Florida Network for Youth and Family Services
Compliance Monitoring Report for

Capital City Youth Services (CCYS)

2407 Roberts Ave.
Tallahassee, Fl 32310

April 10-11, 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 Capital City Youth Services (CCYS) for the FY 2023-2024 at its program office located at 2407 Roberts Ave. Tallahassee, FL 32310. 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. CCYS 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 Cedric Prince, Kevin Lee, Lyxandra Rivera, and Christina Baker. Agency representatives from CCYS present for the entrance interview were: Gwynn Virostek, Regina Flowers, Greg Farmer, Lanekia Bennett, Alecia Hassler, and Gina Dozier. The last onsite QI visit was conducted November 2-3, 2022.

In general, the Reviewer found that CCYS is in compliance with specific contract requirements. **CCYS received an overall compliance rating of 92% for achieving full compliance with 11 indicators** of the CINS/FINS Monitoring Tool. There was one 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 04-10-11-2024

Agency Name: Capital City Youth Services	**Monitor Name: Andrea Haugabook, Lead Reviewer**
Contract Type: CINS/FINS	**Region/Office: 2407 Roberts Ave. Tallahassee, FL 32310**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): April 10-11, 2024**

	Explain Rating						
Major Programmatic Requirements	**Unacceptable**	**Conditionally Unacceptable**	**Fully Met**	**Exceeded**	**Not Applicable**	**Ratings Based Upon:** **I = Interview** **O = Observation** **D = Documentation** **PTV = Submitted Prior To Visit** **(List Who and What)**	**Notes** **Explain Unacceptable or Conditionally Acceptable:**
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 currently has three 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 agency provided a complete list of all current federal, state, and local contracts. It includes the names of the awarding entities and contract start and end dates. In addition to the Florida Network, the agency currently receives funding from: United Way, Department of Children and Families, FEMA, Department of Health and Human Services, Northwest Florida Health, Leon Cares, Community Human Service	

2023-2024 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 04-10-11-2024

Agency Name: Capital City Youth Services	**Monitor Name: Andrea Haugabook, Lead Reviewer**
Contract Type: CINS/FINS	**Region/Office: 2407 Roberts Ave. Tallahassee, FL 32310**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): April 10-11, 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**		
						Partnership/ Leon County City of Tallahassee, and American Rescue Plan Act.	
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 agency provided a certificate of insurance from Hub International Florida with insurers affording coverage listed as: Philadelphia Indemnity Insurance Company, Markel Insurance Company, and United Insurance Company. The certificate covers Worker's Compensation and Employer's liability insurance (01/12/2024-01/12/2025) as required by Chapter 440, F.S. with a minimum of $500,000 per accident, $500,000 per person and $500,000 policy aggregate. Commercial General Liability (07/01/2023-07/01/2024) with a limit of $1,000,000 per occurrence, and $3,000,000 policy aggregate. Automobile Liability Insurance (07/01/2023-07/01/2024)	

2023-2024 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 04-10-11-2024

Agency Name: Capital City Youth Services	**Monitor Name: Andrea Haugabook, Lead Reviewer**
Contract Type: CINS/FINS	**Region/Office: 2407 Roberts Ave. Tallahassee, FL 32310**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): April 10-11, 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**		
						for any auto with a limit of $1,000,000 combined limit. Additionally, there is coverage for professional liability and abuse/ molestation (07/01/2023-07/01/2024) $1,000,000 per occurrence/ $3,000,000 aggregate. The Florida Network of Youth and Family Services 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 COO indicates there are no corrective action items cited by any additional funders.	
Fiscal Practice a. Agency must have employee and fiscal policy/procedures manuals that are in compliance with GAAP and provide sound internal controls. Agency maintains fiscal files that are audit ready. **PTV**	☐	☐	☒	☐	☐	The agency policy entitled, Accounting, last reviewed 03/31/2024 by the CEO indicates that CCYS is to comply with accepted accounting practices. The agency provides sound fiscal controls and maintains files that are audit ready.	
b. Agency maintains a general ledger and the corresponding source documents. A general ledger	☐	☐	☒	☐	☐	The agency provided a general ledger covering the most recent six-	

2023-2024 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 04-10-11-2024

Agency Name: Capital City Youth Services	**Monitor Name: Andrea Haugabook, Lead Reviewer**
Contract Type: CINS/FINS	**Region/Office: 2407 Roberts Ave. Tallahassee, FL 32310**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): April 10-11, 2024**

	Explain Rating						
Major Programmatic Requirements	**Unacceptable**	**Conditionally Unacceptable**	**Fully Met**	**Exceeded**	**Not Applicable**	**Ratings Based Upon:** **I = Interview** **O = Observation** **D = Documentation** **PTV = Submitted Prior To Visit** **(List Who and What)**	**Notes** **Explain Unacceptable or Conditionally Acceptable:**
must be set up to track the activity of the grant separately (standard account numbers / separate funds for each revenue source, etc.). **PTV**						month period. The general ledger is set up to track the activity of the grant separate from all other funds 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 petty cash policy was reviewed, and the agency keeps no petty cash on-hand at the facility.	
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**	☐	☐	☒	☐	☐	A review of the most recent six months of financial records showed that bank statements are reconciled within 6 weeks of receipt. Reconciliations are completed by a contracted bookkeeper. The bookkeeper is on-site weekly to manage invoices, bill payments, and check payments. All receipts are submitted for reimbursement on a check request. The CEO signs off on bills and payments are made by the bookkeeper. Credit card statements are reconciled by the bookkeeper and paid weekly.	

2023-2024 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 04-10-11-2024

Agency Name: Capital City Youth Services	**Monitor Name: Andrea Haugabook, Lead Reviewer**
Contract Type: CINS/FINS	**Region/Office: 2407 Roberts Ave. Tallahassee, FL 32310**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): April 10-11, 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**		
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 has not made any purchases over $1,000 with the Florida Network funds requiring a DJJ inventory tag. The agency has not purchased any computer equipment necessitating the submission of an Informational Resources Request (IRR).	
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 provided the 941 quarterly tax reports covering the most recent six-month period prepared by the Certified Public Accountant and payments are submitted electronically.	
g. Budget to actual reports prepared and reviewed by appropriate management. Variance from the budget are investigated and explained. **PTV/ON SITE**	☐	☐	☒	☐	☐	A review of the agency's Statement of Activity Budget vs. Actual report from July 2023 to February 2024 was prepared by a contracted Certified Public Accountant (CPA), who monitors the reports for variances and reports them back to the CEO. The CEO conveys, variances to the Board of Directors at least quarterly.	

2023-2024 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 04-10-11-2024

Agency Name: Capital City Youth Services	**Monitor Name: Andrea Haugabook, Lead Reviewer**
Contract Type: CINS/FINS	**Region/Office: 2407 Roberts Ave. Tallahassee, FL 32310**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): April 10-11, 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**		
						Interview with the CEO indicated the agency has worked diligently to monitor and improve cost allocations and budget variances over the past fiscal year. They are looking to see the result of that work in the outcome of the next audit report for FY 2023.	
h. A Single Audit is performed as part of the annual audit if expenses are greater than $750,000. The agency must submit a Corrective Action Plan for findings cited in the management letter and single audit. An annual financial audit was completed within 120 days after the previous fiscal year/calendar year and that a copy was provided to the Network unless and extension has been requested and approved in writing. Copy of Audit is submitted to the FNYFS by December 31st. **Can obtain from FNYFS**	☐	☒	☐	☐	☐	The most recent audit report presented was dated January 5, 2023. The audit was completed by James Moore, Certified Public Accountant (CPA) for year ending June 30, 2022, with summarized information as of June 30, 2021. Findings cited in the management letter were followed up with a corrective action plan from the CEO dated 01/05/2023.	The CEO provided an email (dated March 13, 2024) from the CPA confirming they have been engaged to perform the FY23 audit for CCYS and have begun preparing the audit. The onsite work will be completed in May 2024, and the financial audit is expected to be issued in June 2024.

2023-2024 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 04-10-11-2024

Agency Name: Capital City Youth Services	**Monitor Name: Andrea Haugabook, Lead Reviewer**
Contract Type: CINS/FINS	**Region/Office: 2407 Roberts Ave. Tallahassee, FL 32310**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): April 10-11, 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. 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 fiscal policies and procedures from the HP manual/ Employee Manual addresses confidentiality of client information, confidentiality, personnel information and privacy, record retention, retention and disposition, disposal of property, data security and service interruption, social media, computers, internet, and email.	
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**	☐	☐	☒	☐	☐	All direct care workers earn at least $19.00 per hour. The agency provided the accounting of all staff salaries and change of salaries effective October 1, 2023.	

CONCLUSION

CCYS has met the requirements for the CINS/FINS contract as a result of full compliance with 11 out of 12 applicable indicators of the Administrative and Fiscal Contract Monitoring Tool. Two of the fourteen indicators were not applicable because the agency does not keep petty cash at the program and the agency has no inventory valued over $1,000 purchased with FNYFS funds or computer equipment requiring a DJJ IRR form. Consequently, **the overall compliance rate for this contract monitoring visit is 92%.** There is one corrective actions cited below. 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.

SUMMARY OF RECOMMENDATIONS

Recommendation (1)
An annual financial audit should be completed within 120 days after the previous fiscal year/calendar year and a copy provided to the Network unless an extension has been requested and approved in writing. A copy of the audit should be submitted to the FNYFS by December 31st.

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 responsible staff. 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 Capital City Youth Services (CCYS)
CINS/FINS Program

Date: April 10-11, 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	Limited
1.05 Analyzing and Reporting Information	Satisfactory
1.06 Client Transportation	Satisfactory
1.07 Outreach Services	Satisfactory

Percent of Indicators rated Satisfactory: 85.71 %
Percent of Indicators rated Limited: 14.29 %
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: 96.43 %
Percent of indicators rated Limited: 3.57 %
Percent of indicators rated Failed: 0 %

Rating Definitions

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

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

Reviewers

Members

Andrea Haugabook- Lead Reviewer Consultant-Forefront LLC/Florida Network of Youth and Family Services
Cedric Prince – Regional Monitor, Department of Juvenile Justice
Kevin Lee - CDS Family and Behavioral Health Services
Lyxandra Rivera – Anchorage Children's Home of Bay County, Inc.
Christina Baker - Lutheran Services Florida Northwest

Methodology

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

Persons Interviewed

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

Documents Reviewed

	Accreditation Reports		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	X	Key Control Log	4	# MH/SA Records
	Continuity of Operation Plan	X	Fire Drill Log	7	# Personnel /Volunteer Records
X	Contract Monitoring Reports	X	Medical and Mental Health Alerts	12	# Training Records
	Contract Scope of Services		Precautionary Observation Logs	15	# Youth Records (Closed)
X	Egress Plans	X	Program Schedules	5	# Youth Records (Open)
X	Fire Inspection Report	X	List of Supplemental Contracts		# Other: Transportation logs, Internal Incident Reports
	Exposure Control Plan		Vehicle Inspection Reports		

Observations During Review

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

Surveys

5	# of Youth	12	# 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.

