**Compliance**	The seven files reviewed (four closed/three open) had signatures of parents receiving: Possible actions occurring through involvement with CINS/FINS services (case staffing committee, CINS petition, CINS adjudication) and Grievance procedures.	
During intake, all youth were screened for suicidality and assessed as required if needed.	**Compliance**	All seven youth files (four closed/ three open) reviewed were screened for suicidality and assessed as required if needed. (one of the seven files required an assessment after answering yes).	
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 agency has a policy 2.02/ Network Inventory of Risks, Victories, and Needs Assessment (NIRVANA), last reviewed July 2023 by COO.	
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: Three **Total number of Closed (Residential & Community) Files: Four** **Staff Position(s) Interviewed: Clinical Supervisor** **Type of Documentation(s) Reviewed: Electronic Residential files in Lauris and Community Counseling files provided** **Describe any Observations: Lauris (Residential files)**			
Shelter Youth: NIRVANA is initiated within 72 hours of admission	**Exception**	Two of four shelter youth files reviewed contained evidence of NIRVANA being completed within 72 hours of admission. One shelter youth file contained no eligible item to review due to the youth immediately leaving the shelter after the intake.	One of four shelter youth files review showed that the NIRVANA was not initiated within the 72 hours of admission. The NIRVANA was initiated five days after youths intake.
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**	Three of three non-residential youth files reviewed, met compliance with NIRVANA initiated at intake and completed within two to three face to face contacts after the initial intake.	
Supervisor signatures is documented for all completed NIRVANA assessments and/or the chronological note and/or interview guide that is located in the youths' file.	**Compliance**	Six of the seven files provided had supervisor signature documented. One closed youth file did not stay in shelter past the intake process therefore NIRVANA was not initiated.	
(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**	Three of the four shelter youth files reviewed showed evidence of the NIRVANA being completed within 24 hours of youth being admitted to shelter. One file did not stay past the intake.	

A NIRVANA Post-Assessment is completed at discharge for all youth who have a length of stay that is greater than 30 days.	**Exception**	Of the seven files reviewed, two shelter and one non-residential file were in compliance with a NIRVANA post-assessment being completed at discharge. One shelter file and two community counseling files were not applicable.	One shelter youth's NIRVANA Post-Assessment was not completed at discharge and youth was in shelter over 30 days.
A NIRVANA Re-Assessment is completed every 90 days excluding files for youth receiving SNAP services.	**Not Applicable**	A NIRVANA re-assessment was not applicable for any files reviewed because no youth were receiving services longer than 90 days.	
All files include the interview guide and/or printed NIRVANA.	**Compliance**	All seven files reviewed were in compliance with a printed NIRVANA contained within.	
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 agency has a policy 2.03/ Case/Service Plan, last reviewed July 2023 by COO.	
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: Three **Total number of Closed (Residential & Community) Files: Four** **Staff Position(s) Interviewed: Clinical Supervisor** **Type of Documentation(s) Reviewed: Electronic Residential and Community Counseling files**			
The case/service plan is developed on a local provider-approved form or through NETMIS and is based on information gathered during the initial screening, intake, and NIRVANA.	**Compliance**	Of the seven files reviewed, one file was Not Applicable as youth did not stay past the intake. The remaining six files were in compliance with the development of case/service plans completed on provider approved forms and based on all information gathered during the initial screening, intake and NIRVANA.	
Case/Service plan is developed within 7 working days of NIRVANA	**Compliance**	Six of the seven files reviewed were in compliance with the development of a case/ plan within seven working days of NIRVANA. One file was not applicable, as youth did not stay past the intake.	

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**	Six files contained case plans which were in compliance, including: 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 Actual dates of completion was not applicable in four files due to three files being open and receiving services and one file only participated in intake.	Three residential youth files reviewed did not have the signature of parent on the case/service plan and there was no explanation found. One file did not have a supervisor signature and speaking with clinical supervisor the service plan could not be found which was sent via email from the youth's counselor.
Case/service plans are reviewed for progress/revised by counselor and parent (if available) every 30 days for the first three months and every 6 months after	**Exception**	Two of seven files reviewed had case/service plan reviews completed timely. Case/ service plan reviews were not applicable for three files.	Two shelter files had no completed case/service plan reviews and youth have been in shelter over 30 days.
Additional Comments: **There are no additional comments for this indicator.**			
2.04 - Case Management and Service Delivery			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.04		**YES** If NO, explain here: The agency has a policy 2.04/Case Management and Service Delivery, last reviewed July 2023 by the COO.	
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: Three **Total number of Closed (Residential & Community) Files: Four** **Staff Position(s) Interviewed: Clinical Supervisor** **Type of Documentation(s) Reviewed: Electronic Residential and Community Counseling Files**			
Counselor/Case Manager is assigned	**Compliance**	The seven files provided had a Counselor/ Case Manager assigned.	

The Counselor/Case Manager completes the following as applicable: 1. Establishes referral needs and coordinates referrals to services based upon the on-going assessment of the youth's/family's problems and needs 2. Coordinates service plan implementation 3. Monitors youth's/family's progress in services 4. Provides support for families 5. Monitoring of progress for court ordered youth in shelter 6. Makes referrals to the case staffing to address problems and needs of the youth/family 7. Accompanies youth and parent/guardian to court hearings and related appointments 8. Refers the youth/family for additional services when appropriate 9. Provides case monitoring and reviews court orders 10. Provides case termination notes 11. Provides follow-up after 30 days of exit 12. Provides follow-up after 60 days of exit	**Compliance**	Seven of seven files reviewed were in compliance with 1, Establishes referral needs and coordinates referrals to services based upon the on-going assessment of the youth's/family's problems and needs-two files (one Residential and one Community Counseling) were not applicable as the family did not continue with services past the intake process which was documented. 2, Coordinates service plan implementation-of the seven files reviewed six files (three Residential and three Community Counseling) were in compliance-one file (Residential-closed) was N/A as youth only completed the intake and did not remain in shelter. 3, Monitors youths/family progress in services-all files were in compliance and 4, provides support for families all files were in compliance (it should be noted that one closed residential file only completed the intake however the counselor made contact with the family to inquire if youth would be returning to shelter). 5, Monitoring progress for court ordered youth in shelter, of the seven files provided one closed residential file was in compliance, three residential files were Not Applicable. Questions 6 and 7 are Not Applicable. 8, Refers the youth/family for additional services when appropriate, five of the seven files reviewed were in compliance-two files were Not Applicable. 9, Provides case monitoring and reviews court orders, seven files provided met the indicator. 10, provides case termination notes, seven files provided three are still receiving services, four files met indicator. 11, provides follow-up after 30 days of exit- three files met the indicator and four files were Not Applicable as three were still open at the time of review and one had just been discharged. 12, provides follow-up after 60 days of exit, of the seven files provided one Community Counseling file (closed) met the indicator.	
The program maintains written agreements with other community partners that include services provided and a comprehensive referral process	**Compliance**	The program is in compliance with maintaining written agreements with other community partners. Agreements reviewed included services provided and a comprehensive referral process .	
Additional Comments: **There are no additional comments for this indicator.**			

