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Florida Network for Youth and Family Services
Compliance Monitoring Report for

Anchorage Children's Home of Bay County, Inc.

2121 Lisenby Ave.
Panama City, FL 32405

February 21-22, 2024

Compliance Monitoring Services Provided by

EXECUTIVE SUMMARY

Forefront LLC conducted a Quality Improvement (QI) monitoring visit on behalf of the Florida Network of Youth and Family Services (FNYFS) for the Anchorage Children's Home of Bay County, Inc. for the FY 2023-2024 at its program office located at 2121 Lisenby Ave. Panama City, Florida 32405. Forefront LLC (Forefront) is an independent compliance monitoring firm that is contracted by the FNYFS to perform onsite program reviews to assess the agency's adherence to fiscal, programmatic, and overall contract requirements. Anchorage Children's Home of Bay County, 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 Alecia Hassler, Pamela Washington, Cyndy Freshour, Stephanie Solano. Agency representatives from Anchorage Children's Home of Bay County, Inc. present for the entrance interview were: Joel Booth, Naret Morales, Krissy Botzong, Emily Bruerkner, Kyntera Speights, McKinlie Rocpenbeck, Lyxandra Rivera, Aimee Hartzog, Melissa Leal. The last onsite QI visit was conducted June 13-14, 2023.

In general, the Reviewer found that Anchorage Childrens' Home of Bay County, Inc. is in compliance with specific contract requirements. **Anchorage Children's Home of Bay County, Inc. received an overall compliance rating of 100% for achieving full compliance with 13 indicators** of the CINS/FINS Monitoring Tool. There were no corrective actions as a result of the monitoring visit.

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

2023-2024 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 2-21-222-2024

Agency Name: Anchorage Children's Home of Bay County, Inc.	**Monitor Name: Andrea Haugabook, Lead Reviewer**
Contract Type: CINS/FINS	**Region/Office: 2121 Lisenby Ave, Panama City, FL 32405**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): February 21-22, 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 a minimum of two (2) staff members have been trained to be certified as DJJ QI Peer reviewers. Provider shall participate in a minimum of one (1) on-site quality assurance review of a similar type of program in another judicial circuit during each 12-month period of the contract, if requested.	☐	☐	☒	☐	☐	The agency has four certified peer reviewers.	
Additional Contracts a. Provider shall provide a listing of all current federal, state, or local government contracts, as well as other contracts entered into with for profit and not-for-profit organizations. Such a listing shall identify the awarding entity and contract start & end dates. **PTV**	☐	☐	☒	☐	☐	The following list of additional contracts was provided by the agency: 1. Department of Health and Human Services funds transitional living, transitional living maternity, street outreach and Hidle basic shelter from 09/30/2023-09/29/2024. 2. Big Bend Community Based Care funds emergency shelter (07/01/2023-12/31/2027, case management services (07/01/2023-06/30/2024), and visitation services (07/01/2023-06/30/2024). 3. State of Florida Department of	

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						Health funds the Hidle childcare food program (ongoing)	
Limits of Coverage a. Provider shall provide and maintain during this contract, the following minimum kinds of insurance: Worker's Compensation and Employer's liability insurance as required by Chapter 440, F.S. with a minimum of $100,000 per accident, $100,000 per person and $500,000 policy aggregate. Commercial General Liability with a limit of $500,000 per occurrence, and $1,000,000 policy aggregate. Automobile Liability Insurance shall be required and shall provide bodily injury and property damage liability covering the operation of all vehicles used in conjunction with performance of this contract, with a minimum limit for bodily injury of $250,000 per person; with a minimum limit for bodily injury of $500,000 per accident; with a minimum limit for property damage of $100,000 per accident and with a minimum limit for medical payments or $5,000-$10,000 per person. Florida Network is listed as payee or co-payee. **PTV**	☐	☐	☒	☐	☐	The provider supplied a certificate of insurance (COI) dated 02/07/2024, from Fisher Brown Botrell Insurance, Inc. The following companies are underwriters of various coverages listed on the COI: Florida Insurance Trust, Markel-American Ins. Co., Travelers Casualty and Surety Company of America. The COI showed the following minimum kinds of insurance: Worker's Compensation and Employer's liability insurance (effective 06/01/2023-06/01/2024) as required by Chapter 440, F.S. with 2,000,000 per accident, $2,000,000 per person and $2,000,000 policy limit. Commercial General Liability (effective 06/01/2023-6/01/2024) with limits of $1,000,000 per occurrence, $1,000,000 damage to rented property, $20,000 medical expense,	

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						$1,000,000 personal and adv injury, $3,000,000 aggregate, $3,000,000 products a comp/op aggregate and $1,000,000 sexual abuse. Automobile Liability Insurance (effective date 06/01/2023 - 06/01/2024) with a single combined limit $1,000,000, umbrella liability (effective 06/01/2023 - 06/01/2024) $1,000,000 per occurrence, $1,000,000 aggregate, directors' and officers' liability (effective 12/01/2023 - 12/01/2024) $2,000,000 and professional liability of $1,000,000 (effective 06/01/2023 - 06/01/2024). Florida Network is listed as a certificate holder.	
External/Outside Contract Compliance a. Provider has corrective action item(s) cited by an external funding source (Fiscal or Non-Fiscal). **ON SITE**	☐	☐	☒	☐	☐	Interview with the CEO indicates the agency does not have any corrective action items cited by an external funding source.	
Fiscal Practice a. Agency must have employee and fiscal policy/procedures manuals that are in compliance with	☐	☐	☒	☐	☐	A review of the agency's employee and fiscal policies, contained in the financial services policy and procedures manual, showed	

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GAAP and provide sound internal controls. Agency maintains fiscal files that are audit ready. **PTV**						compliance with GAAP and provided sound internal controls.	
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**	☐	☐	☒	☐	☐	The agency provided a general ledger which is tracked according to the funder and activities of each grant. Standard account numbers are use and funds are separated for each revenue source.	
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 Hidle House Program Manager gave an overview of the petty cash procedures. There is a $200 petty cash fund kept in a locked cash box that was observed in a locked cabinet, inside a locked closet in the youth specialists' office. There is a running log that is kept of all the credits and debits to the petty cash fund. The Hidle House Program Manager reported that all staff have access to the petty cash. They bring receipts for small purchases (i.e., food, supplies, allowance for youth) and record it on the log. The petty cash is counted, and balance is verified at the beginning of	

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						each shift. The Hidle House Program Manager balances and clears up discrepancies. The Hidle House Program Manager also submits the receipts to the Finance Director for reimbursement weekly or as needed.	
d. Financial records and reports are current. Includes bank statements reconciled within 6 weeks of receipt. Vendor invoices past 6 months. Invoices are submitted on a monthly basis with supporting documentation. (Disbursements/invoices are approved & monitored by management). **ON SITE**	☐	☐	☒	☐	☐	The most recent six months bank statements were reviewed, and they were all reconciled by the Financial Director and reviewed and signed by the CEO. Invoices and supporting documentation are submitted for payment monthly by the Finance Director. Disbursements are approved and monitored by management.	
e. Agency maintains inventory in accordance with a written policy and FNYFS contractual requirements. If over $1,000 inventory has DJJ Property Inventory Number/Tag. In the event the provider has purchased computer equipment an Informational Resources Request (IRR) has been submitted to DJJ. **PTV/ON SITE**	☐	☐	☐	☐	☒	The agency maintains a fixed asset inventory. All fixed assets are logged and tracked in the general ledger and depreciated accordingly. A record of asset disposal is also maintained. No assets are purchased with Florida Network of Youth and Family Services or Department of Juvenile Justice funds. No computer purchases	

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						requiring an informational resources request form were made.	
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**	☐	☐	☒	☐	☐	The agency uses ADP for payroll functions, tax filings, deposits (including retirement deposits), IRS forms (including W-2 and 1099, if applicable. The most recent three quarterly tax reports were reviewed, and each was electronically filed by ADP.	
g. Budget to actual reports prepared and reviewed by appropriate management. Variance from the budget are investigated and explained. **PTV/ON SITE**	☐	☐	☒	☐	☐	The most recent six months of budget to actual reports were reviewed. Monthly budget reports are prepared by the Finance Director and reviewed by the CEO. Variances are investigated and explained. Meeting minutes show that financial reports are presented to senior management, the Board of Directors and executive committees at regularly scheduled 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**	☐	☐	☒	☐	☐	The agency provided an audit report dated March 11, 2023, for the fiscal year ending June 30, 2022. The audit was completed by James Moore, Certified Public Accountant. The opinion of the auditor was stated in the audit report as Anchorage Children's Home of Bay County, Inc., complied, in all material respects, with the compliance requirements referred to above that could have a direct material effect on each of its major federal programs and state projects for the year ended June 30, 2022. The financial audit for the fiscal year ended June 30, 2023 is still in progress. The financial auditors began working on-site November 13, 2023 and were on site again December 6th and 7th, 2023, according to senior management meeting minutes. It was reported by the Financial Director to the executive committee on February 5, 2024, that the post award notices were recently received from the State of Florida by Northwest Florida Health and forwarded to the accountant.	
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**	☐	☐	☒	☐	☐	A review of the agency's policy manual contained policies and procedures to ensure the security and privacy of all employees and client data. The policy manual contains a policy on confidentiality, access to case records, record security and retention. Personal information is not easily accessible. The agency maintains a backup system in case of accidental loss of financial information and has security measures in place to protect laptops. The agency has procedures in place to shred documents and dispose of computer hard drives properly and has	

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						additional policy's entitled use of Anchorage equipment, and the use of agency computer equipment.	
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 agency provided change of status forms for each employee which showed pay per the Florida Network contractual requirement effective October 1, 2023. Change of status forms list the employee's name, program, job title, supervisor and effective date. The form also details the current status of the employee and the new status along with comments. Each form is signed and dated by the employee and the supervisor. Completed forms are submitted to the business office manager for processing.	

CONCLUSION

Anchorage Children's Home of Bay County, Inc. has met the requirements for the CINS/FINS contract due to full compliance with 13 applicable indicators of the Administrative and Fiscal Contract Monitoring Tool. One of the fourteen indicators was not applicable because the program has not made any purchases with Florida Network or DJJ funds over $1000 requiring an inventory tag. Consequently, **the overall compliance rate for this contract monitoring visit is 100%.** There are no corrective actions cited and no recommendation made from the contract monitoring visit. Overall, the provider is performing satisfactorily in meeting the fiscal and administrative terms of its contract. In addition, the majority of indicators reviewed were carried out in a manner which meets the standard described in the report findings.