The following programmatic updates were provided by the agency:

Strengths and Innovative Approaches

The program's Chief Executive Officer (CEO) obtained a Master of Social Work from Florida State University. The current clinical director is a Licensed Clinical Social Worker and all counselors in the shelter and in the Family Place counseling program are Registered Social Work Interns. The Shelter Manager has a Master's in Education Specialist degree. The SNAP Lead also has a Master of Social Work degree. Currently all leadership positions are filled and there is one vacancy for a counselor position, 2.5 youth care specialists, and one support specialist. The program has one nurse on staff. The shelter counseling staff has no vacancies and the counselors assist in Family Place, whenever possible.

Shelter youth participate in community involvement weekly through partnership with the Meals on Wheels program. The youth assist in packing meals for the elderly and infirmed.

The agency is currently outfitting the warehouse to move the drop-in center offsite. There are no additional changes to leases and/or property purchases. The shelter upgraded the kitchen with new cabinetry and some new appliances since the last QI review. These upgrades allow for more efficient storage and increased prep space and has improved the ability to keep the kitchen clean.

Someplace Else Emergency Shelter – Contracted bed days was modified (lowered) at of the beginning of the fiscal year to 2,061. Since that the time, the Shelter Management Team has worked to ensure the shelter is at the highest capacity possible and has achieved a run rate of over 120% of goal. As of the audit timeframe, the shelter has lost a couple of team members and is in the process of background screening three candidates that are in the hiring process. At least two of those candidates have worked for CCYS in the past and should acclimate to the shelter process relatively quickly upon completion of training.

Family Place Counseling – hired at least one new counselor since the last review and have another intern that is graduating this spring and hope to bring her on board full-time. The Wakulla office has re-opened for counseling in-office, as well as in schools. The program has a Spanish speaking counselor on the team which has been important in assisting in some critical situations with clients and families when called upon.

Two new positions as “lead” counselors, one in the residential shelter and one in Family Place offer assistance to the clinical director with supervision, processing intakes, and providing opportunities for advancement within the agency. Repainting the counseling and administration building allowed many counselors to repaint and furnish their offices and counseling rooms to meet their counseling styles and programs.

SNAP – The program has already surpassed the Snap in Schools goal for the year. There is still a struggle with getting enough families to intake and show up for group and in person facilitation and participation. There has been a second case manager hired for a part time position after the beginning of the fiscal year. Unfortunately, both full time and part time case managers resigned and left the program in February, one with little to no notice. The program is in the process of looking for new candidates for these positions.

General Agency updates

The outreach and development staff member resigned to pursue other endeavors, but has stayed on for a minimal number of hours to assist with grant management, program documentation, and system/IT support on some of the internal tracking systems.

CCYS has an active Street Outreach and Transitional Living Program and our shelter and Counseling Teams cross refer clients often when they are aging out, or a family or youth is in need of services being provided by these two departments. The agency applied and received Federal Health and Human Services funding for the street outreach and transitional living programs.

The Human Resources Coordinator has been active in the community at outreach events for employee recruitment and general community awareness of our programs offered.

Last year during hurricane season, the Someplace Emergency Shelter and Treehouse program had to evacuate due to an impending hurricane. The shelter youth and the treehouse youth evacuated to Panama City where they were hosted by Anchorage. This was the first time in thirty plus years that the program needed to evacuate. Planning, preparation and travel went very well. All youth and staff stayed at Anchorage's residential facility until the storm passed and it was safe to travel back.

The agency applied for and received and increased allocation in Federal Basic Center Grant funds.

CCYS recently upgraded its camera system and added camera viewing in the front entry visiting room (porch), where the youth bags and belongings are searched. There was also an upgrade to the PIXIS in 2022.

Narrative Summary

The Capital City Youth Services program is located at 2407 Roberts Ave., Tallahassee, FL 32310. The program provides transitional living, street outreach, drop-in center (case management) in addition to the CINS contracted services. The main campus is home to Treehouse At-Risk Group Home, Scattered Housing in apartments rented for transitional living clients, a warehouse for supplies and eventual drop-in center. Services are provided to the following Florida counties: Leon, Jefferson, Wakulla, Franklin, Madison, Taylor, Gadsden, and Liberty. All services are provided on-site, in groups, and in school settings.

CCYS is licensed for 18 beds, by the Florida Department of Children and Families, recently renewed 04/01/2024 and accredited through the Council on Accreditation. The program implemented the NoteActive electronic logbook in January 2024 for Someplace shelter only and went live without dual logging, effective 04/01/2024.

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 with Exception**,
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 S**atisfactory with Exception,** and
Indicator 1.07 Outreach Services was rated **Satisfactory with Exception.**

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

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

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**, and
Indicator 4.05 Episodic/Emergency Care was rated **Satisfactory**.

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

Standard 1:

Indicator 1.04 was rated limited due to:
Two of four employees were missing required pre-service trainings.
Two employees had not yet completed the United States Department of Justice Civil Rights & Federal Funds training.
One of five employees had not completed the required number of trainings within the first full year of employment.
One of the two non-licensed mental health clinical staff had not completed training in Assessment of Suicide Risk.

One of five employee files reviewed, did not contain evidence of completion for the sexual harassment, trauma responsive practices, behavior management, CPR, first aid, and CINS/FINS core training, within the first 90 days of employment from the date of hire.

Two of five employee files reviewed did not contain evidence of completion for civil rights and federal funds and equal employment opportunity, information security awareness, prison rape elimination act.

One of the two non-licensed mental health clinical staff had not completed training in Assessment of Suicide Risk.

Two employee training files reviewed, did not show evidence that direct care staff completed 40 hours of mandatory refresher Florida Network, skill pro, and job related trainings annually as required.

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	**YES** If NO, explain here: The agency has a policy, Background Screening was last reviewed by the CEO on 03/31/2024.	

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

Total number of New Hire Employee/Intern/Volunteer Files: Five
Total number of 5 Year Re-screen Employee Files: Two
Type of Documentation(s) Reviewed: E-Verify case status, Background screening results, Suitability assessment results

All positions providing direct services to youth has successfully passed pre-employment suitability assessment on the initial attempt.	**Compliance**	Three of three eligible new hire employees have passed a pre-employment suitability assessment.	
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**	None of the employees had a break in service for 18 months or more.	
Background screening completed prior to hire/start date (or exemption obtained prior to working with youth if rated ineligible) for new hires, volunteers/interns, and contractors. *(Employees who have had a break in service and are in good standing may be reemployed with the same agency without background screening if the break is less than 90 days.)*	**Compliance**	Five of five employee files reviewed, contained evidence of completion of background screening prior to hire/ start date.	

Five-year re-screening is completed every 5 years from the date of the last screening or prior to retained fingerprints expiration date.	**Exception**	One of two employee files reviewed completed 5 year rescreening prior to the retained fingerprint expiration date.	One of two employee files reviewed did not complete a 5 year rescreening prior to the retained fingerprint expiration date.
Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?	**Compliance**	A completed annual affidavit of compliance was submitted to the Background Screening Unit on January 30, 2024.	
Proof of E-Verify for all new employees obtained from the Department of Homeland Security	**Compliance**	Proof of E-Verify was present in all applicable employee files reviewed.	
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 agency has a policy, Abuse Reporting, last reviewed by the CEO on 03/31/2024.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Staff Position(s) Interviewed (No Staff Names): Shelter Manager **Type of Documentation(s) Reviewed: Policy and Procedures, grievance logbook, record of abuse calls** **Describe any Observations: location of grievance box centrally located inside the shelter.**			
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 written policy and procedure including policy number, date of last review and approval and was signed by program's CEO.	

The agency has a process in place for reporting and documenting child abuse hotline calls.	**Compliance**	The agency has a process in place and is following the internal procedures for reporting and documenting child abuse hotline calls. The agency had a total of 13 of child abuse calls in the last 6 months.	
Youth were informed of the Abuse and Contact Number	**Compliance**	A survey was completed by five youth in the program, four youth indicated they were informed of the abuse contact number. One youth indicated they were not informed of the abuse contact number. Evidence showed that the Abuse contact number was posted through the facility by way of facility tour completed on sight. Evidence of youth being informed of abuse and contact number is present in each of the youth files reviewed.	
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 has a policies and procedures which includes the requirements and steps for the grievance process. In addition to grievance boxes, suggestion boxes are also located in the lobby of the Family Place/ Admin building were clients may recommend changes or improvements.	
Shelter only: Grievances are maintained on file at minimum for 1 year.	**Compliance**	Evidence of grievances being maintained on file for a minimum of one year was indicated in the program's policies and procedures.	
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**	Evidence of formal grievance procedures for youth including grievance forms and a locked box was indicated in program's policies and procedures and verified during facility tour.	
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**	An informal interview was conducted with the shelter manager whom indicated that grievance boxes are checked by management daily. Observations in the program logbook showed record that the grievance box is checked daily.	
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.	**Compliance**	An informal interview was conducted with the shelter manager whom indicated that grievances are resolved within 72 hours and documented by a 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 a policy, Incident Reporting, last reviewed by the CEO on 03/31/2024.		
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Staff Position(s) Interviewed *(No Staff Names)* **: Shelter Manager** **Type of Documentation(s) Reviewed: CCC reports, internal incident reports**			
During the past 6 months, the program notified the Department's CCC (Central Communication Center) no later than two hours after any reportable incident occurred or within two hours of the program learning of the incident	**Exception**	Ten of eleven CCC reports reviewed, from the last six months indicated the program notified the Department's CCC no later than two hours of the program learning of the incident.	There was one CCC completed outside of the two hour window. CCC case# 202401494 on 3/22/24. Time of incident was 7:50 pm, but CCC was notified at 11:03pm.
The program completes follow-up communication tasks/special instructions as required by the CCC	**Compliance**	The program has policies and procedures which includes completing follow-up communication task special instructions as required by CCC. Evidence of completion of follow-up was present for the 11 reports reviewed.	
Agency internal incidents are documented on incident reporting forms and all CCC reportable incidents were consistently reported to CCC as required.	**Compliance**	The program has policies and procedures which includes internal incidents being documented on incident reporting forms and all CCC reportable incidents were reported to CCC as required. The agency has internal incidents documented and they are consistent with the reports made to the CCC.	
Incidents are documented in the program logs and on incident reporting forms	**Compliance**	The program has policies and procedures which includes documenting all incidents in the program logs and on incident reports. Evidence of incidents were observed in the program log book and on incident report forms.	
All incident reports are reviewed and signed by program supervisors/ directors	**Compliance**	The program has policies and procedures which includes all incident reports being reviewed and signed by program supervisors. All incident reports reviewed were signed by a supervisor.	