2.05 - Counseling Services			Satisfactory with Exception
Provider has a written policy and procedure that meets the requirement for Indicator 2.05		**YES** If NO, explain here: The agency has a policy 2.05/Counseling Services, last reviewed July 2023 by COO.	
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: Three **Total number of Closed (Residential & Community) Files: Four** **Staff Position(s) Interviewed: Clinical Supervisor** **Type of Documentation(s) Reviewed: Electronic Residential and Community Counseling Files** **Describe any Observations: Lauris (Residential files)**			
Shelter Program			
Shelter programs provides individual and family counseling	**Compliance**	Three of four files reviewed were in compliance with providing individual and family counseling. One file was not applicable as family only completed the intake and youth did not stay in shelter.	
Group counseling sessions held a minimum of five days per week	**Compliance**	Three of the four shelter files reviewed, three met the indicator for minimum number of group counseling sessions held per week and one was not applicable as youth did not stay past the intake process.	
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**	Three residential files reviewed all presented evidence of groups being conducted by staff, youth or guests. All group counseling sessions consist of: a clear leader or facilitator, relevant topic, opportunity for youth participation and last longer than 30 minutes in duration.	
Documentation of groups must include date and time, a list of participants, length of time, and topic.	**Compliance**	Three of four residential files reviewed included documentation of group which included date and time, a list of participants, length of time, and 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**	All three community counseling files reviewed provided therapeutic community-based services designed to provide the intervention necessary to stabilize the family. Services are provided in the program's community counseling building and met the requirements of the indicator.	
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	**Exception**	Coordination between presenting problems, assessment, case service plans, case management and follow-up was evident in four of seven files reviewed. One file was not applicable as youth did not stay in shelter.	Two open residential files have been in shelter over 30 days and did not have case/service plan reviews as evidenced by the electronic files presented therefore coordination between presenting problems and case plan reviews could not be determined.
Maintain individual case files on all youth and adhere to all laws regarding confidentiality	**Compliance**	Seven of seven files reviewed met indicator. Three Community Counseling files had confidential stamped on the files and the four electronic files had Confidential on the forms reviewed as well as needing a password to get into the electronic database (Lauris) used.	
Case notes maintained for all counseling services provided and documents youth's progress	**Compliance**	Seven files provided met indicator. All case notes were maintained for all counseling services and documents youths' progress.	
On-going internal process that ensures clinical reviews of case records and staff performance	**Compliance**	The program has a new shelter manager and clinical director. Together they have established an on-going clinical process to ensure the review of case records and staff performance. Regular meetings with staff and review of records has improved greatly since the last review.	
When an intake is conducted through virtual means, consent is confirmed by the counselor, documented in the file, and reviewed with the supervisor during supervision/case review. There is written documentation provided in the youths file for reasons why virtual sessions are in the best interest of the youth and family.	**Not Applicable**	The agency is not conducting intakes by virtual means.	

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

2.06 - Adjudication/Petition Process		**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.06	**YES**	
	If NO, explain here:	
	The agency has a policy 2.06/Adjudication/Petition Process, last reviewed July 2023 by the COO.	

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: Zero
Total number of Closed (Residential & Community) Files: Zero
Staff Position(s) Interviewed: Vice President of Impact
Type of Documentation(s) Reviewed: Policy
Describe any Observations: Agency has a policy that is compliant with the QI standard and has had no adjudication/petition cases back to the date of the last review.

Must include: a. DJJ rep. or CINS/FINS provider b. Local school district representative	**Compliance**	The program has an established process to receive CINS petition cases. The committee includes the CINS/ FINS provider and representation from the local school district. The program has not had any CINS petition cases in the last six months or back to the date of the last review, therefore there was no practice to review.	
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**	In the event of a CINS petition case, the program has a process in place which includes a staffing committee with members from the State Attorney's office, law enforcement, DCF, SA/MH and others as requested by the youth/ family. The program has not had any CINS petition cases in the last six months or back to the date of the last review, therefore there is not practice to review. Interview with the Vice President of Impact indicates the program serves more petition cases in their north shelter.	
The program has an established case staffing committee, and has regular communication with committee members	**Compliance**	The program has an established case staffing committee with regular communication between the Clinical Director and the Residential Supervisor and other committee members. There has been no cases in the past six months or back to the date of the last review.	
The program has an internal procedure for the case staffing process, including a schedule for committee meetings	**Compliance**	Regularly scheduled meetings between the Clinical Director and Residential Supervisors are held to address case staffing case needs. The program has not had any CINS petition cases in the last six months or back to the date of the last review, therefore there is no practice to review.	
The youth and family are provided a new or revised plan for services	**No eligible items for review**	The program has not had any CINS petition cases in the last six months or back to the date of the last review.	
Written report is provided to the parent/guardian within 7 days of the case staffing meeting, outlining recommendations and reasons behind the recommendations	**No eligible items for review**	The program has not had any CINS petition cases in the last six months or back to the date of the last review.	
If applicable, the program works with the circuit court for judicial intervention for the youth/family	**No eligible items for review**	The program has not had any CINS petition cases in the last six months or back to the date of the last review.	
Case Manager/Counselor completes a review summary prior to the court hearing	**No eligible items for review**	The program has not had any CINS petition cases in the last six months or back to the date of the last review.	
Additional Comments: **There are no additional comments for this indicator.**			
2.07 - Youth Records			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.07		**YES** If NO, explain here: The agency has a policy 2.07/Youth Records, last reviewed July 2023 by the COO.	

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: Residential Supervisor and admin for Community Counseling **Type of Documentation(s) Reviewed: Electronic Residential files and Community Counseling files** **Describe any Observations: Provider only has Community Counseling files on property. Community counseling files are kept in the community counseling building. Files are stored in file cabinets inside a closet with a locked door. All Residential files are electronic.**			
All records are clearly marked 'confidential'.	**Compliance**	Three of three community counseling files had "Confidential" stamped on the front. All residential files are electronic and had "Confidential" on the screening form in Lauris.	
All records are kept in a secure room or locked in a file cabinet that is marked "confidential"	**Compliance**	Three of three community counseling files are on property and are kept in a secure room, in file cabinets marked "Confidential".	
When in transport, all records are locked in an opaque container marked "confidential"	**Compliance**	Vice President of Impact stated when files are transported they are in an opaque container. It was witnessed in the community counseling building, an opaque container with a lock code, marked "Confidential".	
All records are maintained in a neat and orderly manner so that staff can quickly and easily access information	**Compliance**	All records kept on property and electronically are kept neatly and can be accessed easily.	
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 agency has a policy 2.08/Specialized Additional Program Services, last reviewed July 2023 by the COO.	
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.*			
Total number of Open Files: Zero **Total number of Closed Files: Zero** **Staff Position(s) Interviewed: Vice President of Impact** **Type of Documentation(s) Reviewed: Agency's Policy**			
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 had no staff secure cases in the last six months or back to the date of the last review.	

