Florida Network for Youth and Family Services
Compliance Monitoring Report for

CDS Interface Youth Program East

2919 Kennedy Street Palatka, Florida 32177
March 6-7, 2024

Compliance Monitoring Services Provided by
FOREFRONT

EXECUTIVE SUMMARY

Forefront LLC conducted a joint Modified Quality Improvement (QI) and Florida Network of Youth and Family Services (FNYFS) monitoring visit on March 6-7, 2024, for the FY 2022-2023 CDS-Interface Youth Program East (CDS-IYP East) CINS/FINS program at its program office located at 2919 Kennedy Street, Palatka, Florida 32177 location. 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. The CDS-IYP East agency 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 Keith Carr, Consultant for Forefront LLC and members of the Quality Improvement program review team. Agency representatives from CDS-IYP East present for the entrance interview were, Cindy Starling, Chief Executive Officer, Alex Culbreth, Regional Director, Lyntinia McCullough, Community Counselor, LaToya Robinson, Residential Counselor, Monica Heinecker, Senior Youth Care Worker, Karen Bethel, Administrative Assistant. The last QI visit was conducted May 3-4, 2023.

In general, the Reviewer found that CDS Central is in compliance with specific contract requirements. **CDS Central received an overall compliance rating of 100% for achieving full compliance with 12 indicators** of the CINS/FINS Monitoring Tool. There were no corrective actions as a result of the monitoring visit.

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

2023-2024 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 03-6-7-2024-CDSE

Agency Name: CDS-IYP East	**Monitor Name: Keith Carr, Lead Reviewer**
Contract Type : CINS/FINS	**Region/Office: 2919 Kennedy Street Palatka, Florida 32177**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): March 6-7, 2024**

Major Programmatic Requirements	**Explain Rating**					**Ratings Based Upon:** **I = Interview** **O = Observation** **D = Documentation** **PTV = Submitted Prior To Visit** **(List Who and What)**	**Notes** **Explain Unacceptable or Conditionally Acceptable:**
	Unacceptable	**Conditionally Unacceptable**	**Fully Met**	**Exceeded**	**Not Applicable**		
I. Administrative and Fiscal							
DJJ 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.	☐	☐	☒	☐	☐	I,D: The program has three staff members that are certified as peer reviewers for this location. The agency has seven certified peers across all three program locations: Phil Kabler, Alex Culbreth, LaToya Robinson, Sabriena Williams. Naomi Thompson, Brian Smith, Kevin Lee.	**No recommendation or corrective action identified at this time.**
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**	☐	☐	☒	☐	☐	I D: The agency provided a list of all current contracts for the FY2023-2024 including the grantees name and grant amount awarded for the fiscal term. The list included the Florida Network contracts and the 4 additional contracts through other funding sources. The agency reported additional contracts with LSF Health Systems prevention programs; U.S. HHS/Administration for Children and Families/Family and Youth Services Bureau grants related to the Gainesville and Palatka shelters and Partnership for Strong Families and Basic Center.	**No recommendation or corrective action identified at this time.**

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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**	☐	☐	☒	☐	☐	T D,PTV: General Liability through Berkshire Hathaway Specialty Insurance Company, for limits of coverage $1,000,000 each $3,000,000 aggregate, $20,000 individual medical, $1,000,000 personal & adv injury, and $1,000,000 employee benefits, effective 1/10/24 – 1/10/2025. Automobile insurance through Berkshire Hathaway Specialty Insurance Company, for combined single limits of $1,000,000, and PIP Basic for $10,000. Policy effective for 1/10/24 – 1/10/2025. An umbrella liability policy through Berkshire Hathaway Specialty Insurance Company, for $1,000,000 each/aggregate. Policy effective for 1/10/24 – 1/10/2025.	**No recommendation or corrective action identified at this time.**

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						Workers Compensation through Bridgefield Casualty Insurance Company for $500,000 each accident. Effective 5/1/2023 – 5/1/2024. Abuse and Molestation coverage through Berkshire Hathaway Specialty Insurance Company for $1,000,000 each and $3,000,000 aggregate. Effective 1/10/24 – 1/10/2025 Professional Liability Coverage through Berkshire Hathaway Specialty Insurance Company for $1,000,000 each and $3,000,000 aggregate. Effective 1/10/24 – 1/10/2025. Management Liability through the Travelers Casualty and Surety Company of America Company for $1,000,000 for D&O/EPLI, fiduciary liability and/or employee theft that is effective 4/6/2023-4/6/2024.	

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						Florida Network is listed on the Worker's Compensation certificate as certificate holder.	
External/Outside Contract Compliance a. Provider has corrective action item(s) cited by an external funding source (Fiscal or Non-Fiscal). **ON SITE**	☐	☐	☐	☐	☒	At the time of this onsite program review, the agency has no assigned non-fiscal or fiscal related corrective action requirements to fulfill.	**No recommendation or corrective action identified at this time.**
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**	☐	☐	☒	☐	☐	I PTV: Agency reports that they have fiscal Policies and Procedures which are contained in the CDS and Behavioral Health Services' Financial Management Policy. The P-1257 Petty Cash Policy reviewed. The most recent update and revision is related to Fiscal policies and procedures January 2022.	**No recommendation or corrective action identified at this time.**
b. Agency maintains a general ledger and the corresponding source documents. A general ledger must be set up to track the activity of the grant separately (standard account numbers / separate funds for each revenue source, etc.). **PTV**	☐	☐	☒	☐	☐	D: Detailed General Ledger for the current FY July 2023 through February 2024 was provided and reviewed. Agency maintains a detailed general ledger that is structured to track all funding sources as well as activities	**No recommendation or corrective action identified at this time.**

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	Unacceptable	**Conditionally Unacceptable**	**Fully Met**	**Exceeded**	**Not Applicable**		
						for the shelter and each program separately.	
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**	☐	☐	☒	☐	☐	O/D: The agency reported no change in petty cash practice was reported for the agency since the last onsite program review. The agency reported $150 is the maximum amount allotted for petty cash. At time of review, $140 was present in the cash box. The petty cash is stored in a secure location in youth shelter. The petty cash is reconciled on a consistent basis (monthly/quarterly) by the Residential Supervisor and reviewed by the Regional Director,	**No recommendation or corrective action identified at this time.**
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**	☐	☐	☒	☐	☐	PTV,D: Agency provided Bank Statements and Bank Reconciliations for the past six months, August/2023 – January/2024, for one account held with the bank of record. Financial Statements are reported on a monthly basis and were found to be current. Bank reconciliations are conducted each month for the activities and bank statements for the preceding month. Each reconciliation report includes who	**No recommendation or corrective action identified at this time.**

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						completed the reconciliation. Invoices are submitted on a monthly basis with supporting documentation.	
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**	☐	☐	☐	☐	☒	I/D: Per CDS-East Regional Director, the agency has not purchased any property with FNYFS funds for the current fiscal year.	**No recommendation or corrective action identified at this time.**
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**	☐	☐	☒	☐	☐	PTV,D: Agency provided documentation in bank statements that payroll taxes are paid each payroll period to the IRS, for the last six months.	**No recommendation or corrective action identified at this time.**
g. Budget to actual reports prepared and reviewed by appropriate management. Variance from the budget are investigated and explained. **PTV/ON SITE**	☐	☐	☒	☐	☐	PTV,D: Agency provided a year-to-date report for the current fiscal year August 2023-February 2024. The report shows Actual, Budget, and Variance with Total Revenue Over Expense with each program having designated codes. Variances in budget are monitored on a regular basis and are discussed with the Board by the Budget and Financial Committee. If	**No recommendation or corrective action identified at this time.**

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						changes need to be made to the budget, then the individual shelter is notified.	
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**	☐	☐	☒	☐	☐	D: Financial audit conducted for year ending June 30, 2023, and 2022 was completed by James Moore, C.P.A. and Consultants and dated December 2023. Per the audit report, a separate Management Letter requiring a Corrective Action Plan is not required and was not issued by the auditor.	**No recommendation or corrective action identified at this time.**
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**	☐	☐	☒	☐	☐	D: Policies and procedures for IT Confidentiality, HIPAA, Personnel Policies and Personnel Records, Record Elimination, Security, and Loss Prevention was provided for review. Accounting data files are backed up every night. Other critical servers, microcomputers and laptops complete scheduled back-ups on a secured portable hard drive. Obsolete fiscal record documents may be shredded after six years, participant records	**No recommendation or corrective action identified at this time.**

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						follow the funders timeframes and personnel files for a period of not less than seven years.	
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**	☐	☐	☒	☐	☐	PTV, D: Per Interview with Regional Director. As of October 1, 2023 all staff have personnel action forms verifying pay increase of a minimum of $19.00 per hour.	**No recommendation or corrective action identified at this time.**

CONCLUSION

CDS Family & Behavioral Health, Inc. (IYP – East) has met the requirements for the CINS/FINS contract as a result of full compliance with 12 applicable indicators of the Administrative and Fiscal Contract Monitoring Tool. Two of the twelve indicators were not applicable because 1) The agency has not purchased any property with FNYFS funds for the current fiscal year and 2) the provider indicated that there are no outstanding corrective action item(s) cited by an external funding source. Consequently, **the overall compliance rate for this contract monitoring visit is 100%.** There are no corrective actions cited as a result of the contract monitoring visit. Overall, the provider is performing satisfactorily in meeting the fiscal and administrative terms of its contract. In addition, the majority of indicators reviewed were carried out in a manner which meets the standard described in the report findings.

SUMMARY OF RECOMMENDATIONS

No Recommendation or Corrective Action.

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

Florida Network of Youth and Family Services Quality Improvement Program Report

Review of CDS Family Behavioral Interface East (Palatka)
CINS/FINS Program

Date: March 6-7, 2024

Compliance Monitoring Services Provided by

FOREFRONT

CINS/FINS Rating Profile

Standard 1: Management Accountability

1.01 Background Screening of Employees/Volunteers	Satisfactory
1.02 Provision of an Abuse Free Environment	Satisfactory
1.03 Incident Reporting	Satisfactory
1.04 Training Requirements	Satisfactory
1.05 Analyzing and Reporting Information	Satisfactory
1.06 Client Transportation	Satisfactory
1.07 Outreach Services	Satisfactory

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

Standard 2: Intervention and Case Management

2.01 Screening and Intake	Satisfactory
2.02 Needs Assessment	Satisfactory
2.03 Case/Service Plan	Satisfactory
2.04 Case Management & Service Delivery	Satisfactory
2.05 Counseling Services	Satisfactory
2.06 Adjudication/Petition Process	Satisfactory
2.07 Youth Records	Satisfactory
2.08 Special Populations	Not Applicable
2.09 Stop Now and Plan (SNAP)	Not Applicable

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

Standard 3: Shelter Care & Special Populations

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

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

Standard 4: Mental Health/Health Services

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

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

Overall Rating Summary

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

Rating Definitions

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

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

Reviewers

Members

Keith Carr - Lead Reviewer Consultant-Forefront LLC/Florida Network of Youth and Family Services
Kristine Harshaw – Operations Review Specialist, Bureau of Monitoring and Quality Assurance, Fl
Jovia Dukes, – Program Director, Youth and Family Alternatives
Pierre Bandoo – Compliance Administrator, Crosswinds Youth Services
Kim Stone – Operations Supervisor, SMA Beach House

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

Documents Reviewed

X	Accreditation Reports	X	Table of Organization	X	Visitation Logs
X	Affidavit of Good Moral Character	X	Fire Prevention Plan	X	Youth Handbook
X	CCC Reports	X	Grievance Process/Records	6	# Health Records
X	Logbooks	X	Key Control Log	6	# MH/SA Records
	Continuity of Operation Plan	X	Fire Drill Log	6	# Personnel /Volunteer Records
X	Contract Monitoring Reports	X	Medical and Mental Health Alerts	8	# Training Records
X	Contract Scope of Services	X	Precautionary Observation Logs	6	# Youth Records (Closed)
X	Egress Plans	X	Program Schedules	4	# Youth Records (Open)
X	Fire Inspection Report	X	List of Supplemental Contracts	6	# Other: ___
X	Exposure Control Plan	X	Vehicle Inspection Reports		

Observations During Review

X	Intake	X	Posting of Abuse Hotline	X	Staff Supervision of Youth
X	Program Activities		Tool Inventory and Storage	X	Facility and Grounds
X	Recreation	X	Toxic Item Inventory & Storage	X	First Aid Kit(s)
X	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
	Medication Administration	X	Staff Interactions with Youth	X	Census Board

Surveys

3	# 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.

