Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Center for Family and Child Enrichment - Miami
Community Counseling Program

February 28, 2024

Compliance Monitoring Services Provided by

CINS/FINS Rating Profile

Standard 1: Management Accountability

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

Percent of indicators rated Satisfactory: 71 %
Percent of indicators rated Limited: 28.57 %
Percent of indicators rated Failed: 0 %

Standard 2: Intervention and Case Management

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

Percent of indicators rated Satisfactory: 44.44 %
Percent of indicators rated Limited: 44.44 %
Percent of indicators rated Failed: 11.11 %

Standard 4: Mental Health/Health Services

Indicator	Rating
4.02 Suicide Prevention	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: 56.25%

Percent of Indicators rated Limited: 37.5%

Percent of Indicator rated Failed: 6.25%

Rating Definitions

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

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

Reviewers

Members

Marcia Tavares - Lead Reviewer Consultant-Forefront LLC/Florida Network of Youth and Family Services
Paula Friedrich – Regional Monitor, Department of Juvenile Justice
Nathaly Milla – Florida Keys Children Shelter

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		Nurse – Full time
X	Chief Financial Officer		Counselor Non-Licensed		Nurse – Part time
X	Chief Operating Officer		Advocate	3	# Case Managers
	Executive Director		Direct – Care Full time		# Program Supervisors
X	Program Director		Direct – Part time		# Food Service Personnel
	Program Manager		Direct – Care On-Call		# Healthcare Staff
	Program Coordinator		Intern		# Maintenance Personnel
	Clinical Director		Volunteer		# Other (listed by title): ___
	Counselor Licensed	X	Human Resources		

Documents Reviewed

	Accreditation Reports	X	Table of Organization		Visitation Logs
X	Affidavit of Good Moral Character		Fire Prevention Plan	X	Youth Handbook
X	CCC Reports	X	Grievance Process/Records		# Health Records
	Logbooks		Key Control Log		# MH/SA Records
	Continuity of Operation Plan		Fire Drill Log	1	# Personnel /Volunteer Records
X	Contract Monitoring Reports		Medical and Mental Health Alerts	6	# Training Records
	Contract Scope of Services		Precautionary Observation Logs	5	# Youth Records (Closed)
X	Egress Plans		Program Schedules	5	# Youth Records (Open)
	Fire Inspection Report	X	List of Supplemental Contracts		# Other: ___
	Exposure Control Plan		Vehicle Inspection Reports		

Observations During Review

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

Surveys

0	# of Youth	0	# 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

Center for Family and Child Enrichment (CFCE) is a non-profit community-based corporation contracted with the Florida Network of Youth and Family Services (Florida Network) to operate Children in Need of Services/Families in Need of Services (CINS/FINS) non-residential services to youth and families in Miami-Dade County. The program is located at 1825 NW 167 Street, Miami Gardens, Florida. Funding through CINS/FINS allows the agency to serve both male and female youth up to seventeen years old who are locked out, runaway, ungovernable and/or truant, homeless, abuse, neglected, or at-risk. The agency also provides services to special populations who meet the criteria for Family and Youth Respite Aftercare Services (FYRAC) and is also contracted to provide SNAP U12 and SNAP in School and Communities programs. CFCE is currently accredited by the Council of Accreditation (COA) effective through 6/30/2026. The Council on Accreditation (COA) partners with human service organizations worldwide to improve service delivery outcomes by developing, applying, and promoting accreditation standards.

The following programmatic updates were provided by the agency:

Staffing

The agency reported no changes in management structure or staffing since the last QI review. Staffing for programs funded by the Florida Network are as follows: CINS/FINS- five Case Manager positions; and SNAP - one SNAP Coordinator, one SNAP Counselor, and two part time SNAP group facilitators. Credentials of staff is a minimum Bachelor's degree education preferably in behavioral science discipline.

Program updates

CFCE CINS/FINS programs are located at 1825 N.W. 167 Street, Miami Gardens, Florida and provide services in Miami-Dade County. There are no new program initiatives since the last QI review. The program's service models include in-home, office, and in school services through SNAP groups. Files are maintained in file folders but some forms are completed electronically. Other non-CINS activities that complement CINS program are Behavioral Health; Primary (Medical) Care; and PEAK (Providing Educational Alternatives for Kids) Afterschool and summer camp programs. Outreach activities included a back to school event in August that provided school supplies to youth, distribution of 75 turkey boxes during the annual Thanksgiving event, and a toy drive in December. During the Christmas holiday, CINS/FINS and SNAP youth are presented toys and gift that are generously donated by the Bachelor Foundation.

Facility

The agency has completed renovations of the building which started over three years ago and recently completed repairs/re-paving of the parking lot. Planned facility updates for the future will include resurfacing and painting the building exterior (26,000 sq. Ft.) and build-out/refurbishing of the behavioral health office suite, inclusive of new cubicles and treatment rooms. The agency plans to relocate child welfare offices in late 2024 and considering CINS/SNAP co-location.

Funding/Finance

CFCE hosted its inaugural "Mayor's Ball" for City of Miami Gardens with proceeds benefitting CFCE. Additional funding allows CFCE to continue providing COVID testing and vaccinations in the community. New assets acquired include a mobile health clinic for use in providing primary health and dental care in the community.

Governance and Community
Engagements within the past year include new mental health agreement with Citrus Health Network as behavioral health provider in Preferred Provider Network. In addition, the agency added two new board members in November 2023 and January, 2024

Narrative Summary
CFCE is under the leadership of a Board of Directors, CEO, and Chief Officers for: Medical/Pediatrics, Behavioral Health, Program Operations, Finance, and Administrative/Compliance. The CINS/FINS program consists of a program director, administrative assistant, and five fulltime case management staff. The case manager's duties include intake and assessment, development of case plans, providing case management services, and linking youth and families to community services. Through the screening and intake process, trained staff can assess youth and families for eligibility of services. Case management, substance abuse prevention education, and parenting group education are available as well. Aftercare planning includes referral of youth and families to other agency programs or to external community resources. There were two current vacancies for a CINS/FINS case manager and Administrative Assistant at the time of the QI visit.