Staff Secure policy and procedure outlines the following: a. In-depth orientation on admission b. Assessment and service planning c. Enhanced supervision and security with emphasis on control and appropriate level of physical intervention d. Parental involvement e. Collaborative aftercare	**Compliance**	The program has a policy as stated above which outlines: 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	
Program only accept youth that meet legal requirements of F.S. 984 for being formally court ordered in to Staff Secure Services	**No eligible items for review**	The program had no staff secure cases in the last six months or back to the date of the last review.	
Staff Assigned: a. One staff secure bed and assigned staff supervision to one staff secure youth at any given time b. Program assign specific staff during each shift to monitor location/ movement of staff secure youth c. Agency clearly documents the specific staff person assigned to the staff secure youth in the logbook or any other means on each shift	**No eligible items for review**	The program had no staff secure cases in the last six months or back to the date of the last review.	
Agency provides a written report for any court proceedings regarding the youth's progress	**No eligible items for review**	The program had no staff secure cases in the last six months or back to the date of the last 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.*			
Total number of Open Files: Zero **Total number of Closed Files: Zero** **Staff Position(s) Interviewed: Vice President of Impact** **Type of Documentation(s) Reviewed: Agency's Policy**			
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 had any domestic minor sex trafficking cases in the past six months or back to the date of the last 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**	The program has not had any domestic minor sex trafficking cases in the past six months or back to the date of the last 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**	The program has not had any domestic minor sex trafficking cases in the past six months or back to the date of the last review.	
Services provided to these youth specifically designated services designed to serve DMST youth	**No eligible items for review**	The program has not had any domestic minor sex trafficking cases in the past six months or back to the date of the last 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**	The program has not had any domestic minor sex trafficking cases in the past six months or back to the date of the last 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**	The program has not had any domestic minor sex trafficking cases in the past six months or back to the date of the last 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**	The program has not had any domestic minor sex trafficking cases in the past six months or back to the date of the last review.	
All other services provided to DMST youth are consistent with all other general CINS/FINS program requirements	**No eligible items for review**	The program has not had any domestic minor sex trafficking cases in the past six months or back to the date of the last review.	

Domestic Violence

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

Total number of Open Files: Zero
Total number of Closed Files: One
Type of Documentation(s) Reviewed: Youth Electronic file

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")	**Compliance**	The agency had one domestic violence respite case in the past six months.	
Youth admitted to DV Respite placement have evidence in the file of a pending DV charge	**Compliance**	Evidence of a pending domestic violence charge was present in the one domestic violence respite file reviewed.	
Data entry into NetMIS within (3) business days of intake and discharge	**Compliance**	There was evidence of entry into NetMIS within three business days of intake and discharge contained in the one domestic violence respite case file reviewed.	
Youth length of stay in DV Respite placement does not exceed 21 days. If more than 21 days, documentation exists in youth file of transition to CINS/FINS or Probation Respite placement, if applicable.	**Compliance**	Length of stay was less than 21 days for the one domestic violence respite case file reviewed.	
Case plan in file reflects goals for aggression management, family coping skills, or other intervention designed to reduce propensity for violence in the home	**Compliance**	One domestic violence case file reviewed contained a case plan which reflects goals for aggression management, family coping skills, and other interventions to reduce violence in the home.	

All other services provided to Domestic Violence Respite youth are consistent with all other general CINS/FINS program requirements	**Compliance**	All services provided in the domestic violence respite case file reviewed were consistent with all general CINS/ FINS program requirements.	
Probation Respite			
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: Zero **Total number of Closed Files: Zero** **Staff Position(s) Interviewed** *(No Staff Names)* **: Vice President of Impact** **Type of Documentation(s) Reviewed: Agency's Policy**			
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 had any probation respite cases in the past six months or back to the date of the last review.	
All probation respite referrals are submitted to the Florida Network.	**No eligible items for review**	The program has not had any probation respite cases in the past six months or back to the date of the last 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**	The program has not had any probation respite cases in the past six months or back to the date of the last review.	
Data entry into NetMIS and JJIS within (3) business days of intake and discharge	**No eligible items for review**	The program has not had any probation respite cases in the past six months or back to the date of the last 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**	The program has not had any probation respite cases in the past six months or back to the date of the last review.	
All case management and counseling needs have been considered and addressed	**No eligible items for review**	The program has not had any probation respite cases in the past six months or back to the date of the last review.	
All other services provided to Probation Respite youth are consistent with all other general CINS/FINS program requirements	**No eligible items for review**	The program has not had any probation respite cases in the past six months or back to the date of the last 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.*			

Total number of Open Files: Zero
Total number of Closed Files: Zero
Staff Position(s) Interviewed: Vice President of Impact
Type of Documentation(s) Reviewed: Agency's Policy

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 had any intensive case management cases in the past six months or back to the date of the last review.	
Youth receiving services were deemed chronically truant and/or runaway and require more intensive and lengthy services. The youth was determined to be eligible because they have gone through petition and/or case staffing and was in need of case management services.	**No eligible items for review**	The program has not had any intensive case management cases in the past six months or back to the date of the last review.	
Services for youth and family include: a. Two (2) direct contacts per month b. Two (2) collateral contacts per week c. Direct and collateral contacts not obtained must have documentation to support attempts made to obtain them. All reasonable attempts (at minimum of three) must be made to reach all contacts (direct and collateral) and documented in the case file and NetMIS.	**No eligible items for review**	The program has not had any intensive case management cases in the past six months or back to the date of the last review.	
Assessments include a. NIRVANA at intake b. NIRVANA Re-Assessment every 90 days c. Post NIRVANA at discharge as aligned with timeframe requirements	**No eligible items for review**	The program has not had any intensive case management cases in the past six months or back to the date of the last review.	
Service/case plan demonstrates a strength-based, trauma-informed focus	**No eligible items for review**	The program has not had any intensive case management cases in the past six months or back to the date of the last review.	
For any virtual services provided, there is written documentation in the youths' file as to why virtual contact is in the best interest of the youth and family	**No eligible items for review**	The program has not had any intensive case management cases in the past six months or back to the date of the last review.	

Family and Youth Respite Aftercare Services (FYRAC)

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

Total number of Open Files: Zero **Total number of Closed Files: Zero** **Staff Position(s) Interviewed: Vice President of Impact** **Type of Documentation(s) Reviewed: Agency's Policy**			
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 had any family and youth respite aftercare cases in the past six months or back to the date of the last 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**	The program has not had any family and youth respite aftercare cases in the past six months or back to the date of the last review.	
Agency has evidence that all FYRAC referrals have documented approval from the Florida Network office	**No eligible items for review**	The program has not had any family and youth respite aftercare cases in the past six months or back to the date of the last 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**	The program has not had any family and youth respite aftercare cases in the past six months or back to the date of the last 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**	The program has not had any family and youth respite aftercare cases in the past six months or back to the date of the last 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**	The program has not had any family and youth respite aftercare cases in the past six months or back to the date of the last 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**	The program has not had any family and youth respite aftercare cases in the past six months or back to the date of the last 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**	The program has not had any family and youth respite aftercare cases in the past six months or back to the date of the last 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**	The program has not had any family and youth respite aftercare cases in the past six months or back to the date of the last 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**	The program has not had any family and youth respite aftercare cases in the past six months or back to the date of the last review.	
All data entry in NetMIS is completed within 3 business days as required.	**No eligible items for review**	The program has not had any family and youth respite aftercare cases in the past six months or back to the date of the last review.	
Additional Comments: **There are no additional comments for this indicator.**			
2.09- Stop Now and Plan (SNAP)			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.09		**YES** If NO, explain here: The agency has a policy 2.10 SNAP Intake Requirement, last reviewed January 2024 by the COO.	
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: 4 **Total number of Closed Files: 2** **Staff Position(s) Interviewed (No Staff Names): Director of Community Programs** **Type of Documentation(s) Reviewed: SNAP files kept in Community Counseling building**			
SNAP Clinical Groups Under 12			
Youth are screened to determine eligibility of services.	**No eligible items for review**	The program does not serve youth under 12 in the SNAP program.	