Strengths and Innovative Approaches

The CDS-Interface East (CDS-IYP East) is a sub-contract service provider of Childrens In Need of Services and Families In Need of Services (CINS/FINS) with the Florida Network of Youth and Family Services (FNYFS). The CDS agency is headquartered in 3615 SW 13th Street, #4, Gainesville, FL 32608. The CDS-IYP East agency is located at 2919 Kennedy Street, Palatka, Florida 32177 and provides services to Judicial Circuits 7 and 8 which include services to Putnam and Bradford Counties.

The following programmatic updates were provided by the agency:

The CDS agency reported they have been awarded increases in the Florida Network CINS/FINS and LSF Health Systems prevention programs contracts. The agency reported their HHS/Administration for Children & Families/Family & Youth Services Bureau grants related to the Gainesville and Palatka shelters were renewed for three years. The agency reported this is part of its internal planning process, the Partnership for Strong Families moved the Independent Living in-house.

In concert with its Board of Directors and its Development Committee, the agency actively engaged in a number of funding opportunities, including public and private third-party donations and grant applications. The agency reported having received funding and other support from the Clay Electric Foundation (for the IYP-Palatka shelter), Community Foundation for NE Florida (for the IYP-Lake City), Downtown Gainesville and Sunrise Rotary Clubs (for the IYP-Gainesville shelter), U.S. FEMA – Emergency Food and Shelter Program (administered by the United Way of North Central Florida; for the IYP-Gainesville shelter), and the United Way of Suwannee Valley (for the IYP-Lake City shelter). We further participated in the Amazing Give and the U.F. Campaign for Charities.

The CDS Board of Directors has an ongoing internal donation campaign. Towards that end, the agency reported its Annual Meeting and Celebration was underwritten by several business, banking, and individual donors. It is the intent of the Board's Development Committee that this sponsored event will serve as the basis for future fundraising and development activities.

The CDS Board of Directors is in the midst of preparing a new Strategic Implementation Plan and updating its Articles of Incorporation and Bylaws. Further, the Board reported as has been done with the funding opportunities described above, CDS has increased its partnerships, and continued its ongoing partner relationships, including with: BAYS Florida; CARE Connect + BRAVE; Circuits 3 & 8 Behavioral Consortium; Children's Trust of Alachua County; Community Foundation of North Central Florida; Community Foundation for NE Florida; Eighth Judicial Circuit Bar Association; Eighth Judicial Circuit State Attorney's Office; Florida Department of Children & Families; Florida Department of Juvenile Justice (including County Councils and Circuit Advisory Boards); Florida Juvenile Justice Association; Florida Network of Youth and Family Services; Gainesville Black-on-Black Crime Task Force; Greater Gainesville Chamber of Commerce; LSF Health Systems; National Runaway Safeline; National Safe Place Network; North Central Florida Human Trafficking Task Force; Putnam Safety Alliance; United Way of North Central Florida; United Way of St. Johns County; United Way of Suwannee Valley; U.S. HHS/Administration for Children & Families/Family & Youth Services Bureau. We continue to actively pursue new partnerships and

CDS reported that the agency is also developing an ongoing program of larger community events throughout our catchment area. Its most significant events to-date include its 2023 Annual Meeting and Celebration (featuring Susan Frankel, the National Runaway Safeline CEO, as Keynote Speaker), National Runaway Prevention Month, National Safe Place Week, and Child Abuse Prevention Week. Additionally, the agency also participated in other local agencies' events as a supportive partner; for example, they hosted a regional SNAP Facilitators training and Motivation Interviewing, and are under consideration to host a QI Peer Reviewer Refresher course.

CDS has an active public presence, including a website, active Facebook, Instagram, Threads, TikTok, and LinkedIn pages for both CDS and SNAP at CDS, and a small YouTube page.

CDS and its Team have received the following awards: Florida Network of Youth and Family Services 2023 Agency of the Year - CDS; DJJ Service Excellence Award - Stephanie Douglas, MA, LHMC – Family Action Program, IYP-Lake City Supervisor); North Central Florida Human Trafficking Task Force "Rise Award" – CDS Board Treasurer Frank Williams, Esq.; and National Runaway Safeline – National Runaway Prevention Month "Greenest Team" Finalist - CDS

During the past year CDS' reported their management structure has remained stable and the agency has added a Certified Public Accountant as Chief Financial Officer.

Narrative Summary

The CDS-IYP East shelter provides counseling and case management services through its residential and non-residential programs and some services are available virtually to accommodate families on a case by case basis. The residential program provides groups, family, and individual counseling sessions for our participants in the shelter. The non-residential program provides services in schools, in home, and virtually, as needed. CDS-IYP East holds an accreditation from CARF which is valid through April 30, 2024 and is licensed by DCF Child Caring License/Runaway/Emergency Shelter for 12 beds.
The program maintains paper files for all youth records that are kept in a locked cabinet marked confidential behind a locked door. Services are primarily provided in home or at school and can be virtual on a verified and case-by-case basis. The Community Counseling Supervisor advised that truancy court or the residential shelter are the primary source for referrals.

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

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

Standard 2: There are nine indicators for Standard 2. Indicator 2.01 Screening and Intake was rated **Satisfactory**, Indicator 2.02 Needs Assessment was rated **Satisfactory**, Indicator 2.03 Case/Service Plan was rated **Satisfactory with Exceptions**, Indicator 2.04 Case Management and Service Delivery was rated **Satisfactory with Exceptions**, Indicator 2.05 Counseling Services was rated **Satisfactory**, Indicator 2.06 Adjudication/Petition Process was rated **Satisfactory**, Indicator 2.07 Youth Records was rated **Satisfactory**, Indicator 2.08 Specialized Additional Program Services was **Not Applicable**, and Indicator 2.09 Stop Now and Plan (SNAP) was **Not Applicable**.

Standard 3: There are seven indicators for Standard 3. Indicator 3.01 Shelter Environment was rated **Satisfactory with Exceptions**, 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**, and 4.05 Episodic/Emergency Care was rated **Satisfactory with Exceptions**.

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

None of the indicators reviewed were rated Limited or Failed.

CINS/FINS QUALITY IMPROVEMENT TOOL

Quality Improvement Indicators and Results: Please select the appropriate outcome for each indicator for each item within the indicator.	**Summary/Narrative Findings:** The narrative write-up is a thorough summary of each assigned QI indicator, explaining how finding(s) are determined.	**Deficiencies/Exceptions:** Please add additional detailed explanations for any items that have any deficiencies or exceptions.

Standard One – Management Accountability

1.01: Background Screening of Employees, Contractors and Volunteers		**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 1.01	**YES**	
	If NO, explain here:	
	The agency has a policy and procedure P-1025 Background Check, Reference Check, Fingerprinting for Personnel, Volunteers, or Interns; P-1292 Pre-employment Suitability Assessment; P-1268 E-Verify. These policies were approved 1/11/2024 by Cindy Starling COO.	

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

Total number of New Hire Employee/Intern/Volunteer Files: 3
Total number of 5 Year Re-screen Employee Files: 3
Staff Position(s) Interviewed *(No Staff Names)*: **Regional Director**
Type of Documentation(s) Reviewed: staff roster, background screens, pre-employment suitability assessment
Describe any Observations: Observations of staff background screens and pre-employment suitability assessments for three new employees and three five year re-screens were made.

All positions providing direct services to youth has successfully passed pre-employment suitability assessment on the initial attempt.	**Compliance**	The program uses a pre-employment suitability assessment called "Criteria". Three pre-employment suitability assessments were observed for the three employees hired during the review period. Each of the three newly hired staff have successfully passed the suitability assessment on their initial attempt.	
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.	**Compliance**	There were no new employees that did not pass the initial suitability assessment.	
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.	**Compliance**	There were no employees with a break in service as evidenced by the employee roster.	

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**	Each of the three newly hired employees had an eligible background screen completed prior to being hired.	
Five-year re-screening is completed every 5 years from the date of the last screening or prior to retained fingerprints expiration date.	**Compliance**	Three employees were eligible for a five year background re-screen. All three were completed prior to the five year anniversary of their prior screening or the expiration date of the fingerprints. One is still pending results.	
Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?	**Compliance**	Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) was completed and sent to BSU by January 31st as reflected on the affidavit signed on January 10, 2024.	
Proof of E-Verify for all new employees obtained from the Department of Homeland Security	**Compliance**	Proof of E-Verify was obtained for each of the three new employees and is retained in the personnel files.	
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 policies and procedures P-1032 called Behavioral Expectations of Staff; and P-1212 Standards of Conduct. The polices were last approved 1/11/2024 by Cindy Starling, COO.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Staff Position(s) Interviewed *(No Staff Names)* **: Regional Director** **Type of Documentation(s) Reviewed: youth surveys, abuse reports, CCC report, policy** **Describe any Observations: Observations of youth surveys, abuse/incident reports, and CCC reports were made.**			
Agency has a code of conduct of policy and there is evidence that staff are aware of agency's code of conduct.	**Compliance**	The program has a code of conduct for staff, which is signed by staff during orientation.	
The agency has a process in place for reporting and documenting child abuse hotline calls.	**Compliance**	The program has contacted the abuse hotline two times in the last six months. Neither call was involving program staff or the youth's parent or guardian.	

Youth were informed of the Abuse and Contact Number	**Compliance**	Four out of four youth reported they were given information about contacting the abuse hotline during their orientation. Three of the four interviewed youth could identify where the number is located, and none of the four have attempted or needed to make an abuse call.	
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 grievance policy and process that is accessible and responsive to youth needs. In each instance, the program director or supervisor addressed complaints from youth in a timely manner. Each grievance contains a youth and staff signature reflecting youth have agreed with the findings.	
Shelter only: Grievances are maintained on file at minimum for 1 year.	**Compliance**	Grievances are kept in the grievance binder for at least one year.	
Shelter only: There are formal grievance procedures for youth, including grievance forms, and a locked box which are easily accessible to youth in a common area.	**Compliance**	Grievance forms are available to youth in the lobby and are to be returned to the grievance box, where the director has access to their submissions.	
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**	Grievance boxes are checked daily by the regional director and each check is logged in the logbook, noting if there are any and if so how many.	
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**	Each observed grievance was resolved within the required timeframes.	
1.03: Incident Reporting			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 1.03		**YES** If NO, explain here: The agency has a policy and procedure P-1044 Florida Abuse Reporting; P-1045 Incident Reporting Procedure and P-1051 Unusual Event Report - Internal. The policies are approved 1/11/2024 by Cindy Starling Chief Operations Officer.	
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)* **: Regional Director**
Type of Documentation(s) Reviewed: Abuse call binder, incident reports, CCC report
Describe any Observations: Observations of abuse call reports, CCC reports, and internal incident reports were made.

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	**Compliance**	In each of the reviewed incidents, reports were made to the Central Communications Center (CCC) no later than two hours after an incident occurred or within two hours of the program learning of the incident.	
The program completes follow-up communication tasks/special instructions as required by the CCC	**Compliance**	In each of the review incidents, follow up communications and special instructions were completed as required in each instance.	
Agency internal incidents are documented on incident reporting forms and all CCC reportable incidents were consistently reported to CCC as required.	**Compliance**	Internal incidents are recorded in an event log binder and are consistent with the incidents recorded in the CCC reports.	
Incidents are documented in the program logs and on incident reporting forms	**Compliance**	Each of the observed incident reports were appropriately documented on the correct forms.	
All incident reports are reviewed and signed by program supervisors/ directors	**Compliance**	There were eight total reportable incidents during the review period.	