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

Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Anchorage Children's Home of Bay County, Inc.
CINS/FINS Program

Date: February 21-22, 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	**Satisfactory**
3.07 Video Surveillance System	**Satisfactory**

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

Standard 4: Mental Health/Health Services

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

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

Overall Rating Summary

Percent of indicators rated Satisfactory: 100 %

Percent of indicators rated Limited: 0 %

Percent of indicators rated Failed: 0 %

Rating Definitions

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

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

Reviewers

Members

Andrea Haugabook - Lead Reviewer Consultant-Forefront LLC/Florida Network of Youth and Family Services
Stephanie Solano – Regional Monitor, Department of Juvenile Justice
Pamela Washington – Arnette House
Alecia Hassler – CCYS
Cyndy Freshour – Luther Services Florida NW

Methodology

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

Persons Interviewed

	Chief Executive Officer	X	Case Manager	X	Nurse – Full time
	Chief Financial Officer	X	Counselor Non-Licensed		Nurse – Part time
	Chief Operating Officer		Advocate	1	# Case Managers
X	Executive Director	X	Direct – Care Full time	1	# Program Supervisors
	Program Director		Direct – Part time	1	# Food Service Personnel
	Program Manager		Direct – Care On-Call		# Healthcare Staff
	Program Coordinator		Intern	1	# Maintenance Personnel
	Clinical Director		Volunteer	2	# Other (listed by title): Quality Improvement Director, SNAP Facilitator
X	Counselor Licensed	X	Human Resources		

Documents Reviewed

	Accreditation Reports	X	Table of Organization		Visitation Logs
X	Affidavit of Good Moral Character		Fire Prevention Plan	X	Youth Handbook
X	CCC Reports	X	Grievance Process/Records		# Health Records
X	Logbooks		Key Control Log		# MH/SA Records
	Continuity of Operation Plan	X	Fire Drill Log	11	# Personnel /Volunteer Records
	Contract Monitoring Reports	X	Medical and Mental Health Alerts	11	# Training Records
	Contract Scope of Services	X	Precautionary Observation Logs	8	# Youth Records (Closed)
	Egress Plans	X	Program Schedules	9	# Youth Records (Open)
X	Fire Inspection Report	X	List of Supplemental Contracts		# Other: ___
	Exposure Control Plan	X	Vehicle Inspection Reports		

Observations During Review

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

Surveys

6	# of Youth	11	# 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

A program update provided by the Chief Executive Officer (CEO) reported that the Anchorage Family Counseling continues to excel in our community. According to the CEO, the program has consistently exceeded their contracted benchmarks for services and have maintained steady staffing patterns for several months, seeing minimal turnover rates for the last two years. The CEO's update states, "when looking at Case Staffing Committees conducted throughout the state, our team stands out as one of the leading agencies". He attributes this to the very high number of truancy cases that we have been receiving from our local school districts. The number of truancy cases has been overwhelming our team and they have done a remarkable job of keeping up with these referrals and managing a consistent referral stream of counseling referrals as well. The Clinical Director continues to develop the team's clinical skills by maintaining consistent staffings and clinical trainings and the team has truly morphed into an extraordinary unit and are doing really amazing work.

Every Monday, staff and youth load up meals and deliver them to the elderly who qualify for assistance through the Council on Aging. Recently, staff and youth participated in a community service with a local church to build wheelchair ramps and/or help with cleanup for families that were impacted by the tornadoes that impacted the Bay county area in January. The program continues to seek out projects that provide an opportunity for our youth to learn the value of helping others, even when they are in the midst of their struggles and challenges.

CINS/FINS Program Updates

The last year has been filled with extraordinary challenges and opportunities. After struggling to maintain consistent staffing in the shelter throughout the pandemic and into 2022/2023, Hidle House has seemed to turn the corner in this area. This can probably be attributed to the Florida Network's lobbying for a substantial pay raise for our direct care staff in 2023. The increase in pay has brought more quality applicants to the interview table and this has had a positive impact on the overall daily programming in the shelter to get back to sound positive youth development practices. Anchorage Children's Home of Bay County is focusing on efforts to engage youth in the shelter with a variety of community engagement activities.

The CINS/FINS program (shelter and community counseling) is overseen by the Executive Director, Quality Improvement Director, Clinical Director, Human Resource Director, Fundraising Director, Program Administrator, and Program Manager. The shelter is run by twenty additional direct care staff and has one vacant position for a Residential Case Manager. The Community Counseling program has a total of thirteen staff and no current vacant positions.

The S.N.A.P team was recently included in an expansion project with the Fatherhood Initiative. Anchorage Children's Home of Bay County added two case managers and one additional facilitator to successfully implement this new project. The team is currently fully staffed and is on track to meet all of their contract benchmarks for the first time. Due to their expansion, the S.N.A.P program recently moved to the agency's former group home site, which was recently repurposed. This affords the team much more space for families and offers a fenced yard and playground for sibling childcare and activities for groups.

The following programmatic updates were provided by the agency:

Facilities Updates

The agency completed its new Transitional Living apartments at main campus.

Hidle House added inside gym equipment for recreational use in the shelter.

The Food Manager has transformed the dining room into a five star dining area which is very inviting and calming.

New windows have been installed in the Great Room/Training Room and dining room.

A pole barn was built on-site.

Pending Projects

The addition of a new utility shed for outside recreational storage in needed.

The program will be adding two industrial grade washing machines.

The program is working on adding lighting to the basketball court and parking areas.

The program is adding a generator to power essential areas in the Emergency Shelter.

The agency reports that all projects have been funded through local fundraising efforts and grants.

Ongoing Operational Challenges/Concerns

The agency reports, while staffing is more stable, the challenge of maintaining consistent staff is still prevalent. The recent pay raises awarded to direct care staff caused a very significant compression issue with degreed professional positions in the shelter. This has caused challenges in maintaining manager positions. This is especially challenging within the Residential Case Manager positions.

High truancy referrals overwhelm the counseling team. The youth entering shelter present very challenging clinical needs that is far beyond the scope of the training that our staff have to serve these youth. The program is in desperate need of a more robust clinical department (i.e. an additional LCSW).

Narrative Summary:

Anchorage Children's Home (ACH) is a nonprofit organization that operates the Hidle House Youth Shelter. The agency serves the Bay County with a wide variety of social services in addition to CINS/ FINS. The shelter and community counseling offices are located at 2121 Lisenby Avenue in Panama City, Florida. The agency is licensed by the Florida Department of Children and Families. The agency has a child caring agency that's licensed for 20 beds and the license is in effect through November 9, 2024. The agency is accredited by the Council on Accreditation. The agency's accreditation status is in effect through July 31, 2027. The program has not reported any critical incidents, administrative review, or current external investigation from any of its funding sources or local authorities.

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

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

Standard 2: There are nine indicators for Standard 2.
Indicator 2.01 Screening and Intake was rated **Satisfactory with Exception**.
Indicator 2.02 Needs Assessment was rated **Satisfactory 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 with Exception.**
Indicator 2.07 Youth Records was rated **Satisfactory with Exception.**
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 with Exception**.
Indicator 3.02 Program Orientation was rated **Satisfactory**.
Indicator 3.03 Youth Room Assignment was rated **Satisfactory**.
Indicator 3.04 Log Books was rated **Satisfactory**.
Indicator 3.05 Behavior Management Strategies was rated **Satisfactory**.
Indicator 3.06 Staffing and Youth Supervision was rated **Satisfactory with Exception**.
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 with Exception**.
Indicator 4.05 Episodic/Emergency Care was rated **Satisfactory.**

CINS/FINS QUALITY IMPROVEMENT TOOL

Quality Improvement Indicators and Results: Please select the appropriate outcome for each indicator for each item within the indicator.	**Summary/Narrative Findings:** The narrative write-up is a thorough summary of each assigned QI indicator, explaining how finding(s) are determined.	**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 numbered ACM-ADM-HR009. The policy titled Background Screening was last reviewed July 10, 2023 by the CEO.	

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

Total number of New Hire Employee/Intern/Volunteer Files: Eleven new hire employees
Total number of 5 Year Re-screen Employee Files: Two re-screens (five year)
Staff Position(s) Interviewed: HR Director
Type of Documentation(s) Reviewed: Agency for Healthcare Administration (AHCA) background screening results, Berke assessment results, E-Verify reports, Department of Juvenile Justice (DJJ) Background Screening Unit (BSU) annual affidavit.
Describe any Observations: The agency implemented the Berke pre-hire assessment in 2019.

All positions providing direct services to youth has successfully passed pre-employment suitability assessment on the initial attempt.	**Compliance**	There were 13 total employee files reviewed. Eleven of thirteen were new hire employees and all eleven files contained evidence of the employee successfully passing the Berke pre-employment suitability assessment on the initial attempt and prior to providing services to youth.	
For any applicant that did not pass the initial suitability assessment, there was evidence that the applicant retook the assessment and passed within five (5) business days of the initial attempt, not exceeding three (3) attempts within thirty (30) days.	**No eligible items for review**	All new hire employees 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**	Interview with the Human Resource Director indicated that there are no employees who have had a break in service or 18 months or more.	
Background screening completed prior to hire/start date (or exemption obtained prior to working with youth if rated ineligible) for new hires, volunteers/interns, and contractors. *(Employees who have had a break in service and are in good standing may be reemployed with the same agency without background screening if the break is less than 90 days.)*	**Compliance**	Thirteen of thirteen employee files reviewed contained evidence of completed background screening prior to hire/start date.	
Five-year re-screening is completed every 5 years from the date of last screening.	**Compliance**	Two of two employee files reviewed contained evidence of completed five-year rescreening from the date of the last rescreening.	

Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?	**Compliance**	A completed annual affidavit of compliance form was signed by the CEO and submitted to the Department of Juvenile Justice Background Screening Unit via email on 01/25/2024.	
Proof of E-Verify for all new employees obtained from the Department of Homeland Security	**Compliance**	Thirteen of thirteen employee files reviewed contained proof of completion for E-Verify through the Department of Homeland Security.	
Additional Comments: **There are no additional comments for this indicator.**			
1.02: Provision of an Abuse Free Environment			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 1.02		**YES** If NO, explain here: The agency has a policy numbered ACH-HH-BX-002. The policy titled Provision of an Abuse Free Environment was last reviewed March 6, 2023 by the CEO.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Staff Position(s) Interviewed *(No Staff Names)* **: Quality Improvement Director** **Type of Documentation(s) Reviewed: QI Director and Hidle House Program Manager** **Describe any Observations: Reviewed Help Forms, youth surveys, and staff surveys**			
Agency has a code of conduct of policy and there is evidence that staff are aware of agency's code of conduct.	**Compliance**	The program has a code of conduct that prohibits the use of physical abuse, profanity, threats or intimidation. This information is located in the Hidle House Runaway/Crisis Shelter client handbook. The youth read the handbook and sign a receipt form indicating the youth acknowledges the code of conduct. The receipt is placed in the individual youth file.	
The agency has a process in place for reporting and documenting child abuse hotline calls.	**Compliance**	Interview with the quality improvement director indicates the program's practice for reporting and documenting child abuse hotline calls is completed by the counselors and documentation of the call is placed in the individual youth record. The number of child abuse calls are reported by the community counseling staff at each monthly staff meeting.	
Youth were informed of the Abuse and Contact Number	**Compliance**	This information is in the Client Handbook that is given to each youth.	

Grievance			
The program must have an accessible and responsive grievance process for youth to provide feedback and address complaints. Program director/ supervisor will have access to and manage grievances unless it is towards themselves.	**Compliance**	The program currently has a procedure in place but the feedback from staff is not consistently documented. The program plans to document everything moving forward.	
Shelter only: Grievances are maintained on file at minimum for 1 year.	**Compliance**	Grievances are maintained for at least a year.	
Shelter only: 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**	Grievances are easily accessible to youth and the grievance box is checked daily and documented in note active.	
Shelter only: There is evidence that grievance boxes are checked by management or a designated supervisor at least daily as evidenced in the program logbook.	**Compliance**	Grievances are checked and documented in note active.	
Shelter only: All grievances are resolved within 72 hours and documented by program director/supervisor or escalated to higher leadership if grievance involves them directly.	**Exception**	The program had a total of twenty-two grievances on file. Fourteen of the twenty-two grievances were selected for review. Four out of the fourteen grievances selected had feedback of the resolution documented within 72-hours by the program's supervisor with no need for escalation to higher leadership.	Ten of fourteen grievances reviewed did not have a date or the date was outside the 72-hour window for resolution by the program supervisor.
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 policies numbered ACH-ADM-PQI-016, Incident Reporting. The policy was last reviewed July 10, 2023 by the CEO.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Staff Position(s) Interviewed: Hidle House Program Manager **Type of Documentation(s) Reviewed: CCC Incident Reports, In-House Incident Reports** **Describe any Observations: Eight , CCC incidents were reviewed including one Program Disruption, six Complaints Against Staff and one Youth Behavior Incidents, The Incident Report notebook and the Note Active log were reviewed. The Incident report forms contained follow ups and supervisor's signatures.**			
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**	The agency had a total of eight incidents reported to the Center Communication Center (CCC) from August 2023 - February 2024. Seven of eight reportable incidents were reported within the two hours of the reportable incident or two hours of the program learning of the incident.	One of eight CCC reports reviewed was reported outside of the two hour reporting window.
The program completes follow-up communication tasks/special instructions as required by the CCC	**Compliance**	Follow up communication tasks/ special instructions as required by the CCC is recorded on the program's internal incident report form. The incident reporting forms have supervisory signatures and are used to follow up as required by the CCC. Follow up for internal incidents were also noted on the form.	