The NIRVANA was completed at initial intake, or within two sessions.	**No eligible items for review**	The program does not serve youth under 12 in the SNAP program.	
There is evidence of the completed Child Behavior Checklist (CBCL) by the caregiver (pre and post) and is located within the file.	**No eligible items for review**	The program does not serve youth under 12 in the SNAP program.	
There is evidence of the completed Teacher Report Form (TRF) is completed by the teacher (pre and post) and is located within the file.	**No eligible items for review**	The program does not serve youth under 12 in the SNAP program.	
There is evidence of the completed TOPSE is completed by the caregiver (pre and post) and is located within the file.	**No eligible items for review**	The program does not serve youth under 12 in the SNAP program.	
SNAP Clinical Groups Under 12 - Discharge			
There is evidence of the completed SNAP Discharge Report located within the file for any discharged youth.	**No eligible items for review**	The program does not serve youth under 12 in the SNAP program.	
There is evidence of the SNAP Boys/SNAP Girls Child Group Evaluation Form located in the file.	**No eligible items for review**	The program does not serve youth under 12 in the SNAP program.	
There is evidence of the SNAP Boys/SNAP Girls Parent Group Evaluation Form located in the file.	**No eligible items for review**	The program does not serve youth under 12 in the SNAP program.	
SNAP Clinical Groups for Youth 12-17			
Youth are screened to determine eligibility of services.	**Compliance**	Six of six files showed evidence of completed screening to determine eligibility.	
The Consent to Treatment and Participation in Research Form is completed and located within the file.	**Compliance**	Six of six files reviewed had forms completed and located in files.	
The NIRVANA was completed at initial intake, or within two sessions.	**Compliance**	Six of six files reviewed had NIRVANA completed.	
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.	**Compliance**	Six of six files reviewed had HIT form completed.	
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.	**Compliance**	Six of six files reviewed had SSSI youth forms completed.	
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.	**Compliance**	Six of six files reviewed had SSSI teacher forms completed.	

SNAP for Schools & Communities			
The program demonstrated all of the required weekly attendance sheets that included youth names and/or identifying numbers completed with the teacher and trained SNAP Facilitator signatures. (*This must include a total of 13 attendance sheets for a full cycle*)	**Compliance**	Two of two group sessions reviewed had all attendance sheets completed.	
The program maintained evidence of a completed "Class Goal" Document for the class reviewed.	**Compliance**	Two of two group sessions reviewed had "Class Goal" documents present.	
The program maintained evidence of both pre AND post Measure of Classroom Environment (MoCE) completed documents for the class reviewed.	**Compliance**	Two of two group sessions presented had Pre and Post MoCE completed.	
The program maintained evidence of completed pre and post evaluation documents for the class reviewed.	**Compliance**	Two of two group sessions reviewed had per and post evaluations.	
There is evidence of the fidelity adherence checklist maintained in the file for each class reviewed.	**Compliance**	Two of two group sessions reviewed had Fidelity Adherence Checklist completed.	
Additional Comments: **There are no additional comments for this indicator.**			
3.01 - Shelter Environment			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 3.01		**YES** If NO, explain here: The agency has a police 3.01, Chief Operating Officer, last reviewed July 2023 by the COO.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Staff Position(s) Interviewed (No Staff Names): Residential Supervisor, Chief Operating Officer, VP of Impact **Type of Documentation(s) Reviewed: Logbooks from August 1, 2023 - January 30, 2024, DCF Child Care License, Chemical inventory sheets, Safety Data Sheets, Annual Fire Inspection, Monthly Fire Drills from August 2023 - January 2024, Mock Emergency Drills from August 2023 - January 2024, Current Residential Group Care Inspection, Current DOH Food Service Inspection, Current Approved Daily Menus, Daily Programming Schedule,** **Describe any Observations: Tour of shelter property, to include interior and exterior of facility and grounds.**			

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**	During the tour, all furnishings throughout the center were found to be in good repair, well maintained, and clean. There was no evidence of insect or pest infestation throughout the interior and exterior of the center. The shelter has one main room where youth are housed. The main room consists of a dayroom and four youth bedrooms; two for males and two for females. Each bedroom is able to accommodate up to three youth. Each bedroom has a shower and a bathroom. At the time of the review, all youth restrooms and showers were operational and clean. All walls, doors, windows, youth rooms, and common areas were free of graffiti. All areas provide sufficient natural lighting and have adequate working lights. There was no debris noted on the exterior of the building or grounds. All garbage cans were observed with covers. During the tour, all doors were found secured. Entrance to the shelter is secured and open only by staff, after verifying person(s) attempting to enter. Egress plans are located in all common areas and in each youth room. General client rules, grievance forms, abuse hotline information, DJJ incident reporting number, and other related notices are posted in the common area of the youth rooms. All bedrooms, bathrooms, and common areas were inspected and found to be free of any hazardous or unauthorized items.	
Facility Inspection: a. All agency and staff vehicles are locked. b. Agency vehicles are equipped with major safety equipment including first aid kit, (all items in the first aid kit are current and do not have expired items; all expired items should be replaced regularly), fire extinguisher, flashlight, glass breaker and, seat belt cutter.	**Compliance**	The program has one vehicle used to transport youth. The vehicle is a 2017 Ford Transit 350 van. The vehicle was properly maintained, has seating for 12, which includes the driver. The vehicle has all major safety equipment, which included a first aid kit, fire extinguisher with a current inspection, and has a glass breaker and seat belt cutter attached to the vehicle key ring.	