1.04: Training Requirements (*Staff receives training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions*) — **Satisfactory with Exception**

Provider has a written policy and procedure that meets the requirement for Indicator 1.04	**YES**	
	If NO, explain here:	
	Agency policy and procedure P-1030 is called 1.04 Training Requirements. The policy was reviewed and approved on 1/11/2024 by Cindy Starling, Chief Operations Officer.	

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: 3
Total number of Annual In-Service Staff Files: 5
Total number of Non-Licensed Mental Health Clinical Shelter Staff Files: n/a
Annual Training Plan Timeframe (*Program timeframe for annual trainings*)**: 2023-24**
Staff Position(s) Interviewed *(No Staff Names)* **: Regional Director**
Type of Documentation(s) Reviewed: training files, SkillPro training system records
Describe any Observations: Observations of the program training files and training documentation from SkillPro was made.

First Year Direct Care Staff

All direct care staff have completed new hire pre-service training requirements for safety and supervision as required.	**Compliance**	Three new hire training records were reviewed. Two of the three new employees have completed all of the requirements for a first year employee. One staff in still within the first ninety days of employment and has time to complete the required courses. At this time, the staff is always accompanied by trained staff until the training is complete.	
All staff completed the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days from date of hire.	**Compliance**	Each of the three newly hired employees have completed the Civil Rights and Federal Funds training.	
All direct care CINS/FINS staff (full time, part time, or on-call) demonstrated a minimum of 80 hours of training or more for the first full year of employment.	**Compliance**	One of the three new hires is applicable for a minimum of eighty hours of training in the first year of employment. One staff is still in the first ninety days, and one staff is not direct care staff.	
All staff receives all mandatory training during the first 90 days of employment from date of hire.	**Exception**	One of the three newly hired employees completed all of the required trainings within the first ninety days. One staff completed the trainings; however, several were completed outside the first ninety days of employment.	One new hire began training in August 2023 but did not complete the required trainings until 2024. These include information security awareness, trauma responsiveness, CINS/FINS Core training, Florida Network suicide prevention training, medication distribution, motivational interviewing, Pyxis training, Adverse Childhood Experiences training, mental health/substance abuse, universal precautions, and adolescent behavior. All of these trainings were completed, however late.

Staff Required to Complete Data Entry for NIRVANA or access the Florida Department of Juvenile Justice Information System (JJIS)			
Any designated staff that is responsible for entering NIRVANA or ensuring accurate and complete data entry in the Florida Department of Juvenile Justice Information System (JJIS) have completed all of the required trainings.	**Compliance**	One of the three newly hired staff were appliable for NIRVANA training, which was completed within the first ninety days of employment.	
Staff Participating in Case Staffing & CINS Petitions (within first year of employment)			
Documentation of instructor led FL Statute 984 CINS Petition Training by a local DJJ Attorney. *Effective for staff hired after 7/1/23*	**Not Applicable**	There were no new hires requiring CINS Petitions training.	
Non-licensed Mental Health Clinical Shelter Staff (within first year of employment)			
Documentation of non-licensed mental health clinical staff person's training in Assessment of Suicide Risk form or written confirmation by a licensed mental health professional of training (includes date, signature and license number of the licensed mental health professional supervisor).	**Not Applicable**	There are no non-licensed mental health staff at the program. Staff responsible for assessments of suicide risks are the program's licensed mental health staff.	
In-Service Direct Care Staff			
Direct care staff completes 24 hours of mandatory refresher Florida Network, SkillPro, and job-related training annually *(40 hours if the program has a DCF child caring license).*	**Exception**	Five in-service training files were reviewed. All five staff completed the required hours of in-service training with two minor exceptions.	One staff is missing Managing Aggressive Behavior (MAB) and one is missing information security awareness. Three hours for MAB and one for Information Security Awareness for a total of four hours missing.
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 an annual in-service and initial pre-service training plan.	
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's administrative assistant, along with the regional director, is responsible for managing employee training files and tracking for training.	

The program maintains an individual training file or employee file AND a FLN Training Log (or similar document that includes all requirements) for each staff, which includes an annual employee training hours tracking form and related documentation, such as electronic record/transcript, training certificates, sign-in sheets, and agendas for each training attended.	**Compliance**	The program maintains an individual training file for each staff containing the Florida Network training log used for tracking training hours, which serves as a training transcript. Training records also contain certificates, tests, sign-in sheets, and agendas for each training.	
Additional Comments: **There are no additional comments for this indicator.**			
1.05 - Analyzing and Reporting Information			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 1.05		**YES** If NO, explain here: Agency policies related to this indicator include P-1180 is called Quality Improvement Program; P-1107 Data Integrity Policies; P-1079 Data Collection; P-1049 Risk Management Planning approved on 1/11/2024 by Cindy Starling, Chief Operations Officer.	
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)* **: Agency Chief Operations Officer.** **Type of Documentation(s) Reviewed: Risk monitoring, case file review and related performance documents.** **Describe any Observations: See report.**			
Case record review reports demonstrate reviews are conducted quarterly, at a minimum	**Compliance**	The agency conducts client case file reviews on a monthly basis to ensure that all client cases meet minimum requirements. The agency provided evidence of case file reviews conducted on a monthly basis.	
The program conducts reviews of incidents, accidents, and grievances quarterly, at a minimum	**Compliance**	The agency has a process for reviewing all categories of risk management including all reportable and internal incidents, injuries, accidents and grievances. The agency provided evidence of monthly review of all aforementioned categories.	
The program conducts an annual review of customer satisfaction data	**Compliance**	The agency provided evidence of customer satisfaction data conducted on a monthly basis for the previous six months.	
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**	The agency reviews all FNYFS monthly data extracts. The agency provided evidence of reviews all FNYFS data extracts and all related contract and service delivery categories on a monthly basis for the previous six months.	

The program has a process in place to review and improve accuracy of data entry & collection	**Compliance**	The agency has a dedicated date entry staff person who is required to enter data according to contract requirements. The agency utilizes a review process on a monthly basis to ensure all data is entered within the required timeframe, all areas are accurate and all fields accurate.	
There is documentation that findings are regularly reviewed by management and communicated to staff and stakeholders.	**Compliance**	The agency conducts review sessions on all aspects of performance, risk management, quality improvements and accreditation. There is evidence that monthly reviews of the aforementioned information is conducted with supervisory, management and leadership staff.	
There is evidence the program demonstrates that program performance is routinely reviewed with the Board of Directors. All final reports that include a Limited or Failed score is submitted electronically or by mail to the providers Executive Committee on the Board of Directors.	**Compliance**	The agency provided evidence of data and reports submitted to the Board of Directors on a routine basis. The agency provides Board members copies of all contract performance and accreditation reports on an annual basis. The agency did not have any recent reports with Limited or Failed ratings.	
There is evidence that strengths and weaknesses are identified, improvements are implemented or modified, and staff are informed and involved throughout the process.	**Compliance**	The agency conducts comprehensive reviews of all areas of performance related to contract and compliance requirements. Areas in which the agency conducts reviews includes annual data collection of screenings, admissions, discharges, emergency shelter participants, NetMIS, data entry, medical emergencies, incident summary report, and personnel summaries.	
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: Agency policies related to this indicator include P-1013 is called Vehicle Use and Safety Information approved on 1/11/2024 by Cindy Starling, Chief Operations Officer.	
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: Last six months. **Staff Position(s) Interviewed** *(No Staff Names)* **: Regional Director and Residential Supervisor.** **Type of Documentation(s) Reviewed: Client transportation documents.** **Describe any Observations: See report.**			

Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	**Compliance**	The agency provided a comprehensive list of staff members approved to be able to transport youth. The list is reviewed by both the personnel department and agency's Regional Director and the Residential Supervisor staff.	
Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	**Compliance**	The agency policy and it's insurance carrier requires that all staff members have a valid driver's license in order to covered under its automobile insurance. At the time of this onsite review, all current residential staff assigned to transportation duties have evidence of a valid driver's license.	
Agency's Transportation policy prohibit transporting a client without maintaining at least one other passenger in the vehicle during the trip and include exceptions in the event that a 3rd party is NOT present in the vehicle while transporting	**Compliance**	The agency policy states that it is prohibited to transport a client without maintaining a minimum of one additional passenger. However, the policy does include exceptions. The exception is if a 3rd party is necessary for transport, the policy states that the individual will be an approved volunteer, intern, agency staff, or another youth.	
In the event that a 3rd party cannot be obtained for transport, the agency's supervisor or managerial personnel consider the clients' history, evaluation, and recent behavior	**Compliance**	The agency policy requires in the event where a 3rd party cannot be obtained, the agency has a system in place which requires appropriate approval from management staff where consideration is given regarding the client's history, valuation, and recent behavior. The agency also assesses the youth's behavior during the entire stay in the event that there's a need to change their status as it relates to this requirement.	
The 3rd party is an approved volunteer, intern, agency staff, or other youth	**Compliance**	The agency policy requires if a 3rd party is necessary for transport, the policy states that the individual will be an approved volunteer, intern, agency staff, or another youth.	
The agency demonstrated evidence via logbook or other written verification that supervisor approval was obtained prior to all single youth transports.	**Exception**	A total of 73 single transport events were reviewed for the previous six months to assess adherence to the single transport requirements of this indicator. Of these event 68 contained demonstrated evidence to successfully verify documentation to meet the supervisor prior approval to single transport event.	The review of 73 single transports events found 5 of the said events missing dates and contained inconsistency in documentation of the supervisor review notating prior approval.

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 both the vehicle Travel Log and Transportation logbook was reviewed for the previous six months. The travel log documents the date of travel, destination and purpose of trip, trip details (i.e. start/end time) driver, second adult, and approvals information. There was evidence of all sections of the agency travel logs being completed as required over the sample period. The Transportation Logbook was cross referenced with the Travel Log for single client transports. A sample of these transports were reviewed from the last six months and all documented the youth was approved for the transport prior to it taking place.	

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

1.07 - Outreach Services		**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 1.07	**YES** If NO, explain here: Agency policies related to this indicator include P-1050 is called Outreach Plan for Targeting Youth For Program Services approved and Roles and P-1053 Responsibilities - Prevention Outreach. These policies were reviewed and approved on 1/11/2024 by Cindy Starling, Chief Operations Officer.	

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: Regional Director and Community Counseling staff.
Type of Documentation(s) Reviewed: NetMIS
Describe any Observations: See report.

The program has a lead staff member designated to participate in local DJJ board, Circuit and Council meetings with evidence that includes minutes of the event or other verification of staff participation.	**Compliance**	The agency provided verification of attendance to meetings with DJJ Circuit Advisory Board (CAB7) and Putnam County Juvenile Justice Council. The agency has demonstrated consistent attendance at all scheduled meeting in the last six months.	
The program maintains written agreements with other community partners which include services provided and a comprehensive referral process.	**Compliance**	The agency has evidence of agreements with local community-based organizations. Agreements are with local school board, mental health receiving facilities, law enforcement, and several others. The agency has evidence of referral to outside mental health and substance abuse prevention services providers in the community.	
The program will maintain documentation of outreach activities and enter into NetMIS the title, date, duration (hours), zip code, location description, estimated number of people reached, modality, target audience and topic.	**Compliance**	The agency utilizes community counseling and other designated staff members to primarily conduct all outreach activities. The agency documents all outreach events and includes the event, date, location, duration of the event, target group and contacts made.	
The program has designated staff that conducts outreach which is defined in their job description.	**Compliance**	The agency has community counseling and other designated program staff members to conduct outreach activities. Staff serving in this role are The me of position title for staff reviewed Community counseling	
Additional Comments: **There are no additional comments for this indicator.**			
2.01 - Screening and Intake			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.01		**YES** If NO, explain here: Agency policies related to this indicator include P-1112 is called Screening Process. This policy was reviewed and approved on 1/11/2024 by Cindy Starling, Chief Operations Officer.	

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 open and three closed residential files were reviewed.
Total number of Closed (Residential & Community) Files: Two open and three closed community counseling files were reviewed.
Staff Position(s) Interviewed *(No Staff Names)* **: One community counseling, one residential counselor, and the Regional Director who is a Licensed Clinician were interviewed.**
Type of Documentation(s) Reviewed: Client case files.
Describe any Observations: See report.