Agency internal incidents are documented on incident reporting forms and all CCC reportable incidents were consistently reported to CCC as required.	**Compliance**	Internal incidents were reported using the Incident Reporting form and the CCC reportable incidents were consistently documented.	
Incidents are documented in the program logs and on incident reporting forms	**Exception**	The program reports all incidents on their internal reporting forms. Eight of eight incidents reviewed were documented on the program's internal log. Five of the eight CCC incidents reviewed were noted in the program log book.	Three of the eight CCC incidents reviewed were not noted in the program log book.
All incident reports are reviewed and signed by program supervisors/ directors	**Compliance**	The incident reporting forms have supervisory signatures and are used to follow up as required by the CCC. The forms consistently had supervisory signatures.	
1.04: Training Requirements (*Staff receives training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions*)			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 1.04		**YES** If NO, explain here: The agency has policies numbered ACH-ADM-PQI-019, Training Program. The policy was last reviewed January 8, 2024 by the CEO.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of New Hire Staff Files: four **Total number of Annual In-Service Staff Files: five** **Total number of Non-Licensed Mental Health Clinical Shelter Staff Files: two** **Annual Training Plan Timeframe: Based on Hire Date** **Staff Position(s) Interviewed: Hidle House Program Manager** **Type of Documentation(s) Reviewed: training files** **Describe any Observations: The documentation in the training files consisted of certificates and dated tracking pages. Each file had a list of completed trainings.**			
First Year Direct Care Staff			
All direct care staff have completed new hire pre-service training requirements for safety and supervision as required.	**Exception**	Two of four direct care staff have completed new hire pre-service training requirements for safety and supervision.	Two of the four first year staff have completed the on line portion of CPR, but not the required in-person training.
All staff completed the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days from date of hire.	**Exception**	Two of four first year staff have completed the United States Department of Justice (DOJ) Civil Rights and Federal Funds training within 30 days of date of hire.	Two of the four first year staff have not completed the United States Department of Justice (DOJ) Civil Rights and Federal Funds training.
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 staff are still in their first 90 days. One of those staff have exceeded the 80 hour requirement.	
All staff receives all mandatory training during the first 90 days of employment from date of hire.	**Exception**	Two staff are still in their first 90 days and have time to complete the DOJ Civil Rights and Federal Funds, DJJ Skill Pro #112 Equal 7Employment Opportunity, #45 Information Security Awareness, #1546 PREA, Part Two and Trauma Responsive Practices.	One employee completed Adolescent Development late and must complete CPR in person training.

Staff Required to Complete Data Entry for NIRVANA or access the Florida Department of Juvenile Justice Information System (JJIS)			
Any designated staff that is responsible for entering NIRVANA or ensuring accurate and complete data entry in the Florida Department of Juvenile Justice Information System (JJIS) have completed all of the required trainings.	**No eligible items for review**	Four of four staff files reviewed do not administer the NIRVANA and are not responsible for entering into the Juvenile Justice Information System.	
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**	Four staff files reviewed are within the first year of employment and have time to get the FL Statute 984 CINS Petition training.	
Non-licensed Mental Health Clinical Shelter Staff (within first year of employment)			
Documentation of non-licensed mental health clinical staff person's training in Assessment of Suicide Risk form or written confirmation by a licensed mental health professional of training (includes date, signature and license number of the licensed mental health professional supervisor).	**No eligible items for review**	Two non-licensed mental health clinical staff have completed training in assessment of suicide risk by a licensed mental health professional. Evidence of completion of training included date, signature and license number of the licensed mental health professional supervisor.	
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).	**Exception**	Three staff files reviewed had over 40 hours of training.	One staff was missing the Florida Network Youth Suicide Prevention. Two staff were missing the First Aid training.
Required Training Documentation			
The agency has a training plan that includes all of the required training topics including the pre-service and in-service.	**Compliance**	The agency has 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**	The agency's Quality Improvement Director is responsible to manage all employee's individual training files and completes routine tracking and reviews of staff files to ensure compliance.	

The program maintains an individual training file or employee file AND a FLN Training Log (or similar document that includes all requirements) for each staff, which includes an annual employee training hours tracking form and related documentation, such as electronic record/transcript, training certificates, sign-in sheets, and agendas for each training attended.	**Compliance**	The program maintains an individual training file or employee file with a training log, which includes tracking of annual employee training hours and certificates of completion or transcript.	
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 ADH-ADM-PQI-004 Performance and Quality Improvement Program. The policy was last reviewed July 10, 2023 by the CEO.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Staff Position(s) Interviewed: Hidle House Program Manager **Type of Documentation(s) Reviewed: PQI Policy, CQI committees, CQI quarterly committee meeting agendas and minutes, reports in the meetings of EOM Data from the Florida Network** **Describe any Observations: The reports show that the information and date are shared up the line from staff to senior management to the Board of Directors and that information is acted on to make improvements where necessary.**			
Case record review reports demonstrate reviews are conducted quarterly, at a minimum	**Compliance**	Quality Improvement meetings are held quarterly with the program supervisor and the staff. Meeting minutes demonstrate evidence of case record reviews being completed and findings discussed.	
The program conducts reviews of incidents, accidents, and grievances quarterly, at a minimum	**Compliance**	Reviews of incidents, accidents and grievances are reported at the quality improvement meetings which are held quarterly with the program supervisor and the staff. Meeting minutes reflect the information reviewed pertaining to those areas respectively.	
The program conducts an annual review of customer satisfaction data	**Compliance**	Annual customer satisfaction data is reviewed by the program supervisor and staff during the quality improvement meeting and reported to senior management and board of directors annually.	
The program demonstrates a monthly review of the statewide End-of-Month ("EOM") report generated by the Florida Network Office. This includes monthly data, fiscal year to date data, benchmarks for residential and community counseling, screening data, report card measures, follow-up reporting measures.	**Compliance**	Monthly staff meeting minutes reviewed, discussed risk management issues and trends. Other suggestions are aired also. Review of statewide end-of-month reports from the Florida Network is conducted in senior management meetings every month. Senior management meeting minutes included a review of the report card, discussion of data and benchmarks and what needs to be worked on.	
The program has a process in place to review and improve accuracy of data entry & collection	**Compliance**	Upon review of all data, senior leadership puts an action plan in place to review areas that need improvement and accuracy of data entry and collection.	

There is documentation that findings are regularly reviewed by management and communicated to staff and stakeholders.	**Compliance**	A review of the agency's board meeting minutes showed evidence that senior management regularly reports a review of findings to its stakeholders.	
There is evidence the program demonstrates that program performance is routinely reviewed with the Board of Directors. 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**	Board meeting minutes evidenced that the agency routinely reports program performance to the board of directors. There are currently no limited or failed scores to report to the board of directors.	
There is evidence that strengths and weaknesses are identified, improvements are implemented or modified, and staff are informed and involved throughout the process.	**Compliance**	Monthly staff meetings and quality improvement meetings identify strengths and weaknesses. Improvements are implemented or modified and staff are informed and involved throughout the process ongoing.	
Additional Comments: **There are no additional comments for this indicator.**			
1.06: Client Transportation			**Satisfactory**
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 ACH-HH-PMI-005 Transportation. The policy was last reviewed September 1, 2023 by the CEO.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Dates or Timeframe Reviewed: September 2023 to Present **Staff Position(s) Interviewed: Program Manager** **Type of Documentation(s) Reviewed: Transportation Log, Log Book, Program Manager's text messages** **Describe any Observations: Staff members would text the program manager for approval prior to transporting youth and an approved response for the program manager would serve as authorization. The staff would document the approval and transport in the program's log book as well as on the transportation log. All transportation logs are later signed by the program manager once completed.**			
Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	**Compliance**	Upon hire, all employees undergo a driver's license and history check by the director of human resources. Once approved, the employee is added to the agency's automobile insurance coverage.	
Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	**Compliance**	The agency has a process in place to conduct driver license checks to ensure all employees have a valid driver's license. All employees at the time of this review have valid driver's licenses and are covered under the agency insurance policy.	
Agency's Transportation policy prohibit transporting a client without maintaining at least one other passenger in the vehicle during the trip and include exceptions in the event that a 3rd party is NOT present in the vehicle while transporting	**Compliance**	The agency's transportation policy prohibits 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. The agency has a process in place to obtain supervisor approval prior to conducting a single transport.	

In the event that a 3rd party cannot be obtained for transport, the agency's supervisor or managerial personnel consider the clients' history, evaluation, and recent behavior	**Compliance**	The agency's policy states, 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.	
The 3rd party is an approved volunteer, intern, agency staff, or other youth	**Compliance**	The agency has a policy that indicates the 3rd party is an approved volunteer, intern, agency staff, or other youth.	
The agency demonstrated evidence via logbook or other written verification that supervisor approval was obtained prior to all single youth transports.	**Compliance**	A total of 37 single transports took place between September 2023 and the time of this review. Upon review of 15 of 37 single transports, all 15 were documented in the program's logbook and verification of supervisor approval prior to each of the transports was documented via text messages on the program manager's cell phone. Time stamps on the supervisors' text message log, confirmed prior approval was obtained before the single transport took place in all 15 occurrences.	
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 transportation log that documents the name of the driver, date, time, mileage, number of passengers, purpose of travel and location. The logs are reviewed and signed by the program manager weekly.	
Additional Comments: **There are no additional comments for this indicator.**			
1.07 - Outreach Services			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 1.07		**YES** If NO, explain here: ACH-CS-SOAR-01 Service Environment, ACH-CS SOAR-02 Client Engagement, ACH-CS-SOAR-03 Drop in Center, ACH-CS-SOAR-04 Emergency Access to SOAR, ACH-CS-SOAR 05 Assessments, ACH-CS-SOAR-06 Case Planning, ACH-CS-SOAR-07, ACH-CS-SOAR-08 Transportation, ACH-CS-SOAR-09 Harm Reduction, ACH-CS-SOAR-10 Tracking and Reporting, ACH-CS-SOAR-11 Professional Development, ACH-CS-SOAR-12 S Staff Safety, ACH-CS-SOAR-13 Daily Operations. All policies reviewed and signed by CEO, 1-8-24	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Staff Position(s) Interviewed (No Staff Names): Program Manager **Type of Documentation(s) Reviewed: NetMIS printout of outreach events, DJJ Circuit meeting email, Interagency Agreements/MOU's, Policies, Meeting minutes from staff meetings, management meetings and board of directors meetings.** **Describe any Observations: There were over 100 outreach events covering a wide range of target audiences including law enforcement personnel, youth and parents, school personnel, general public, human services and civic organizations, elected official, churches, local DJJ or other government offices, and judges and court personnel. The agency has 92 cooperative agreements and MOU's covering a wide range of entities that work together. The outreach team meets quarterly and reports on their activities. That report is shared with the management team who then shares it with the Board of Directors.**			
The program has a lead staff member designated to participate in local DJJ board, Circuit and Council meetings with evidence that includes minutes of the event or other verification of staff participation.	**Compliance**	The program manager participates in local DJJ board, circuit and council meetings and showed evidence of attendance with meeting minutes, attendance sheets and agendas.	