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 with Exception**, Indicator 1.02 Provision of an Abuse Free Environment was rated **Satisfactory,** Indicator 1.03 Incident Reporting was rated **Satisfactory**, Indicator 1.04 Training Requirements was rated **Limited**, Indicator 1.05 Analyzing and Reporting Information was rated **Satisfactory,** Indicator 1.06 Client Transportation was rated **Not Applicable**, and Indicator 1.07 Outreach Services was rated **Limited.**

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

Standard 3: There are seven indicators for Standard 3, Indicators 3.01-3.07, but they are all Not Applicable for Community Counseling Programs.

Standard 4: There are five indicators for Standard 4. Four of the indicators are Not Applicable for Community Counseling Programs; Indicator 4.01, 4.03, 4.04 and 4.05. Indicator 4.02 was rated **Satisfactory with Exception.**

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

Standard 1:
Indicator 1.04 - Limited
SNAP staff indicated they participated in SNAP groups beginning in April or May 2023; however, the program does not maintain documentation to indicate which staff facilitated each SNAP group. Therefore, it could not be determined if the staff completed the SNAP certification training prior to conducting SNAP group.

Two in-service staff did not complete all mandatory training required annually. One staff completed all required in-service trainings, except for PREA Part 2, which was due by May 17, 2023. Another staff, a contracted staff working in the program since 2018, did not complete any of the required in-service trainings. An interview with the program administrator indicated they were not aware contracted staff were subject to the training requirements.

The training log currently used by the program is cumulative rather than annually focused and does not indicate which trainings are due to be completed prior to each staff's anniversary date.

Indicator 1.07 - Limited
Provider staff did not attend all Circuit 17 CAB meetings held in the past six months. Attendance was verified for one of the six meetings. A second meeting was listed on the outreach log but participation could not be verified.

The program documents outreach activities in NetMIS; however, there is no supporting documentation to verify staff participation in those events.

Standard 2:
Indicator 2.01 - Limited
Seven out of the ten files reviewed were missing the suicide risk screening questions and did not include the screening during intake. The three files, which included risk screening questions failed to document question number three.

Indicator 2.03 - Failed
None of the service plans were individualized or were based on needs identified from the Nirvana Assessments.

None of the service plans were individualized and were based on the initial screening, presenting problems, or responses found on the Nirvana Assessments. Service types, target dates, and/or referrals were unclear or non-existent.

Five closed files reviewed did not have ninety-day follow ups even though discharge for all clients were past the ninety days.

Indicator 2.04 - Limited
With the exception of one record, the case records did not include referral for services in accordance with clients' needs. For all ten files reviewed, no case notes were found for any coordination of service plan implementation. There were no notes found for any clients' progress based on the goals established. Records reviewed do not indicate the case managers met with youth to monitor progress after intake took place or made contact with school officials to assess improvement with school attendance and grades. Contact with parent for service plan review and case termination was typically noted to occur via telephone.

Indicator 2.05 - Limited
There was no indication services were provided to youth or families after initial intake process except for notes from case managers about their progress.

Reviewer found no documentation of service coordination or services provided after intake in any of the files reviewed.

Indicator 2.09 Limited
Pre and Post TRF forms were not completed in the two closed records and no documentation was included in the file to explain why they were not completed.

There was no evidence of the SNAP Boys/SNAP Girls Child Group Evaluation Form located in the two applicable closed files.

There was no evidence of the SNAP Boys/SNAP Girls Parent Group Evaluation Form located in the two closed files.

None of the two SNAP groups completed met for 13 sessions. One of the groups met for 11 sessions and the other group met for 12 sessions.

No evidence of a completed "Class Goal" was documented for the two classes reviewed.

Neither of the two SNAP groups provided evidence the pre/post MoCE was completed for the class.

No evidence of completed pre and post evaluation documents were observed for the two classes reviewed.

No evidence of the fidelity adherence checklist was observed for either of two classes reviewed.

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 with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 1.01		**NO** Policy 5.03, Background Screening, needs to be revised to reflect re-screening from the date of last screening, not every 5 years, and re-employment of employees who have had a break in service who are in good standing, may be reemployed without background screening if the break is less than 90 days, not 180 days as stated in the agency's policy and procedure. The provider has a policy and procedure titled Background Screening that was last revised 7/1/2023 by the program 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 New Hire Employee/Intern/Volunteer Files: No new hires **Total number of 5 Year Re-screen Employee Files: 1 re-screened employee file** **Staff Position(s) Interviewed (No Staff Names): Human Resources (HR)** **Type of Documentation(s) Reviewed: Staff roster, Department of Juvenile Justice Background Screening results, Annual Affidavit of Compliance with Level 2 Screening Standards**			
All positions providing direct services to youth has successfully passed pre-employment suitability assessment on the initial attempt.	**No eligible items for review**	The provider has not hired any new staff since the last onsite QI visit.	
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**	No new staff was hired.	
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**	No new staff was hired.	
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.)*	**No eligible items for review**	No new staff was hired.	

Five-year re-screening is completed every 5 years from the date of last screening.	**Compliance**	The program had one staff who met the criteria for 5-year re-screening. The staff was re-screened on time and had valid retained prints in the clearinghouse.	
Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?	**Exception**	The program submitted the Annual Affidavit of Compliance with Level 2 Screening Standards to the Background Screening unit via email on 2/15/2024.	Annual Affidavit of Compliance with Level 2 Screening Standard was submitted late on 2/15/24, after the January 31st deadline.
Proof of E-Verify for all new employees obtained from the Department of Homeland Security	**No eligible items for review**	No new staff was hired.	
Additional Comments: **There are no additional comments for this indicator.**			

1.02: Provision of an Abuse Free Environment		**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 1.02	**YES** If NO, explain here: The provider has the required policy and procedure, 5.2 Abuse Reporting, that was last revised 7/1/23 by the program 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): Program director
Type of Documentation(s) Reviewed: program handbook, abuse call log, grievance log, code of conduct,
Describe any Observations: abuse hotline postings

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's policy #139 addresses standards of conduct and ethics for staff which prohibits threatening, intimidating, coercing, or interfering with the performance of other staff. Each new employee is provided the standard of conduct at the time of hire. Staff are required to review the document and sign. and a binder to maintain grievances. A review of the binders indicated there were no reports of abuse or grievances filed in the last six months. Tour of the program offices revealed the Abuse Hotline and CCC telephone numbers are visibly posted.	
The agency has a process in place for reporting and documenting child abuse hotline calls.	**Compliance**	The program's policy requires youth and staff to have unimpeded access in order to place calls to the Florida Abuse Hotline to report any suspected or alleged abuse/neglect. Procedures indicate that any child abuse occurring at the facility is to be reported to the Florida Abuse Hotline and then to the DJJ Central Communications Center. However, any abuse which occurred at the youth's home will only be reported to the Florida Abuse Hotline. No abuse hotline calls were reported during the annual review period.	