Facility Inspection: All chemicals are listed, approved for use, inventoried weekly and perpetually, stored securely and Material Safety Data Sheets (MSDS) are maintained on each item (minimum 1 time per week or per agency policy). A perpetual inventory will be the primary means of maintaining a current and real-time inventory. The weekly inventory will be conducted weekly at a minimum to ensure that a perpetual inventory is being maintained consistently and accurately. If more than one location is used to store chemicals, there is an inventory wherever chemicals are stored that is current and well maintained unless previously approved by the Network.	**Compliance**	Five random chemicals were selected and compared with the perpetual inventory sheets: Windex, Tide, Lysol, Pine Sol, Clorox. All chemicals had the appropriate inventory which corresponded with the amount on hand. The perpetual inventory sheets are being properly completed as chemicals are used, indicating when chemicals are checked out and returned, and the amount used. The inventory sheet also has a comment section, where staff note when chemicals need to be replenished. Staff conduct a weekly inventory of all chemicals, whether they are used or not. SDS sheets are maintained in a binder in the chemical storage closet, with the chemicals which are stored. No chemicals were missing MSDS sheets.	
Facility Inspection: Washer/dryer are operational & general area/lint collectors are clean. Agency has a current DCF Child Care License which is displayed in the facility. Each youth has own individual bed with clean covered mattress, pillow, sufficient linens and blanket. Youth have a safe, lockable place to keep personal belongings, if requested.	**Compliance**	The washer and dryer are located in the laundry room, which is in the common area of the youth dayroom. This room is secured when not in use. A laundry schedule is posted on the laundry room door. The effective date of the DCF license is January 16, 2024, and is posted at the entrance of the shelter. Each youth has their individual bed with clean linens, pillow, and blankets. Youth have individual bins in the nurses room, which remains locked. Youth are only allowed entry in this area under direct staff supervision.	
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 provided the most recent fire inspection, dated May 30, 2023. There was one area identified needing correction (one egress door requiring a manual release) during this inspection, which was corrected and reinspected on August 14, 2023, with no discrepancy noted. The program conducted fire drills on the following dates for each shift: 1st shift, August 12, 2023, September 9, 2023, October 13, 2023, November 5, 2023, December 24, 2023. 2nd shift, August 8, 2023, September 12, 2023, October 30, 2023, November 7, 2023, December 14, 2023. 3rd shift, August 14, 2023, September 19, 2023, October 30, 2023, November 17, 2023, December 14, 2023.The program conducted mock emergency drills on the following dates for each shift: 1st shift, August 26, 2023, October 14, 2023. 2nd shift, August 31, 2023, October 30, 2023. 3rd shift, August 29, 2023, October 27, 2023, December 24, 2023. The initial annual fire safety equipment inspection was conducted May 30, 2023. All extinguishers, sprinklers, alarm systems, and kitchen hood system were found to be in compliance. One area was found requiring correction (one egress door requiring a manual release device). Reinspection was conducted on August 14, 2023, and the area was corrected, with no reinspection required.	
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 program's most recent residential group care inspection was conducted on January 24, 2024. One area was found to need correction (hot water temperature needed to be raised), and this was corrected while the inspector was on site, leaving no deficiencies pending. The program had a Department of Health Food Service Inspection conducted on March 31, 2023, with no discrepancies pending and no reinspection required. The program has a weekly menu posted which is current and was reviewed and signed by a licensed dietician on June 19, 2023. All food items were properly stored, in original containers, and properly labeled. All food storage areas were clean, with no evidence of vermin infestation. The refrigerator and freezer was clean and properly working with a refrigerator temperature of 46 degrees F, and the freezer had a temperature of -2 degrees F.	
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 daily programming schedule is designed to have youth engaged in structured activities during awake hours. The daily programming schedule provides for one hour of fitness (physical activity) daily, from 4:00am - 5:00pm. A notice is posted in the common youth room which allows for youth to attend faith-based activities and services which are aligned with their spiritual beliefs. If youth choose not to participate in faith-based activities, alternate activities are afforded during this time.	
Additional Comments: **There are no additional comments for this indicator.**			
3.02 - Program Orientation			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 3.02		**YES** If NO, explain here: The agency has a policy 3.02, Chief Operating Officer, last reviewed July 2023 by the COO.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: Three **Total number of Closed Files: Five** **Staff Position(s) Interviewed: Vice President of Impact, Director of Case Management** **Type of Documentation(s) Reviewed: Electronic youth records** **Describe any Observations: Review of orientation and alert documents in the electronic youth records**			
Youth received a comprehensive orientation and handbook provided within 24 hours	**Compliance**	Five of five shelter youth files reviewed showed evidence the youth received a comprehensive orientation and handbook within 24 hours.	

Orientation includes the following: a. Youth is given a list of contraband items b. Disciplinary action is explained c. Dress code explained d. Review of access to medical and mental health services e. Procedures for visitation, mail and telephone f. Grievance procedure g. Disaster preparedness instructions h. Physical layout of the facility i. Sleeping room assignment and introductions j. Suicide prevention- alerting staff of feelings or awareness of others having suicidal thoughts	**Exception**	All five shelter youth files reviewed were oriented in the following topics: Contraband items, disciplinary action, dress code, access to medical and mental health services, visitation, mail, and telephone procedures, grievance procedures, physical layout of the facility, sleeping room assignments, suicide prevention services which is covered under counseling services. Four of the five youth received orientation on disaster preparedness.	One youth did not have disaster preparedness/ emergency evacuation marked off on his orientation form.
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**	Five of five residential youth files had documentation of the orientation topics taken, and the dates of the instruction, as well as the signature of youth and staff involved. This documentation was maintained in the electronic youth records.	
Additional Comments: **There are no additional comments for this indicator.**			
3.03 - Youth Room Assignment			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 3.03		**YES** If NO, explain here: The agency has a policy 3.03, Chief Operating Officer, July 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: Three
Total number of Closed Files: Five
Staff Position(s) Interviewed: Director of Case Management, Vice President of Impact
Type of Documentation(s) Reviewed: Electronic Youth Records
Describe any Observations: Review of youth initial classification and room assignment considerations

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**	Five of five youth files reviewed via electronic records contained documentation which confirmed a review of available information about the youth's history and exposure to trauma was conducted. This review included initial collateral contacts, initial observations of the youth, separation of younger youth from older youth, separation of violent from non-violent youth, the identification of youth susceptible to victimization, medical or mental disabilities, suicide risk or sexual aggression, and any acute health symptoms which would require isolation.	
An alert is immediately entered into the program's alert system when a youth is admitted with special needs and risks such as risk of suicide, mental health, substance abuse, physical health or security risk factors	**Compliance**	Three of the five applicable youth were identified with special needs which required an alert to be immediately entered into the program's alert system. The remaining two youth did not have anything identified during admission which required an alert to be entered.	
Additional Comments: **There are no additional comments for this indicator.**			
3.04 - Log Books			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 3.04		**YES** If NO, explain here: The agency has a policy 3.04 Log Books, updated July 2023 by the COO.	
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 1, 2023 - January 30, 2024 **Staff Position(s) Interviewed: Residential Supervisor, Chief Operating Officer** **Type of Documentation(s) Reviewed: Logbooks from August 1, 2023 - January 30, 2024,** **Describe any Observations: A review of entries in program logbooks**			
Log book entries that could impact the security and safety of the youth and/or program are highlighted	**Compliance**	Logbooks were reviewed from August 1, 2023 - January 30, 2023, and any safety or security issues noted were highlighted for quick reference.	
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 logbook entries were legible and contained sufficient information to describe any event taking place. All entries reviewed contained the date and time of the event, the names of any staff and/or youth involved, a brief description of the event, and the full name of the staff making the entry.	