The program maintains written agreements with other community partners which include services provided and a comprehensive referral process.	**Compliance**	The program maintains written agreements with other community partners which include services provided and a comprehensive referral process.	
The program will maintain documentation of outreach activities and enter into NetMIS the title, date, duration (hours), zip code, location description, estimated number of people reached, modality, target audience and topic.	**Exception**	A total of six outreach events were reviewed. Three community events and one Department of Juvenile Justice (DJJ) council meeting was reviewed, properly documented and entered into NetMis accordingly.	DJJ Circuit 5 Advisory Board Meeting Minutes for 9/21/23 and 10/19/23 was provided by the designated representative. However, these meetings were not entered into NetMis nor is an Outreach form completed for these meetings documenting attendance of the representative.
The program has designated staff that conducts outreach which is defined in their job description.	**Compliance**	Outreach events are conducted by the Program Manager and is defined in their job description.	
Additional Comments: **There are no additional comments for this indicator.**			
2.01 - Screening and Intake			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 2.01		**YES** If NO, explain here: The agency has several policies; ACH-CS-SD-004/ Screening and Assessment Initiation, ACH-CS-SD-013/ Referrals for Service, ACH-CS-SD-014/ Centralized Intake and ACH-AFC-AD-003/ Suicide Prevention and Intervention all reviewed 01-08-2024 by the Executive Director.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open (Residential & Community) Files: Four total files reviewed (One residential and three community counseling) **Total number of Closed (Residential & Community) Files: Five total files reviewed (Three residential and two community counseling)** **Staff Position(s) Interviewed** *(No Staff Names)* **: Clinical Director** **Type of Documentation(s) Reviewed: Suicide screening**			
Shelter youth: Eligibility screening form is completed immediately for all shelter placement inquiries.	**Compliance**	A total of four shelter files (three closed and one open) was reviewed. All of the shelter files had an eligibility screening form completed immediately for shelter placement inquiries.	
Community counseling: Eligibility screening form is completed within 3 business days of referral by a trained staff using the Florida Network screening form.	**Compliance**	A total of five community counseling files (two closed and three open) were reviewed. Of the five files reviewed, four had screenings completed within 3 business days of referral. One of five files reviewed included a screening that was not completed within 3 business days of referral, however, there was documentation of attempts made to contact the parent to complete the screening. The screening was completed via phone, once the parent was contacted.	
There is evidence all referrals for service is screened for eligibility and is logged in NetMIS within 72 hours of screening completion.	**Exception**	A total of nine files (five community counseling files and four residential shelter files) were reviewed. In all files, a screening for eligibility had been completed. In six of the nine files, a printout of the NetMis screening was included in the file with the date of entry documented at the top of the form.	In three out of the four , there was no documentation of the date in which the client screening was entered into NetMis, therefore, it could not be determined if it was entered within the deadline.

Youth and parents/guardians receive the following in writing: a. Available service options b. Rights and responsibilities of youth and parents/guardians	**Compliance**	All of the nine files reviewed included documentation that the youth and parent received the parent handbook and the CINS/FINS pamphlet. The informed consent included several of the rights and responsibilities of both the youth and the parent. Additionally, the files included a signed youth "rights and responsibilities" form. The quality improvement administrator provided a copy of the parent handbook. This handbook included details about the parents' rights/responsibilities as well as information about services provided.	
The following is also available to the youth and parents/guardians: a. Possible actions occurring through involvement with CINS/FINS services (case staffing committee, CINS petition, CINS adjudication) b. Grievance procedures	**Compliance**	All of the nine files reviewed included documentation that the youth and parent received the grievance policy and the CINS/FINS pamphlet. A copy of the grievance policy was also observed in the files.	
During intake, all youth were screened for suicidality and correctly assessed as required if needed.	**Compliance**	Eight of nine files reviewed were screened properly for suicidality. One file did not have a suicide assessment completed despite the client answering "yes" to one of the suicide screening questions. Upon interviewing the clinical director, It was indicated that the counselor had staffed the question with the clinical director and it was determined that the question was actually a "no" based on the context of the answer the youth had given the counselor. However, this was not documented in the file. The file also stated that the reason for not completing a suicide assessment was due to the family needing to leave abruptly.	
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 program has a policy, ACH-CS-SD-035/ NIRVANNA last reviewed 01-08-2024 by the Executive Director.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open (Residential & Community) Files: Five **Total number of Closed (Residential & Community) Files: Four** **Type of Documentation(s) Reviewed: Youth files, NIRVANA Assessments**			
Shelter Youth: NIRVANA is initiated within 72 hours of admission	**Compliance**	A total of four shelter files (three closed and one open) were reviewed. All of the four files initiated a NIRVANA within 72 hours of admission.	
Non-Residential youth: NIRVANA is initiated at intake and completed within 2 to 3 face-to-face contacts after the initial intake **OR** updated, if most recent assessment is over 6 months old	**Compliance**	A total of five community counseling files (2 closed and three open) were reviewed. All of the five files initiated a NIRVANA within 2 to 3 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**	Of the nine files reviewed, all NIRVANA assessments included a supervisor signature.	
(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**	Of the four shelter files reviewed, all included a NIRVANA self-assessment that was completed within 24 hours of admission.	
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 nine files reviewed, eight of the files had a post assessment at discharge if their length of services was greater than 30 days.	Of the nine files reviewed, one shelter file did not have a post-assessment completed despite a length of stay that is greater than 30 days. An assessment was not located in the file, nor was it located in NetMis.
A NIRVANA Re-Assessment is completed every 90 days excluding files for youth receiving SNAP services.	**Compliance**	Of the nine files reviewed, eight of the files had a re-assessment completed every 90 days.	One of the nine files included a 90 day NIRVANA re-assessment that was late. Interview with the clinical director indicated that the re-assessment was late due to a misunderstanding about how to enter a re-assessment after a post-assessment had been put into the system. However, the date of the actual re-assessment being done was still later than 90 days.
All files include the interview guide and/or printed NIRVANA.	**Compliance**	All of the nine files reviewed included either the interview guide or printed NIRVANA.	
Additional Comments: **There are no additional comments for this indicator.**			
2.03 - Case/Service Plan			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 2.03		**YES** If NO, explain here: The program has several policies, ACH-AFC-CS-005/ Service Planning, and ACH-AFC-CS-007/ Case Service Plan, both reviewed 01-02-2024 by the Executive Director.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open (Residential & Community) Files: Four **Total number of Closed (Residential & Community) Files: Five**			
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.	**Exception**	A total of nine files (five community counseling files, four shelter files) were reviewed. The reviewed files contained four open files and five closed files. In all files, the service plan was developed on a provider-approved form. A total of eight files based their service plan on information gathered during the NIRVANA.	One of the nine files reviewed indicated that the NIRVANA was completed after the service plan. Therefore, the NIRVANA could not have been used to inform the case plan.
Case/Service plan is developed within 7 working days of NIRVANA	**Exception**	Of the nine files reviewed, eight had a case plan developed within seven working days of the completion of the NIRVANA.	One of the nine files reviewed indicated that the case plan was completed before the NIRVANA was completed.

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**	Of the nine files reviewed, seven included the following: individualized needs/goals; service type/frequency/location; persons responsible for goal; target dates for completion; actual completion dates; signature of youth, parent, counselor, and supervisor; and the date the plan was initiated.	Two of the nine files were missing the actual completion dates on the service plan. These were both closed files. One of the files also did not have prioritized needs/goals that were identified by the NIRVANA as the NIRVANA was completed after the service plan.
Case/service plans are reviewed for progress/revised by counselor and parent (if available) every 30 days for the first three months and every 6 months after	**Exception**	Of the nine files reviewed, four were reviewed every 30 days. Four files did not require a review as the date of service did not allow for the service plan to be in place for a minimum of 30 days.	Of the files reviewed, one included a service plan review that was completed after 30 days of service plan completion.
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 program has a policy, ACH-CS-SD-015/ Case Management reviewed 01-08-2024 by the Executive Director.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open (Residential & Community) Files: Four **Total number of Closed (Residential & Community) Files: Five** **Type of Documentation(s) Reviewed: Youth files and inter-agency agreements**			
Counselor/Case Manager is assigned	**Compliance**	A total of nine files (five community counseling files and four residential shelter files) were reviewed. In all files, a counselor or case manager was assigned to each case.	

The Counselor/Case Manager completes the following as applicable: 1. Establishes referral needs and coordinates referrals to services based upon the on-going assessment of the youth's/family's problems and needs 2. Coordinates service plan implementation 3. Monitors youth's/family's progress in services 4. Provides support for families 5. Monitoring progress of 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 post discharge 12. Provides follow-up after 60 days post discharge	**Compliance**	All of the nine files reviewed included documentation of coordination of referrals/services, usage of assessment in provision of services, support for families, case progress monitoring, case termination notes, and 30, 60 day follow ups when appropriate.	
The program maintains written agreements with other community partners that include services provided and a comprehensive referral process	**Compliance**	In reviewing the agency's written agreement log, it was observed that the agency maintained written agreements with the local school district and several other community referral sources. These agreements were detailed and included the specific details involved in how to refer and when to refer to the agency.	
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 several policies, ACH-AFC-CS-001/ Clinical Staffing and ACH-HH-CS-003 Counseling last reviewed 08-08-2024 and 03-06-2024, respectively by the Executive Director.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open (Residential & Community) Files: Four **Total number of Closed (Residential & Community) Files: Five** **Staff Position(s) Interviewed** *(No Staff Names)* **: Residential Case Manager, Shelter Manager** **Type of Documentation(s) Reviewed: Youth Files**			
Shelter Program			
Shelter programs provides individual and family counseling	**Compliance**	Of the four shelter files reviewed, all indicated that the program provides individual and family counseling.	

Group counseling sessions held a minimum of five days per week	**Exception**	Evidence of group counseling logs was present for the dates included in all of the four shelter files reviewed. Interview with the shelter manager indicated that they are actively working to increase the amount of weekly groups and group session consistency. The agency has recently hired new residential case managers who have worked to attain this goal.	Of the group logs reviewed for the four client file service time periods, none indicated that group was held five times per week. The group session frequency was largely inconsistent throughout the time periods reviewed and mainly due to understaffing.
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**	Of the group logs reviewed, all included documentation of a clear facilitator, a relevant topic, and an opportunity for youth to participate. Interview with the residential case manager, reported that all shelter groups are held for at least 30 minutes at a time.	
Documentation of groups must include date and time, a list of participants, length of time, and topic.	**Exception**	A review of the group logs for the dates of the lengths of stay for each of the four shelter files, included a date and topic.	The group logs for the dates included in all of the four shelter files reviewed did not include a time or length of time.
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**	Of the five community counseling files reviewed, all showed evidence of services that were provided at the local provider's counseling office or the school. All files also showed evidence that services were designed to cater to the service that was needed to alleviate the crisis within the family.	
Counseling Services			
There is evidence the program completes review of all case files for coordination between presenting problem(s), psychosocial assessment, case/service plan, case/service plan reviews, case management, and follow-up.	**Compliance**	All nine files included case review forms that documented a review of the case and the coordination between all clinical services rendered.	
Maintain individual case files on all youth and adhere to all laws regarding confidentiality.	**Exception**	Of the nine files reviewed, eight had a confidential marking on the front of the file. All included individual client information in a an opaque folder.	Of the nine files reviewed, one file did not have a confidential marking on the front of the file. This was a closed file.
Case notes maintained for all counseling services provided and documents youth's progress.	**Compliance**	All nine files included a chronological record that included case notes and documentation of youth goal progress.	
On-going internal process that ensures clinical reviews of case records and staff performance.	**Compliance**	All nine files included case review forms that documented a review of the case that included the clinical director. Documentation of case feedback was evident on the case review form, as well as the chronological progress notes.	