Youth were informed of the Abuse and Contact Number	**Compliance**	Youth and parent are made aware of the Abuse Hotline, grievance, and CCC telephone numbers at the time of orientation by way of the program handbook.	
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 maintains a written policy and procedures, Policy #129, to address complaints and grievances which are to be immediately forwarded to the quality improvement director for investigation.	
Shelter only: Grievances are maintained on file at minimum for 1 year.	**Not Applicable**	Indicator is applicable to residential programs only. CFCE is a community counseling program.	
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.	**Not Applicable**	Indicator is applicable to residential programs only. CFCE is a community counseling program.	
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.	**Not Applicable**	Indicator is applicable to residential programs only. CFCE is a community counseling program.	
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.	**Not Applicable**	Indicator is applicable to residential programs only. CFCE is a community counseling program.	

1.03: Incident Reporting			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 1.03		YES If NO, explain here: The provider has the required policy and procedures, 5.01 Incident Reporting, that was last revised 7/1/2023 by the program 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): program director **Type of Documentation(s) Reviewed CENTRAL COMMUNICATIONS CENTER (CCC) Incidents Detail Report and agency Internal Reports** **Describe any Observations: CCC number posted in facility**			
During the past 6 months, the program notified the Department's CCC (Central Communication Center) no later than two hours after any reportable incident occurred or within two hours of the program learning of the incident	**No eligible items for review**	The program had no incidents reported to the Central Communications Center (CCC) during the annual compliance review period. The program's policy and procedures require adherence to the Department's requirements including reporting to the CCC within two hours of each incident. The program's policy calls for incidents to be documented in the program logs and on incident reporting forms.	
The program completes follow-up communication tasks/special instructions as required by the CCC	**No eligible items for review**	The program had no incidents reported to the Central Communications Center (CCC) during the annual compliance review period.	
Agency internal incidents are documented on incident reporting forms and all CCC reportable incidents were consistently reported to CCC as required.	**No eligible items for review**	The program had no incidents reported to the Central Communications Center (CCC) during the annual compliance review period.	
Incidents are documented in the program logs and on incident reporting forms	**No eligible items for review**	The program had no incidents reported to the Central Communications Center (CCC) during the annual compliance review period.	
All incident reports are reviewed and signed by program supervisors/ directors	**No eligible items for review**	The program had no incidents reported to the Central Communications Center (CCC) during the annual compliance review period.	

1.04: Training Requirements (*Staff receives training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions*)			**Limited**
Provider has a written policy and procedure that meets the requirement for Indicator 1.04		**YES** If NO, explain here: The provider has the required policy and procedures, 6.04 Training, that was last revised 4/20/2023 by the program 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 New Hire Staff Files: 1 **Total number of Annual In-Service Staff Files: 5** **Annual Training Plan Timeframe** (*Program timeframe for annual trainings*)**:staff's anniversary date** **Staff Position(s) Interviewed (No Staff Names): program manager, HR** **Type of Documentation(s) Reviewed: Staff training records, annual training plan**			
First Year Direct Care Staff			
All direct care staff have completed new hire pre-service training requirements for safety and supervision as required.	**Compliance**	The provider has one new staff hired 2/27/2023 who is a SNAP facilitator. The staff completed all the required pre-service training prior to working independently with youth.	
All staff completed the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days from date of hire.	**Compliance**	The new hire staff completed the requirements for the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days from date of hire.	
All direct care CINS/FINS staff (full time, part time, or on-call) demonstrated a minimum of 80 hours of training or more for the first full year of employment.	**Compliance**	Reviewed documentation indicated the one new staff completed 118.5 hours of training within the first year that ended 2/27/2024.	
All staff receives all mandatory training during the first 90 days of employment from date of hire.	**Exception**	The new first year staff completed all mandatory trainings during the first 90 days of employment. It was observed that the SNAP Certification training was not completed until 8/1/2023 and is required prior to facilitating the SNAP model.	SNAP staff indicated they participated in SNAP groups beginning in April or May 2023; however, the program does not maintain documentation to indicate which staff facilitated each SNAP group. Therefore, it could not be determined if the staff completed the SNAP certification training prior to conducting SNAP group.

Staff Required to Complete Data Entry for NIRVANA or access the Florida Department of Juvenile Justice Information System (JJIS)			
Any designated staff that is responsible for entering NIRVANA or ensuring accurate and complete data entry in the Florida Department of Juvenile Justice Information System (JJIS) have completed all of the required trainings.	**Compliance**	One applicable staff member responsible for entering NIRVANA completed the NIRVANA.	
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*	**Not Applicable**	The new hire SNAP staff does not participate in case staffing and CINS petition.	
Non-licensed Mental Health Clinical Shelter Staff (within first year of employment)			
Documentation of non-licensed mental health clinical staff person's training in Assessment of Suicide Risk form or written confirmation by a licensed mental health professional of training (includes date, signature and license number of the licensed mental health professional supervisor).	**Not Applicable**	CFCE is not a residential provider.	
In-Service Direct Care Staff			
Direct care staff completes 24 hours of mandatory refresher Florida Network, SkillPro, and job-related training annually *(40 hours if the program has a DCF child caring license).*	**Exception**	Five staff in-service training records were reviewed. Three of five records documented the required in-service trainings were completed by the staff's anniversary date in 2023, as required and two were not.	Two in-service staff did not complete all mandatory training required annually. One staff completed all required in-service trainings, except for PREA Part 2, which was due by May 17, 2023. Another staff, a contracted staff working in the program since 2018, did not complete any of the required in-service trainings. An interview with the program administrator indicated they were not aware contracted staff were subject to the training requirements.
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 outlines all of the mandatory training topics, including pre-service and in-service. The training log in each file included shows all required and completed trainings.	
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 program administrator manages all staff training for the program and a training file is maintained for each staff.	