1.04: Training Requirements (*Staff receives training in the necessary and essential skills required to provide CINS/FINS services and perform*		**Limited**
Provider has a written policy and procedure that meets the requirement for Indicator 1.04	**YES**	
	If NO, explain here:	
	The agency has a policy, Training Plan Policy, last reviewed by the CEO on 03/31/2024.	

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

Total number of New Hire Staff Files: Five
Total number of Annual In-Service Staff Files: Six
Total number of Non-Licensed Mental Health Clinical Shelter Staff Files: Two
Annual Training Plan Timeframe (Program timeframe for annual trainings): Anniversary of the employee's hire date
Staff Position(s) Interviewed (No Staff Names): HR Coordinator, Shelter Manager
Type of Documentation(s) Reviewed: Training plans, documentation of completion of training, policy. NetMIS, Bridge, SkillPro, and other internal training transcript
Describe any Observations: Several employee trainings were missing and not documented as being complete.

First Year Direct Care Staff			
All direct care staff have completed new hire pre-service training requirements for safety and supervision as required.	**Exception**	A review of four employee training files indicated that one direct care staff had completed the new hire preservice training requirements for safety and supervision as required.	Two of four new hire staff training files reviewed did not complete the new hire pre-service training requirements for safety and supervision as required.
All staff completed the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days from date of hire.	**Exception**	A review of four employee training files indicated that two employees completed the United States Department of Justice Civil Rights & Federal Funds training within 30 days.	A review of four employee training files indicated that two employees had not yet completed the United States Department of Justice Civil Rights & Federal Funds training as of 4/11/24.

All direct care CINS/FINS staff (full time, part time, or on-call) demonstrated a minimum of 80 hours of training or more for the first full year of employment.	**Exception**	A review of four employee training files indicated that one of four direct care CINS FINS employees completed a minimum of 80 hours of training or more for the first full year of employment. Two of four have the balance of this training year to meet the 80 hour training requirement.	One of four training files reviewed did not complete a minimum of 80 hours of training in the first full year of employment. The employee's hire date was 2/8/2023 and as of the date of this QI review, the employee only completed 62.8 hours of training.
All staff receives all mandatory training during the first 90 days of employment from date of hire.	**Exception**	Four of four employee training files reviewed indicated child abuse recognition, reporting, and prevention, human trafficking intervention for direct care staff, and behavior management, Florida Network youth suicide prevention was completed in the first 90 days of employment from date of hire. Four of four employee files showed completion of sexual harassment, trauma responsive practices, behavior management, CPR, first aid, and CINS/FINS core training, within the first 90 days of employment from the date of hire. Three of four employee files reviewed completed civil rights and federal funds and equal employment opportunity, information security awareness, prison rape elimination act.	One of four employee files reviewed, did not contained evidence of completion for sexual harassment, trauma responsive practices, behavior management, CPR, first aid, and CINS/FINS core training, within the first 90 days of employment from the date of hire. Two of four employee files reviewed did not contain evidence of completion for civil rights and federal funds and equal employment opportunity, information security awareness, prison rape elimination act.
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**	A review of five employee training files indicated that the designated staff responsible for entering NIRVANA in the Department of Juvenile Justice Information System have completed the required trainings.	
Staff Participating in Case Staffing & CINS Petitions (within first year of employment)			
Documentation of instructor led FL Statute 984 CINS Petition Training by a local DJJ Attorney. *Effective for staff hired after 7/1/23*	**Compliance**	A review of five employee training files indicated evidence of Instructor led FL Statute 984 CINS Petition training by a local DJJ Attorney.	
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).	**Exception**	A review of two employee training files indicated that one non-licensed mental health clinical staff had completed training in Assessment of Suicide Risk.	One of the two non-licensed mental health clinical staff had not completed training in Assessment of Suicide Risk.

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**	Four of six employee training files reviewed, showed evidence that direct care staff completed 40 hours of mandatory refresher Florida network, skill pro, and job related trainings annually.	Two employee training files reviewed, did not show evidence that direct care staff completed 40 hours of mandatory refresher Florida network, skill pro, and job related trainings annually.
Required Training Documentation			
The agency has a training plan that includes all of the required training topics including the pre-service and in-service.	**Compliance**	The program has policies and procedures which includes training plan that includes all of the required training topics for pre-service and in-service 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 program 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. Interview with the HR Coordinator indicated that this position had been vacant for two years. Since the exit of the previous HR personnel, training was a responsibility shared between the COO and the current HR Coordinator. It has recently become the sole responsibility of the HR Coordinator, who is actively working to put processes in place to ensure all staff are compliant with training requirements.	
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**	A review of six employee training files indicated that the program maintains an individual training file or log that documents annual training 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 agenda for each training attended.	
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, Analyzing and Reporting Information, last reviewed by the CEO on 03/31/2024.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Staff Position(s) Interviewed (No Staff Names): Shelter Manager **Type of Documentation(s) Reviewed: Council on Accreditation - Organizational Strengths, Client Satisfactory Surveys, yearly grievance data, client file review summaries**			

Case record review reports demonstrate reviews are conducted quarterly, at a minimum	**Compliance**	A review of sample from the past six months of aggregated data and committee meeting minutes analyzing data indicated that reviews are conducted quarterly.	
The program conducts reviews of incidents, accidents, and grievances quarterly, at a minimum	**Compliance**	A review of sample from the past six months of aggregated data and committee meeting minutes analyzing data indicated that the program conducts reviews of incidents, accidents, and grievances quarterly.	
The program conducts an annual review of customer satisfaction data	**Compliance**	A review of sample from the past six months of aggregated data and committee meeting minutes analyzing data indicated that the program conducts an annual review of customer satisfaction data.	
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**	A review of sample from the past six months of aggregated data and committee meeting minutes analyzing data indicated that the program demonstrates a monthly review of the statewide End-of-Month report generated by the Florida Network Office.	
The program has a process in place to review and improve accuracy of data entry & collection	**Compliance**	A review of sample from the past six months of aggregated data and committee meeting minutes analyzing data indicated that the program has processes in place to review and improve 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 sample from the past six months of aggregated data and committee meeting minutes analyzing data indicated that there is documentation that findings are regularly reviewed by management and communicated to staff and 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**	A review of sample from the past six months of aggregated data and committee meeting minutes analyzing data indicated that there is evidence the program demonstrates performance is routinely reviewed with the Board of Directors.	
There is evidence that strengths and weaknesses are identified, improvements are implemented or modified, and staff are informed and involved throughout the process.	**Compliance**	A review of sample from the past six months of aggregated data and committee meeting minutes analyzing data indicated that there is evidence that strengths and weaknesses are identified, improvements are implemented or modified, and staff are informed and involved throughout the process.	
Additional Comments: **There are no additional comments for this indicator.**			
1.06: Client Transportation			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 1.06		**YES** If NO, explain here: The agency has a policy, Transportation and Vehicles, last reviewed by the CEO on 03/31/2024.	

Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Dates or Timeframe Reviewed: Past six months **Staff Position(s) Interviewed** *(No Staff Names)* **: Shelter Manager** **Type of Documentation(s) Reviewed: Transportation logs, Program Log book**			
Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	**Compliance**	The program demonstrated evidence of approved agency drivers that are authorized to drive clients in an agency vehicle.	
Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	**Compliance**	The program demonstrated evidence of approved agency drivers and documentation of valid Florida's driver's license and covered under company's insurance policy.	
Agency's Transportation policy prohibit transporting a client without maintaining at least one other passenger in the vehicle during the trip and include exceptions in the event that a 3rd party is NOT present in the vehicle while transporting	**Compliance**	The program has policy and procedures prohibiting the transportation of a client without maintain at least one other passenger.	
In the event that a 3rd party cannot be obtained for transport, the agency's supervisor or managerial personnel consider the clients' history, evaluation, and recent behavior	**Compliance**	The program has policy and procedures indicating a supervisor will consider the client's history, evaluation, and recent behavior in the event a third party cannot be obtained for transport.	
The 3rd party is an approved volunteer, intern, agency staff, or other youth	**Compliance**	The program had policy and procedure indicating that third 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.	**Exception**	A review of program's driving log indicated a total of 80 single youth transports and a total of 78 supervisor approvals for those single transports.	Two of eighty single youth transports reviewed did not have evidence of prior approval by a supervisor.
There is documentation of use of vehicle that notes name or initials of driver, date and time, mileage, number of passengers, purpose of travel and location.	**Compliance**	A review of the program's driving log indicated name or initials of driver, date and time, number of passengers, and purpose of travel for all transports.	
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: The agency has a policy, Outreach Policy, last reviewed by the CEO on 04/1/2024.	

Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Staff Position(s) Interviewed *(No Staff Names)* **: HR Coordinator** **Type of Documentation(s) Reviewed: Outreach Events, NetMIS outreach entries**			
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**	Position title of lead staff reviewed: Director of Outreach Services	
The program maintains written agreements with other community partners which include services provided and a comprehensive referral process.	**Compliance**	The program has policy and procedure for outreach which includes written agreements with other community partners that includes services provided and a comprehensive referral process. There are several written agreements maintained with 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 review of the NETMIS data log indicated the program maintains documentation of all outreach activities. Three of six outreach events reviewed were entered into NetMIS.	Three of six outreach events reviewed were not entered into NetMIS.
The program has designated staff that conducts outreach which is defined in their job description.	**Compliance**	The program's outreach and development staff resigned, however the program has an active street outreach program and the human resource coordinator has been actively participating in outreach events in effort to recruit talent and provide general awareness of the available programs and services.	
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 policies titled Access & Eligibility Criteria/Referral Process, Intake, and Chronological Records and Case Notes Policy , last reviewed on 3/31/24 and signed by CEO.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			

Total number of Open (Residential & Community) Files: Two
Total number of Closed (Residential & Community) Files: Eight
Staff Position(s) Interviewed *(No Staff Names)* **: Clinical Director, Shelter Manager**
Type of Documentation(s) Reviewed: Five residential and five community counseling files

Shelter youth: Eligibility screening form is completed immediately for all shelter placement inquiries.	**Compliance**	Five randomly selected files (four closed files and one open file) served in the last six months were reviewed to determine their adherence to this indicator. Five of the five files reviewed contained completed eligibility screening forms.	
Community counseling: Eligibility screening form is completed within 3 business days of referral by a trained staff using the Florida Network screening form.	**Exception**	Five randomly selected files (four closed files and one open file) served in the last six months were reviewed to determine their adherence to this indicator. Four of the five files reviewed contained completed eligibility screening forms within three days of a referral.	One of the five files reviewed had a referral that was not dated therefore; it was unable to be determined if an eligibility screening was completed within three business days of receiving the referral.
There is evidence all referrals for service is screened for eligibility and is logged in NetMIS within 72 hours of screening completion.	**Compliance**	Ten randomly selected files were reviewed to determine adherence to the requirements of this indicator. Five of the files were residential clients (4 closed and one open) and five of the files were community counseling clients (four open and one closed). Ten of the ten files contained evidence that referrals were screened for eligibility and documented into NetMIS within 72 hours of screening completion.	
Youth and parents/guardians receive the following in writing: a. Available service options b. Rights and responsibilities of youth and parents/guardians	**Exception**	Ten randomly selected files were reviewed to determine adherence to the requirements of this indicator. Five of the files were residential clients (4 closed and one open) and five of the files were community counseling clients (four open and one closed). Five of the five residential files and three of the five community counseling files contained documentation that indicated youth and parents/guardians received available services options and the rights and responsibilities of youth and parents/guardians.	Two of the five community counseling files reviewed did not have parent/guardian initials to indicate they had received the rights and responsibilities parent brochure.

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**	Ten randomly selected files were reviewed to determine adherence to the requirements of this indicator. Five of the files were residential clients (4 closed and one open) and five of the files were community counseling clients (four open and one closed). Ten out of ten files had evidence that youth and parents/guardian received information regarding possible actions occurring through CINS/FINS involvement as well as grievance procedures.	
During intake, all youth were screened for suicidality and correctly assessed as required if needed.	**Compliance**	Ten randomly selected files were reviewed to determine adherence to the requirements of this indicator. Five of the files were residential clients (4 closed and one open) and five of the files were community counseling clients (four open and one closed). Ten of ten files reviewed had documentation that youth were screened for suicidality and assessed as required.	
Additional Comments: **There are no additional comments for this indicator.**			
2.02 - Needs Assessment			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 2.02		**YES** If NO, explain here: The agency has a policy Assessment and service plan development, last reviewed by the CEO on 03/31/2024.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open (Residential & Community) Files: Two **Total number of Closed (Residential & Community) Files: Eight** **Staff Position(s) Interviewed** *(No Staff Names)* **: Clinical Director, Shelter Manager** **Type of Documentation(s) Reviewed: Five residential and five community counseling files**			
Shelter Youth: NIRVANA is initiated within 72 hours of admission	**Compliance**	Five randomly selected files (four closed files and one open file) served in the last six months were reviewed to determine their adherence to this indicator. Four of the five files were eligible to be reviewed for this indicator. Four of the four files reviewed contained evidence of Nirvana being initiated within 72 hours of admission.	
Non-Residential youth: NIRVANA is initiated at intake and completed within 2 to 3 face-to-face contacts after the initial intake **OR** updated, if most recent assessment is over 6 months old	**Compliance**	Five randomly selected files (four closed files and one open file) served in the last six months were reviewed to determine their adherence to this indicator. Four of the five files were eligible to be reviewed for this indicator. Four of the four files reviewed contained evidence of Nirvana being initiated at intake and completed within two to three face-to-face contacts.	

Supervisor signatures is documented for all completed NIRVANA assessments and/or the chronological note and/or interview guide that is located in the youths' file.	**Exception**	Ten randomly selected files were reviewed to determine adherence to the requirements of this indicator. Five of the files were residential clients (4 closed and one open) and five of the files were community counseling clients (four open and one closed). It was determined that three of the five residential files and four of the community counseling files were eligible to be reviewed for adherence to this indicator. Three of the three residential files and three of the four community counseling files contained evidence of supervisor signature on completed Nirvana assessments.	One of the four community counseling files did not have evidence of a supervisor signature on the Nirvana Post-Assessment.
(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.	**Exception**	Five randomly selected files (four closed files and one open file) served in the last six months were reviewed to determine their adherence to this indicator. Four of the five files reviewed had evidence of a Nirvana Self-Assessment being completed within 24 hours of admittance into shelter.	One of the five residential files reviewed did not have a date on the Nirvana Self-Assessment therefore; it could not be determined if the assessment had been completed within 24 hours of shelter admittance.
A NIRVANA Post-Assessment is completed at discharge for all youth who have a length of stay that is greater than 30 days.	**Compliance**	Ten randomly selected files were reviewed to determine adherence to the requirements of this indicator. Five of the files were residential clients (4 closed and one open) and five of the files were community counseling clients (four open and one closed). One community counseling file was eligible to be reviewed for this indicator and the file contained evidence that a Post-Assessment was completed as required.	
A NIRVANA Re-Assessment is completed every 90 days excluding files for youth receiving SNAP services.	**No eligible items for review**	None of ten files selected for review required a NIRVANA Re-Assessment at the time of this QI review.	
All files include the interview guide and/or printed NIRVANA.	**Compliance**	Ten randomly selected files were reviewed to determine adherence to the requirements of this indicator. Five of the files were residential clients (4 closed and one open) and five of the files were community counseling clients (four open and one closed). It was determined three of the four residential files and four of the five community counseling files were eligible to be reviewed for adherence to this indicator. Seven of the seven eligible files reviewed contained the printed Nirvana and/or the completed interview guide.	
Additional Comments: **There are no additional comments for this indicator.**			
2.03 - Case/Service Plan			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.03		**YES** If NO, explain here: The agency has policy titled Assessment and Service Plan Development which was reviewed on 3/31/24 and signed by CEO.	

Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open (Residential & Community) Files: Two **Total number of Closed (Residential & Community) Files: Eight** **Staff Position(s) Interviewed** *(No Staff Names)* **: Clinical Director, Shelter Manager** **Type of Documentation(s) Reviewed: Five residential and five community counseling files**			
The case/service plan is developed on a local provider-approved form or through NETMIS and is based on information gathered during the initial screening, intake, and NIRVANA.	**Compliance**	The case/ service plans reviewed are developed by the provider based on information gathers during the initial screening, intake and NIRVANA.	
Case/Service plan is developed within 7 working days of NIRVANA	**Compliance**	Ten randomly selected files were reviewed to determine adherence to the requirements of this indicator. Four of the five residential files contained case/ service plans developed on the provider's approved form with information gathered during the initial screening, intake and NIRVANA. One youth was only in shelter for 5 days and a service plan was not required. Two of five community counseling youth files reviewed contained case/ service plans developed within 7 working days. Three youth files indicated they did not stay in services long enough to have a case/ service plan.	

Case plan/service plan includes: 1. Individualized and prioritized need(s) and goal(s) identified by the NIRVANA 2. Service type, frequency, location 3. Person(s) responsible 4. Target date(s) for completion and actual completion date(s) 5. Signature of youth, parent/guardian, counselor, and supervisor 6. Date the plan was initiated	**Compliance**	Three of five case/ service plans reviewed included: 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 Two case/service plans did not have parent signature present, however, indication that the parent was notified and attempts made to obtain the signature was documented on each, in lieu of the missing signature.	
Case/service plans are reviewed for progress/revised by counselor and parent (if available) every 30 days for the first three months and every 6 months after	**Compliance**	One of eight case/service plan was reviewed for progress by counselor at 30 days. All other case/ service plans were not due for review at the time of this QI site visit.	
Additional Comments: **There are no additional comments for this indicator.**			
2.04 - Case Management and Service Delivery			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.04		**YES** If NO, explain here: The agency has a policy that meets the requirements of the indicator. The policies, Case supervision, chronological records and case policy notes was last reviewed by the CEO on 03/31/2024.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open (Residential & Community) Files: Two **Total number of Closed (Residential & Community) Files: Eight** **Staff Position(s) Interviewed** *(No Staff Names)* **: Clinical Director, Shelter Manager** **Type of Documentation(s) Reviewed: Five residential and five community counseling files**			
Counselor/Case Manager is assigned	**Compliance**	There is a counselor/case manager assigned in all cases reviewed.	

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**	The assigned counselor/case manager completed the following in each of the cases reviewed 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. 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. Referrals for the youth/family for additional services when appropriate 9. Case monitoring and reviews court orders 10. Case termination notes 11. Follow-up after 30 days post discharge 12. Follow-up after 60 days post discharge	
The program maintains written agreements with other community partners that include services provided and a comprehensive referral process	**Compliance**	Evidence of several written agreements with other community partners was presented for review which all include services provided and a comprehensive referral process.	
Additional Comments: **There are no additional comments for this indicator.**			
2.05 - Counseling Services			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.05		**YES** If NO, explain here: The agency has a policy that meets the requirements of the indicator. The policy, Service modalities and interventions was last reviewed by the CEO on 03/31/2024.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open (Residential & Community) Files: Two **Total number of Closed (Residential & Community) Files: Eight** **Staff Position(s) Interviewed** *(No Staff Names)* **: Clinical Director, Shelter Manager** **Type of Documentation(s) Reviewed: Five residential and five community counseling files**			
Shelter Program			
Shelter programs provides individual and family counseling	**Compliance**	Five of five shelter files reviewed contained evidence of individual and family counseling.	
Group counseling sessions held a minimum of five days per week	**Compliance**	The program conducts group counseling sessions at least five days per week as evidenced in the program log.	