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.	**No eligible items for review**	None of the nine files included any virtual services.	
Additional Comments: **There are no additional comments for this indicator.**			
2.06 - Adjudication/Petition Process			**Satisfactory with Exception**
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, ACH-CS-SM-007/ Case Staffing Committee, reviewed 01-08-24 by the Executive Director.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open (Residential & Community) Files: One **Total number of Closed (Residential & Community) Files: Zero** **Staff Position(s) Interviewed** *(No Staff Names)* **:** **Type of Documentation(s) Reviewed: Youth files**			
Must include: a. DJJ rep. or CINS/FINS provider b. Local school district representative	**Compliance**	One adjudication/petition file was reviewed. The file indicated that the CINS/FINS provider, DJJ attorney, and a school district member was present at the case staffing meetings.	
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**	Documentation within the file also indicated that several other representatives attended case staffing's. This primarily included the DJJ attorney, the client's counselor, and the client's case manager.	
The program has an established case staffing committee, and has regular communication with committee members	**Compliance**	The documentation within the file indicated that the same group of individuals attended most of the case staffing meetings. The documentation also indicated that the committee engaged in regular follow-up case staffing meetings. They also communicated frequently via email between case staffing meetings.	
The program has an internal procedure for the case staffing process, including a schedule for committee meetings	**Compliance**	The documentation within the file indicated that the same group of individuals attended most of the case staffing meetings. The documentation also indicated that the committee engaged in regular follow-up case staffing meetings. They also communicated frequently via email between case staffing meetings.	
The youth and family are provided a new or revised plan for services	**Compliance**	The documentation within the file indicated that a new plan for services was created after each case staffing meeting. These were documented on case staffing forms within the file.	

Written report is provided to the parent/guardian within 7 days of the case staffing meeting, outlining recommendations and reasons behind the recommendations	**Exception**	The file included a written document detailing the recommendations made by the case staffing committee during each case staffing meeting. The form also included the reason behind these recommendations.	The file reviewed did not include documentation detailing if or when a copy of the written case staffing report was provided to the parent/guardian. Therefore, it could not be determined the parent/guardian received the case staffing report within seven days of the meeting.
If applicable, the program works with the circuit court for judicial intervention for the youth/family	**Compliance**	The file included evidence that the agency worked with the circuit court for judicial intervention. The case staffing report indicated that a CINS petition was eventually requested and that the agency attended court hearings.	
Case Manager/Counselor completes a review summary prior to the court hearing	**Compliance**	The file reviewed included several review summaries of the case which were completed prior to court hearings.	
Additional Comments: **There are no additional comments for this indicator.**			
2.07 - Youth Records			**Satisfactory with Exception**
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, ACH-HH-DR-001/ Case Files, reviewed 03-06-23 by the Executive Director.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Staff Position(s) Interviewed *(No Staff Names)* **: Quality Improvement Director** **Describe any Observations: Location of youth files, container used to transport youth files.**			
All records are clearly marked 'confidential'.	**Compliance**	Interview with the quality improvement director indicated where the records are kept. Observation of two community counseling offices revealed that open records are kept in the counselor's offices in locked filing cabinets. The records inside of the filing cabinets were observed to be clearly marked "confidential."	
All records are kept in a secure room or locked in a file cabinet that is marked "confidential"	**Exception**	Locked filing cabinets were observed and the doors to the offices were capable of being locked as well.	None of the filing cabinets observed were marked "confidential."
When in transport, all records are locked in an opaque container marked "confidential"	**Compliance**	The quality improvement director indicated that the records were transported in locked boxes when in transport. Observation of two of these transport boxes in a community counseling office confirmed they are opaque, marked "confidential", and locked with a combination code.	
All records are maintained in a neat and orderly manner so that staff can quickly and easily access information	**Compliance**	Upon observation of the files inside of the locked filing cabinets, revealed they were organized and easily accessible.	

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 program has several policies, ACH-AFC-DD-003 Family/ Youth Respite Aftercare Services (reviewed 03/04/2019) and ACH-AFC-CS-001 Clinical Staffing (revised 09/08/2008) by the Executive Director.	
Staff Secure			
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: Zero **Total number of Closed Files: Zero** **Staff Position(s) Interviewed** *(No Staff Names)* **: Director of Quality Improvement, Program Manager** **Type of Documentation(s) Reviewed: Policy and Procedure**			
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 on-site QI review.	
Staff Secure policy and procedure outlines the following: a. In-depth orientation on admission b. Assessment and service planning c. Enhanced supervision and security with emphasis on control and appropriate level of physical intervention d. Parental involvement e. Collaborative aftercare	**Compliance**	The program has policies and procedures in place to that outline the following regarding the staff secure: 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	**Compliance**	According to program policy the program only accepts youth that meet legal requirements of F.S. 984 for being formally court ordered in to Staff Secure Services.	
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 on-site QI 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 on-site QI review.	
Domestic Minor Sex Trafficking (DMST)			

Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: Zero **Total number of Closed Files: Zero** **Staff Position(s) Interviewed** *(No Staff Names)* **: Quality Improvement Director, Program Manager**			
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 last six months or since the date of the last on-site 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 last six months or since the date of the last on-site 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 last six months or since the date of the last on-site 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 last six months or since the date of the last on-site 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 last six months or since the date of the last on-site 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 last six months or since the date of the last on-site 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 last six months or since the date of the last on-site 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 last six months or since the date of the last on-site 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: Zero** **Staff Position(s) Interviewed** *(No Staff Names)* **: Quality Improvement Director, Program Manager**			

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 domestic violence cases in the last six months or back to the date of the last on-site QI review.	
Youth admitted to DV Respite placement have evidence in the file of a pending DV charge	**No eligible items for review**	The program had no domestic violence cases in the last six months or back to the date of the last on-site QI review.	
Data entry into NetMIS within (3) business days of intake and discharge	**No eligible items for review**	The program had no domestic violence cases in the last six months or back to the date of the last on-site QI review.	
Youth length of stay in DV Respite placement does not exceed 21 days. If more than 21 days, documentation exists in youth file of transition to CINS/FINS or Probation Respite placement, if applicable.	**No eligible items for review**	The program had no domestic violence cases in the last six months or back to the date of the last on-site QI review.	
Case plan in file reflects goals for aggression management, family coping skills, or other intervention designed to reduce propensity for violence in the home	**No eligible items for review**	The program had no domestic violence cases in the last six months or back to the date of the last on-site QI review.	
All other services provided to Domestic Violence Respite youth are consistent with all other general CINS/FINS program requirements	**No eligible items for review**	The program had no domestic violence cases in the last six months or back to the date of the last on-site QI review.	
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: One** **Staff Position(s) Interviewed** *(No Staff Names)* **: Quality Improvement Director, Program Manager** **Type of Documentation(s) Reviewed: Youth 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**	Reviewed one probation respite file that occurred within the review period.	
All probation respite referrals are submitted to the Florida Network.	**Compliance**	Interview with the Program Manager indicated that there was a referral submitted to the Florida Network for the probation respite file reviewed.	
All Probation Respite Referral come from DJJ Probation and there is evidence that the youth is on Probation regardless of adjudication status.	**Compliance**	The file did include a referral for services that was completed by the juvenile probation officer.	
Data entry into NetMIS and JJIS within (3) business days of intake and discharge	**Compliance**	The file did include documentation that the intake and discharge data was entered within three business days.	
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.	**Compliance**	The file indicated that the length of stay was between 14 and 30 days.	

All case management and counseling needs have been considered and addressed	**Compliance**	The file included a NIRVANA assessment, screening, intake form, and service plan that documented the consideration of various service needs before providing services.	
All other services provided to Probation Respite youth are consistent with all other general CINS/FINS program requirements	**Compliance**	The file included documentation that all case management and counseling services met the CINS/FINS program standards.	
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** *(No Staff Names)* **: Quality Improvement Director, Program Manager**			
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 last six months or since the date of the last on-site 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 last six months or since the date of the last on-site 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 last six months or since the date of the last on-site 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 last six months or since the date of the last on-site 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 last six months or since the date of the last on-site 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 last six months or since the date of the last on-site 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: Two
Staff Position(s) Interviewed *(No Staff Names)* **: Quality Improvement Director, Program Manager**
Type of Documentation(s) Reviewed: Youth files

Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	**Compliance**	The program has served two Family Youth Respite After Care cases. Both files are closed cases.	
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.	**Compliance**	Both files were referred by the department of juvenile justice due to a domestic violence arrest.	
Agency has evidence that all FYRAC referrals have documented approval from the Florida Network office	**Compliance**	Both files had documentation of prior approval from the Florida Network.	
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.	**Compliance**	Both files reviewed included a signed form that oriented the parent and child to the services. They also included a signed service plan that was completed during the first face-to-face meeting/assessment.	
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.	**Compliance**	Both files included face-to-face counseling sessions that were focused on family dynamics. The file either included several family sessions or focused on relational issues within the child/parent relationship during individual sessions. There was evidence of parent involvement in both cases.	
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.	**Compliance**	Both files either included several family sessions or focused on relational issues within the child/parent relationship during individual sessions. There was evidence of parent involvement in both cases. Session documentation indicated various relevant interventions including family relations, communication skills, emotion regulation skills, and coping skills.	

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**	Of the two files reviewed, neither engaged in group session counseling. Only individual/family sessions were utilized.	
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**	Both files are within the first 30 days of completion and not due for the 30 and/ or 60 day follow-up.	
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	**Compliance**	Both files indicated that services did not exceed 13 sessions in either case.	
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**	Of the two files reviewed, neither indicated that services were provided virtually.	
All data entry in NetMIS is completed within 3 business days as required.	**Compliance**	Evidence of data entry into NetMis within three business days was present in both files reviewed.	

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 several policies, ACH-CS-SNAP-001 SNAP Intake, ACH-CS-SNAP-002 Discharge, ACH-CS-SNAP-003 Fidelity Adherence, ACH-CS-SNAP-004 Group Delivery, ACH-CS-SNAP-005 SNAP in Schools, last reviewed 03/05/2018 by the Executive Director.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: Three **Total number of Closed Files: Two** **Type of Documentation(s) Reviewed: SNAP Youth files, Two completed SNAP in Schools files**			
SNAP Clinical Groups Under 12			
Youth are screened to determine eligibility of services.	**Compliance**	Five of five SNAP files for clinical groups under 12 contained completed screening forms to determine eligibility of services.	
The NIRVANA was completed at initial intake, or within two sessions.	**Compliance**	The NIRVANA was completed at initial intake or within two sessions in five of five SNAP files reviewed.	
There is evidence of the completed Child Behavior Checklist (CBCL) by the caregiver (pre and post) and is located within the file.	**Compliance**	A completed Pre-Child Behavior Checklist was completed by the caregiver in five of files reviewed and a post checklist was completed in the two closed files reviewed. Three files remained open at the time of the review.	
There is evidence of the completed Teacher Report Form (TRF) is completed by the teacher (pre and post) and is located within the file.	**Compliance**	Evidence of a completed Pre-Teacher Report Form was present in five of five files reviewed and a Post-Teacher Report Form was present in the two closed files reviewed. Three files remained open at the time of the review.	
SNAP Clinical Groups Under 12 - Discharge			
There is evidence of the completed SNAP Discharge Report located within the file for any discharged youth.	**Compliance**	Two of two closed SNAP files reviewed contained completed SNAP discharge reports.	
There is evidence of the completed SNAP Discharge Report located within the file for any discharged youth.	**Compliance**	Two of two closed SNAP files reviewed contained completed SNAP discharge reports.	
There is evidence of the SNAP Boys/SNAP Girls Child Group Evaluation Form located in the file.	**Compliance**	Two of two closed SNAP files reviewed contained a SNAP Child Group Evaluation Form in the file.	