Recording errors are struck through with a single line. The staff person must initial and date the correction. The use of whiteout and erasures is prohibited.	**Exception**	Logbooks were reviewed from August 1, 2023 - January 30, 2023. The majority of entries were legible and neatly written, with minimal errors.	There were three entries (December 19, 2023, December 22, 2023, December 31, 2023) with errors completely scratched out, rather than struck through with a single line, staff initial, and date.
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**	All logbooks contained weekly reviews conducted by the program director, indicating the dates reviewed, and any areas needing correction.	
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**	Every oncoming shift documented the review of the logbook at the beginning of each shift, indicating a review of the previous two shifts.	
At the beginning of their shift, oncoming supervisor and shelter counselor reviews the logbook of all shifts since their last log entry and makes a signed and dated entry and into log book indicating the dates reviewed.	**Compliance**	All logbooks contained a review conducted by the oncoming supervisor, confirming a review of all shifts since their last log entry in order to become aware of any unusual occurrences.	
Logbook entries include: a. Supervision and resident counts b. Visitation and home visits	**Compliance**	Logbooks contained entries regarding supervision, resident counts, visitation and home visits where appropriate.	
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 agency has a policy 3.05 Behavior Management Strategies, last updated July 2023 by the COO.	
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: Residential Director **Type of Documentation(s) Reviewed: Youth Orientation Handbook, staff training records** **Describe any Observations: One supervisor and two staff training records**			
The program has a detailed written description of the BMS and it is explained during program orientation	**Compliance**	The program has a detailed description of the behavior management strategies. A review of youth orientation handbook verified youth are provided instruction and orientation on the advancing youth development (AYD), which is the program's behavior management strategy.	
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 BMS has different levels, which contain expectations and privileges youth get for advancing to each level. They also contain interventions staff use to teach youth new behaviors, in addition to consequences for negative actions. Behavioral interventions are applied immediately, and in direct correlation to the severity of the behavior. Rewards and incentives include phone calls, use of video games, canteen (store) purchases, and youth can be given permission to stay up later in common areas. Consequences and sanctions are designed to promote learning and skill building and are applied consistently. Physical interventions are utilized only as a last resort. The program does not utilize group discipline or room restriction for disciplinary purposes. Youth are never denied any basic rights as a means of discipline.	
Program's use of the BMS			
All staff are trained in the theory and practice of administering BMS rewards and consequences	**Compliance**	Two staff training records were reviewed, and both were trained in the theory and practice of administering rewards and consequences as they relate to BMS.	
There is a protocol for providing feedback and evaluation of staff regarding their use of BMS rewards and consequences	**Compliance**	Supervisors provide feedback to staff and evaluation on their use of BMS during coaching sessions.	
Supervisors are trained to monitor the use of rewards and consequences by their staff	**Compliance**	A review of one supervisor training records confirmed training was completed in the area of monitoring the use of behavioral interventions by staff.	
Additional Comments: **There are no additional comments for this indicator.**			

3.06 - Staffing and Youth Supervision			Limited
Provider has a written policy and procedure that meets the requirement for Indicator 3.06	**YES**		
	If NO, explain here:		
	The agency has a policy 3.06 Staffing and Youth Supervision, last updated Chief Operating Officer, July 2023		

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

Dates or Timeframe Reviewed: August 1, 2023 - January 30, 2024
Staff Position(s) Interviewed: Chief Operating Officer, Residential Director
Type of Documentation(s) Reviewed: Staff Scheduled, Overtime Roster, On Call Roster, 15 minute check sheets, Logbooks from August 1, 2023 - January 30, 2024
Describe any Observations: Hard copy and video review of 15 minute checks, Hard copy review of staff schedules, overtime roster, and on-call roster

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**	At the time of the review, the program had ten youth on census, with a maximum capacity of twelve. The program maintains minimum staffing ratios evidenced by the staff schedules provided for the past six months.	
All shifts must always provide a minimum of two direct care staff present that have met the minimum training requirements	**Compliance**	A review of the program's staff schedules, over-time roster and on-call roster confirmed a minimum of two staff on duty and present for all shifts over the past six months.	
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**	Five staff and one intern records were reviewed, and all had a current background screening conducted, and were properly trained prior to being included in the staff-to-youth ratio.	
The staff schedule is provided to staff or posted in a place visible to staff	**Compliance**	Program staff schedule is posted in secured nurses room, next to the census board.	
There is a holdover or overtime rotation roster which includes the telephone numbers of staff who may be accessed when additional coverage is needed	**Compliance**	The on-call rotation roster is posted in the secured nurses room, next to the census board. The holdover or overtime roster includes the telephone numbers of staff who may be accessed when additional coverage is needed.	

Staff observe youth at least every 15 minutes while they are in their sleeping room, either during the sleep period or at other times, such as during illness or room restriction	**Exception**	A total of three different dates, when youth were sleeping in their rooms, were observed on the program's video surveillance system. Four hour increments of time was observed on each date. One of three dates observed contained no inconsistencies between the video and the bed check documentation. The program maintains a 15 minute bed check sheet for each youth, documenting real time checks for each youth during the sleep periods and at any time youth are in their rooms for extended periods. A review of the program's video surveillance system on January 5, 2024 from 12:00am - 4:00am revealed all bed checks were conducted within the required 15 minute increments and coincided with the staff documentation on the program's 15 minute check sheet.	Two of three dates reviewed for four hour increments contained the following inconsistencies between the video surveillance and documented bed checks: January 9, 2024, the 15 minute check sheet did not have checks documented from 3:00am - 3:45am. The 15 minute check sheet showed a check conducted at 2:45am and the next documented check was at 4:00am. January 27, 2024, a check was observed on video at 3:04am and then at 3:32am, making this a 28 minute difference in time. The 15 minute check list showed a check was conducted at 3:00am, 3:15am, and 3:30am, making the 3:15am documented check a falsified check. Also on January 27, 2024, a check was observed on video at 5:16am and then at 5:51am, making this a 34 minute difference in time. The 15 minute check list showed a check was conducted at 5:16am, 5:28am, and 5:50am, making the 5:28am documented check a falsified check. This was brought to the attention of the residential supervisor, program case manager, and program chief operating officer. The residential supervisor contacted the Department's central communications center (CCC) at 9:42am to report this incident. The call was taken by duty officer Brandon, who provided CCC#202400569.

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

3.07 - Video Surveillance System		**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 3.07	**YES**	
	If NO, explain here:	
	The agency has a policy 3.07 Video Surveillance System, last updated July 2023 by the COO.	