The program maintains an individual training file or employee file AND a FLN Training Log (or similar document that includes all requirements) for each staff, which includes an annual employee training hours tracking form and related documentation, such as electronic record/transcript, training certificates, sign-in sheets, and agendas for each training attended.	**Exception**	Trainings were documented in the individual staff training record and captured on the FLN Training Log. Trainings completed in SkillPro are reflected on each staff's Individual SkillPro Training Report. The training log is utilized to document completed trainings.	The training log currently used by the program is cumulative rather than annually focused and does not indicate which trainings are due to be completed prior to each staff's anniversary date.
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		**NO** If NO, explain here: Policy and procedure 1.05 lists the requirements of the indicator but does not describe activities or procedures conducted to collect and review information required. The provider has a policy, 1.05 Analyzing and Reporting Information, that lists the requirement of the indicator. The policy was last revised 9/23/2023 by the program 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): program director **Type of Documentation(s) Reviewed: CFCE CQI Plan FY2023-2024, CQI Policy and Procedures, consumer satisfaction surveys, board of director meeting minutes, staff meeting agendas/minutes, and NetMIS data reports.**			
Case record review reports demonstrate reviews are conducted quarterly, at a minimum	**Compliance**	The cases are reviewed peer-to-peer with the case managers on a monthly basis during staff meetings. The program supervisor also reviews individual case files at intakes and closing of files. A review of staff meeting minutes held August 2023 through February 2024 demonstrated a total of 21 cases were reviewed.	
The program conducts reviews of incidents, accidents, and grievances quarterly, at a minimum	**Compliance**	Incident, accidents, and grievances are tracked by the program director and reported to the Risk Management committee. Risk Management and Safety Committee meetings are held separately by the provider on a monthly basis. Data from the committees pertaining to incidents, accidents, and grievances/complaints is presented at the Continuous Quality Improvement (CQI) Joint Committee meetings. No incidents, accidents, or grievances were reported by the program for the review period.	
The program conducts an annual review of customer satisfaction data	**Compliance**	Client satisfaction surveys are entered into Netmis each month by program staff and analyzed at least annually. The program compiled it's annual satisfaction survey report on 2/9/24. Reviewed minutes for staff meeting held 2/26/24 shows the survey results were discussed with program staff.	

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**	EOM reports are emailed to the CEO and program director. The program reviews outcomes data submitted via the Florida Network's (FN) Report cards monthly at the CINS/FINS staff meetings held monthly. Agendas and sign in sheets are maintained for staff meetings.	
The program has a process in place to review and improve accuracy of data entry & collection	**Compliance**	The program's administrative assistant is responsible for verifying timely submission and accuracy of program data that is captured in NetMIS. The administrative assistant communicates with program staff to reconcile any discrepancies and maintains communication with the Florida Network to ensure contractual requirements are met.	
There is documentation that findings are regularly reviewed by management and communicated to staff and stakeholders.	**Compliance**	The agency's joint CQI committee is represented by all departments and programs within CFCE and meets on a monthly basis. Information reviewed at the joint CQI committee meetings include: peer review of records; incidents, accidents, grievances; consumer satisfaction information; outcome and performance information; safe and risk management issues; and operations and management data. Documentation support monthly meetings are held as evidenced by meeting agendas and minutes. All findings and recommendations for corrective actions are reported to the joint CQI committee.	
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**	The CEO reports on CINS/FINS performance via CQI reports at Board of Directors meetings. Evidence of monthly Board meetings held between August 2023 and January 2024 supported CQI reports were presented at the board meetings.	
There is evidence that strengths and weaknesses are identified, improvements are implemented or modified, and staff are informed and involved throughout the process.	**Compliance**	CFCE has designated quality assurance staff to oversee the multiple data sources to assess service delivery. Quality assurance and improvement activities that are monitored include performance improvement plans and corrective action plans. Findings and recommendations are complied and presented quarterly to the joint CQI committee.	
Additional Comments: **There are no additional comments for this indicator.**			
1.06: Client Transportation			**Not Applicable**
Provider has a written policy and procedure that meets the requirement for Indicator 1.06		**N/A** If NO, explain here: CFCE prohibits staff from transporting youth in personal or agency vehicles.	

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 director**

Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	**Not Applicable**	CFCE prohibits staff from transporting youth in personal or agency vehicles.	
Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	**Not Applicable**	CFCE prohibits staff from transporting youth in personal or agency vehicles.	
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	**Not Applicable**	CFCE prohibits staff from transporting youth in personal or agency vehicles.	
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	**Not Applicable**	CFCE prohibits staff from transporting youth in personal or agency vehicles.	
The 3rd party is an approved volunteer, intern, agency staff, or other youth	**Not Applicable**	CFCE prohibits staff from transporting youth in personal or agency vehicles.	
The agency demonstrated evidence via logbook or other written verification that supervisor approval was obtained prior to all single youth transports.	**Not Applicable**	CFCE prohibits staff from transporting youth in personal or agency vehicles.	
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.	**Not Applicable**	CFCE prohibits staff from transporting youth in personal or agency vehicles.	
Additional Comments: **There are no additional comments for this indicator.**			
1.07 - Outreach Services			**Limited**
Provider has a written policy and procedure that meets the requirement for Indicator 1.07		**YES** If NO, explain here: The provider has the required policy and procedure, 1.01 Outreach services, that was last revised 7/20/2023 by the program 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): program director
Type of Documentation(s) Reviewed: DJJ Meeting Agenda, partnership agreements, NetMIS Outreach report

