Florida Network for Youth and Family Services
Compliance Monitoring Report for

CDS Family and Behavioral Health Services, Inc. - Interface N.W.

1884 SW Grandview Street
Lake City, Florida 32055

May 15-16, 2024

Compliance Monitoring Services Provided by

FOREFRONT

EXECUTIVE SUMMARY

Forefront LLC conducted a Quality Improvement (QI) monitoring visit on behalf of the Florida Network of Youth and Family Services (FNYFS) for the CDS Family and Behavioral Health Services, Inc. - Interface N.W. (IYP-NW) for the FY 2023-2024 at its program office located at 1884 SW Grandview Street, Lake City, Florida 32055. 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. IYP-NW 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. Agency representatives from IYP-NW present for the entrance interview were: Phil Kabler, Chief Executive Officer, Cindy Starling, Chief Operations Officer, Sabriena Williams, Regional Director, Stephanie Douglas, LMHC, Senior Counselor/Case Manager, Brandi Bell, Residential Supervisor, Kathy Hardee, Registered Nurse, Tonda Nelson, Residential Counselor, Jennifer Bedenbaugh, Non-Residential Counselor/Case Manager, Walter Dishbrow, Administrative Assistant. The last onsite QI visit was conducted April 19-20, 2023.

In general, the Reviewer found that the IYP-NW is in compliance with specific contract requirements. IYP-NW **received an overall compliance rating of 100% for achieving full compliance with 12 applicable indicators out of fourteen** on 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 5-15-16-2023-2024

Agency Name: CDS Family and Behavioral Health Services Inc. - Interface N.W.	**Monitor Name: Keith Carr**
Contract Type : CINS/FINS	**Region/Office: 1884 SW Grandview Street Lake City, Fl 32055**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): May 15-16, 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, Cindy Starling, Alex Culbreth, LaToya Robinson, Sabriena Williams. Naomi Thompson, Brian Smith, and Kevin Lee.	**No recommendation or corrective action.**
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**	☐	☐	☒	☐	☐	D,PTV: 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.	**No recommendation or corrective action.**
Limits of Coverage	☐	☐	☒	☐	☐	D,PTV: General Liability through Berkshire Hathaway Specialty Insurance Company, for limits of	**No recommendation or corrective action.**

2023-2024 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 5-15-16-2023-2024

Agency Name: CDS Family and Behavioral Health Services Inc. - Interface N.W.	**Monitor Name: Keith Carr**
Contract Type : CINS/FINS	**Region/Office: 1884 SW Grandview Street Lake City, Fl 32055**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): May 15-16, 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**		
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**						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 05/01/2024 – 05/01/2025. 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 05/01/2024 – 05/01/2025. An umbrella liability policy through Berkshire Hathaway Specialty Insurance Company, for $1,000,000 each/aggregate. Policy effective for 05/01/2024 – 05/01/2025. Workers Compensation through Bridgefield Casualty Insurance Company for $500,000 each accident.	

2023-2024 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 5-15-16-2023-2024

Agency Name: CDS Family and Behavioral Health Services Inc. - Interface N.W.	**Monitor Name: Keith Carr**
Contract Type : CINS/FINS	**Region/Office: 1884 SW Grandview Street Lake City, Fl 32055**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): May 15-16, 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**		
						Effective 05/01/24 – 05/01/2025. PACKAGE POLICY - MANAGEMENT LIABILITY though 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 04/06/2024-05/01/2025. Florida Network of Youth and Family Services 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**	☐	☐	☐	☐	☒	I: During the Entrance Conference, the provider indicated that there are no outstanding corrective action item(s) cited by an external funding source.	**No recommendation or corrective action.**
Fiscal Practice	☐	☐	☒	☐	☐	I,PTV: The agency reported that they have fiscal Policies and Procedures which are contained in the IYP and	**No recommendation or corrective action.**

2023-2024 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 5-15-16-2023-2024