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**	All 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	
Documentation of groups must include date and time, a list of participants, length of time, and topic.	**Compliance**	Documentation of groups all included the date and time of occurrence, a list of participants, length of time, and topic.	
Community Counseling			
Community counseling programs provide therapeutic community-based services designed to provide the intervention necessary to stabilize the family. Services are provided in the youth's home, a community location, the local provider's counseling office or virtually if written documentation is provided in the youth's file for reasons why it is in the best interest of the youth and family.	**Compliance**	Five of five community counseling files reviewed indicates that therapeutic community-based services were provided in effort to stabilize the family. All services were provided in the youth's home, a community location, or the local provider's counseling office. No virtual services are taking place.	
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**	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 was present in each case file reviewed.	
Maintain individual case files on all youth and adhere to all laws regarding confidentiality.	**Compliance**	The program maintains individual case files on all youth and adheres to all laws regarding confidentiality.	
Case notes maintained for all counseling services provided and documents youth's progress.	**Compliance**	All files reviewed contained case notes were maintained for all counseling services provided and documented the youth's progress.	
On-going internal process that ensures clinical reviews of case records and staff performance.	**Compliance**	The program demonstrates an on-going internal process that ensures clinical reviews of case records and staff performance.	
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**	No intakes are conducted through virtual means.	
Additional Comments: **There are no additional comments for this indicator.**			

2.06 - Adjudication/Petition Process			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 2.06		**YES** If NO, explain here: The agency has a policy that meets the requirements of the indicator. The policy, CINS case staffing committee policy was last reviewed by the CEO on 03/31/2024.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open (Residential & Community) Files: Zero **Total number of Closed (Residential & Community) Files: Zero** **Staff Position(s) Interviewed** *(No Staff Names)* **: Shelter Manager**			
Must include: a. DJJ rep. or CINS/FINS provider b. Local school district representative	**Compliance**	The program has a CINS case staffing committee policy which includes: a. DJJ rep. or CINS/FINS provider b. Local 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**	The program's policy and procedure addresses case staffing committee members that 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	
The program has an established case staffing committee, and has regular communication with committee members	**Compliance**	The program has an established case staffing committee (which includes the clinical director or designee), and has regular communication with committee members.	
The program has an internal procedure for the case staffing process, including a schedule for committee meetings	**Compliance**	The program has an internal procedure for the case staffing process, including a schedule for committee meetings to be held in the conference room at CCYS Leon County or via zoom.	
The youth and family are provided a new or revised plan for services	**No eligible items for review**	The program had no CINS case staffing petition cases during the review period or back to the date of the last review.	
Written report is provided to the parent/guardian within 7 days of the case staffing meeting, outlining recommendations and reasons behind the recommendations	**No eligible items for review**	The program had no CINS case staffing petition cases during the review period or back to the date of the last review.	

If applicable, the program works with the circuit court for judicial intervention for the youth/family	**No eligible items for review**	The program had no CINS case staffing petition cases during the review period or back to the date of the last review.	
Case Manager/Counselor completes a review summary prior to the court hearing	**No eligible items for review**	The program had no CINS case staffing petition cases during the review period or back to the date of the last review.	
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 that meets the requirements of the indicator. The policy, Supervision of Clients and Staff Responsibilities was last reviewed by the CEO on 03/31/2024.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Staff Position(s) Interviewed *(No Staff Names)* **: Clinical Director, Shelter Manager** **Type of Documentation(s) Reviewed: 10 youth file records** **Describe any Observations: location of file/ record storage**			
All records are clearly marked 'confidential'.	**Exception**	Eight of ten files reviewed were clearly marked 'confidential'.	Two community counseling files were not marked confidential.
All records are kept in a secure room or locked in a file cabinet that is marked "confidential"	**Compliance**	All records are kept in a secure room or locked in a file cabinet that is marked "confidential".	
When in transport, all records are locked in an opaque container marked "confidential"	**Compliance**	When in transport, all records are locked in an opaque container marked "confidential".	
All records are maintained in a neat and orderly manner so that staff can quickly and easily access information	**Compliance**	All records are maintained in a neat and orderly manner so that staff can quickly and easily access information.	
Additional Comments: **There are no additional comments for this indicator.**			
2.08 - Specialized Additional Program Services			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 2.08		**YES** If NO, explain here: The agency has a policy that meets the requirements of the indicator. The policies, Specialized populations and CINS staff secure was last reviewed by the CEO on 03/31/2024.	

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)* **: Shelter 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 agency has a policy that meets the requirements of the indicator. The policy CINS staff secure was last reviewed by the CEO on 03/31/2024. There have been no staff secure cases in the past six months or back to the date of the last review.	
Staff Secure policy and procedure outlines the following: a. In-depth orientation on admission b. Assessment and service planning c. Enhanced supervision and security with emphasis on control and appropriate level of physical intervention d. Parental involvement e. Collaborative aftercare	**Compliance**	The agency's has a policy to address staff secure which includes the following information: 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**	The program's policy indicates they only accept 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**	There have been no staff secure cases in the past six months or back to the date of the last review.	
Agency provides a written report for any court proceedings regarding the youth's progress	**No eligible items for review**	There have been no staff secure cases in the past six months or back to the date of the last review.	
Domestic Minor Sex Trafficking (DMST)			
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			

Total number of Open Files: Zero
Total number of Closed Files: Zero
Staff Position(s) Interviewed *(No Staff Names)* **: Shelter 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 agency had no cases of domestic minor sex trafficking in the past six months or back to the date of the last review.	
Agency has evidence that the FNYFS was contacted for approval prior to admission for all Domestic Minor Sex Trafficking (DMST) placements.	**No eligible items for review**	The agency had no cases of domestic minor sex trafficking in the past six months or back to the date of the last review.	
There is evidence the youth was entered into NetMIS as a Special Populations youth at admission and a Human Trafficking Screening Tool (HTST) was completed.	**No eligible items for review**	The agency had no cases of domestic minor sex trafficking in the past six months or back to the date of the last review.	
Services provided to these youth specifically designated services designed to serve DMST youth	**No eligible items for review**	The agency had no cases of domestic minor sex trafficking in the past six months or back to the date of the last review.	
Did the placement of DMST youth require additional supervision for the safety of the youth or the program? If so, did the agency provide the appropriate level of supervision and safety measures?	**No eligible items for review**	The agency had no cases of domestic minor sex trafficking in the past six months or back to the date of the last review.	
Length of Stay: a. Youth in program do not have length of stay in DMST placement that exceeds seven (7) days b. Agency has approval for stays and support beyond seven (7) days for DMST placements that are obtained on a case-by-case basis? (If applicable.)	**No eligible items for review**	The agency had no cases of domestic minor sex trafficking in the past six months or back to the date of the last review.	
Agency has evidence that staff assigned to DMST youth under this provision are to enhance the regular services available through direct engagement in positive activities designed to encourage the youth to remain in shelter	**No eligible items for review**	The agency had no cases of domestic minor sex trafficking in the past six months or back to the date of the last review.	
All other services provided to DMST youth are consistent with all other general CINS/FINS program requirements	**No eligible items for review**	The agency had no cases of domestic minor sex trafficking in the past six months or back to the date of the last review.	
Domestic Violence			

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

Total number of Open Files: Zero **Total number of Closed Files: Two** **Staff Position(s) Interviewed** *(No Staff Names)* **: Clinical Director and Shelter Manager** **Type of Documentation(s) Reviewed: Youth case files**			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	**Yes**	Two of two domestic violence youth case files were reviewed.	
Youth admitted to DV Respite placement have evidence in the file of a pending DV charge	**Compliance**	Evidence of a pending DV charge was present in two of two cases reviewed.	
Data entry into NetMIS within (3) business days of intake and discharge	**Compliance**	Data entry into NetMIS within (3) business days of intake and discharge for both DV cases reviewed.	
Youth length of stay in DV Respite placement does not exceed 21 days. If more than 21 days, documentation exists in youth file of transition to CINS/FINS or Probation Respite placement, if applicable.	**Compliance**	Youth length of stay in DV Respite placement did not exceed 21 days in either case reviewed.	
Case plan in file reflects goals for aggression management, family coping skills, or other intervention designed to reduce propensity for violence in the home	**Compliance**	Each DV file contained case plans that reflect goals for aggression management, family coping skills, or other intervention designed to reduce propensity for violence in the home.	
All other services provided to Domestic Violence Respite youth are consistent with all other general CINS/FINS program requirements	**Compliance**	All other services provided to Domestic Violence Respite youth were consistent with all other general CINS/FINS program requirements for both DV cases.	
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)* **: Clinical Director and Shelter 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")	**Yes**	One probation respite file was reviewed.	
All probation respite referrals are submitted to the Florida Network.	**Compliance**	A probation respite referral was submitted to the Florida Network.	
All Probation Respite Referral come from DJJ Probation and there is evidence that the youth is on Probation regardless of adjudication status.	**Compliance**	Evidence that the youth was on Probation regardless of adjudication status is contained within the youth record.	

Data entry into NetMIS and JJIS within (3) business days of intake and discharge	**Compliance**	One youth record reviewed was in compliance for data entry into NetMIS and JJIS within (3) business days of intake and discharge.	
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 length of stay was no more than fourteen (14) to thirty (30) days in the case reviewed.	
All case management and counseling needs have been considered and addressed	**Compliance**	All case management and counseling needs have been considered and addressed	
All other services provided to Probation Respite youth are consistent with all other general CINS/FINS program requirements	**Compliance**	All other services provided to Probation Respite youth are consistent with all other general CINS/FINS program requirements	
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: Not applicable **Total number of Closed Files: Not applicable** **Staff Position(s) Interviewed** *(No Staff Names)* **: Not applicable** **Type of Documentation(s) Reviewed: Not applicable**			
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**	This program 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**	This program is not contracted to provide intensive case management services.	
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**	This program is not contracted to provide intensive case management services.	

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**	This program is not contracted to provide intensive case management services.	
Service/case plan demonstrates a strength-based, trauma-informed focus	**Not Applicable**	This program is not contracted to provide intensive case management services.	
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**	This program is not contracted to provide intensive case management services.	
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)* **: Clinical Director and Shelter 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")	**Yes**	Two FYRAC case files were reviewed.	
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**	Two youth files reviewed contained referrals from 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.	
Agency has evidence that all FYRAC referrals have documented approval from the Florida Network office	**Exception**	Two FYRAC case files were reviewed.	No proof of approval from the Network was present in two FYRAC files.

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**	Intake and initial assessment sessions met the following criteria for each FYRAC file reviewed: 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.	
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 reviewed showed life management sessions which met 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.	
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**	Individual Sessions for each of the FYRAC files were completed in the following manner: 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.	
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	**Compliance**	All group sessions, focus on the same issues as individual/family sessions and are conducted in compliance ratios and time per session.	
There is evidence of completed 30 and/or 60 day follow-ups and is documented in NetMIS following case discharge.	**Compliance**	Evidence of completed 30 and 60 day follow-ups are documented in NetMIS following case discharge for both cases.	