Shelter youth: Eligibility screening form is completed immediately for all shelter placement inquiries.	**Compliance**	A total of ten files were reviewed. Of the ten files, five were residential and five were community counseling client files. Out of the five residential files, two were open and three were closed. Out of the five community counseling files, two were open and three were closed. All five of the residential files met the requirements of having the eligibility screening completed within the required timeframe.	
Community counseling: Eligibility screening form is completed within 3 business days of referral by a trained staff using the Florida Network screening form.	**Compliance**	A review of the agency's screening process for eligibility of each client admitted to the program was conducted. Eligibility screenings were completed within three business days or less of receiving the referral in all five community counseling client files reviewed.	
There is evidence all referrals for service is screened for eligibility and is logged in NetMIS within 72 hours of screening completion.	**Compliance**	All ten client files were properly screened, deemed eligible and have evidence which indicates they are logged into NetMIS within 72 hours or less of completing the screening process.	
Youth and parents/guardians receive the following in writing: a. Available service options b. Rights and responsibilities of youth and parents/guardians	**Compliance**	All ten client files contained evidence of all youth and parents received documentation about service options, rights and responsibilities of the youth and parents/guardians.	
The following is also available to the youth and parents/guardians: a. Possible actions occurring through involvement with CINS/FINS services (case staffing committee, CINS petition, CINS adjudication) b. Grievance procedures	**Compliance**	The parents are provided an informed consent form, packet, and CINS/FINS brochure at intake that includes information about case staffing and grievance procedures.	
During intake, all youth were screened for suicidality and correctly assessed as required if needed.	**Compliance**	All 10 files contained evidence that a completed suicide risk screening form was performed on each child during the intake process.	
Additional Comments: **There are no additional comments for this indicator.**			
2.02 - Needs Assessment			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.02		**YES** If NO, explain here: The agency has the required policy and procedure P-1019 called Needs Assessment that was last reviewed and approved on 1/11/2024 by Cindy Starling, Chief Operations Officer.	

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 open and three closed residential files were reviewed. **Total number of Closed (Residential & Community) Files: Two open and three closed community counseling files were reviewed.** **Staff Position(s) Interviewed (No Staff Names): One community counseling, one residential counselor, and the Regional Director who is a Licensed Clinician were interviewed.** **Type of Documentation(s) Reviewed: Client case files.** **Describe any Observations: See report.**			
Shelter Youth: NIRVANA is initiated within 72 hours of admission	**Compliance**	A review of all five of the residential client files indicated each one contained evidence of meeting the requirement of a Needs Assessment being initiated within 72 hours.	
Non-Residential youth: NIRVANA is initiated at intake and completed within 2 to 3 face-to-face contacts after the initial intake **OR** updated, if most recent assessment is over 6 months old	**Compliance**	A review of all five of the non-residential client files indicated each one contained evidence of meeting the requirement of the 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.	**Compliance**	All ten client files reviewed contained evidence of a completed Needs Assessment signed by a supervisor.	
(Shelter Only) NIRVANA Self-Assessment (NSR) is completed within 24 hours of youth being admitted into shelter. If unable to complete, there must be documentation in NetMIS and the youth's file explaining the barriers to completion.	**Compliance**	A review of all five of the residential client files indicated each file contained evidence of meeting the requirement of a NIRVANA self-assessment report (NSR) with 24 hours being admitted to the shelter.	
A NIRVANA Post-Assessment is completed at discharge for all youth who have a length of stay that is greater than 30 days.	**Compliance**	A review of client files discharged more than 30 days indicated each contained evidence of a completed NIRVANA Post-Assessment at discharge.	
A NIRVANA Re-Assessment is completed every 90 days excluding files for youth receiving SNAP services.	**Compliance**	Five of the current client files applicable to be reviewed for this indicator contained evidence of a completed NIRVANA Re-Assessment is completed 90 days post the client's discharge.	
All files include the interview guide and/or printed NIRVANA.	**Compliance**	All ten client files reviewed contained evidence of a interview guide or completed NIRVANA.	
Additional Comments: **There are no additional comments for this indicator.**			

2.03 - Case/Service Plan			Satisfactory with Exception
Provider has a written policy and procedure that meets the requirement for Indicator 2.03		**YES** If NO, explain here: The agency has the required policy and procedure P-1162 called Individual Plan. This policy was last reviewed and approved on 1/11/2024 by Cindy Starling, Chief Operations Officer.	
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 open and three closed residential files were reviewed. **Total number of Closed (Residential & Community) Files: Two open and three closed community counseling files were reviewed.** **Staff Position(s) Interviewed (No Staff Names): One community counseling and one residential counselor were interviewed.** **Type of Documentation(s) Reviewed: Client case files.** **Describe any Observations: See report.**			
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**	All ten client files contained evidence of a Case/Service Plan developed on the agency's form and is based on information collected during the screening, intake and NIRVANA assessment processes.	
Case/Service plan is developed within 7 working days of NIRVANA	**Compliance**	All ten client files had a treatment plan which was developed within 7 working days of the NIRVANA assessment.	

Case plan/service plan includes: 1. Individualized and prioritized need(s) and goal(s) identified by the NIRVANA 2. Service type, frequency, location 3. Person(s) responsible 4. Target date(s) for completion and actual completion date(s) 5. Signature of youth, parent/guardian, counselor, and supervisor 6. Date the plan was initiated	**Exception**	A total of ten files were reviewed and contained evidence of a documented individualized service plan. Nine of the ten service plans contained individualized goals, frequency, target dates, completion dates, signature of client, signature of parent, signature counselor and signature of the supervisor. Each file also contained the date the plan was initiated.	One out of nine client files did not have evidence of a required signature from a 30-Day Review. The service plan format for residential and community counseling service plans contain a different goal identification layout and format. The current residential file format does not clearly separate individual presenting problems captured during screening/assessment phases with associated objectives.
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**	All ten client case plans contained evidence of being reviewed by the counselor, youth and parent and supervisor on review cycle of every 30 days.	
Additional Comments: **There are no additional comments for this indicator.**			
2.04 - Case Management and Service Delivery			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 2.04		**YES** If NO, explain here: The agency has the required policy and procedure P-1162 called Individual Plan. This policy was last reviewed and approved on 1/11/2024 by Cindy Starling, Chief Operations Officer.	
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 open and three closed residential files were reviewed. **Total number of Closed (Residential & Community) Files: Two open and three closed community counseling files were reviewed.** **Staff Position(s) Interviewed (No Staff Names): One community counseling and one residential counselor were interviewed.** **Type of Documentation(s) Reviewed: Client case files.** **Describe any Observations: See report.**			

Counselor/Case Manager is assigned	**Compliance**	All ten client case files have evidence of each file having an officially assigned counselor/case manager.	
The Counselor/Case Manager completes the following as applicable: 1. Establishes referral needs and coordinates referrals to services based upon the on-going assessment of the youth's/family's problems and needs 2. Coordinates service plan implementation 3. Monitors youth's/family's progress in services 4. Provides support for families 5. Monitoring progress of court ordered youth in shelter 6. Makes referrals to the case staffing to address problems and needs of the youth/family 7. Accompanies youth and parent/guardian to court hearings and related appointments 8. Refers the youth/family for additional services when appropriate 9. Provides case monitoring and reviews court orders 10. Provides case termination notes 11. Provides follow-up after 30 days post discharge 12. Provides follow-up after 60 days post discharge	**Exception**	All applicable client case files have evidence of established referral needs base on a need identified during the screening process. Each applicable file was referred to the appropriate local service entity to address a need or risk identified on the screening, intake and needs assessment. Evidence of a referral for support services was provided to the families. The applicable files contain copies of referrals in each individual file. Review on progress for each applicable referral is documented. Discharge plans were completed on client cases with closed files. None of the ten files reviewed were applicable for a case staffing.	One 30-Day follow up after post discharge was completed past the required timeframe.
The program maintains written agreements with other community partners that include services provided and a comprehensive referral process	**Compliance**	The agency provided evidence of written partnership agreements with community partners that include local schools, mental health providers, hospitals, and sheriff's office. The agreements were all current and included services provided and a 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 P-1163 and procedure called Case Management, Counseling and Service Delivery. This policy was last reviewed and approved on 1/11/2024 by Cindy Starling, Chief Operations Officer.	
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 open and three closed residential files were reviewed. **Total number of Closed (Residential & Community) Files: Two open and three closed community counseling files were reviewed.** **Staff Position(s) Interviewed (No Staff Names): One community counseling and one residential counselor were interviewed.** **Type of Documentation(s) Reviewed: Client case files.** **Describe any Observations: See report.**			
Shelter Program			
Shelter programs provides individual and family counseling	**Compliance**	All residential counseling client files have evidence of providing individual and family counseling services to each client and their families.	
Group counseling sessions held a minimum of five days per week	**Compliance**	The agency has evidence of documented groups listed in its daily activities schedule. A review of group sessions completed in the last six months by the shelter program was conducted. The agency has evidence of completing a minimum of five groups per week for the last six months.	
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**	A review of group documentation indicates groups are conducted by residential counseling and direct care staff members a minimum of five days per week. In some instances, groups are delivered by special guests and other subject matter experts.	
Documentation of groups must include date and time, a list of participants, length of time, and topic.	**Compliance**	All groups conducted in the last six months have evidence of documenting date, time, participants, duration of group 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**	The agency's community counseling program has evidence of providing a broad range of intervention services. The agency has evidence in each client file which indicates appropriate services to address risks identified in the screening, intake, assessments in the residential shelter, administrative offices, in local elementary/middle schools and in the community.	
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**	A review of agency's counseling regimen of services provided to clients was conducted. The agency has evidence of coordinating services to be provided to the client based on information obtained during screening, intake, and assessment phases of service delivery.	

Maintain individual case files on all youth and adhere to all laws regarding confidentiality.	**Compliance**	The agency has evidence of maintaining an individual case file on all clients. Each client files have evidence of following the agency's confidentiality protocols.	
Case notes maintained for all counseling services provided and documents youth's progress.	**Compliance**	All residential and community counseling client files selected over the last 6 months reviewed found evidence of progress notes documented in each file.	
On-going internal process that ensures clinical reviews of case records and staff performance.	**Compliance**	The agency has evidence in each file that ensures demonstrated proof of 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**	The agency has a process for assessing cases that may require that an intake be conducted virtually. The agency primarily serves all clients in person. At the time of this onsite program review, the sample of cases did not have any clients which were provided services virtually.	
Additional Comments: **There are no additional comments for this indicator.**			
2.06 - Adjudication/Petition Process			**Not Applicable**

Provider has a written policy and procedure that meets the requirement for Indicator 2.06	**YES** If NO, explain here: The agency had 2 policies for this indicator; #P-1159/Case Staffing Committee :Parent(2/08) #P-1160/Case Staffing: Plan of Service (2/08). The agency policy was reviewed on 1/11/2024 by the agency's COO Cindy Starling.	

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

Total number of Open (Residential & Community) Files: 0
Total number of Closed (Residential & Community) Files: 0
Staff Position(s) Interviewed *(No Staff Names)* **: Regional Director**
Type of Documentation(s) Reviewed: N/A
Describe any Observations: CDS Family & Behavioral Health Services, Inc. East Shelter. The East shelter has the ability to enter into a CINS petition process for a child, however they attempt the route of truancy court prior to entering into this lengthy process.
The process for truancy court begins in the schools with the Family Action Counselor. She meets with each individual school in the county for their truancy meetings held monthly or when needed. At this time each child's case is discussed between her, the school personnel, and if in attendance, the parent of each child to make a determination as to whether or not the child needs to enter into the truancy court process. The Family Action Counselor will meet with the parent at these meetings and attempt to get the child in a non-residential program before being court ordered. If the parent is not present, will attempt to call the parent and if unsuccessful, the process will then go to the Student Intervention Team (SIT) meeting for a decision. The SIT meeting is held in the East shelter prior to truancy court. The Regional Director, the Family Action Counselor, the school board attorney, the Director of home School, the truancy officer, and the Director of the Juvenile Crime Prevention Office (JCPO), are all present to discuss each case and make a recommendation for moving forward. After the SIT meeting, the information discussed is presented in truancy court by the lawyer and the truancy officer to the truancy judge. The judge then makes a ruling as to what services are needed for the child and the parent. The child can then be court ordered to be in Family Action Program and/or or be in the shelter for 35 days and substance abuse classes and the parent can be court ordered to the JCPO parenting classes and any other services the judge deems necessary (anger management ,substance use classes, etc..). The parent and the child have to satisfy these orders to close the truancy case. If not satisfied, the case can be continued for a time until the judge makes a determination as to other services needed. If this process is unsuccessful the case could be closed and then move to the CINS petition process.