There is evidence of the SNAP Boys/SNAP Girls Parent Group Evaluation Form located in the file.	**Compliance**	Two of two closed SNAP files reviewed contained a SNAP Parent Group Evaluation Form in the file.	
SNAP Clinical Groups for Youth 12-17			
Youth are screened to determine eligibility of services.	**Not Applicable**	The agency does not provide SNAP clinical groups for youth ages 12-17.	
The Consent to Treatment and Participation in Research Form is completed and located within the file.	**Not Applicable**	The agency does not provide SNAP clinical groups for youth ages 12-17.	
The NIRVANA was completed at initial intake, or within two sessions.	**Not Applicable**	The agency does not provide SNAP clinical groups for youth ages 12-17.	
There is evidence of the completed 'How I Think Questionnaire' (HIT) form located within the file or evidence of at least three (3) documented attempts in the youths' file to obtain this information.	**Not Applicable**	The agency does not provide SNAP clinical groups for youth ages 12-17.	
There is evidence of the completed Social Skills Improvement System (SSIS) Student form located within the file or evidence of at least three (3) documented attempts in the youths' file to obtain this information.	**Not Applicable**	The agency does not provide SNAP clinical groups for youth ages 12-17.	
There is evidence of the completed Social Skills Improvement System (SSIS) Teacher/Adult form located within the file or evidence of at least three (3) documented attempts in the youths' file to obtain this information.	**Not Applicable**	The agency does not provide SNAP clinical groups for youth ages 12-17.	
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 completed files reviewed for SNAP in Schools sessions contained a total of 13 attendance sheets for a full cycle. Attendance sheets included the youth names and was completed with the teacher and trained SNAP facilitators signatures.	
The program maintained evidence of a completed "Class Goal" Document for the class reviewed.	**Compliance**	Two of two completed files reviewed for SNAP in Schools sessions contained a completed class goal sheet.	
The program maintained evidence of both pre AND post Measure of Classroom Environment (MoCE) completed documents for the class reviewed.	**Compliance**	Two of two completed files reviewed for SNAP in Schools sessions contained a completed measure of classroom environment sheet.	
The program maintained evidence of completed pre and post evaluation documents for the class reviewed.	**Compliance**	Two of two completed files reviewed for SNAP in Schools sessions contained completed pre and post evaluation documents for the class.	
There is evidence of the fidelity adherence checklist maintained in the file for each class reviewed.	**Compliance**	Two of two completed files reviewed for SNAP in Schools sessions contained a completed fidelity adherence checklists.	
Additional Comments: **There are no additional comments for this indicator.**			

3.01 - Shelter Environment			Satisfactory with Exception
Provider has a written policy and procedure that meets the requirement for Indicator 3.01		**YES** If NO, explain here: The agency has several policies ACH-HH-PM-002 Code of ethics, ACH-HH-PM-005 Transportation, ACH-HH-PM-009 Room Assignments and ACH-HH-PM-010 Staffing Requirements and Scheduling, all last reviewed 03/6/2023 by the Executive Director.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Staff Position(s) Interviewed (No Staff Names): Shelter Manager, Assistant Shelter Manager, 3 Youth Care Specialist **Type of Documentation(s) Reviewed: evacuation plans**			
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**	All furnishings appeared to be in good repair, normal wear and tear were observed in the living quarters during the facility tour. The program was free from insect infestation. There was no evidence of any insect droppings or infestation in the shelter. During that time, seven bathrooms out of nine were observed. Each bathroom had a walk-in shower, toilet, and sink with a lower cabinet. All seven were in functional order and free of leaks. The living area had no visible graffiti. All places had adequate lighting. The outside areas were well maintained. The grounds are free of hazards and well-maintained. The dumpster was covered at the time of observation. All doors are in good working order and secure. It was observed that the staff used their keys or name badges to enter particular doors that were not accessible to the youth. The exit plans were located in several different areas in the shelter living area. The youth rules and expectations are listed in the common areas. On the table is a Help Me form that the youth fill out and place in the grievance box, and the abuse hotline number is located. The DCF license and DJJ incident reporting number is located in the Intake Office on the wall. The shelter is licensed for 20 beds, with a renewal date of November 9, 2024.	
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 a GMC Savanna large 12-passenger van with a first aid kit in the front storage compartment. The fire extinguisher (checked on 2/2024), flashlight, glass breaker, and seat belt cutter were all in the driver's side door. All the doors were locked upon entering and locked once finished. The program also has a Kia Carnival 7-passenger Mini Van with a flashlight, glass breaker, and seat belt cutter located in the front driver-side door. The fire extinguisher (checked on 2/2024) and first aid kit was current and located in the rear storage area.	

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**	Two chemical cabinets are located in the laundry room with locks on both. MSDS notebook and MSDS sheets for all chemicals are located in the laundry room on the wall. MSDS were accurate, complete and maintained weekly and a perpetual inventory was being used to maintain the current real-time inventory. The shelter has one laundry room with three washers and two commercial dryers. The dryers were both lint-free.	
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 shelter has one laundry room with three washers and two commercial dryers. The dryers were both lint-free. The shelter has a current DCF License, valid until 11/09/2024, displayed in the intake office. The youth have their bed with cleaned, covered mattresses, pillows, lining, and blankets. Youth also have a safe place in the Staff office to store their necessary valuables.	
Additional Facility Inspection Narrative (if applicable)			
Fire and Safety Health Hazards: a. Annual facility fire inspection was conducted, and the facility is in compliance with local fire marshal and fire safety code within jurisdiction. b. Agency completes a minimum of 1 fire drill on each shift monthly (within 2 minutes or less). c. Completes 1 mock emergency drill per shift per quarter. d. All annual fire safety equipment inspections are valid and up to date (extinguishers, sprinklers, alarm system and kitchen overhead hood, including fire extinguishers in all vehicles).	**Exception**	The program completed a total of nineteen fire and mock drills over the past six month period. One fire drill per shift/ per month and one mock emergency drill per shift per quarter. An annual facility fire inspection was conducted, and the facility is in compliance with local fire marshal and fire safety code within jurisdiction. 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).	There was one fire drill missing on second shift in September 2023.

Fire and Safety Health Hazards: a. Agency has a current Satisfactory Residential Group Care inspection report from the Department of Health. b. Agency has a current Satisfactory Food Service inspection report from the Department of Health and food menus are posted, current and signed by Licensed Dietician annually. c. All cold food is properly stored, marked and labeled and dry storage/pantry area is clean and food is properly stored. d. Refrigerators/Freezers are clean and maintained at required temperatures and all small and medium sized appliances are operable and clean for use as needed.	**Compliance**	The Agency has a current Residential Group Care/Food service inspection that was issued on 1/10/24. All food was observed to be properly stored and organized in a clean operable in the refrigerator/freezers or pantry. The temp for the two refrigerators was 30 degrees and the one walk in freezer was at zero degrees.	
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 shelter has a daily activity schedule for the youth, which is located in the dayroom. The youth are engaged in activities from 6:00 am to 9:30 pm. Youth have access to youth faith-based activities. The staff asked each youth on Saturday night if they would like to attend Sunday morning church. The staff provides other activities for the others who do not want to attend church. This reviewer observed the clients in class, living areas, and staff engaging with the youth. The schedule has one hour of physical activity. There are 45 minutes of homework/study hours for the youth in the program.	
Additional Comments: **There are no additional comments for this indicator.**			
3.02 - Program Orientation			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 3.02		**YES** If NO, explain here: The agency has a policy ACH-HH-AD-002 Intake/ Orientation Process, last reviewed March 6, 2023 by the Executive Director.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: 3 **Total number of Closed Files: 2** **Staff Position(s) Interviewed** *(No Staff Names)* **: Billie P, Youth Specialist** **Type of Documentation(s) Reviewed: Intake paperwork, Electric log book,** **Describe any Observations: Intake and Discharge**			
Youth received a comprehensive orientation and handbook provided within 24 hours	**Compliance**	A review of a total of five charts, two closed and three open files revealed all five files had documentation that the youth had received the handbook.	

Orientation includes the following: a. Youth is given a list of contraband items b. Disciplinary action is explained c. Dress code explained d. Review of access to medical and mental health services e. Procedures for visitation, mail and telephone f. Grievance procedure g. Disaster preparedness instructions h. Physical layout of the facility i. Sleeping room assignment and introductions j. Suicide prevention- alerting staff of feelings or awareness of others having suicidal thoughts	**Compliance**	A review of five youth files revealed that all five youth files documentation of completion of orientation which included 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	
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**	Documentation of each component of orientation as well as the signatures of the staff and youth involved was located in all five files reviewed.	
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 ACH-HH-PM-009 Room Assignments, last reviewed March 6, 2023 by the CEO.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: Three **Total number of Closed Files: Two** **Staff Position(s) Interviewed** *(No Staff Names)* **: Shelter Care Specialist, Shelter Manager, and Assistant Manager** **Type of Documentation(s) Reviewed: Log sheets, Electric log book, and census board in the youth care specialist office.**			

A process is in place that includes an initial classification of the youths, to include:			
a. Review of available information about the youth's history, status and exposure to trauma b. Initial collateral contacts, c. Initial interactions with and observations or the youth d. Separation of younger youth from older youth, e. Separation of violent youth from non-violent youth f. Identification of youth susceptible to victimization g. Presence of medical, mental or physical disabilities h. Suicide risk i. Sexual aggression and predatory behavior j. Acute health symptoms requiring quarantine or isolation	**Compliance**	The reviewed five total charts, two closed and three open charts. All five charts had all the following information in them and was very organized and easy to fine: Youths history of trauma, collateral contacts, identification of youth susceptible to victimization, suicide risk, and health symptoms.	
An alert is immediately entered into the program's alert system when a youth is admitted with special needs and risks such as risk of suicide, mental health, substance abuse, physical health or security risk factors	**Compliance**	All youth are recorded on the census board in the youth specialist office upon entering the program. Alerts for each youth are clearly marked on the census board. Alerts address special needs, risk of suicide, mental health, substance abuse, physical health and/ or security risk factors. Four of five youth files reviewed had evidence of the alert system in the file. One file did not have the alerts properly identified inside or outside of the youth file. It was added the file during this on-site review.	
Additional Comments: **There are no additional comments for this indicator.**			
3.04 - Log Books			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 3.04		**YES** If NO, explain here: The agency has a policy, ACH-HH-DR-002 Daily Log Documentation, last reviewed on 3/6/23 by the Executive Director.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Dates or Timeframe Reviewed: Six months **Staff Position(s) Interviewed** *(No Staff Names)* **: Shelter Manager, Assistant Shelter Manager.** **Type of Documentation(s) Reviewed: electric log book**			
Log book entries that could impact the security and safety of the youth and/or program are highlighted	**Compliance**	In the Electronic log book the program staff highlights entries with the following colors. Blue = Arrival/departure of youth from the facility, Green = Intake or discharge, Yellow = Medical information/Med pass, Pink = Behaviors/supervisory reviews/ staff reviews, and Red = Drills.	
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**	The program manager, showed daily logbook entries and they all show, date, time, youths name, staffs name, and a brief statement providing pertinent information. Each entry has an signature of initial of the person making the entry.	