The program has a lead staff member designated to participate in local DJJ board, Circuit and Council meetings with evidence that includes minutes of the event or other verification of staff participation.	**Exception**	An interview with the program director and review of the program's organizational chart indicated there is not one staff position responsible for outreach activities, including the required participation with the Circuit Juvenile Justice Advisory Board (CAB), but rather completion of the required outreach activities was stated to be the responsibility of all program staff. Circuit 17 CAB meetings were held monthly during the past six months. Reviewed documentation indicated the program administrator participated at one CAB meeting on July 14, 2023. A second meeting attendance in November 2023 was listed on the outreach log but proof of attendance was not presented.	Provider staff did not attend all Circuit 17 CAB meetings held in the past six months. Attendance was verified for one of the six meetings. A second meeting was listed on the outreach log but participation could not be verified.
The program maintains written agreements with other community partners which include services provided and a comprehensive referral process.	**Compliance**	The program maintains a binder which contains multiple agreements with other community partners to ensure a comprehensive referral process.	
The program will maintain documentation of outreach activities and enter into NetMIS the title, date, duration (hours), zip code, location description, estimated number of people reached, modality, target audience and topic.	**Exception**	The program participated in a recruitment fair and consortium to distribute materials to approximately 100 people in September 2023. Additional outreach activities entered into the NetMIS system included an individual meeting at an elementary school, a CAB meeting in November 2023, and participation in a community presentation by U Turn Youth Consulting in December 2023; however, there was no documentation to verify staff participation in those events. SNAP program activities, which is a separately contracted program, were also entered into NETMIS as outreach activities.	The program documents outreach activities in NetMIS; however, there is no supporting documentation to verify staff participation in those events.
The program has designated staff that conducts outreach which is defined in their job description.	**Compliance**	Per interview with the program director, completion of the required outreach activities is the responsibility of all program staff. Multiple staff was observed conducting outreach on the outreach log.	

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

2.01 - Screening and Intake	**Limited**
Provider has a written policy and procedure that meets the requirement for Indicator 2.01	**YES** If NO, explain here: The provider has the required policy and procedure, 2.01 Screening for CINS/FINS Eligibility, that was last revised 7/20/2023 by the program 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: 5
Total number of Closed (Residential & Community) Files:5
Staff Position(s) Interviewed *(No Staff Names)* **: Community counseling case managers**
Type of Documentation(s) Reviewed: Youth records

Shelter youth: Eligibility screening form is completed immediately for all shelter placement inquiries.	**Not Applicable**	CFCE is not a residential provider.	
Community counseling: Eligibility screening form is completed within 3 business days of referral by a trained staff using the Florida Network screening form.	**Compliance**	Reviewer observed all ten files reviewed included eligibility forms that were completed within the first referral day. Also, all screenings were completed by trained staff and the Florida Network screening form was used for all ten files reviewed.	
There is evidence all referrals for service is screened for eligibility and is logged in NetMIS within 72 hours of screening completion.	**Compliance**	All ten files reviewed documented completion of the screening within 72 hours of referral.	
Youth and parents/guardians receive the following in writing: a. Available service options b. Rights and responsibilities of youth and parents/guardians	**Compliance**	All files reviewed had forms which explained services provided as well as rights and responsibilities to youth and legal guardians.	
The following is also available to the youth and parents/guardians: a. Possible actions occurring through involvement with CINS/FINS services (case staffing committee, CINS petition, CINS adjudication) b. Grievance procedures	**Compliance**	CINS/FINS Services (Case staffing Committee, CINS petition, CINS adjudication) and Grievance Procedures are available services, which were explained to youth and legal guardians during intake.	
During intake, all youth were screened for suicidality and correctly assessed as required if needed.	**Exception**	All ten files were reviewed to determine if youth were screened for suicidality using the suicide screening questions included on the CINS/FINS intake form. Only three of the ten files included the risk screening questions; however, one of the suicide risk screening questions was missing in the three files. Due to missing or incomplete suicide screening questions, there is no evidence youth were adequately screened for suicide.	Seven out of the ten files reviewed were missing the suicide risk screening questions and did not include the screening during intake. The three files, which included risk screening questions failed to document question number three.
Additional Comments: **There are no additional comments for this indicator.**			
2.02 - Needs Assessment			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 2.02		**YES** If NO, explain here: The provider has the required policy and procedures, 3.03 Nirvana-Network Inventor of Risk, Victories and Needs Assessment, that was last revised on 07/01/2023 by the program 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: 5 **Total number of Closed (Residential & Community) Files: 5** **Staff Position(s) Interviewed** *(No Staff Names)*: **Community counseling case managers** **Type of Documentation(s) Reviewed: Youth records**			
Shelter Youth: NIRVANA is initiated within 72 hours of admission	**Not Applicable**	CFCE is not a residential provider.	

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**	Reviewer found all ten files included a Nirvana assessment that was completed within a day of initial screening and all Nirvana Assessments were done face-to-face.	
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**	All Nirvana assessments found in the files reviewed had a supervisor's 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.	**Not Applicable**	CFCE is not a residential provider.	
A NIRVANA Post-Assessment is completed at discharge for all youth who have a length of stay that is greater than 30 days.	**Compliance**	All five closed records reviewed contained a post Nirvana-Assessment completed by the assigned case manager.	
A NIRVANA Re-Assessment is completed every 90 days excluding files for youth receiving SNAP services.	**Exception**	Five closed records of the ten youth records reviewed had a length of stay (LOS) over 90 days.	No documentation of Nirvana Re-Assessments were found in any of the five closed files reviewed with LOS over 90 days.
All files include the interview guide and/or printed NIRVANA.	**Compliance**	All ten files reviewed had printed Nirvana Assessment.	

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

2.03 - Case/Service Plan		**Failed**
Provider has a written policy and procedure that meets the requirement for Indicator 2.03	**YES** If NO, explain here: The provider has the required policy and procedure, 4.03 Case/Service Plan, that was last revised on 07/01/2023 by the program 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: 5
Total number of Closed (Residential & Community) Files:5
Staff Position(s) Interviewed *(No Staff Names)* **: Community counseling case managers**
Type of Documentation(s) Reviewed: youth records

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**	All ten records reviewed contained service plans that appeared to be identical and were not based on information gathered during the intake and Nirvana. Nirvana responses from all youth records reviewed were not used to create service plans. Although most files reviewed had truancy problems, the service plans did not indicate other problems identified from the Nirvana assessment for example, low GPA, peer problems, defiant behavior at home.	None of the service plans were individualized or were based on needs identified from the Nirvana Assessments.