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**	There was a total of two cases reviewed for FYRAC services. Both cases were closed prior to needing an extension.	
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**	There were no virtual services offered in the cases reviewed.	
All data entry in NetMIS is completed within 3 business days as required.	**Compliance**	All data was entered into NetMIS within 3 business days as required.	
Additional Comments: **There are no additional comments for this indicator.**			
2.09- Stop Now and Plan (SNAP)			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.09		**YES** If NO, explain here: The agency has a policy that meets the requirements of the indicator. The policy, SNAP was last reviewed by the CEO on 04/10/2024.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: Three **Total number of Closed Files: Two** **Staff Position(s) Interviewed** *(No Staff Names)* **: SNAP Coordinator** **Type of Documentation(s) Reviewed: SNAP youth files and SNAP in Schools files**			
SNAP Clinical Groups Under 12			
Youth are screened to determine eligibility of services.	**Compliance**	Five of five youth files reviewed were screened to determine eligibility of services.	
The NIRVANA was completed at initial intake, or within two sessions.	**Compliance**	The NIRVANA was completed at initial intake, or within two sessions in five of five 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**	There was completed Child Behavior Checklists (CBCL) by the caregiver (pre and post) located within five of five files reviewed.	
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**	Completed Teacher Report Forms (TRF), completed by the teacher (pre and post) was located within five of the five files reviewed.	

There is evidence of the completed TOPSE is completed by the caregiver (pre and post) and is located within the file.	**Compliance**	A completed TOPSE was present in five of five files reviewed.	
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 closed files reviewed showed evidence of the completed SNAP Discharge Report located within the file for any discharged youth.	
There is evidence of the SNAP Boys/SNAP Girls Child Group Evaluation Form located in the file.	**Compliance**	Two of closed files reviewed contained evidence of the SNAP Boys/SNAP Girls Child Group Evaluation Form located in the file.	
There is evidence of the SNAP Boys/SNAP Girls Parent Group Evaluation Form located in the file.	**Compliance**	Evidence of the SNAP Boys/SNAP Girls Parent Group Evaluation Form located in two closed files reviewed.	
SNAP Clinical Groups for Youth 12-17			
Youth are screened to determine eligibility of services.	**Not Applicable**	This program does not serve SNAP for youth 12-17.	
The Consent to Treatment and Participation in Research Form is completed and located within the file.	**Not Applicable**	This program does not serve SNAP for youth 12-17.	
The NIRVANA was completed at initial intake, or within two sessions.	**Not Applicable**	This program does not serve SNAP for youth 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**	This program does not serve SNAP for youth 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**	This program does not serve SNAP for youth 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**	This program does not serve SNAP for youth 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**	Three of three sessions reviewed 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.	
The program maintained evidence of a completed "Class Goal" Document for the class reviewed.	**Compliance**	Three of three sessions reviewed maintained evidence of a completed "Class Goal" Document for the class reviewed.	
The program maintained evidence of both pre AND post Measure of Classroom Environment (MoCE) completed documents for the class reviewed.	**Compliance**	Three of three sessions reviewed maintained evidence of both pre AND post Measure of Classroom Environment (MoCE) completed documents for the class reviewed.	
The program maintained evidence of completed pre and post evaluation documents for the class reviewed.	**Compliance**	Three of three sessions reviewed maintained evidence of completed pre and post evaluation documents for the class reviewed.	
There is evidence of the fidelity adherence checklist maintained in the file for each class reviewed.	**Compliance**	Three of three sessions reviewed contained evidence of the fidelity adherence checklist maintained in the file for each class reviewed.	
Additional Comments: **There are no additional comments for this indicator.**			
3.01 - Shelter Environment			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 3.01		**YES** If NO, explain here: The agency has a policy that meets the requirements of the indicator. The policy, Aggressive Clients was last reviewed by the CEO on 03/31/2024.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Staff Position(s) Interviewed *(No Staff Names)* **: Shelter Manager** **Type of Documentation(s) Reviewed: Egress plans, inspection reports, MSDS logs, perpetual inventory logs, and activity schedule**			

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**	A walk through of the facility revealed: 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.	
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**	During the facility inspection, all of the agency and staff vehicles were locked. The facility has two vehicles, the first vehicle is a 2019 Ford Transit van grey in color, and their second vehicle is a 2021 Ford Transit van white in color. They both are equipped with their own fire extinguishers, full and complete first aid kits. They also have their own flashlights, glass breaker, and seatbelt cutters. These items are housed within the binder, with the required paperwork, and the keys.	
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**	All of the chemicals within this shelter is being housed in one central locked location, inside of a room that has carpet covering the floor in which they have plans on removing the carpet to prevent any spills soaking into the carpet. The Material Safety Data Sheet (MSDS) are stored in the same room as all of their chemicals. All MSDS sheets are maintained on each item and inventoried weekly in accordance with the agency's policy and the FL Network's standards. A perpetual inventory was reviewed and is current and being maintained in real-time.	

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 washers and dryers are all operational and free of lint and trash. Their Department of Children and Family child care license is being displayed in the front lobby, and in the dayroom area where the clients spend most of their time throughout the day. Each of the sleeping areas appeared to be clean with linens included. Cellphones and all other valuables are locked up by the staff for the clients.	
Additional Facility Inspection Narrative (if applicable)			
Fire and Safety Health Hazards: a. Annual facility fire inspection was conducted, and the facility is in compliance with local fire marshal and fire safety code within jurisdiction. b. Agency completes a minimum of 1 fire drill on each shift monthly (within 2 minutes or less). c. Completes 1 mock emergency drill per shift per quarter. d. All annual fire safety equipment inspections are valid and up to date (extinguishers, sprinklers, alarm system and kitchen overhead hood, including fire extinguishers in all vehicles).	**Compliance**	The annual facility fire inspection was conducted on 03/29/2024, and is located in the living room area. All annual fire safety equipment inspections are valid and up to date, inspected August 2023, (extinguishers, sprinklers, alarm system and kitchen overhead hood, including fire extinguishers in all vehicles), A review of the agency's fire drill logs showed that at least one fire drill is completed on each shift monthly and at least one mock drill is completed on each shift per quarter. Random dates selected to verify fire drills were: 1st shift 03/15/2024 11:20am, 2nd shift 03/16/2024 4:49pm, and 3rd shift 03/16/2024 7:57am. Mock drills were observed on the following random days: 1st shift 3/07/2024 8:00am, 2nd shift 03/19/2024 6:00pm, and 3rd shift 03/04/2024 2:00am.	
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 food inspection report from the Health Department is hanging on the wall in the kitchen, behind some plexiglass. All of the cold food has been properly stored in its original packaging, if not opened, and in Ziplock bags with its date on it if it had been previously opened or served. The refrigerators temperatures were 36 degrees, and the freezers were set at ten degrees. They all were clean.	
Additional Fire and Safety Health Hazards Narrative (if applicable)			

Youth Engagement			
	Compliance	This shelter meets all of the criteria for this section. All of the clients that are housed at this shelter, and attends school outside of Leon County. Youth must attend school at the shelter five days a week. This facility conducts groups every day other than when they have other agencies come in to conduct groups such as music therapy, and painting.	
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 several policies that meets the requirements of the indicator. The policies, Client Rights, Chores, Contraband, On Call Assistance, Clothing and Personal Needs List, Dress code and, Search, were last reviewed by the CEO on 03/31/2024.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: One **Total number of Closed Files: Four** **Staff Position(s) Interviewed (No Staff Names): Shelter Manager** **Type of Documentation(s) Reviewed: Five Residential files**			
Youth received a comprehensive orientation and handbook provided within 24 hours	**Compliance**	Every client receives a handbook during the intake process according to the five residential files, and the agency policies.	
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**	All required information was given to all five the residential clients per their files I reviewed. The required information was given to them while their intake was in progress.	

Documentation of each component of orientation, including orientation topics and dates of presentation, as well as signatures of the youth and staff involved is maintained in the individual youth record	**Compliance**	The agency has a policy where the documentation of every orientation, with its dates, topics, as well as the signatures of the clients, and staff involved.	
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 policies that meets the requirements of the indicator. The policies, Room Assignments and Bed Checks were last reviewed by the CEO on 03/31/2024.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: One **Total number of Closed Files: Four** **Staff Position(s) Interviewed (No Staff Names): Shelter Manager** **Type of Documentation(s) Reviewed: Five Residential Files**			
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 agency has a policy in which the youth's history, exposure to trauma, their initial contacts, their issues or lack of with the separation of younger and older youth, the presence of medical, mental, or physical disabilities, suicide risk, whether or not there is any sexual or predatory behavior and acute health symptoms requiring quarantine or isolation is all documents in the initial classification of the youth. Documentation of all these elements are found in the five youth records reviewed.	
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**	This agency has a policy in placed where alerts are entered immediately entered into the programs alert system. When a client is accepted with special needs and or risk such as suicide, mental health, substance abuse, physical health, and security risk factors. In which they document within the clients files, and use color coded stickers that are placed in their files and on the clients board, as observed.	
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 that meets the requirements of the indicator. The policy, Log Book was last reviewed by the CEO on 03/31/2024.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Dates or Timeframe Reviewed: Six months **Staff Position(s) Interviewed** *(No Staff Names)* **: Shelter Manager** **Type of Documentation(s) Reviewed: electric log book and paper log book**			
Log book entries that could impact the security and safety of the youth and/or program are highlighted	**Compliance**	Log book entries that could impact the security and safety of the youth and/or program are highlighted	
All entries are brief, legibly written in ink and include: • Date and time of the incident, event or activity • Names of youth and staff involved • Brief statement providing pertinent information • Name and signature of person making the entry	**Compliance**	All 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	
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**	Recording errors are struck through with a single line. Initials of the staff person and date of the correction is common practice and the use of whiteout and erasures is prohibited.	
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**	Evidence of weekly reviews by the program director and shelter manager were observed in the program's logbooks. Notes are made indicating their reviews as required, which included the dates reviewed and if any correction, recommendations and follow-up was required. Each entry was signed and dated.	
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**	All staff review the logbook for the previous two shifts and make entries that are signed and dated indicating the dates reviewed.	
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**	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.	