Recording errors are struck through with a single line. The staff person must initial and date the correction. The use of whiteout and erasures is prohibited.	**Compliance**	A random review of electronic log book entries for the past six months showed one strike-through of a recording errors. It was properly documented with a single line and the staff person initialed and dated the correction. There was no evidence of the use of whiteout and erasures.	
The program director or designee reviews the facility logbook(s) every week and makes a note chronologically in the logbook indicating the dates reviewed and if any correction, recommendations and follow-up are required and sign/date the entry	**Compliance**	The shelter supervisor, and Residential Case Manager both have the electric log book on their on-call phone and can review it when needed. If they review it they make an entry with date and time stamp.	
All staff review the logbook of the previous two shifts and makes an entry signed and dated into the logbook indicating the dates reviewed	**Compliance**	A review of the Electronic Logbook, showed entries by the oncoming shift into the logbook, indicating they have reviewed the past two shift changes. An observation of five out of five shifts documented this practice.	
At the beginning of their shift, oncoming supervisor and shelter counselor reviews the logbook of all shifts since their last log entry and makes a signed and dated entry and into log book indicating the dates reviewed.	**Compliance**	The shelter manager, reviews the logbook daily and addresses any issues as they arise. This was observed on 2/12/24 and 2/19/24.	
Logbook entries include: a. Supervision and resident counts b. Visitation and home visits	**Compliance**	The electronic log was observed to have resident counts, visitation and offsite visits in the logs.	
Additional Comments: **There are no additional**			
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 ACH-HH-BX-004 Self-Management System, last reviewed March 6, 2023 by the CEO.		
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Staff Position(s) Interviewed *(No Staff Names)* **: Youth Specialist, Program Manager and Assistant Shelter Manager** **Type of Documentation(s) Reviewed: Behavior Management System, Orientation Documentation, Youth files**			
The program has a detailed written description of the BMS and it is explained during program orientation	**Compliance**	The program has a written description of the behavior management system (BMS). The youth specialist reported that the BMS is explained to each youth at orientation and the youth signature in their file is proof that they have received information regarding the BMS.	
Behavior Management Strategies must include:			

a. BMS is designed to teach youth new behaviors and help youth understand the natural consequences for their actions b. Behavioral interventions are applied immediately, with certainty, and reflect the severity of the behavior c. BMS uses a wide variety of awards/incentives to encourage participation and completion of the program d. Appropriate consequences and sanctions are used by the program and consequences for behavior are logical and designed to promote skill-building for the youth e. Counseling, verbal intervention and de-escalation techniques are used prior to physical intervention (Only techniques approved by the Florida Network and DJJ are used if physical intervention is required) f. Only staff discipline youth. Group discipline is not imposed g. Room restriction is not used as part of the system or for youth who are physically and/or emotionally out of control h. Youth should never be denied basic rights such as meals, clothing, sleep, services, exercise, or correspondence privileges	**Compliance**	The agency's policy addressing Behavior Management Strategies includes: 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 The BMS is based on a point system which allows youth to earn rewards like, raffles, extra TV time, and off-campus activities, with accumulated points. There are several levels in the BMS and staff always uses the BMS as a positive incentive. Observation of the use of the BMS was evident on-site. A youth who earned extra TV time had a TV (mounted on a portable TV cart) in their bedroom.	
Program's use of the BMS			
All staff are trained in the theory and practice of administering BMS rewards and consequences	**Compliance**	Evidence of all shelter staff are trained by the Program Manager, during orientation, on the theory and practice of administering BMS and its consequences was present in the staff training files.	
There is a protocol for providing feedback and evaluation of staff regarding their use of BMS rewards and consequences	**Compliance**	Per interview with the Assistant Shelter Manager, staff are trained in the use of BMS and are monitored by the Program Manager who provides feedback and evaluation individually regarding the use of BMS rewards and consequences.	
Supervisors are trained to monitor the use of rewards and consequences by their staff	**Compliance**	Interview with the shelter manager indicates that supervisors are trained to monitor the use of rewards and consequences by their staff.	
Additional Comments: **There are no additional**			
3.06 - Staffing and Youth Supervision			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 3.06		**YES** If NO, explain here: The agency has a policy ACH-HH-PM-010 Staffing Requirements and scheduling, last reviewed March 6, 2023 by the CEO.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			

Dates or Timeframe Reviewed: 01/26/2024, 01/31/2024, 02/10/2024, 2/11/23, Type of Documentation(s) Reviewed: Staff Schedules, Electronic log book, overtime/ holdover list, video surveillance			
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**	It was reviewed in the Electronic Log Book that the staff-to-youth ratios of one to six during awake hours and one to twelve during the sleep period, are being followed. There are two staff on overnights.	
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 staff training showed that the program maintains a minimum of two direct care staff who have met the training requirements.	
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**	Thirteen of thirteen employee files reviewed contained evidence of completed background screenings prior to hire/start date and evidence of proper training for all youth care workers, supervision staff, and treatment staff.	
The staff schedule is provided to staff or posted in a place visible to staff	**Compliance**	The staff schedule was observed posted in the youth care specialist office on the wall.	
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 holdover/overtime list was observed and it included 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 review of the Hidle House Video Surveillance review binder, indicated that staff observed youth sleeping in their rooms every 15 minutes. Dates reviewed are as follows: 1/31/24 for 3:10 am, 3:19 am, 3:29 am, and 3:39 am, all bed checks were conducted within the 10-minute time frame and on 2/11/24, bed checks reveied and completed on-time, occured at 2:40 am, 2:50 am, 3:04 am, 3:10 am, and 3:30 am. On January 26th, a bed check was not conducted from 3am to 4 am. This missed bed check was observed by the supervisor as evidenced in the Hidle House Video Surveillance supervisor review binder. Upon interview with the program manager, it was reported that there was an internal corrective action process that has been implemented to address the issues cited above. A supervisory review of the video surveillance system conducted on 02/10/2024 showed evidence of staff not conducting/ documenting bed checks as required on January 26th. The staff member is currently on a Performance Improvement Plan as of 02/12/2024. The plan is based on observations of sleeping on shift and not participating in shift assignments. The plan details specific responsibilities and expectations for the staff member to: always remain awake on shifts and take equal responsibility in assignments. Through proper review and follow-up of the identified issue, the program showed evidence of internal mitigation to circumvent a larger systematic problem. The program is closely monitoring and documenting its efforts to remain in compliance with 15 minute bed checks.	On January 15, 2023, youth were in there rooms between 6pm and 7pm, and bed checks were not observed. On 2/11/24, no bed checks were completed from 2:01 am to 2:40 am. The staff was observed sitting on the couch and appeared to be asleep.

Additional Comments: **There are no additional**

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 HH-DO-018 Video Surveillance System last reviewed March 6, 2023 by the CEO.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Dates or Timeframe Reviewed: Six months **Staff Position(s) Interviewed: Shelter Care Manager** **Type of Documentation(s) Reviewed: Log Books, list of personnel designated to review the video surveillance system** **Describe any Observations: Posted "Notice of security cameras in use" signs**			
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**	A sign on the front door states, "Notice security cameras in use." The camera system can capture videos and pictures that can be retained for up to 30 days. The system can record date, time, and location. The system can work if there is a power outage. All cameras are located in areas where staff and clients congregate and where visitors enter and exit. The searches are conducted where they are visible on camera.	
A list of designated personnel who can access the video surveillance system is maintained (includes off-site capability per personnel)?	**Compliance**	This list was located in the Youth Care Specialist Office. Shelter Care Manager, Assistant Shelter Care Manager, Residential Case Manager are all designated personnel who can access the video surveillance system.	
Supervisory review of video is conducted a minimum of once every 14 days and timeframes reviewed are noted in the logbook.	**Compliance**	Shelter Care Manager reviews the videos and keeps an ongoing log with her findings in a separate logbook.	
The reviews assess the activities of the facility and include a review of random sample of overnight shifts	**Compliance**	The random reviews of the overnight sleeping times of the youth are recorded and kept in a separate logbook.	
Grant the requesting of video recordings to yield a result within 24-72 hours from program quality improvement visits and when an investigation is pursued after an allegation of an incident	**Compliance**	The program has the capability to provide video recordings upon request within 24-72 hours from the program's quality improvement visit and when an investigation is pursued after and allegation of an incident.	

Camera service order/requests will be made within 24 hours of discovery of camera malfunctioning or being inoperable. All efforts made to obtain repairs are documented and maintained	**Compliance**	The Shelter Care Manager reported that all cameras are in working condition. It was also reported that any service order/ requests will be made within 24 hours of discovery of camera malfunctioning or being inoperable. The cameras were all in working order.	
Additional Comments: **There are no additional**			
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 ACH-HH-AD-003 Intake Assessment, last reviewed March 6, 2023 by the CEO.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: Three **Total number of Closed Files: Three** **Staff Position(s) Interviewed: RN** **Type of Documentation(s) Reviewed: Cover sheet with picture/alerts, Anchorage Home Screening Form, Hidle House Shelter Intake & Assessment Form- Youth Specialist, Assessment of Suicide Assessment, Suicide/Self-harm Plan, Anchorage Children's Home Progress Notes, Hidle House Clinical Staffing, Hidle House Medication Receipt Form, Medication Oversight and Inventory, Anchorage Children's Home Health Screening form** **Describe any Observations: File review**			
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**	A review of six files were conducted (three open and three closed). Four youth had current medications, five youth had existing acute or chronic medical conditions, two had allergies, none had recent injuries or illnesses, one had presence of back pain, one was observed for evidence of illness, one had presence of scars, and one had asthma. No other observations were reported.	
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**	All six youth were applicable for referrals. All referrals were made, parent or guardian was notified, and documented in progress notes.	
When needed, the parent is involved with the coordination and scheduling of follow-up medical appointments	**Compliance**	The parent or guardian was included in the referral process and youth files contained emails and progress notes with information.	
All medical referrals are documented on a daily log.	**Compliance**	All medical referrals are documented in progress notes in the youth's individual file.	

The program has a thorough referral process and a mechanism for necessary follow-up medical care as required and/or needed	**Compliance**	The referrals process for the agency consists of notifying the parent or guardian of the youth's needs. It is the responsibility of the parent to transport the youth to the doctor and follow up. This information is documented in progress notes.	
Additional Comments: **There are no additional**			
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 ACH-HH-SS-006 Suicide Prevention and Intervention, last reviewed March 6, 2023 by the CEO.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open (Residential & Community) Files: Three **Total number of Closed (Residential & Community) Files: Three** **Staff Position(s) Interviewed: Clinical Director and QI Director** **Type of Documentation(s) Reviewed: Cover sheet with picture/alerts, Anchorage Home Screening Form, Hidle House Shelter Intake & Assessment Form- Youth Specialist, Assessment of Suicide Assessment, Suicide/Self-harm Safety Plan, Anchorage Children's Home Progress Notes, Hidle House Clinical Staffing, Hidle House Medication Receipt Form, Medication Oversight and Inventory, Anchorage Children's Home Health Screening form**			
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**	Six files were reviewed for suicide screening during the initial intake and screening process. All six were completed upon intake and signed by the supervisor and placed in the youth's file.	
The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	**Compliance**	The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services.	
Supervision of Youth with Suicide Risk *(Shelter Only)*			
Youth are placed on the appropriate level of supervision based on the results of the suicide risk assessment.	**Compliance**	Six files were reviewed and two were applicable for suicide risk assessment. Both were completed and documented in youth's individual record.	
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**	Six files were reviewed and two were applicable for one-on-one supervision or constant supervision. One youth had Constant Sight and Sound Observation Log pre-populated with times on December 18, 2023. The program has transitioned to utilizing a non-pre-populated form for documenting sight and sound. Observation of a more recent form completed with written times of 30 minutes or less intervals was conducted.	
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 constant supervision log includes: the time of day, behavioral observations, any warning signs observed, and the observers' initials. All observation logs are reviewed by the supervisor and included in the youth's file upon completion.	