Case/Service plan is developed within 7 working days of NIRVANA	**Compliance**	All service plans in the youth records were developed within the first day of completion of the Nirvana Assessment.	
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**	The service plans contained in the ten records reviewed did not include all required elements of the indicator. All of the plans appeared similar despite youth having different presenting problems. All ten plans included person(s) responsible, all required signatures, and date the plan was initiated.	None of the service plans were individualized and were based on the initial screening, presenting problems, or responses found on the Nirvana Assessments. Service types, target dates, and/or referrals were unclear or non-existent.
Case/service plans are reviewed for progress/revised by counselor and parent (if available) every 30 days for the first three months and every 6 months after	**Exception**	Two of the ten service plans were not applicable for review as the case was opened for less than 30 days. Three of the applicable eight plans were reviewed timely for progress.	Five closed files reviewed did not have ninety-day follow ups even though discharge for all clients were past the ninety days.
Additional Comments: **There are no additional comments for this indicator.**			

2.04 - Case Management and Service Delivery		**Limited**
Provider has a written policy and procedure that meets the requirement for Indicator 2.04	**YES** If NO, explain here: The provider has the required policy and procedures, 4.04 Case Management Services, that was last revised on 07/01/2023 by the program manager.	

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: 5
Total number of Closed (Residential & Community) Files: 5
Staff Position(s) Interviewed *(No Staff Names)*: **Community counseling case managers**
Type of Documentation(s) Reviewed: youth records

Counselor/Case Manager is assigned	**Compliance**	All 10 records reviewed included evidence of the case manager's name assigned to the case.	
The Counselor/Case Manager completes the following as applicable: 1. Establishes referral needs and coordinates referrals to services based upon the on-going assessment of the youth's/family's problems and needs 2. Coordinates service plan implementation 3. Monitors youth's/family's progress in services 4. Provides support for families 5. Monitoring 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	**Exception**	Referral for other services was observed in one of the ten records reviewed. None of the records reviewed indicated parental support was needed, or were referred for case staffing and had court involvement. Documentation supported the five closed records contained case termination notes and post discharge 30 and 60 day follow-ups were conducted.	With the exception of one record, the case records did not include referral for services in accordance with clients' needs. For all ten files reviewed, no case notes were found for any coordination of service plan implementation. There were no notes found for any clients' progress based on the goals established. Records reviewed do not indicate the case managers met with youth to monitor progress after intake took place or made contact with school officials to assess improvement with school attendance and grades. Contact with parent for service plan review and case termination was typically noted to occur via telephone.

The program maintains written agreements with other community partners that include services provided and a comprehensive referral process	Compliance	Program does maintain written agreements with multiple community partners that include services provided and a comprehensive referral process.	
Additional Comments: **There are no additional comments for this indicator.**			
2.05 - Counseling Services			Limited
Provider has a written policy and procedure that meets the requirement for Indicator 2.05		**YES** If NO, explain here: The provider has the required policy and procedures, 4.02 Community Counseling Services, that was last revised on 07/01/2023 by the program 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: 5 **Total number of Closed (Residential & Community) Files:5** **Staff Position(s) Interviewed (No Staff Names): Community counseling case managers** **Type of Documentation(s) Reviewed: youth records**			
Shelter Program			
Shelter programs provides individual and family counseling	Not Applicable	CFCE is not a residential provider.	
Group counseling sessions held a minimum of five days per week	Not Applicable	CFCE is not a residential provider.	
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	Not Applicable	CFCE is not a residential provider.	
Documentation of groups must include date and time, a list of participants, length of time, and topic.	Not Applicable	CFCE is not a residential provider.	
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.	Exception	All ten records reviewed included a service plan; however, none of the service plans addressed therapeutic intervention even though the needs were identified from the Nirvana Assessment.	There was no indication services were provided to youth or families after initial intake process except for notes from case managers about their progress.

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.	**Exception**	None of the records included counseling services as an intervention. Truancy prevention goals were stated but documentation of services provided to reduce truancy or improve grades were not evident.	Reviewer found no documentation of service coordination or services provided after intake in any of the files reviewed.
Maintain individual case files on all youth and adhere to all laws regarding confidentiality.	**Compliance**	Agency maintains individuals case files for each youth. Files adhere to laws regarding confidentiality.	
Case notes maintained for all counseling services provided and documents youth's progress.	**Exception**	Minimal case notes were documented in the ten files reviewed and were limited to intake, service plan reviews, termination, and follow ups.	No chronological notes were maintained for counseling services recommended or documentation of youth's progress.
	Compliance	The program has an internal process for clinical reviews of case records and staff performance. The program director reviews files at intake and discharge monthly. Nine of the 10 records reviewed were reviewed by the supervisor.	
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 records reviewed were provided a virtual intake.	

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

2.06 - Adjudication/Petition Process		Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 2.06	**YES** If NO, explain here: The provider has the required policy and procedure, 4.05 CINS Adjudication Services, that was last reviewed 7/1/2023 by the program 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)*: **program director**
Type of Documentation(s) Reviewed: Policy and procedure

Must include: a. DJJ rep. or CINS/FINS provider b. Local school district representative	**Compliance**	Per interview with the program director, there were no case staffing requests since the last QI review. Per the policy and procedure, the case staffing committee consists of a DJJ Representative, the CINS/FINS provider, and a school district representative.	