Must include: a. DJJ rep. or CINS/FINS provider b. Local school district representative	**Compliance**	At the time of this onsite program review, the agency does not have any clients on Adjudication or Petition status. Agency does have an up-to-date policy and procedure which specifically addresses the requirements of this indicator in the event the services are requested.	
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**	At the time of this onsite program review, the agency does not have any clients on Adjudication or Petition status. Agency does have an up-to-date policy and procedure which specifically addresses the requirements of this indicator in the event the services are requested.	

The program has an established case staffing committee, and has regular communication with committee members	**Compliance**	At the time of this onsite program review, the agency does not have any clients on Adjudication or Petition status. Agency does have an up-to-date policy and procedure which specifically addresses the requirements of this indicator in the event the services are requested.	
The program has an internal procedure for the case staffing process, including a schedule for committee meetings	**Compliance**	At the time of this onsite program review, the agency does not have any clients on Adjudication or Petition status. Agency does have an up-to-date policy and procedure which specifically addresses the requirements of this indicator in the event the services are requested.	
The youth and family are provided a new or revised plan for services	**No eligible items for review**	At the time of this onsite program review, the agency does not have any clients on Adjudication or Petition status. Agency does have an up-to-date policy and procedure which specifically addresses the requirements of this indicator in the event the services are requested.	
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**	At the time of this onsite program review, the agency does not have any clients on Adjudication or Petition status. Agency does have an up-to-date policy and procedure which specifically addresses the requirements of this indicator in the event the services are requested.	
If applicable, the program works with the circuit court for judicial intervention for the youth/family	**No eligible items for review**	At the time of this onsite program review, the agency does not have any clients on Adjudication or Petition status. Agency does have an up-to-date policy and procedure which specifically addresses the requirements of this indicator in the event the services are requested.	
Case Manager/Counselor completes a review summary prior to the court hearing	**No eligible items for review**	At the time of this onsite program review, the agency does not have any clients on Adjudication or Petition status. Agency does have an up-to-date policy and procedure which specifically addresses the requirements of this indicator in the event the services are requested.	
Additional Comments: **There are no additional comments for this indicator.**			

2.07 - Youth Records			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 2.07		**YES** If NO, explain here: The agency's policy number is P-1046 titled Youth Case Record last reviewed on 1/11/2024 by the agency's COO Cindy Starling.	
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)* **: Regional Director, Senior Youth Care Worker** **Type of Documentation(s) Reviewed: Open and closed files, Staff Control Room** **Describe any Observations: Reviewed total of 6 youth files 4 open 2 closed all clearly marked with confidential stamp. All records are kept double locked in staff control room area then stored in lock file cabinet marked confidential. Observed a lockable opaque container marked confidential for transporting youth records.**			
All records are clearly marked 'confidential'.	**Compliance**	All files reviewed in the client file review samples are marked confidential as required.	
All records are kept in a secure room or locked in a file cabinet that is marked "confidential"	**Compliance**	All files reviewed in the client file review samples are maintained in locked cabinets in each counselor's officer. All closed or active or working residential files are secured in the direct care staff office in locked cabinets marked confidential as required.	
When in transport, all records are locked in an opaque container marked "confidential"	**Compliance**	The agency provides community counseling staff with case locking mobile cabinets in the event case files are needed outside of the office.	
All records are maintained in a neat and orderly manner so that staff can quickly and easily access information	**Compliance**	All files reviewed in the client file review samples are neat and do not have ripped, torn or off-centered forms. All files are in alignment with the agency's case file organization requirements. Youth case record include Chronological Sheet, Youth Demographic Data, Correspondence, Individual plan, Needs Assessment Information (NIRVANA), Case Management Documentation, Progress Note Documentation, and other Information Deemed Necessary.	
Additional Comments: There are no additional comments for this indicator.			

2.08 - Specialized Additional Program Services		Not Applicable
Provider has a written policy and procedure that meets the requirement for Indicator 2.08	**YES** If NO, explain here: Indicate policy title(s), policy number(s), authorized signee, date(s) of last review/revision/approval: The agency's policy number is P-1248 titled Staff Secure Shelter Services, P-1249 titled Staff Secure Shelter - Program Overview, P-1267 titled Domestic Violence Respite, P-1279 titled Probation Respite, P-1282 titled Domestic Minor Sex Trafficking, P-1283 titled FYRAC Non-Residential Services, P-1301 Specialized Additional Program services. each policy numbers were last reviewed on 1/11/2024 by the agency's COO Cindy Starling.	

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: 0
Total number of Closed Files: 0
Staff Position(s) Interviewed (No Staff Names): None.
Type of Documentation(s) Reviewed: The agency did not have any case staffing referrals.
Describe any Observations: None.

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**	Agency does have an up-to-date policy and procedure which specifically addresses the requirements of this indicator in the event the services are requested. The program has not served this program type since the last QI review.	
Staff Secure policy and procedure outlines the following: a. In-depth orientation on admission b. Assessment and service planning c. Enhanced supervision and security with emphasis on control and appropriate level of physical intervention d. Parental involvement e. Collaborative aftercare	**No eligible items for review**	Agency does have an up-to-date policy and procedure which specifically addresses the requirements of this indicator in the event the services are requested. The program has not served this program type since the last QI review.	
Program only accept youth that meet legal requirements of F.S. 984 for being formally court ordered in to Staff Secure Services	**No eligible items for review**	Agency does have an up-to-date policy and procedure which specifically addresses the requirements of this indicator in the event the services are requested. The program has not served this program type since the last QI review.	

Staff Assigned: a. One staff secure bed and assigned staff supervision to one staff secure youth at any given time b. Program assign specific staff during each shift to monitor location/ movement of staff secure youth c. Agency clearly documents the specific staff person assigned to the staff secure youth in the logbook or any other means on each shift	**No eligible items for review**	Agency does have an up-to-date policy and procedure which specifically addresses the requirements of this indicator in the event the services are requested. The program has not served this program type since the last QI review.	
Agency provides a written report for any court proceedings regarding the youth's progress	**No eligible items for review**	Agency does have an up-to-date policy and procedure which specifically addresses the requirements of this indicator in the event the services are requested. The program has not served this program type since the last QI review.	
Domestic Minor Sex Trafficking (DMST)			
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: 0 **Total number of Closed Files:0** **Staff Position(s) Interviewed** *(No Staff Names)* **: No samples.** **Type of Documentation(s) Reviewed:** **Describe any Observations: None.**			
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 did not have any Domestic Minor Sex Trafficking cases. Agency does have an up to date policy and procedure which specifically addresses the requirements of this indicator in the event services are requested. The program has not served this program type since the last QI review.	
Agency has evidence that the FNYFS was contacted for approval prior to admission for all Domestic Minor Sex Trafficking (DMST) placements.	**No eligible items for review**	The agency did not have any Domestic Minor Sex Trafficking cases. Agency does have an up to date policy and procedure which specifically addresses the requirements of this indicator in the event services are requested. The program has not served	
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 did not have any Domestic Minor Sex Trafficking cases. Agency does have an up to date policy and procedure which specifically addresses the requirements of this indicator in the event services are requested. The program has not served	
Services provided to these youth specifically designated services designed to serve DMST youth	**No eligible items for review**	The agency did not have any Domestic Minor Sex Trafficking cases. Agency does have an up to date policy and procedure which specifically addresses the requirements of this indicator in the event services are requested. The program has not served	

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 did not have any Domestic Minor Sex Trafficking cases. Agency does have an up to date policy and procedure which specifically addresses the requirements of this indicator in the event services are requested. The program has not served	
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 did not have any Domestic Minor Sex Trafficking cases. Agency does have an up to date policy and procedure which specifically addresses the requirements of this indicator in the event services are requested. The program has not served this program type since the last QI 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 did not have any Domestic Minor Sex Trafficking cases. Agency does have an up to date policy and procedure which specifically addresses the requirements of this indicator in the event services are requested. The program has not served this program type since the last QI 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 did not have any Domestic Minor Sex Trafficking cases. Agency does have an up to date policy and procedure which specifically addresses the requirements of this indicator in the event services are requested. The program has not served this program type since the last QI 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: 0 **Total number of Closed Files:0** **Staff Position(s) Interviewed** *(No Staff Names)* **: None.** **Type of Documentation(s) Reviewed:** **Describe any Observations: None.**			
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 did not have any Domestic Violence referrals. Agency does have an up to date policy and procedure which specifically addresses the requirements of this indicator in the event the services are requested.	
Youth admitted to DV Respite placement have evidence in the file of a pending DV charge	**No eligible items for review**	The agency did not have any Domestic Violence referrals. Agency does have an up to date policy and procedure which specifically addresses the requirements of this indicator in the event the services are requested.	
Data entry into NetMIS within (3) business days of intake and discharge	**No eligible items for review**	The agency did not have any Domestic Violence referrals. Agency does have an up to date policy and procedure which specifically addresses the requirements of this indicator in the event the services are requested.	

Youth length of stay in DV Respite placement does not exceed 21 days. If more than 21 days, documentation exists in youth file of transition to CINS/FINS or Probation Respite placement, if applicable.	**No eligible items for review**	The agency did not have any Domestic Violence referrals. Agency does have an up to date policy and procedure which specifically addresses the requirements of this indicator in the event the services are requested.	
Case plan in file reflects goals for aggression management, family coping skills, or other intervention designed to reduce propensity for violence in the home	**No eligible items for review**	The agency did not have any Domestic Violence referrals. Agency does have an up to date policy and procedure which specifically addresses the requirements of this indicator in the event the services are requested.	
All other services provided to Domestic Violence Respite youth are consistent with all other general CINS/FINS program requirements	**No eligible items for review**	The agency did not have any Domestic Violence referrals. Agency does have an up to date policy and procedure which specifically addresses the requirements of this indicator in the event the services are requested.	
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: 0 **Total number of Closed Files:0** **Staff Position(s) Interviewed** *(No Staff Names)* **: None.** **Type of Documentation(s) Reviewed: Not applicable.** **Describe any Observations: None.**			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	**No eligible items for review**	The program has not served this program type since the last QI review. The agency did not have any Probation Respite referrals. Agency does have an up to date policy and procedure which specifically addresses the requirements of this indicator in the event the services are requested.	
All probation respite referrals are submitted to the Florida Network.	**No eligible items for review**	The program has not served this program type since the last QI review. The agency did not have any Probation Respite referrals. Agency does have an up to date policy and procedure which specifically addresses the requirements of this indicator in the event the services are requested.	
All Probation Respite Referral come from DJJ Probation and there is evidence that the youth is on Probation regardless of adjudication status.	**No eligible items for review**	The program has not served this program type since the last QI review. The agency did not have any Probation Respite referrals. Agency does have an up to date policy and procedure which specifically addresses the requirements of this indicator in the event the services are requested.	
Data entry into NetMIS and JJIS within (3) business days of intake and discharge	**No eligible items for review**	The program has not served this program type since the last QI review. The agency did not have any Probation Respite referrals. Agency does have an up to date policy and procedure which specifically addresses the requirements of this indicator in the event the services are requested.	