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**	A review of six youth files revealed two applicable files indicated supervision level was not changed/reduced until a licensed professional completed a further assessment.	
There was evidence that documentation was reviewed by supervisory staff each shift. If program uses an observation log, completed logs are maintained in the youth's file.	**Compliance**	There was evidenced that documentation was reviewed by supervisory staff each shift. The observation logs are maintained in the youth's file.	
Youth with Suicide Risk *(Community Counseling Only)*			
Youth identified for suicide risk during intake was immediately assessed by a licensed professional or non-licensed professional (under the direct supervision of a licensed mental health professional) and the parents and supervisor were both notified of the results.	**Compliance**	A review of six youth files revealed two applicable files were immediately assessed by a licensed professional and the parents and supervisor were notified as required.	
During the intake, if the appropriate staff is unavailable, youth identified for suicide risk was immediately referred by the provider and the parent/guardian is notified of the suicide risk findings disclosed and advised that an Assessment of Suicide Risk should be completed ASAP by a licensed professional.	**Compliance**	During intake, if the appropriate staff is unavailable youth identifies 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.	
Information on resources available in the community for further assessment was provided to the parent/guardian and is documented in the youth's file and signed by the parent/guardian OR a written follow-up notification was sent by certified mail if the parent/guardian was not present during the screening and was notified by telephone.	**Compliance**	A review of six files indicated information on resources available in the community for further assessment was provided to the parent/guardian and is documented in the youth's files and signed by the parent guardian.	
If the parent/guardian cannot be contacted, all efforts to contact them are documented in the case file.	**Compliance**	A review of six files indicated if the parent/guardian cannot be contacted, all efforts to contact them are documented in the case files.	
When the screening was completed during school hours on school property, the appropriate school authorities were notified.	**Compliance**	None of the files reviewed were screened on the school property during school hours.	
Additional Comments: **There are no additional**			

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 ACH-HH-HC-006 Medication Management, last reviewed February 5, 2024 by the CEO.		
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: Two **Total number of Closed Files: Three** **Staff Position(s) Interviewed: RN** **Type of Documentation(s) Reviewed: Cover sheet with picture/alerts, Anchorage Home Screening Form, Hidle House Shelter Intake & Assessment Form- Youth Specialist, Assessment of Suicide Assessment, Suicide/Self-harm Plan, Anchorage Children's Home Progress Notes, Hidle House Clinical Staffing, Hidle House Medication Receipt Form, Medication Oversight and Inventory, Anchorage Children's Home Health Screening form** **Describe any Observations: Youth was escorted to medical window by staff member. The youth approached the nurse individually. The nurse verified the youth's allergy and alert status. The nurse verified the youth and the medications. Medication was administered one at a time. Each time medication was given the nurse would do a count of medication prior to administering medication to youth. The youth would take medication and initial the med book. Nurse verified each time medication was given to ensure youth swallowed medication. The nurse would also initial each time youth took medication. The Six Rights of Medication Delivery took place (right youth, right medication, right dosage, right time, right route, and right documentation).**			
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 one full-time registered nurse and credentials were verified through Nurses.	
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**	A review of training for all non-nursing shelter staff designated to assist with the self-administration of medication indicated that all non-nursing staff are trained by a registered nurse and they demonstrated evidence of their competency to assist with self-administration of medication distribution. Annual medication training re-certification is maintained in their training file.	
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 agency conducts monthly staff meetings. A review of monthly meeting minutes and attendance revealed the RN conducts monthly meetings that assess strategies in medication errors, analyze contributing factors to medication errors, and conduct role-playing in medication administration.	

The agency has strategies implemented to ensure medications are provided within the 2-hour time frame.	**Compliance**	Shift schedules reviewed identified who would be in charge of administering medication during each shift. The program maintains a strategy of giving medications 1 hour before and/or 1 hour after time that it should be given. The agency has many methods to ensure medications are given at the correct time and the correct dosage is given: An Echo will sound off when medication should be given, 2. A board in the Specialist office maintains youth name, medication, and dosage. 3. There is a board with the same information in the room where the Pyxis is. 4. Lastly, the Med Binder considered the "Bible" maintains the most up-to-date information (Name of youth, time it should be taken, medication name, dosage, and inventory).	
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 shift schedules showed, the non-licensed staff members who are clearly identified and designated to assist with the self-administration of medications on each shift.	
The agency has clear methods of communicating which youth are on medications with the times and dosage easily discernable by all staff on each shift.	**Compliance**	The agency has clear methods of communicating which youth are on medications with the times and dosage easily discernable by all staff on each shift as previously described.	
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 delivery process of medications is consistent with the FNYFS Medication Management and Distribution Policy as required. The agency's policy and internal quality assurance process includes: a. appropriate medication management and distribution methods, b. track medication errors, c. identify systemic issues and implement mitigation strategies.	
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**	A review of four youth files revealed upon admission the youth and parent/guardian were interviewed by the Registered Nurse when she is onsite about the youth's current medications as part of the Medical and Mental Health Assessment screening process. If the RN was not available, and interview would be completing within 3 days by the RN as required. 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.	
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**	Through observation it was verified all medications are stored in Pyxis ES Medication cabinet and inaccessible to youth. The Pyxis machine is stored in accordance with guidelines in FS 499.0121 and policy section in Medication Management. Oral medications are stored separately for injectable epi-pen and topical machines. A refrigerator is available for storing medication but it's been seven years since the refrigerator was last used for medication. Controlled medication are stored in Pyxis machine. Pyxis keys with the appropriate labels are stored in a locked cabinet above the Pyxis machine and spares ae kept in the nurses office.	
Medication Distribution			
a. Agency maintains a minimum of 2 site-specific System Managers for the Pyxis ES Station b. Only designated staff delineated in User Permissions have access to secured medications, with limited access to controlled substances (narcotics) c. A Medication Distribution Log shall be used for distribution of medication by non-licensed and licensed staff d. Agency verifies medication using one of three methods listed in the FNYFS Policies & Procedures Manual e. When nurse is on duty, medication processes are ALWAYS conducted by the nurse or when the nurse is not onsite, then the designated staff who has been trained by a licensed Registered Nurse provides the medication. f. Agency does not accept youth currently prescribed injectable medications, except for epi-pens h. Non-licensed staff have received training in the use of epinephrine auto-injectors provided by a registered nurse	**Compliance**	The agency maintains three (3) site specific system managers for the Pyxis ES Station. Only designated staff have access to secured medications. A Medication Distribution log is maintained by all staff. The agency verifies medication using one of the three methods listed in the FYFNS Policies and Procedures Manual. Nurse always conducts medication distribution when on-site. The agency does not accept injectable medications with the exception of epi-pens. Non-licensed staff have received training in the use of epinephrine auto-injectors provided by a registered nurse.	

The medication distribution log documentation includes: a. the time of medication administration b. evidence of youth initials that the dosage was given c. evidence of staff initials that the dosage was given	**Compliance**	A review of medication logs indicated the following information: Youth name, Youth DOB, Youth Allergies, medication name, Pharmacy name, RX number, Date received, expiration date, MD name, Reason for medication, youth signature, instructions on label, time medication should be given, med form completed by and date, reviewed by and date. DISTRIBUTION SECTION contains: date, time, start count, amt given, end count, staff initials, youth initials. INVENTORY SECTION contains: date, time, count, staff initials. MEDICATION IDENTIFIERS: initials, signature, and printed name of staff who administered medication. MED AUDITS: Date, time, signature, and printed name of RN when audits completed.	
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**	A review of medication logs indicated that staff provide youth with medications within one hour of the schedules time of delivery as ordered by the medication. Documentation and CCC reports indicated when they do not occur within timeframe.	
During the review period, there were no instances where youth missed their medication due to failure to open the pyxis machine.	**Compliance**	There were no instances where youth missed their medication 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.	**Compliance**	The RN on-site provides the required training for medicine management. There were no instances during the annual compliance review period where a staff member conducted three errors within a one year period. The RN is aware that if this happens certification is suspended until an in-person medication administration training takes place.	

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**	A perpetual inventory with running balances as well as a shift-to-shift count is conducted for controlled substances with a witness and documented. Over the counter medication are inventories weekly. Sharps are secured, counted, and documented weekly.	
There are monthly reviews of the Pyxis reports to monitor medication management practice.	**Compliance**	The RN conducts monthly reviews of the Pyxis reports to monitor medication management practices .	
Medication discrepancies are cleared after each shift.	**Compliance**	Medication discrepancies are cleared after each shift as indicated by the nurse.	
Additional Comments: **There are no additional comments for this indicator.**			
4.04 - Medical/Mental Health Alert Process			**Satisfactory with Exception**
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 numbered ACH-HH-HC-007 Medical/ Mental Health Issues Alert , last reviewed March 6, 2023 by the CEO.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: Three **Total number of Closed Files: Three** **Staff Position(s) Interviewed: RN** **Type of Documentation(s) Reviewed: Cover sheet with picture/alerts, Anchorage Home Screening Form, Hidle House Shelter Intake & Assessment Form- Youth Specialist, Assessment of Suicide Assessment, Suicide/Self-harm Plan, Anchorage Children's Home Progress Notes, Hidle House Clinical Staffing, Hidle House Medication Receipt Form, Medication Oversight and Inventory, Anchorage Children's Home Health Screening form** **Describe any Observations: File review**			
Youth with a medical, mental health, or food allergy was appropriately placed on the program's alert system	**Compliance**	Six youth files reviewed and all six were applicable to be placed on the program's alert system. All six were placed on the alert system as required.	
Alert system includes precautions concerning prescribed medications, medical/mental health conditions	**Compliance**	The alert system was color coded with three colors and covered the medication, medical, and mental health conditions as required.	
Staff are provided sufficient training, information and instructions to recognize/respond to the need for emergency care for medical/mental health problems	**Compliance**	All staff are provided sufficient training, information, and instructions to recognize/report to the need for emergency care for medical mental health problems.	

A medical and mental health alert system is in place that ensures information concerning a youth's medical condition, allergies, common side effects of prescribed medications, foods and medications that are contraindicated, or other pertinent mental health treatment information, is communicated to all staff	**Exception**	Five of the six youth files were properly labeled with alerts. The open files alerts corresponded with the alerts board in the specialist office.	One open file did not have the alerts properly identified either inside or outside the file. It was corrected on-site, by a staff member, prior to the end of the on-site review.
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 numbered ACH-HH-EM-008 Emergency Care, last reviewed March 6, 2023 by the CEO.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: Zero **Total number of Closed Files: Zero** **Staff Position(s) Interviewed: RN** **Type of Documentation(s) Reviewed: Map containing locations of all first aid kits** **Describe any Observations: During a tour of the facility I observed the knife for life and wire cutters locked in the Specialist Office. I saw most of the first aid kits. I was able to see all the first aid kits on the second day with a tour conducted by RN. Another peer reviewer observed the knife for life, wire cutters, and first aid kits in both vehicles.**			
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 all Central Communications Center (CCC) reports, incident reports, and episodic log indicated no off-site emergency medical or dental care was conducted during the annual compliance review period or back to the date of the last review. The program does maintain a log and policy indicates that an incident report will be submitted for the medical or dental care and youth's return, verification receipt of medical clearance via discharge instructions will be put in the youth's file.	
All staff are trained on emergency medical procedures	**Compliance**	All staff completed Hidle Emergency and Safety Procedures, Emergency Plan and Safety and Security Issues, prior to working on the floor. All this training is documented on Hidle House Direct Care Training Plan Certificate of Completion and signed off by the employee and supervisor.	
The program has a Knife-for-life and wire cutters accessible to staff in a secure location(s)	**Compliance**	The agency has Knife-for-life and wire cutters located in specialist office and each of the two vehicles. First aid kits are located in the nurse office, kitchen, counseling room, specialist office, and each of the two vehicles.	
Additional Comments: **There are no additional comments for this indicator.**			