Other members may include: a. State Attorney's Office b. Others requested by youth/ family c. Substance abuse representative d. Law enforcement representative e. DCF representative f. Mental health representative	**Compliance**	Per the program's policy and procedure, other members of the committee may include: State Attorney's Office; others requested by youth/ family; substance abuse representative; law enforcement representative; DCF representative; and mental health representative.	
The program has an established case staffing committee, and has regular communication with committee members	**Compliance**	Per the provider's policy and procedures, the program has a case staffing committee who will be contacted within five working days if a request for case staffing is made	
The program has an internal procedure for the case staffing process, including a schedule for committee meetings	**Compliance**	Internal procedures for the case staffing are outlined in the provider's policy and procedures reviewed.	
The youth and family are provided a new or revised plan for services	**Not Applicable**	There were no case staffing requests since the last QI review.	
Written report is provided to the parent/guardian within 7 days of the case staffing meeting, outlining recommendations and reasons behind the recommendations	**Not Applicable**		
If applicable, the program works with the circuit court for judicial intervention for the youth/family	**Not Applicable**		
Case Manager/Counselor completes a review summary prior to the court hearing	**Not Applicable**		

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

2.07 - Youth Records		**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.07	**YES** If NO, explain here: The program has a written policy and procedures 2.07 that addresses the requirement for Youth Records, that was revised on 7/1/2023 by the program 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: 5
Total number of Closed (Residential & Community) Files:5
Staff Position(s) Interviewed (No Staff Names): Community counseling case managers
Type of Documentation(s) Reviewed: youth records
Observation: File transport container

All records are clearly marked 'confidential'.	**Compliance**	All 10 case files reviewed were marked confidential on the front and back of the folders	

All records are kept in a secure room or locked in a file cabinet that is marked "confidential"	**Compliance**	A tour of the facility was conducted to observe where the case files are kept. The files are kept in secure locked file cabinets with confidential marked on the file cabinet.	
When in transport, all records are locked in an opaque container marked "confidential"	**Compliance**	The program has a locked opaque containers marked "confidential" to use for the transportation of records.	
All records are maintained in a neat and orderly manner so that staff can quickly and easily access information	**Compliance**	All files are maintained in file folders in hard copy format. Records were observed to be clearly divided into sections which were consistent in their organization among community counseling files.	
Additional Comments: **There are no additional comments for this indicator.**			
2.08 - Specialized Additional Program Services			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.08		**YES** If NO, explain here: The provider has the required policy and procedures, 4.07 Specialized Additional Program Services, that was last reviewed 7/1/2023 by the program director.	
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: 0 **Total number of Closed Files: 0** **Staff Position(s) Interviewed** *(No Staff Names)* **: Program Director**			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	**Not Applicable**	The provider is not contracted to provide Intensive Case Management services.	
Youth receiving services were deemed chronically truant and/or runaway and require more intensive and lengthy services. The youth was determined to be eligible because they have gone through petition and/or case staffing and was in need of case management services.	**Not Applicable**		
Services for youth and family include: a. Two (2) direct contacts per month b. Two (2) collateral contacts per week c. Direct and collateral contacts not obtained must have documentation to support attempts made to obtain them. All reasonable attempts (at minimum of three) must be made to reach all contacts (direct and collateral) and documented in the case file and NetMIS.	**Not Applicable**		

Assessments include a. NIRVANA at intake b. NIRVANA Re-Assessment every 90 days c. Post NIRVANA at discharge as aligned with timeframe requirements	Not Applicable		
Service/case plan demonstrates a strength-based, trauma-informed focus	Not Applicable		
For any virtual services provided, there is written documentation in the youths' file as to why virtual contact is in the best interest of the youth and family	Not Applicable		
Family and Youth Respite Aftercare Services (FYRAC)			
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: 0 **Total number of Closed Files: 0** **Staff Position(s) Interviewed** *(No Staff Names)* **: Program Director**			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	No eligible items for review	The program has not served any youth who met the criteria for FYRAC in the last six months or since the last onsite QI review.	
Youth is referred by DJJ for a domestic violence arrest on a household member, and/or the youth is on probation regardless of adjudication status and at risk of violating.	No eligible items for review		
Agency has evidence that all FYRAC referrals have documented approval from the Florida Network office	No eligible items for review		
Intake and initial assessment sessions meets the following criteria: a. Services shall be documented through the signature of the youth and his/her parent/guardian as well as orientation to the program which is kept in the youths file. b. The initial assessment shall be face-to-face, in person or through virtual means, to include a gathering of all family history and demographic information, as well as the development of the service plan. c. For youth on probation, a copy of the youths Community Assessment Tool (CAT) to assist with development of the family service plan.	No eligible items for review		
Life Management Sessions meets the following criteria: a. Sessions are face-to-face, sixty (60) minutes in length and focus on strengthening the family unit b. Services are highly supportive, individualized, and flexible and require a "whole family" approach to dealing with the problems affecting the youth and family.	No eligible items for review		

Individual Sessions: a. The program conducted sessions with the youth and family to focus on work to engage the parties and identify strengths and needs of each member that help to improve family functioning. b. Issues to be covered through each session include but are not limited to: Identifying emotional triggers; body cues; healthy coping strategies through individual, group and family counseling; understanding the cycle of violence and the physical and emotional symptoms of anger; developing safety plans; and educating families on the legal process and rights.	**No eligible items for review**		
Group Sessions: a. Focus on the same issues as individual/family sessions with application to youth pulling on similar experiences with other group members with the overall goal of strengthening relationships and prevention of domestic violence. b. Shall be no more than eight (8) youth at one (1) time and shall be for a minimum of sixty (60) minutes per session	**No eligible items for review**		
There is evidence of completed 30 and/or 60 day follow-ups and is documented in NetMIS following case discharge.	**No eligible items for review**		
Youth and family participate in services for thirteen (13) sessions or ninety (90) consecutive days of services, or there is evidence in the youth's file that an extension is granted by DJJ circuit Probation staff	**No eligible items for review**		
Any service that is offered virtually, is documented in the youth's file why it was in the youth and families best interest.	**No eligible items for review**		
All data entry in NetMIS is completed within 3 business days as required.	**No eligible items for review**		
Additional Comments: **There are no additional comments for this indicator.**			