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 1, 2023 - January 30, 2024
Staff Position(s) Interviewed: Residential Director, VP of Impact
Type of Documentation(s) Reviewed: Logbooks from August 1, 2023 - January 30, 2024, List of designated personnel authorized to access video system
Describe any Observations: Review of logbooks

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 program has a notice at the entrance of the lobby on a blue placard providing written notification of video surveillance for the purpose of security. The program's video system is able to store recording on a cloud system for a period of 30 days. The program's recording system includes date, time, and location stamp, and has sufficient resolution which enables face recognition. The program has a backup generator which operates the entire facility, to include the video system, in the event of a power outage. Cameras are located throughout the facility, both interior and exterior, set up in such a manner as to capture areas where youth, staff, and visitors congregate, enter, and exit.	
A list of designated personnel who can access the video surveillance system is maintained (includes off-site capability per personnel)?	**Compliance**	The program provided a list of personnel, (supervisors and up, both on-site and off-site) who can access the video system, for review.	
Supervisory review of video is conducted a minimum of once every 14 days and timeframes reviewed are noted in the logbook.	**Compliance**	A review of logbooks from August 1, 2023 through January 30, 2024 was conducted. The logbooks contained entries which verified supervisory video reviews were conducted every fourteen days, to include timeframes reviewed.	
The reviews assess the activities of the facility and include a review of random sample of overnight shifts	**Compliance**	The supervisory reviews include reviewing activities of the facility, and a random review of overnight shifts.	
Grant the requesting of video recordings to yield a result within 24-72 hours from program quality improvement visits and when an investigation is pursued after an allegation of an incident	**Compliance**	If a third party requests a video recording from the program, the program will take the request, copy the sample of video requested, and upload the video onto the program's SharePoint system for review. This is generally done within 24 hours.	

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**	During the review, all cameras were operational. In the event of a camera malfunctioning or becoming inoperable a service order will be made within 24 hours of discovery. No malfunctions have occurred in the past six months.	
Additional Comments: **There are no additional comments for this indicator.**			
4.01 - Healthcare Admission Screening			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 4.01		**YES** If NO, explain here: The agency has a policy 4.01 Healthcare Admission Screening, last updated July 2023 by the COO.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: Three **Total number of Closed Files: Five** **Staff Position(s) Interviewed:** **Type of Documentation(s) Reviewed: Youth files, Program Logbooks** **Describe any Observations:**			
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**	Eight of eight youth files reviewed contained a healthcare screening which 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.	
Referral and Follow-Up			
Youth with chronic medical conditions have a referral to ensure medical care (e.g. diabetes, pregnancy, seizure disorder, cardiac disorders, asthma, tuberculosis, hemophilia, head injuries, etc.)	**Compliance**	The program is not currently servicing any youth with chronic health conditions. In the event medical care is required for chronic health conditions, the program coordinates with the youth's parent or guardian to follow-up and ensure medical care is received.	

When needed, the parent is involved with the coordination and scheduling of follow-up medical appointments	**Compliance**	The program relies on parent involvement and coordination in scheduling follow-up medical appointments for youth.	
All medical referrals are documented on a daily log.	**Compliance**	Logbook entries reviewed showed evidence of parent involvement with coordination and scheduling follow-up medical appointments for youth.	
The program has a thorough referral process and a mechanism for necessary follow-up medical care as required and/or needed	**Compliance**	Interview with the Residential Supervisor indicated that it is the program's practice to coordinate necessary follow-up care with the youth's parent or guardian as required and/ or needed.	
Additional Comments: **There are no additional comments for this indicator.**			
4.02 - Suicide Prevention			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 4.02		**YES** If NO, explain here: The agency has a policy 4.02 Comprehensive Master Plan for Suicide Prevention and Response, last updated July 2023 by the COO.	
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: Three **Total number of Closed (Residential & Community) Files: Five** **Staff Position(s) Interviewed: Residential Supervisor** **Type of Documentation(s) Reviewed: Youth records, Sight and sound 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**	Eight of eight youth files reviewed contained suicide risk screenings completed at intake, with results reviewed and signed by the supervisor.	
The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	**Compliance**	The program is using a suicide risk assessment that meet the requirements of the Florida Network of Youth and Family Services.	
Supervision of Youth with Suicide Risk *(Shelter Only)*			
Youth are placed on the appropriate level of supervision based on the results of the suicide risk assessment.	**Compliance**	Shelter youth are placed on an appropriate level of supervision based on the outcome of the suicide assessment as evidenced in the youth files reviewed, sight and sound logs, and agency's policy and procedures.	

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**	One of one youth file reviewed was escalated to constant supervision. The youth file contained a sight and sound log showing evidence that the youth was monitored by staff every 15 minutes.	
Documentation includes the time of day, behavioral observations, any warning signs observed, and the observers' initials and was maintained in either an observation log or in the shelter daily log.	**Compliance**	The program's sight and sound logs contain: time of day, behavioral observation, observer's initials and is maintained in the program's observation log.	
Supervision level was not changed/reduced until a licensed professional or a non-licensed mental health professional under the supervision of a licensed professional completed a further assessment OR Baker Act by local law enforcement	**Compliance**	The supervision level is changed upon youth meeting with a license professional and is noted on the sight and sound document reviewed in one of one youth files. Additionally, this practice is confirmed by interview with the residential supervisor.	
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**	The program's sight and sound logs are scanned and uploaded to the youths' electronic file. The documentation is reviewed and signed by supervisory staff each shift.	
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**	The program's policy reflects that community counseling youth identified for suicide risk during intake are immediately assess by a licensed professional or non-licensed professional under the direct supervision of a licensed mental health professional. Parents are notified of the result as well as the supervisor. None of the community counseling files reviewed were identified for suicide risk during intake.	
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**	Agency maintains a policy that is consistent with referring youth identified for suicide risk immediately and the youths' parent or guardian notified of the suicide risk findings disclosed and advised that an assessment of suicide risk should be completed ASAP by a licensed professional, if the appropriate staff is unavailable during the intake. None of the community counseling files reviewed were identified for suicide risk during intake.	

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**	Interview with residential supervisor indicated, program offers parents information on resources available in the community. It is documented in the youth's file and signed by the parent or guardian during screening for services. None of the community counseling youth files reviewed were eligible for suicide risk during intake.	
If the parent/guardian cannot be contacted, all efforts to contact them are documented in the case file.	**No eligible items for review**	None of the community counseling youth files reviewed were eligible for suicide risk during intake.	
When the screening was completed during school hours on school property, the appropriate school authorities were notified.	**No eligible items for review**	Screenings take place at the program's community counseling office. No screenings take place on school property	
Additional Comments: **There are no additional comments for this indicator.**			
4.03 - Medications			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 4.03		**YES** If NO, explain here: The agency has a policy 4.03 Medication Disposal, last updated January 2024 by the COO	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: Two **Total number of Closed Files: Zero** **Staff Position(s) Interviewed: Nurse** **Type of Documentation(s) Reviewed: Medication distribution logs, youth records**			
The agency has a Registered Nurse (RN) and/or a Licensed Practical Nurse (LPN) that is being supervised by RN and all of their credentials have been verified.	**Compliance**	The agency has a registered nurse whose credentials were verified. The nurse is a part-time employee.	
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**	The agency has a list of non-nursing shelter staff designated to assist with the self-administration of documentation. The non-nursing staff list is posted in the med room. Confirmation of annual training was reviewed for each non-nursing staff member and training was provided by the registered nurse. Evidence of their competency to assist with self-administration of medication distribution was demonstrated by the nurse.	