Length of stay is no more than fourteen (14) to thirty (30) days. Any placement beyond thirty (30) days contains evidence in the file that the JPO was contacted in writing to request the need of an extension no later than the 25th day the youth was admitted into the program.	**No eligible items for review**	The program has not served this program type since the last QI review. The agency did not have any Probation Respite referrals. Agency does have an up to date policy and procedure which specifically addresses the requirements of this indicator in the event the services are requested.	
All case management and counseling needs have been considered and addressed	**No eligible items for review**	The program has not served this program type since the last QI review. The agency did not have any Probation Respite referrals. Agency does have an up to date policy and procedure which specifically addresses the requirements of this indicator in the event the services are requested.	
All other services provided to Probation Respite youth are consistent with all other general CINS/FINS program requirements	**No eligible items for review**	The program has not served this program type since the last QI review. The agency did not have any Probation Respite referrals. Agency does have an up to date policy and procedure which specifically addresses the requirements of this indicator in the event the services are requested.	
Intensive Case Management (ICM)			
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: 0 **Total number of Closed Files:0** **Staff Position(s) Interviewed** *(No Staff Names)* **: None.** **Type of Documentation(s) Reviewed: Not applicable.** **Describe any Observations: None.**			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	**Not Applicable**	The agency reports they are not contracted to provide ICM services.	
Youth receiving services were deemed chronically truant and/or runaway and require more intensive and lengthy services. The youth was determined to be eligible because they have gone through petition and/or case staffing and was in need of case management services.	**Not Applicable**		
Services for youth and family include: a. Two (2) direct contacts per month b. Two (2) collateral contacts per week c. Direct and collateral contacts not obtained must have documentation to support attempts made to obtain them. All reasonable attempts (at minimum of three) must be made to reach all contacts (direct and collateral) and documented in the case file and NetMIS.	**Not Applicable**		

Assessments include a. NIRVANA at intake b. NIRVANA Re-Assessment every 90 days c. Post NIRVANA at discharge as aligned with timeframe requirements	**Not Applicable**		
Service/case plan demonstrates a strength-based, trauma-informed focus	**Not Applicable**		
For any virtual services provided, there is written documentation in the youths' file as to why virtual contact is in the best interest of the youth and family	**Not Applicable**		
Family and Youth Respite Aftercare Services (FYRAC)			
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: 0 **Total number of Closed Files:0** **Staff Position(s) Interviewed** *(No Staff Names)* **: None.** **Type of Documentation(s) Reviewed: Not applicable.** **Describe any Observations: None.**			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	**Not Applicable**	The agency reported that it does not have a Family and Youth Respite Aftercare Services contract with the Florida Network of Youth and Family Services (FNYFS).	
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.	**Not Applicable**		
Agency has evidence that all FYRAC referrals have documented approval from the Florida Network office	**Not Applicable**		
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.	**Not Applicable**		

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.	**Not Applicable**		
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.	**Not Applicable**		
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	**Not Applicable**		
There is evidence of completed 30 and/or 60 day follow-ups and is documented in NetMIS following case discharge.	**Not Applicable**		
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	**Not Applicable**		
Any service that is offered virtually, is documented in the youth's file why it was in the youth and families best interest.	**Not Applicable**		

All data entry in NetMIS is completed within 3 business days as required.	**Not Applicable**		
Additional Comments: **There are no additional comments for this indicator.**			
2.09- Stop Now and Plan (SNAP)			**Not Applicable**
Provider has a written policy and procedure that meets the requirement for Indicator 2.09		**YES** If NO, explain here: Indicate policy number, authorized signee, date(s) of last review/revision/approval: The agency's policy number is P-1291 titled SNAP for school and communities P-1299 titled SNAP Screening and Intake P-1300 titled SNAP Discharge Requirements. It was last reviewed on 1/11/2024 by the agency's COO Cindy Starling.	
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 to this agency site. **Staff Position(s) Interviewed: Regional Director** **Type of Documentation(s) Reviewed: Reviewed agency policy and procedure. Agency does not have a contract agreement with the FL Network at this time.** **Describe any Observations: Not applicable.**			
SNAP Clinical Groups Under 12			
Youth are screened to determine eligibility of services.	**Not Applicable**	The agency does not have a contract with the Florida Network of Youth and Family Services to provide Stop Now and Plan (SNAP).	
The NIRVANA was completed at initial intake, or within two sessions.	**Not Applicable**		
There is evidence of the completed Child Behavior Checklist (CBCL) by the caregiver (pre and post) and is located within the file.	**Not Applicable**		
There is evidence of the completed Teacher Report Form (TRF) is completed by the teacher (pre and post) and is located within the file.	**Not Applicable**		
SNAP Clinical Groups Under 12 - Discharge			
There is evidence of the completed SNAP Discharge Report located within the file for any discharged youth.	**Not Applicable**	The agency does not have a contract with the Florida Network of Youth and Family Services to provide Stop Now and Plan (SNAP).	

There is evidence of the completed SNAP Discharge Report located within the file for any discharged youth.	**Not Applicable**		
There is evidence of the SNAP Boys/SNAP Girls Child Group Evaluation Form located in the file.	**Not Applicable**		
There is evidence of the SNAP Boys/SNAP Girls Parent Group Evaluation Form located in the file.	**Not Applicable**		
SNAP Clinical Groups for Youth 12-17			
Youth are screened to determine eligibility of services.	**Not Applicable**	The agency does not have a contract with the Florida Network of Youth and Family Services to provide Stop Now and Plan (SNAP).	
The Consent to Treatment and Participation in Research Form is completed and located within the file.	**Not Applicable**		
The NIRVANA was completed at initial intake, or within two sessions.	**Not Applicable**		
There is evidence of the completed 'How I Think Questionnaire' (HIT) form located within the file or evidence of at least three (3) documented attempts in the youths' file to obtain this information.	**Not Applicable**		
There is evidence of the completed Social Skills Improvement System (SSIS) Student form located within the file or evidence of at least three (3) documented attempts in the youths' file to obtain this information.	**Not Applicable**		
There is evidence of the completed Social Skills Improvement System (SSIS) Teacher/Adult form located within the file or evidence of at least three (3) documented attempts in the youths' file to obtain this information.	**Not Applicable**		
SNAP for Schools & Communities			
The program demonstrated all of the required weekly attendance sheets that included youth names and/or identifying numbers completed with the teacher and trained SNAP Facilitator signatures. (*This must include a total of 13 attendance sheets for a full cycle*)	**Not Applicable**	The agency does not have a contract with the Florida Network of Youth and Family Services to provide Stop Now and Plan (SNAP).	
The program maintained evidence of a completed "Class Goal" Document for the class reviewed.	**Not Applicable**		

The program maintained evidence of both pre AND post Measure of Classroom Environment (MoCE) completed documents for the class reviewed.	**Not Applicable**		
The program maintained evidence of completed pre and post evaluation documents for the class reviewed.	**Not Applicable**		
There is evidence of the fidelity adherence checklist maintained in the file for each class reviewed.	**Not Applicable**		
Additional Comments: **There are no additional comments for this indicator.**			
3.01 - Shelter Environment			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 3.01		**YES** If NO, explain here: The agency's policy number is P-1293 and is titled Shelter Environment. It was last reviewed on January 11, 2024 by the agency's Chief Operations Officer.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Staff Position(s) Interviewed : Residential Supervisor and direct care staff members **Type of Documentation(s) Reviewed: Shelter inspections, drills, inventory and schedule.** **Describe any Observations: See report.**			

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 tour of the facility was conducted in the first day of the review by the Regional Director. The program's CARF accreditation is located in the main entrance and expires on April 30, 2024. The facility is also licensed through the Department of Children and Families Child Caring License/Runaway/Emergency Shelter for 12 beds. This license is also posted in the main entry way and expires on March 21, 2024. The exterior of the facility is well maintained and appeared to be free of insect infestation, hazards, and debris. There is a basketball goal and volleyball net for recreation as well as benches for outside activities.. The expansive back yard has a privacy fence that has recently been expanded on. The youth assist in maintaining the flower bed that is located at the entrance of the building. The interior of the building was clean and all furnishings were in good repair, also appearing free of insect infestation, hazards, and debris. Upon inspection of both the male and female group rooms, bedrooms and bathrooms, all were clean, free of debris/hazards and graffiti. Lighting was adequate in all areas. All doors were secured. In and out access was limited to staff members and key control was in compliance. Detailed egress plans were located throughout the facility as well as the DCF Abuse Hotline phone number, DJJ Incident reporting number and all related notices are posted. Grievance forms are easily accessible and grievance boxes are located in both the male and female group rooms.	
Facility Inspection: a. All agency and staff vehicles are locked. b. Agency vehicles are equipped with major safety equipment including first aid kit, (all items in the first aid kit are current and do not have expired items; all expired items should be replaced regularly), fire extinguisher, flashlight, glass breaker and, seat belt cutter.	**Compliance**	The facility has two vehicles for transportation, a 2003 white Ford van and a 2016 white Ford van. Each vehicle was equipped with major safety equipment including: first aid kits, fire extinguisher, flashlight, glass breaker and seatbelt cutter. There was no expired items located in the first aid kits.	

Facility Inspection: All chemicals are listed, approved for use, inventoried weekly and perpetually, stored securely and Material Safety Data Sheets (MSDS) are maintained on each item (minimum 1 time per week or per agency policy). A perpetual inventory will be the primary means of maintaining a current and real-time inventory. The weekly inventory will be conducted weekly at a minimum to ensure that a perpetual inventory is being maintained consistently and accurately. If more than one location is used to store chemicals, there is an inventory wherever chemicals are stored that is current and well maintained unless previously approved by the Network.	**Exception**	All chemicals are approved for use and MSDS sheets are maintained for each chemical. A perpetual inventory is being maintained by the facility. The agency maintains a current and real-time inventory.	The agency policy states, "Inventory will be conducted weekly at a minimum to ensure that a perpetual inventory is being maintained consistently and accurately." The current practice is inventory is being conducted on a monthly basis.
Facility Inspection: Washer/dryer are operational & general area/lint collectors are clean. Agency has a current DCF Child Care License which is displayed in the facility. Each youth has own individual bed with clean covered mattress, pillow, sufficient linens and blanket. Youth have a safe, lockable place to keep personal belongings, if requested.	**Compliance**	The facility's washer and dryer is operational. The general area is clean and free of debris. Lint filter was clean. The agency has a current Department of Children and Families (DCF) license and it is displayed in the main entrance area. The current DCF license expires on March 21, 2024. Each youth has their own personal bed with a clean covered mattress, pillow and sufficient linens and a blanket. Youth also have a safe locked closet to keep their personal belongings such as backpacks for school and hygiene products.	
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 fire inspection was conducted on October 19, 2023 and the facility is in compliance with the local fire marshal and safety code. A review of the facility's fire drills for the past six months indicated there was one fire drill completed per each shift each month within two minutes or less. The facility is also completing one mock drill per shift per quarter. All annual fire safety equipment inspections are valid. The overhead hood inspection was completed on December 6, 2023 and all fire extinguishers, including those in each vehicle, was completed on October 25, 2023.	