2.09- Stop Now and Plan (SNAP)			**Limited**
Provider has a written policy and procedure that meets the requirement for Indicator 2.09		**YES** If NO, explain here: The program has written policies and procedures 4.11 (SNAP Group Delivery), 4.12 (SNAP Group Delivery), 4.13 (Fidelity Adherence Monitoring), 4.14 (SNAP Discharge Requirements), and 4.15 (SNAP for Schools and Community) for SNAP services. The policy was last reviewed by the program director on 7/1/2023.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: 1 **Total number of Closed Files: 2** **Staff Position(s) Interviewed** *(No Staff Names)*: **SNAP Coordinator** **Type of Documentation(s) Reviewed: youth records**			
SNAP Clinical Groups Under 12			
Youth are screened to determine eligibility of services.	**Compliance**	All three files documented the youth were screened to determine eligibility using the NETMIS screening form and the SNAP Brief Intake screening form.	
The NIRVANA was completed at initial intake, or within two sessions.	**Compliance**	A Nirvana needs assessment was completed at intake in each file.	
There is evidence of the completed Child Behavior Checklist (CBCL) by the caregiver (pre and post) and is located within the file.	**Compliance**	All three files had completed pre-CBCLs completed at intake. Two of the records were closed and contained post-CBCLs	
There is evidence of the completed Teacher Report Form (TRF) is completed by the teacher (pre and post) and is located within the file.	**Exception**	One open record included a completed pre-Teacher Report Form (TRF).	Pre and Post TRF forms were not completed in the two closed records and no documentation was included in the file to explain why they were not completed.
SNAP Clinical Groups Under 12 - Discharge			
There is evidence of the completed SNAP Discharge Report located within the file for any discharged youth.	**Compliance**	Evidence supported the SNAP discharge report was completed in the two closed records reviewed.	
There is evidence of the SNAP Boys/SNAP Girls Child Group Evaluation Form located in the file.	**Exception**	Two applicable youth records that were closed were reviewed.	There was no evidence of the SNAP Boys/SNAP Girls Child Group Evaluation Form located in the two applicable closed files.
There is evidence of the SNAP Boys/SNAP Girls Parent Group Evaluation Form located in the file.	**Exception**	Two applicable youth records that were closed were reviewed.	There was no evidence of the SNAP Boys/SNAP Girls Parent Group Evaluation Form located in the two closed files.

SNAP Clinical Groups for Youth 12-17			
Youth are screened to determine eligibility of services.	Not Applicable	CFCE does not currently provide SNAP to youth ages 12-17	
The Consent to Treatment and Participation in Research Form is completed and located within the file.	Not Applicable	CFCE does not currently provide SNAP to youth ages 12-18	
The NIRVANA was completed at initial intake, or within two sessions.	Not Applicable	CFCE does not currently provide SNAP to youth ages 12-19	
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	CFCE does not currently provide SNAP to youth ages 12-20	
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	CFCE does not currently provide SNAP to youth ages 12-21	
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	CFCE does not currently provide SNAP to youth ages 12-22	
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*)	Exception	Two full cycle SNAP groups were reviewed. Weekly attendance sheets were completed for each session for each group.	None of the two SNAP groups completed met for 13 sessions. One of the groups met for 11 sessions and the other group met for 12 sessions.
The program maintained evidence of a completed "Class Goal" Document for the class reviewed.	Exception	Two SNAP groups were reviewed for evidence of Class Goal Document.	No evidence of a completed "Class Goal" was documented for the two classes reviewed.
The program maintained evidence of both pre AND post Measure of Classroom Environment (MoCE) completed documents for the class reviewed.	Exception	Two SNAP groups were reviewed for evidence of pre and post MoCE.	Neither of the two SNAP groups provided evidence the pre/post MoCE was completed for the class
The program maintained evidence of completed pre and post evaluation documents for the class reviewed.	Exception	Two SNAP groups were reviewed for evidence of pre and post evaluation.	No evidence of completed pre and post evaluation documents were observed for the two classes reviewed.
There is evidence of the fidelity adherence checklist maintained in the file for each class reviewed.	Exception	Two SNAP groups were reviewed for evidence of the fidelity adherence checklist.	No evidence of the fidelity adherence checklist was observed for either of two classes reviewed.
Additional Comments: **There are no additional comments for this indicator.**			

4.02 - Suicide Prevention			Satisfactory with Exception
Provider has a written policy and procedure that meets the requirement for Indicator 4.02		YES If NO, explain here: The provider has the required policy and procedures 3.02.01 that was reviewed and approved May 3, 2023 by the program 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: 0 **Total number of Closed (Residential & Community) Files: 0** **Staff Position(s) Interviewed** *(No Staff Names)* **: Program Director**			
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.	**Exception**	A review of ten case records was completed. It was determined youth were not screened for suicide during intake because the suicide screening questions were not included in all of the records reviewed. This exception was previously noted and rated in indicator 2.01 above.	Seven records were missing the suicide risk screening questions while three reviewed records had only a portion of suicide risk screening questions completed at intake.
The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	**Compliance**	The program's suicide risk assessment was previously approved by the Florida Network and has not changed since the last QI review.	
Supervision of Youth with Suicide Risk *(Shelter Only)*			
Youth are placed on the appropriate level of supervision based on the results of the suicide risk assessment.	**Not Applicable**	Not applicable to community counseling program.	
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	**Not Applicable**		
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.	**Not Applicable**		

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	**Not Applicable**		
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.	**Not Applicable**		
Youth with Suicide Risk *(Community Counseling Only)*			
Youth identified for suicide risk during intake was immediately assessed by a licensed professional or non-licensed professional (under the direct supervision of a licensed mental health professional) and the parents and supervisor were both notified of the results.	**No eligible items for review**	Per the program director, no youth were identified as suicide risk during the annual review period.	
During the intake, if the appropriate staff is unavailable, youth identified for suicide risk was immediately referred by the provider and the parent/guardian is notified of the suicide risk findings disclosed and advised that an Assessment of Suicide Risk should be completed ASAP by a licensed professional.	**No eligible items for review**	Per the program director, no youth were identified as suicide risk during the annual review period.	
Information on resources available in the community for further assessment was provided to the parent/guardian and is documented in the youth's file and signed by the parent/guardian OR a written follow-up notification was sent by certified mail if the parent/guardian was not present during the screening and was notified by telephone.	**No eligible items for review**	Per the program director, no youth were identified as suicide risk during the annual review period.	
If the parent/guardian cannot be contacted, all efforts to contact them are documented in the case file.	**No eligible items for review**	Per the program director, no youth were identified as suicide risk during the annual review period.	
When the screening was completed during school hours on school property, the appropriate school authorities were notified.	**No eligible items for review**	Per the program director, no youth were identified as suicide risk during the annual review period.	
Additional Comments: **There are no additional comments for this indicator.**			