Logbook entries include: a. Supervision and resident counts b. Visitation and home visits	**Compliance**	Observation of supervision, resident counts, visitation and home visits were present in the program's logbook.	
Additional Comments: **There are no additional comments for this indicator.**			
3.05 - Behavior Management Strategies			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 3.05		**YES** If NO, explain here: The agency has a policy that meets the requirements of the indicator. The policy, Behavior Management was last reviewed by the CEO on 03/31/2024.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Staff Position(s) Interviewed *(No Staff Names)* **: Youth care worker, Shelter Manager** **Type of Documentation(s) Reviewed: CCYS Behavior Management System Handbook**			
The program has a detailed written description of the BMS and it is explained during program orientation	**Compliance**	A comprehensive explanation of the Behavior Management Strategies (BMS) is found in the Capitol City Youth Services (CCYS) behavior management system handbook which is given and explained to the youth at orientation.	
Behavior Management Strategies must include:			
a. BMS is designed to teach youth new behaviors and help youth understand the natural consequences for their actions b. Behavioral interventions are applied immediately, with certainty, and reflect the severity of the behavior c. BMS uses a wide variety of awards/incentives to encourage participation and completion of the program d. Appropriate consequences and sanctions are used by the program and consequences for behavior are logical and designed to promote skill-building for the youth e. Counseling, verbal intervention and de-escalation techniques are used prior to physical intervention (Only techniques approved by the Florida Network and DJJ are used if physical intervention is required) f. Only staff discipline youth. Group discipline is not imposed g. Room restriction is not used as part of the system or for youth who are physically and/or emotionally out of control h. Youth should never be denied basic rights such as meals, clothing, sleep, services, exercise, or correspondence privileges	**Compliance**	The program uses natural consequences for violations of program rules. Consequences may include a "take five". Youth are encouraged to practice and successfully demonstrate an social skills, included in the CCYS behavior management system, especially "target skills". Target skills are individually identified at intake based upon the youth's presenting problems and incorporated into the youth's service plan. The staff uses teaching techniques to assist youth in developing their individualized target skills. The teaching techniques include: effective praise, proactive teaching and corrective teaching. The staff also utilizes trauma informed care designed to promote and build resiliency in youth while also building positive and supportive relationships with staff. Youth have groups and hands on exercises to foster critical thinking, problem solving, modeling real-life scenarios, practicing new behaviors, etc. The program uses special snacks and gift cards as incentives to encourage youth to work on target skills.	

Program's use of the BMS			
All staff are trained in the theory and practice of administering BMS rewards and consequences	**Compliance**	All staff are trained during orientation.	
There is a protocol for providing feedback and evaluation of staff regarding their use of BMS rewards and consequences	**Compliance**	Behavioral interventions are applied immediately and reviewed by the Shelter Manager. Appropriate use of the BMS by staff is acknowledged by the Shelter Manager. Inappropriate use is addressed one-on-one between the Shelter Manager and the staff member involved.	
Supervisors are trained to monitor the use of rewards and consequences by their staff	**Compliance**	Supervisor monitors the use of the behavioral interventions through observation, documentation in the log book and gives feedback during staff meetings and one-on-one interactions.	
Additional Comments: **There are no additional comments for this indicator.**			

3.06 - Staffing and Youth Supervision		**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 3.06	**YES** If NO, explain here: The agency has a policy that meets the requirements of the indicator. The policy, Supervision of Clients and Staff Responsibilities was last reviewed by the CEO on 03/31/2024.	

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

Dates or Timeframe Reviewed: most recent 30 days
Staff Position(s) Interviewed *(No Staff Names)* **: Shelter Manager**
Type of Documentation(s) Reviewed: Staff Schedules, agency policy, hold-over/ over-time schedule
Describe any Observations: Review of video recordings over past 30 days was conducted.

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**	Staff schedules for the past six months indicated that the program maintains staffing ratios in accordance with the FL Network's standards. A subsequent review of the cameras on 3/17/2024 midnight shift, 3/26/2024 evening shift, 4/7/2024 midnight shift, 4/3/2024 midnight shift, and on 3/29/2024 midnight shift and review of the shift logs, confirmed the shelter's compliance with their policy and the FL Network's standards, which states they will maintain at least the minimum staffing ratios of one staff to every six clients during the awake hours, and one staff to 12 clients during their hours of sleeping.	

All shifts must always provide a minimum of two direct care staff present that have met the minimum training requirements	**Compliance**	Per this agency policies all shifts must have at least two direct care staff (Youth Care Specialist) that have met minimum training necessary to work with the clients. Observation of the staff schedules confirmed compliance with the requirements of the agency maintaining at least two direct care staff on all shifts who have met the minimum training requirements necessary to work with the clients.	
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**	Per this agency policies all shifts must have at least two direct care staff (Youth Care Specialist), supervisor, treatment staff that have the necessary training, and background screening necessary to work with the clients. All staff on the staff schedule have been background screened and properly trained to work with the clients.	
The staff schedule is provided to staff or posted in a place visible to staff	**Compliance**	The agency are in compliance of having the staffing schedule posted. It is located near in the staffing station in the living room area that the clients utilizes throughout the day.	
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 overtime rotation roster which includes the names and the numbers of every staff is located on the bottom of their weekly schedule located in their staff station on the wall.	
Staff observe youth at least every 15 minutes while they are in their sleeping room, either during the sleep period or at other times, such as during illness or room restriction	**Compliance**	Camera checks and bed check logs were reviewed on 3/17/2024, 4/7/2024, 4/3/2024, 3/29/2024. The staff are conducting bed checks as documented on the bed logs, within every fifteen minutes.	
Additional Comments: **There are no additional comments for this indicator.**			
3.07 - Video Surveillance System			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 3.07	**YES**		
	If NO, explain here:		
	The agency has a policy that meets the requirements of the indicator. The policy, Alarm and security system was last reviewed by the CEO on 03/31/2024.		

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

Dates or Timeframe Reviewed: random dates within the recent 30 days of video recordings
Staff Position(s) Interviewed (No Staff Names): Shelter Manager
Type of Documentation(s) Reviewed: Supervisor Video Review log, List of staff with access to video surveillance system
Describe any Observations: Agency camera system

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**	This agency a surveillance system that meets all of the criteria of their policy. They have notifications throughout the shelter notifying all clients, staff, and visitors that they are under video surveillance at all times. This agency has seventeen operating cameras on the exterior and the interior of the shelter. Each of them are able to retain images for at least thirty days. They have the ability to continue recording whenever there is a power outage, because they have batteries in them. All seventeen cameras are visible, and none of them are located in any of the bathrooms or sleeping quarters.	
A list of designated personnel who can access the video surveillance system is maintained (includes off-site capability per personnel)?	**Compliance**	This agency has a list of their designated personnel of who can access their surveillance system.	
Supervisory review of video is conducted a minimum of once every 14 days and timeframes reviewed are noted in the logbook.	**Compliance**	This agency has a list of their designated personnel who has access to their surveillance system located on the first page of their video log.	
The reviews assess the activities of the facility and include a review of random sample of overnight shifts	**Compliance**	A review of five different shifts was conducted. Four in which was the overnight shifts, and one was of the evening shift. The four overnight shifts reviewed were as follows. 3/17/2024, 3/29/2024, 4/3/2024, 4/72024. And the evening shift was on 3/26/2024. On these days observation was made of varies activities and bed checks.	
Grant the requesting of video recordings to yield a result within 24-72 hours from program quality improvement visits and when an investigation is pursued after an allegation of an incident	**Compliance**	Interview with the shelter manager indicates that the program has the ability to grant a request of video recording within 24-72 hours .	
Camera service order/requests will be made within 24 hours of discovery of camera malfunctioning or being inoperable. All efforts made to obtain repairs are documented and maintained	**Compliance**	This agency policy covers the fact that there must be proof of an request within twenty four hours of being discovered that any of the cameras are malfunctioning, or inoperable.	

Additional Comments: **There are no additional comments for this indicator.**			
4.01 - Healthcare Admission Screening			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 4.01		**YES** If NO, explain here: The agency has a policy, Health Screening on Admission, reviewed and approved by the CEO on April 2024.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: One **Total number of Closed Files: Four** **Staff Position(s) Interviewed** *(No Staff Names)* **: Shelter Manager** **Type of Documentation(s) Reviewed: Policy/Procedures. Shelter Intake form** **Describe any Observations: Files were neat and organized. Information contained in each of the files was easy to find.**			
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**	Five residential files were reviewed. One file was open and four were closed. A health screening was present in each of the files reviewed. Each screening included: current medications; existing medical conditions; allergies; recent injuries or illnesses; presence of pain or other physical distress; observation for evidence of illness, injury, physical distress; presence of scars, tattoos; and acute health symptoms that may require quarantine or isolation.	
Referral and Follow-Up			
Youth with chronic medical conditions have a referral to ensure medical care (e.g. diabetes, pregnancy, seizure disorder, cardiac disorders, asthma, tuberculosis, hemophilia, head injuries, etc.)	**No eligible items for review**	The program has procedures in place to address youth with chronic medical conditions to have a referral and ensure medical care. Five out of five files reviewed did not reveal a medical condition for which a referral was needed.	
When needed, the parent is involved with the coordination and scheduling of follow-up medical appointments	**No eligible items for review**	The program has procedures in place to coordinate and schedule follow-up medical appointments when parents are involved. Five out of five files reviewed did not need parental involvement due to medical appointments.	