Fire and Safety Health Hazards: a. Agency has a current Satisfactory Residential Group Care inspection report from the Department of Health. b. Agency has a current Satisfactory Food Service inspection report from the Department of Health and food menus are posted, current and signed by Licensed Dietician annually. c. All cold food is properly stored, marked and labeled and dry storage/pantry area is clean and food is properly stored. d. Refrigerators/Freezers are clean and maintained at required temperatures and all small and medium sized appliances are operable and clean for use as needed.	**Compliance**	Facility has a current Satisfactory Residential Group care inspection report from the Department of Health completed on January 19, 2024. Facility has a current Satisfactory Food Service inspection report from the Department of Health completed on March 7, 2023 and expires on May 31, 2025. Food menus are posted, current and signed by a Licensed Dietician on February 7, 2024 All cold food was stored properly, marked and labeled. The dry storage area was clean and food was properly stored. The refrigerators and freezers were all clean, well maintained and at required temperatures. All appliances were operable and clean.	
Additional Fire and Safety Health Hazards Narrative (if applicable)			
Youth Engagement			
a. Youth are engaged in meaningful, structured activities (e.g., education, recreation, counseling services, life and social skill training) seven days a week during awake hours. Idle time is minimal. b. At least one hour of physical activity is provided daily. c. Youth are provided the opportunity to participate in a variety of faith-based activities. Non-punitive structured activities are offered to youth who do not choose to participate in faith-based activities. d. Daily programming includes opportunities for youth to complete homework and access a variety of age appropriate, program approved books for reading. Youth are allowed quiet time to read. e. Daily programming schedule is publicly posted and accessible to both staff and youth.	**Compliance**	The Daily programming schedule is posted in both youth group rooms. A review of the schedule indicated that youth are engaged in meaningful structured activities including education, recreation, counseling services, life skills and social skills, seven days a week during awake hours. Youth are provided the opportunity to participate in faith based activities if they choose. Non-punitive structured activities are provided to youth who choose not to participate. Daily programming includes participants the opportunities to complete homework and access a variety of program approved books for participants. Youth are allowed quiet time to read.	
Additional Comments: **There are no additional comments for this indicator.**			
3.02 - Program Orientation			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 3.02		**YES** If NO, explain here: The agency has a policy P-1114 Admission/Intake and Participant Orientation last reviewed by the Chief Operations Officer on 1/11/2024	

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.*

Four open residential charts and five closed residential charts were reviewed for this indicator.

Youth received a comprehensive orientation and handbook provided within 24 hours	**Compliance**	Of the nine client file charts reviewed all youth signed that they received a copy of a comprehensive orientation and handbook on the day of intake.	
Orientation includes the following: a. Youth is given a list of contraband items b. Disciplinary action is explained c. Dress code explained d. Review of access to medical and mental health services e. Procedures for visitation, mail and telephone f. Grievance procedure g. Disaster preparedness instructions h. Physical layout of the facility i. Sleeping room assignment and introductions j. Suicide prevention- alerting staff of feelings or awareness of others having suicidal thoughts	**Compliance**	The program's orientation included the following items: list of contraband items, explanation of dress code, procedures for visitation, phone calls and mail, grievance process, review of how to access medical and mental health services, disaster preparedness process, a tour of the facility, sleeping room assignments and introductions and suicide preparedness.	
Documentation of each component of orientation, including orientation topics and dates of presentation, as well as signatures of the youth and staff involved is maintained in the individual youth record	**Compliance**	Documentation was noted in all client file charts reviewed which included each component of orientation, including orientation topics, dates of presentation as well as signatures of youth 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 a policy and procedures titled P-1116 Residential Admission: Sleeping Arrangements las t reviewed on January 11, 2024 by the Chief Operations Officer.	

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.*

Five closed residential charts and four open residential charts were reviewed for this indicator.

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**	All nine client file charts reviewed indicated that during the intake process, each youth is assigned a bed based on initial interactions and observations and a review of information received from parents/guardians or any other collateral contacts regarding the youth's history and exposure to trauma. When assigning a bed the program considers several factors including, suicide risk, mental/physical disabilities, physical characteristics, aggressive or violent behavior and gang affiliation.	
An alert is immediately entered into the program's alert system when a youth is admitted with special needs and risks such as risk of suicide, mental health, substance abuse, physical health or security risk factors	**Compliance**	All nine client file charts reviewed indicated that an alert was entered each time a youth was admitted with special needs and risks such as suicide risk, mental health, substance use, physical health or security risk factors.	
Additional Comments: **There are no additional comments for this indicator.**			
3.04 - Log Books			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 3.04		**YES** If NO, explain here: The agency has a policy and procedures titled P1149 Logbook. The policy was last reviewed on January 11, 2024 by the Chief Operations Officer.	
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.*			
Logbooks were reviewed for the past six months			
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 safety and security of youth and program were all highlighted as required.	
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 were brief, written in black ink and included the following: date and time of incident, event or activity, names of staff and youth involved, a brief statements providing pertinent information and the name and signature of the person making the entry.	

Recording errors are struck through with a single line. The staff person must initial and date the correction. The use of whiteout and erasures is prohibited.	**Compliance**	All recording errors were struck through with a single line, including the staff's initial and date of the error.	
The program director or designee reviews the facility logbook(s) every week and makes a note chronologically in the logbook indicating the dates reviewed and if any correction, recommendations and follow-up are required and sign/date the entry	**Compliance**	The program director or designee are reviewing the log weekly, indicating dates reviewed and if any recommendations, corrections or follow ups are required. Entry's are 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**	Program staff members are reviewing the logbook at the beginning of their shift, making a signed and dated entry indicating the dates that have been 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**	The logbooks indicate that at the beginning of their shift, the oncoming supervisor and shelter counselor are reviewing the logbooks of all shifts since the last log entry. All entries are signed, dated and indicate the dates reviewed.	
Logbook entries include: a. Supervision and resident counts b. Visitation and home visits	**Compliance**	All program logbooks reviewed include supervision and resident counts and visitation and home visits are documented.	
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 and procedures titled P-1123 Behavior Management Strategies. The policy last reviewed on January 11, 2024 by the Chief Operations Officer.	
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.*			
The Regional Director was interviewed for this indicator.			
The program has a detailed written description of the BMS and it is explained during program orientation	**Compliance**	Youth are provided an orientation booklet at intake that explains the Behavior Management System (FACE) in detail.	

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 FACE Behavior Management System is designed to teach youth prosocial behaviors and to help them understand the consequences of their actions. Behavioral interventions are applied immediately, with certainty and reflect the severity of the youth's behavior. The Behavior Management System uses a variety of incentives to encourage participation such as using the points that they have earned to purchase items from the Achievement Store. Appropriate consequences and sanctions are used and counseling, verbal intervention and de-escalation are used prior to any physical intervention is implemented. Group discipline is not imposed and room restriction is not a part of the Behavior Management System. Youth are not denied their basic rights.	
Program's use of the BMS			
All staff are trained in the theory and practice of administering BMS rewards and consequences	**Compliance**	Staff are trained during their initial on the job training in the theory and practice of administering the Behavior Management System rewards and consequences.	
There is a protocol for providing feedback and evaluation of staff regarding their use of BMS rewards and consequences	**Compliance**	Feedback and evaluation is provided to staff regarding their use of the Behavior Management Systems rewards and consequences.	
Supervisors are trained to monitor the use of rewards and consequences by their staff	**Compliance**	Supervisors are trained to monitor the use of consequences and rewards by their staff.	
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 and procedures titled P-1121 Supervision and Staffing Ratio/Scheduling. The policy was last reviewed on January 11,2024 by the Chief Operations Officer.	
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.*			
The Regional Director was interviewed for this indicator.			
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**	A review of the schedule for the previous six months indicated that all shifts were covered by a minimum of two direct care staff maintaining minimum staffing ratios as required by the Florida Administrative Code and contract requirements.	
All shifts must always provide a minimum of two direct care staff present that have met the minimum training requirements	**Compliance**	A review of the schedule for the previous six months indicated that all shifts were covered by a minimum of two direct care staff.	
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**	Program staff included in staff-to-youth ratio included only staff that are background screened and properly trained.	
The staff schedule is provided to staff or posted in a place visible to staff	**Compliance**	The staff schedule is posted in the staff control room on the desk.	
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**	Staff are expected to remain on duty until coverage can be acquired. There is a list of staff members and their contact information located in the staff control room.	
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**	Five days of video surveillance was reviewed to verify that all bed checks were completed within the fifteen minute time frame. The review of video confirmed that all checks were completed on time with no inconsistences.	
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 and procedures titled P-1280 Video Surveillance System. The policy was last reviewed on January 11, 2024 by the Chief Operations Officer.	
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.*			
The Regional Director was interviewed for this indicator.			
Surveillance System			
The agency, at a minimum, shall demonstrate: a. A written notice that is conspicuously posted on the premises for the purpose of security b. System can capture and retain video photographic images which must be stored for a minimum of 30 days c. System can record date, time, and location; maintain resolution that enables facial recognition d. Back-up capabilities consist of cameras' ability to operate during a power outage e. Have cameras placed in interior (e.g. intake office, counseling office, cafeteria, day room) and exterior (e.g. entrance/exit, recreation area, parking lot) general locations of the shelter where youth and staff congregate and where visitors enter and exit; to include locations where youth searches are conducted. Cameras are never placed in bathrooms or sleeping quarters. f. All cameras are visible	**Compliance**	The agency has a written notice posted in the program entry way indicating video surveillance for the purpose of security. The video surveillance system can capture and retain video photographic images and can be stored for 30 days. The system records time, date and location maintaining resolution that enable facial recognition. The surveillance system has back up capabilities and has the ability to operate during a power outage. Cameras are placed in both the interior and exterior to the building located in general areas where youth and staff congregate. All cameras are visible and not place in area's such as bathrooms and sleeping quarters. The program has sixteen operational cameras and are currently in the process of adding new cameras to the system.	
A list of designated personnel who can access the video surveillance system is maintained (includes off-site capability per personnel)?	**Compliance**	The Regional Director and Program Supervisor are designated with the capability to access the video surveillance both on-site and off-site.	
Supervisory review of video is conducted a minimum of once every 14 days and timeframes reviewed are noted in the logbook.	**Compliance**	A review of the logbooks for the previous six months indicate that the Regional Director and Program Supervisor are regularly reviewing cameras every two weeks and are documenting time frames reviewed.	
The reviews assess the activities of the facility and include a review of random sample of overnight shifts	**Compliance**	The reviews include a random sample of overnight shifts and activities.	

Grant the requesting of video recordings to yield a result within 24-72 hours from program quality improvement visits and when an investigation is pursued after an allegation of an incident	**Compliance**	The Regional Director reported request of video recordings from the agency's IT Department are granted 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**	There were no incidents of camera malfunctions during this review period.	
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 number is P-1117 and is called Preliminary Physical Health Screening. The policy was reviewed on January 11, 2024,and approved by the agency's Chief Operations Officer	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: 1 **Total number of Closed Files:5** **Staff Position(s) Interviewed (No Staff Names): Senior Youth Care worker, Regional Director** **Type of Documentation(s) Reviewed: Youth files** **Describe any Observations: See report.**			
Preliminary Healthcare Screening			
Screening includes : a. Current medications b. Existing (acute and chronic) medical conditions c. Allergies d. Recent injuries or illnesses e. Presence of pain or other physical distress f. Observation for evidence of illness, injury, physical distress, difficulty moving, etc. g. Observation for presence of scars, tattoos, or other skin markings h. Acute health symptoms requiring quarantine or isolation	**Compliance**	A total of five closed records and one open record were reviewed for healthcare screening. Each reviewed youth had a healthcare screening which included current medications, existing medical condition, allergies, recent injuries or illnesses, presence of pain or other physical distress, difficulty moving, etc., observation for presence of scars, tattooed or other skin markings, and acute health symptoms requiring quarantine or isolation.	

Referral and Follow-Up			
Youth with chronic medical conditions have a referral to ensure medical care (e.g. diabetes, pregnancy, seizure disorder, cardiac disorders, asthma, tuberculosis, hemophilia, head injuries, etc.)	**Compliance**	The Regional Director indicated the program does not provide referrals for medical care. It is the programs practice to coordinate medical care with the parent/guardian to ensure treatment for chronic medical conditions are addressed.	
When needed, the parent is involved with the coordination and scheduling of follow-up medical appointments	**No eligible items for review**	In the six client files reviewed, there were no medical appointments required during the shelter stay.	
All medical referrals are documented on a daily log.	**No eligible items for review**	A total of six records were reviewed and none of the six had any medical referrals.	
The program has a thorough referral process and a mechanism for necessary follow-up medical care as required and/or needed	**Compliance**	The Regional Director indicated they have a process in place in which the parent/guardian is actively involved in coordination and scheduling of follow-up medical appointments or care, as the program is unable to take youth to medical appointments. If the parent/guardian does not follow through, the program will continue to try to work with the parent/guardian, discharge the youth, or report the issues, if necessary.	
Additional Comments: **There are no additional comments for this indicator.**			

4.02 - Suicide Prevention		**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 4.02	**YES**	
	If NO, explain here:	
	The agency has a policy number is P-1247 and is called Suicide Assessment (residential). The policy was reviewed on January 11, 2024,and approved by the agency's Chief Operations Officer.	