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**	The program supervisor covered medication administration during the monthly meeting for 11/23 and 12/23. Documentation of meeting minutes was reviewed for two months which did not identify any medication errors.	
The agency has strategies implemented to ensure medications are provided within the 2-hour time frame.	**Compliance**	The program uses a white board in the medication room to inform staff of all youth taking medications. The program also have an electronic device to remind staff to administer medications ensuring timely administration of meds.	
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**	A review of the programs staff shift schedule, clearly identifies the person responsible for assisting with self-administration of medications highlighted in blue for 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 programs use of the white board in the med room has a clear method of communicating which youth are on medications. It is also communicated on the medication distribution log with times and dosages easily discernable by all staff on shift.	
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 programs delivery process of medication is consistent with the FNYFS Medication Management and Distribution policy. The agency has internal controls to ensure appropriate medication management and distribution methods, track medication errors, and identify systematic issues and implementation mitigation strategies as appropriate. The staff uses the medication distribution logs appropriately. Two of two youth records reviewed had medication logs appropriately documented with no errors. Nurse indicated that she would re-train any staff member that had a medication error. There has not been any need to re-training in the past six months.	
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**	Two of two youth medication logs reviewed were signed and date by the registered nurse upon review when completed by a certified supervisor upon 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**	Pyxis machine was located in a safe area in the facility and is in accordance to the policy. All medication were store appropriately in the pyxis machine. Agency also has refrigerator that is used for medication purpose with the correct temperature. Pyxis keys were provided with the correct label on the key.	
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**	Agency maintains a list of all staff who is approved to administer medication including the registered nurse. The list designates staff delineated in user permission who have access to secured medications. Agency also has a binder with medication distribution logs for each youths' current medication and all medications are verified by a pharmacy or the registered nurse when she is on site. The nurse conducts all medication processes when she is onsite. It is the agency's policy to not accept youth currently prescribed injectable medications. All non-licensed staff have received training from the registered nurse in the use of epi-pens.	

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**	Medication distribution logs reviewed include: the time of the medication, initial of the youth and staff as well as the dose given.	
There is evidence that staff provide youth with medications within one hour of the scheduled time of delivery as ordered by the medication. Documentation is provided for instances this does not occur within the required timeframe.	**Compliance**	Medication distribution logs reviewed evidenced that staff provide youth with medications within one hour of the scheduled time of delivery as ordered by the medication. There was no evidence of missed medication doses.	
During the review period, there were no instances where youth missed their medication due to failure to open the pyxis machine.	**Compliance**	There was no evidence of youth missing medications due to failure to open the pyxis machine.	
If applicable: Any staff member deemed responsible for a medication error, there was evidence that the staff member received refresher training from an RN and demonstrated competency prior to being assigned future medication administration responsibilities. There is evidence that any staff member deemed responsible for 3 errors within a 1-year time frame, had their certification suspended and was not recertified until the completion of the full **in-person** medication administration training, demonstrating competency and re-certification from an RN.	**No eligible items for review**	No staff medication errors occurred over the past six month period.	
Medication Inventory			
a. For controlled substances, a perpetual inventory with running balances is maintained as well as a shift-to shift count verified by a witness and documented b. Over-the-counter medications that are accessed regularly and inventoried weekly c. Syringes and sharps (needles, scissors, etc.) are secured, and counted and documented weekly	**Compliance**	Interview with the program's nurse revealed all medications are counted by the incoming shift and the outgoing shift. Inventory is kept with a running balance and verified by a witness. Over the counter medications are inventoried by staff weekly. Syringes and sharps are not allowed in the facility.	
There are monthly reviews of the Pyxis reports to monitor medication management practice.	**Compliance**	The pyxis machine is reviewed monthly by program's registered nurse.	
Medication discrepancies are cleared after each shift.	**Compliance**	Medication discrepancies are cleared each shift by the supervisor and all discrepancies are reviewed by the registered nurse.	
Additional Comments: **There are no additional comments for this indicator.**			

4.04 - Medical/Mental Health Alert Process			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 4.04		**YES** If NO, explain here: The agency has a policy 4.04 Medical/ Mental Health Alert Process, last updated July 2023 by the COO.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: Two **Total number of Closed Files: One** **Staff Position(s) Interviewed: Nurse** **Type of Documentation(s) Reviewed: Youth records, medication distribution logs**			
Youth with a medical, mental health, or food allergy was appropriately placed on the program's alert system	**Compliance**	Three of three youth files reviewed with medical, mental health, or food allergies were appropriately placed on the program's alert system. The alert system is located on a board in the medication room and all staff have access to it. A list of food allergies is posted in the kitchen as well.	
Alert system includes precautions concerning prescribed medications, medical/mental health conditions	**Compliance**	The program's alert system includes precautions concerning prescribed medications and medical/ mental health conditions.	
Staff are provided sufficient training, information and instructions to recognize/respond to the need for emergency care for medical/mental health problems	**Compliance**	Program's staff are provided sufficient training, information and instructions to recognize/ respond to the need for emergency medical/ mental health problems as evidence in the staff training files reviewed.	
A medical and mental health alert system is in place that ensures information concerning a youth's medical condition, allergies, common side effects of prescribed medications, foods and medications that are contraindicated, or other pertinent mental health treatment information, is communicated to all staff	**Compliance**	A medical and mental health alert system is in place that ensures information concerning a youth's medical condition, allergies, common side effects of prescribed medications, foods and medications that are contradicted or other pertinent mental health treatment information, is communicated to all staff. Alerts are communicated to all staff in the several ways. All alerts are written in the program's logbooks upon the youths' entry into the shelter. It is indicated in the youth electronic record and it is posted on the board in the med room.	
Additional Comments: **There are no additional comments for this indicator.**			

4.05 - Episodic/Emergency Care			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 4.05	**YES**		
	If NO, explain here:		
	The agency has a policy 4.05 Episodic/ Emergency Care, last updated July 2023 by the COO.		
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open or Closed Files: Zero **Staff Position(s) Interviewed: Vice President of Impact** **Type of Documentation(s) Reviewed: Agency's policy, first aid/ emergency episodic log, Incident reports, CCC reports** **Describe any Observations: location of knife for life**			
Off Site Emergency Care			
a. If off-site emergency medical or dental care was provided, an incident report was submitted for the medical or dental care b. Upon youth return, there is a verification receipt of medical clearance via discharge instructions with follow-up is present in file c. Youth's parent/guardian was notified d. A daily log is maintained for emergency care provided	**No eligible items for review**	A review of the programs first-aid/emergency episodic log showed no evidence of off-site episodic care taking place over the past six months or back to the date of the last review. There were no entries recorded on the log consistent with off-site emergency off-site medical or dental care. All entries on the program's episodic log were of a non-emergent nature. The program's episodic log tracks who was notified in the event of off-site emergency care. Internal incident reports are also documented in the event of off-site emergency care and entries made in the program's daily logbook pertaining to such events, upon occurrence.	
All staff are trained on emergency medical procedures	**Compliance**	A review of the employee training logs evidenced that staff are trained and are aware of emergency medical procedures.	
The program has a Knife-for-life and wire cutters accessible to staff in a secure location(s)	**Compliance**	The program has a knife for life and wire cutters in a secured in the laundry room which is directly to the left of the direct care workers' desk in the common area. The laundry room is accessible to all staff and a part of the general common area of the shelter.	
Additional Comments: **There are no additional comments for this indicator.**			