All medical referrals are documented on a daily log.	**No eligible items for review**	Per policy: Mental Health/Substance Abuse master plan, medical referrals are required to be documented. Five out of the five files which were reviewed, none needed medical referrals. Shelter manager was interviewed regarding adherence to this policy, and she stated that if a referral is made, it will be noted in youth's file.	
The program has a thorough referral process and a mechanism for necessary follow-up medical care as required and/or needed	**Compliance**	Per policy: Mental Health/Substance Abuse master plan, a thorough referral process exists in the program.	
Additional Comments: **There are no additional comments for this indicator.**			
4.02 - Suicide Prevention			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 4.02		**YES** If NO, explain here: The agency has policies in place that meet the requirement for Indicator 4.02: Mental Health and Substance Abuse Master Plan and Suicide Prevention. Both policies were approved and reviewed by the CEO on April 2024	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open (Residential & Community) Files: Three **Total number of Closed (Residential & Community) Files: Six** **Staff Position(s) Interviewed** *(No Staff Names)* **: Shelter Manager** **Type of Documentation(s) Reviewed: Shelter Intake form, ASR, and CSS log**			
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**	Nine files were reviewed: Five were residential (one open/ four closed), and four(two open/ two closed) were community counseling. A suicide screening was present in all nine files. On three residential files, a youth answered "Yes" to at least one of the suicide questions, and placed on Constant Sight and Sound. One out of the four in community counseling answered "Yes" to one or more suicide risk questions, and was immediately assessed by a trained staff member.	
The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	**Compliance**	The suicide risk tool used, is approved by the Florida Network.	
Supervision of Youth with Suicide Risk *(Shelter Only)*			

Youth are placed on the appropriate level of supervision based on the results of the suicide risk assessment.	**Compliance**	Three out of five files reviewed needed an Assessment for Suicide Risk (ASR) to be completed. All three of those youths were placed at an appropriate level following the results of the assessment.	
Staff person assigned to monitor youth maintained one-to-one supervision or constant supervision and documented his/her observations of the youth's behavior at 30 minute or less intervals	**Compliance**	Three out of five files reviewed contained CSS logs. Staff assigned to monitor youth placed on constant supervision, did so every ten minutes. Observations were documented on constant sight and sound (CSS) log.	
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**	Three out of five files reviewed contained CSS logs. Only three CSS logs were reviewed, and all included time of day; behavioral observations; any warning signs; and staff initials.	
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**	Three of the five residential files reviewed needed an ASR. Upon reviewing the ASRs and CSS logs, it was observed that a youth's supervision only changed once a licensed professional reviewed the results of the ASR.	
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**	Five residential files were reviewed. Only three were required to have observation logs. Each of the observation logs completed by staff on each shift. Completed 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**	Four community counseling files were reviewed. One out of the four required an ASR. ASR was completed by non-licensed professional under the direct supervision of a licensed mental health professional.	

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**	Of the four community counseling files reviewed, a trained/qualified member was present and able to complete an ASR.	
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**	Screenings in the four community counseling files reviewed were completed with the parent/guardian and no further assessment was necessary.	
If the parent/guardian cannot be contacted, all efforts to contact them are documented in the case file.	**Compliance**	Four community counseling files reviewed contained chronological notes detailing attempts and completed calls with parents/guardians.	
When the screening was completed during school hours on school property, the appropriate school authorities were notified.	**No eligible items for review**	Four community counseling files were reviewed. None of the screening were completed during school hours on school property.	
Additional Comments: **There are no additional comments for this indicator.**			

4.03 - Medications			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 4.03		**YES** If NO, explain here: This policy content addresses all requirements for this indicator. The policy, medication, was reviewed and approved by the Chief Executive Officer in April 2024	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: One **Total number of Closed Files: Four** **Staff Position(s) Interviewed** *(No Staff Names)* **: CEO, Shelter Manager, YCS, RN** **Type of Documentation(s) Reviewed: RN transcript**			
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 an RN on staff. Date of employment was April 2022.	
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 sign-in sheets, meeting minutes, and medication policy and procedure shows the program's non-nursing staff is trained and demonstrates competency to assist with self-administration of medication distribution. Morning medication pass was observed. Non-nursing shelter staff, whom has been employed with the agency for 12 years, was able to provide a step by step procedure of medication pass. In the training log, documentation of annual re-certification was observed.	
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**	A review of the agency's staff meetings indicated that meetings to review and assess, implement strategies to reduce medication errors shelter wide, and analyze factors that contributed to medications errors are being held at least quaterly. Meeting minutes dated 10/04/2023 and 1/24/2024, showed evidence that staff are allowed the opportunities to practice and role-play solutions.	
The agency has strategies implemented to ensure medications are provided within the 2-hour time frame.	**Compliance**	The agency uses numerous strategies to ensure meds are provided within a two hour window. These include alarms; med book with youth's picture, list of medications, and times they should be administered; and the youth's file also contains a list of the medications.	

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**	Staff schedule clearly identifies which staff is responsible for assisting in 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 does have clear methods of identifying youth who are on medications. They provide a "hot dot" system; medications are listed on a pink paper, which is placed in the youth's file; and the medication log for each of the youth's medications.	
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**	An AM medication pass was observed. Medication pass occurred as prescribed in Florida Network policy and as detailed in the agency's policy (Medication).	
Admission/Intake of Youth			
a. Upon admission, the youth and parent/guardian (if available) were interviewed by the Registered Nurse (when on-site) about the youth's current medications as part of the Medical and Mental Health Assessment screening process and/or an interview was conducted by the RN within three (3) business days if the RN was not on the premise at admission. **If the agency does not have a RN, there was a medication review conducted by a certified Leadership position.* b. Upon intake/admission, there is evidence that the on-shift certified supervisor of higher level staff did review all medication forms by the next business day.	**Compliance**	Five residential files were reviewed. A health screening was present in each of the five files that were reviewed. All health screenings were signed by the RN and a supervisor within three business days.	
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**	The agency adheres to guidelines set forth by the Florida Network of Youth and Family Services (FNYFS). All medications are stored in the Pyxis; oral medications are stored separately from injectable epi-pen and topical medications; the temperature in the medication fridge was 42 degrees at time of the visit, the room in which it is located in is inaccessible to youth; all narcotics are stored in the Pyxis station; and all Pyxis keys were present and appropriately labeled.	
Medication Distribution			
a. Agency maintains a minimum of 2 site-specific System Managers for the Pyxis ES Station b. Only designated staff delineated in User Permissions have access to secured medications, with limited access to controlled substances (narcotics) c. A Medication Distribution Log shall be used for distribution of medication by non-licensed and licensed staff d. Agency verifies medication using one of three methods listed in the FNYFS Policies & Procedures Manual e. When nurse is on duty, medication processes are ALWAYS conducted by the nurse or when the nurse is not onsite, then the designated staff who has been trained by a licensed Registered Nurse provides the medication. f. Agency does not accept youth currently prescribed injectable medications, except for epi-pens h. Non-licensed staff have received training in the use of epinephrine auto-injectors provided by a registered nurse	**Compliance**	The program maintains a minimum of eight System Managers for the Pyxis ES Station. Furthermore, the program has designated certain staff permissions to have access to secured medications, with limited access to controlled substances. The program utilizes a medication distribution log for distribution of medication by a non-licensed and licensed staff member. The agency verifies medication using one of the three methods listed in FNYFS policy and procedure document. The delivery process is consistent with the FNYFS medication management and distribution policy. The program does not accept youth who are prescribed injectable medications, excluding epi-pens. When on duty, the RN does assist with the delivery of medications to clients. The RN also conducts a follow up review on all health records of clients admitted to the program when she is not on duty.	

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, provided clear indication of the time of medication administration; youth initials were present; and staff initials were present that the dosage was given.	
There is evidence that staff provide youth with medications within one hour of the scheduled time of delivery as ordered by the medication. Documentation is provided for instances this does not occur within the required timeframe.	**Compliance**	Medication logs were reviewed. It was evident that all medication passes were completed within one hour of the scheduled time of delivery as ordered by the medication.	
During the review period, there were no instances where youth missed their medication due to failure to open the pyxis machine.	**Compliance**	There was no evidence of instances were 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.	**No eligible items for review**	There was no occurrences of medication error where it was necessary for the staff member to receive refresher training from and RN.	
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**	During this on-site visit, it was observed that the program keeps a perpetual inventory of controlled substances; all over-the-counter medications are inventoried weekly; and all sharps are secured/counted and documented weekly.	

There are monthly reviews of the Pyxis reports to monitor medication management practice.	**Compliance**	Pyxis reports are generated monthly and reviewed by the RN.	
Medication discrepancies are cleared after each shift.	**No eligible items for review**	During this on-site review, medication discrepancies were not noted for the review period. The RN was able to provide a thorough explanation on how such a discrepancy would be cleared.	
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 policy is Mental Health and Substance abuse Master plan. This policy content addresses all requirements for this indicator. The policy was reviewed and approved by the Chief	
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: One **Total number of Closed Files: Four** **Staff Position(s) Interviewed** *(No Staff Names)* **: Shelter manager** **Type of Documentation(s) Reviewed: Training log, Policies and Procedures**			
Youth with a medical, mental health, or food allergy was appropriately placed on the program's alert system	**Exception**	Five files were reviewed. Four out of the five had all necessary alerts.	One file was missing a yellow alert. Per Policy for Mental health/substance abuse, a food allergy requires a yellow alert, which was not present in youth's file.
Alert system includes precautions concerning prescribed medications, medical/mental health conditions	**Compliance**	Five out of five reviewed, showed evidence of proper alerts concerning prescribed medications and medical/mental health conditions.	
Staff are provided sufficient training, information and instructions to recognize/respond to the need for emergency care for medical/mental health problems	**Compliance**	Based on documents reviewed (training logs/meeting minutes/incident reports/CCC calls), staff receive sufficient training to recognized/respond to any medical/mental health emergency.	

A medical and mental health alert system is in place that ensures information concerning a youth's medical condition, allergies, common side effects of prescribed medications, foods and medications that are contraindicated, or other pertinent mental health treatment information, is communicated to all staff	**Compliance**	Proper alert system in place in order to identify and alert staff of any medical conditions, allergies, common side effects of prescribed medications, foods and medications that are contraindicated, or other pertinent mental health treatment information.	
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: Mental Health/Substance Abuse Master Plan, meets the requirements for Indicator 4.05. Policy was reviewed and approved by CEO on April 2024.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: One **Total number of Closed Files: Four** **Staff Position(s) Interviewed** *(No Staff Names)* **: Shelter Manager** **Type of Documentation(s) Reviewed: Unusual Incident reports, CCC reports, and Episodic log**			
Off Site Emergency Care			
a. If off-site emergency medical or dental care was provided, an incident report was submitted for the medical or dental care b. Upon youth return, there is a verification receipt of medical clearance via discharge instructions with follow-up is present in file c. Youth's parent/guardian was notified d. A daily log is maintained for emergency care provided	**Compliance**	A review of episodic log along with unusual incident reports, which some required a call to the CCC, provided evidence of procedures for off-site emergency care. The program maintains a daily log for emergency care provided and submits an unusual incident report for the medical or dental care. Verification of medical clearance via discharge instructions with follow-up is present in the youth file, documentation of notification of the parent/ guardian is also noted in the youth file.	
All staff are trained on emergency medical procedures	**Compliance**	Evidence of training for all staff on emergency medical procedures was shown through meeting minutes; staff training logs; and training sign in sheets reviewed on-site.	
The program has a Knife-for-life and wire cutters accessible to staff in a secure location(s)	**Compliance**	A set of Knife for life and wire cutters are kept locked away in the staff station. An additional set is kept in the binder with the transportation logs and taken by staff in company vehicles, when transporting youth.	
Additional Comments: **There are no additional comments for this indicator.**			