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

Total number of Open (Residential & Community) Files: 1
Total number of Closed (Residential & Community) Files:5
Staff Position(s) Interviewed *(No Staff Names)* **: Regional Director, Residential Counselor,**
Type of Documentation(s) Reviewed: Youth Files, Suicide assessment form, Observation log, Logbook
Describe any Observations: See report.

Suicide Risk Screening and Approval (*Residential and Community Counseling*)			
Suicide risk screening occurred during the initial intake and screening process. Suicide screening results reviewed and signed by the supervisor and documented in the youth's case file.	**Compliance**	Six Residential files were reviewed for suicide risks screening. Five files were closed, one opened. Each of six screenings were completed by the appropriate staff and reviewed/signed by a supervisor.	

The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	**Compliance**	The program utilizes the standard screening tool that was previously approved by the Florida Network for suicide risk assessment.	
Supervision of Youth with Suicide Risk *(Shelter Only)*			
Youth are placed on the appropriate level of supervision based on the results of the suicide risk assessment.	**Compliance**	Six residential files were reviewed for suicide risks screening. Each youth was placed on constant sight and sound supervision upon completion of their suicide screening and remained on until a suicide assessment was completed indicating they could return to standard supervision.	
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**	Files reviewed for adherence to suicide prevention requirements indicated the documentation contained evidence that all suicide precaution observations were conducted on youth at 30 minute intervals and signed by the Regional Director.	
Documentation includes the time of day, behavioral observations, any warning signs observed, and the observers' initials and was maintained in either an observation log or in the shelter daily log.	**Compliance**	Documentation on each youth 30 minute observation log included the time, behavior observation, 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**	All six client files demonstrated that youth remained at the appropriated level until seen by licensed staff or regional director.	
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**	Each observation log was signed by an supervisor or youth care worker and 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.	**No eligible items for review**	The program reports no youth met this criteria. Any youth with an identified suicide risk would be referred to SMA healthcare for higher level care.	
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**	The program reports no youth met this criteria.	

Information on resources available in the community for further assessment was provided to the parent/guardian and is documented in the youth's file and signed by the parent/guardian OR a written follow-up notification was sent by certified mail if the parent/guardian was not present during the screening and was notified by telephone.	**No eligible items for review**	The program reports no youth met this criteria.	
If the parent/guardian cannot be contacted, all efforts to contact them are documented in the case file.	**No eligible items for review**	The program reports no youth met this criteria.	
When the screening was completed during school hours on school property, the appropriate school authorities were notified.	**No eligible items for review**	The program reports no youth met this criteria.	
Additional Comments: **There are no additional comments for this indicator.**			
4.03 - Medications			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 4.03		**YES** If NO, explain here: The agency's policy number is P-1120 titled Medication Provision, Storage, Access, Inventory, and Disposal and P-1200 titled Medication - Training and Education both last reviewed on 1/11/2024 by the agency's COO Cindy Starling.	
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 open residential client files **Total number of Closed Files: Six closed residential client files** **Staff Position(s) Interviewed** *(No Staff Names)* **: Senior Youth Care Worker** **Type of Documentation(s) Reviewed: Medication Record Log (MRL),client files with medication related documentation** **Describe any Observations: Unable to witness onsite medication no clients on prescribed medication.**			
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.	**No eligible items for review**	The program currently has no registered nurse (RN). Last onsite RN May, 2023. The Regional Director reported July 5, 2023 as the official date of separation	

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**	At the time of the onsite review, there were no clients that required prescribed or controlled medication. The review team was not able to review a live demonstration of the agency's ability to assist in the delivery of medication to clients. The agency has evidence of all staff being trained by the former Registered Nurse or a RN from another existing program.	
The agency held at least quarterly staff meetings conducted by RN and/or Shelter Manager to review and assess: a. strategies implemented to reduce medication errors shelter wide b. analyze factors that contributed to medication errors c. allow staff the opportunity to practice and role-play solutions	**Compliance**	The agency has evidence of date(s) of quarterly meetings held to demonstrate its efforts to review medication practice. The official medication review sessions were conducted on 2/28/2024 Medication Error Rate, 11/15/2023 Medical and Medication Issues, and 10/23/2023 Medication Management. The agency utilized each session to focus on contributing factors to medication errors and for staff to review and conduct exercises to correct existing and potential problems.	
The agency has strategies implemented to ensure medications are provided within the 2-hour time frame.	**Compliance**	The agency implemented setting an alarm clock in the medication room. The agency uses specific times called "quiet time" during medication distribution sessions with clients. Staff are also using personal cell phone to set alarms to remind staff of medication times.	
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**	Observed all non-licensed staff members clearly identified on the staff team schedule by identifying with a picture of a pill by the assigned staff member names for assisting with the self-administration of medications on each shift.	
The agency has clear methods of communicating which youth are on medications with the times and dosage easily discernable by all staff on each shift.	**Compliance**	The agency utilizes an alert board, client medication board, Medication Distribution Log and client files to communicate which youth are on mediations for the prescribed times and dosage.	
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.	**No eligible items for review**	At the time of this onsite Quality Improvement review, there were no children that were required to be given prescribed 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**	A review of practice confirmed the program upon intake/admission, there is evidence that the on-shift Senior Youth Care Worker reviews all medication forms by the next business day.	
Medication Storage			
a. All medications are stored in a Pyxis ES Medication Cabinet that is inaccessible to youth (when unaccompanied by authorized staff) b. Pyxis machine is stored in accordance with guidelines in FS 499.0121 and policy section in Medication Management c. Oral medications are stored separately from injectable epi-pen and topical medications d. Medications requiring refrigeration are stored in a secure refrigerator that is used only for this purpose, at temperature range 2-8 degrees C or 36-46 degrees F. (If the refrigerator is not secure, the room is secure and inaccessible to youth.) e. Narcotics and controlled medications are stored in the Pyxis ES Station f. Pyxis keys with the following labels are accessible to staff in the event they need to access medications if there is a Pyxis malfunction: a TOP COVER b BACK PANEL- LEFT TALL CABINET LOCK- LEFT, c BACK PANEL- RIGHT TALL CABINET LOCK- RIGHT	**Compliance**	The program utilizes a Pyxis ES Medication located in the control room, is inaccessible to youth, and stored in accordance with Florida statute and the program's policy. The Pyxis machine stores all prescription medications, over the counter, injectable, and topical in individual containers, therefore keeping all medications separate. The program maintains a mini refrigerator specifically designated for medication requiring refrigeration, though no on-site medication required refrigeration at this time. The refrigerator has a temperature gauge to maintain the required temperature range. The Pyxis keys are accessible to staff in the event they need to access medication if there is a Pyxis malfunction.	

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 two site-specific system managers for the Pyxis machine. The system managers are delegated with user permissions to access secure medication. A review of documentation confirmed a Medication Distribution Log (MDL) is used for the distribution of medication by all staff. The registered nurse (RN) verifies all medication using one of the three methods required by the Florida Network manual. The RN provides medication management if on-site. All medication management procedures adhere to the Florida Network medication management policy. Except youth requiring Epi-pens, the program does not accept youth prescribed injectable medications. Documentation reviewed confirmed all non-licensed staff have received training in the use of Epi-pens.	
The medication distribution log documentation includes: a. the time of medication administration b. evidence of youth initials that the dosage was given c. evidence of staff initials that the dosage was given	**Compliance**	Medication Record Log includes time of medication administration, youth initials of dosage given, staff initials 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.	**No eligible items for review**	No youth assigned medication.	
During the review period, there were no instances where youth missed their medication due to failure to open the pyxis machine.	**No eligible items for review**	No youth assigned medication.	
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**	At the time of this program review, the agency Regional Director reported that the RN has been vacant since July 2023. The agency has been and is actively advertising and recruiting to fill the position. The agency utilizes RNs from other 2 program locations and RN technical assistance provided by the Florida Network of Youth and Family Services. The agency has a comprehensive corrective action policy and procedure for overseeing all re-training of staff that commit a maximum of 3 errors within a year. At the time of this program review, there no staff which had committed 3 medication errors in a year and required the agency to intervene with the medication mitigation and corrective action training.	

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**	Reviewed and confirmed the program maintained a perpetual inventory for controlled substances, including witnessed shift-to-shift counts. Control medication simply identified using a blue color MDL, notating on alert board & client medication board capital C in blue. Documentation confirmed all medications are inventoried weekly. The program does not utilize syringes or medical sharps. Program does not offer over the counter medication, only prescribed medication.	
There are monthly reviews of the Pyxis reports to monitor medication management practice.	**Compliance**	Documentation confirmed the agency has access to Pyxis reports and produces reports on a monthly basis.	
Medication discrepancies are cleared after each shift.	**Compliance**	A review of the agency's practice confirmed the program clears all medication discrepancies after each shift, if applicable. At the time of this program review, the agency did not have any discrepancies.	
Additional Comments: **There are no additional comments for this indicator.**			
4.04 - Medical/Mental Health Alert Process			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 4.04		**YES** If NO, explain here: The agency policy number P-1119 Medical and Mental Health Alert process. The policy was reviewed on January 11, 2024, and approved by the agency's Chief Operations Officer.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files:1 **Total number of Closed Files5:** **Staff Position(s) Interviewed** *(No Staff Names)* **:Regional Director** **Type of Documentation(s) Reviewed: Youth files, Board codes, Intake assessment form, screening** **Describe any Observations: See report.**			
Youth with a medical, mental health, or food allergy was appropriately placed on the program's alert system	**Compliance**	All six files reviewed contained evidence of each youth having a medical, mental health concern, or food allergy. The agency's process is to put the codes on the front of the files.	
Alert system includes precautions concerning prescribed medications, medical/mental health conditions	**Compliance**	The program includes medical/mental health conditions, possible side effects/adverse reactions concerning prescribed medications on each youth's prescription medication log sheet.	

Staff are provided sufficient training, information and instructions to recognize/respond to the need for emergency care for medical/mental health problems	**Compliance**	Staff received training in first-aid and CPR.	
A medical and mental health alert system is in place that ensures information concerning a youth's medical condition, allergies, common side effects of prescribed medications, foods and medications that are contraindicated, or other pertinent mental health treatment information, is communicated to all staff	**Compliance**	A current list of youth alerts is maintained by staff. Medical alerts include: medical condition, allergies, common side effects of prescribed medications, foods and medications that are contraindicated or other pertinent mental health treatment information. Lists are maintained in several locations including med room and kitchen.	
Additional Comments: **There are no additional comments for this indicator.**			
4.05 - Episodic/Emergency Care			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 4.05		**YES** If NO, explain here: The agency policy number P-1166 Episodic Emergency. The policy was reviewed on January 11, 2024, and approved by the agency's Chief Operations Officer.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: 0 **Total number of Closed Files:3** **Staff Position(s) Interviewed** *(No Staff Names)* **: Senior YCW** **Type of Documentation(s) Reviewed: Episodic Log, CCC reports** **Describe any Observations: See report.**			
Off Site Emergency Care			
a. If off-site emergency medical or dental care was provided, an incident report was submitted for the medical or dental care b. Upon youth return, there is a verification receipt of medical clearance via discharge instructions with follow-up is present in file c. Youth's parent/guardian was notified d. A daily log is maintained for emergency care provided	**Exception**	Three client files were reviewed for this indicator, all three flies are closed cases. All incident reports included evidence of documented offsite provision of medical care. Two of the three cases have evidence the incident was documented in the emergency care log and parent/guardian were notified.	One out of the three files did not have emergency discharge paperwork. The agency only received the returned to school paperwork.
All staff are trained on emergency medical procedures	**Compliance**	A review of eight staff member files contained training on emergency medical procedures.	
The program has a Knife-for-life and wire cutters accessible to staff in a secure location(s)	**Compliance**	The agency maintains three locked knife-for-life emergency cutting tools. Each tool is maintained in both vans and the control room.	
Additional Comments: **There are no additional comments for this indicator.**			