Agency Name: CDS Family and Behavioral Health Services Inc. - Interface N.W.	**Monitor Name: Keith Carr**
Contract Type : CINS/FINS	**Region/Office: 1884 SW Grandview Street Lake City, Fl 32055**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): May 15-16, 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**		
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**						Behavioral Health Services' Financial Management Policy. The P-1012 Fiscal Management – 10/19, P-1257 Petty Cash Policy, Refund Policy – 07/2008, Reserve Policy – 02/09, Fiscal Comprehensive Audit – P-1245/10/19, Annual Budget – P-1246 /10/19, Debt and Other Liabilities P-1252 10/19, Expenses and Accounts Payable P-1254 10/19. The most recent update and revisions related to Fiscal policies and procedures is January 2022.	
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 April 2024 was provided and reviewed. Agency maintains a detailed general ledger that is structured to track all funding sources, as well as activities for the shelter and each program category separately.	**No recommendation or corrective action.**

2023-2024 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 5-15-16-2023-2024

Agency Name: CDS Family and Behavioral Health Services Inc. - Interface N.W.	**Monitor Name: Keith Carr**
Contract Type : CINS/FINS	**Region/Office: 1884 SW Grandview Street Lake City, Fl 32055**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): May 15-16, 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**		
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. Petty cash documents presented for review include August 2024, September 2024, November 2024, January 2024, and April 2024. The petty cash was reconciled on site for the reviewer and no discrepancies in fund on hand were observed. Additionally, the petty cash is reconciled on a consistent basis (monthly/quarterly) by the Residential Supervisor and reviewed by the Regional Director, Comptroller/Chief Financial Officer and Chief Operations Officer. Disbursements and invoices are approved by the Regional Director.	**No recommendation or corrective action.**
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	☐	☐	☒	☐	☐	PTV,D: Agency provided Bank Statements and Bank Reconciliations	**No recommendation or corrective action.**

2023-2024 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 5-15-16-2023-2024

Agency Name: CDS Family and Behavioral Health Services Inc. - Interface N.W.	**Monitor Name: Keith Carr**
Contract Type : CINS/FINS	**Region/Office: 1884 SW Grandview Street Lake City, Fl 32055**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): May 15-16, 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**		
monthly basis with supporting documentation. (Disbursements/invoices are approved & monitored by management). **ON SITE**						for the past six months, 05/14/2024, 04/01/2024, 03/02/2024, 01/2024, and 11/30/2023, for one accounts held with SouthState. 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 completed the reconciliation e.g. ProActive Tax & Accounting and internal fiscal staff member. 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: The agency has not purchased any property with FNYFS funds for the current fiscal year.	**No recommendation or corrective action.**

2023-2024 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 5-15-16-2023-2024

Agency Name: CDS Family and Behavioral Health Services Inc. - Interface N.W.	**Monitor Name: Keith Carr**
Contract Type : CINS/FINS	**Region/Office: 1884 SW Grandview Street Lake City, Fl 32055**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): May 15-16, 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**		
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. The agency produce a current list of recorded payments for the last six months from November 2023 – April 2024.	**No recommendation or corrective action.**
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 July 2023-current. The report shows Actual, Budget, and Variance with Total Revenue Over Expense with each program having designated codes. IYP Budget report includes Assets, Liabilities, Fund Balance, Revenues, Total Revenues, Expenses, and Other Income Expense. Agency list Actual Budge and Variance in separate categories for the date 11/7/2023. Variances in budget are monitored on a regular	**No recommendation or corrective action.**

2023-2024 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 5-15-16-2023-2024

Agency Name: CDS Family and Behavioral Health Services Inc. - Interface N.W.	**Monitor Name: Keith Carr**
Contract Type : CINS/FINS	**Region/Office: 1884 SW Grandview Street Lake City, Fl 32055**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): May 15-16, 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**		
						basis by Fiscal Manager and are discussed with the Board by the Budget and Financial Committee.	
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,PTV: The agency provided a copy of their most recent Financial Audit conducted for the year ending June 30, 2023, and 2022 was completed by Thomas and Company, C.P.A., P.A. Certified. Public Accounts and Business Consultants.	**No recommendation or corrective action.**
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 on a nightly cadence. Other critical servers, microcomputers and laptops complete scheduled back-ups on a	**No recommendation or corrective action.**

2023-2024 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 5-15-16-2023-2024

Agency Name: CDS Family and Behavioral Health Services Inc. - Interface N.W.	**Monitor Name: Keith Carr**
Contract Type : CINS/FINS	**Region/Office: 1884 SW Grandview Street Lake City, Fl 32055**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): May 15-16, 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**		
						secured portable hard drive. Obsolete fiscal record documents may be shredded after six years, participant records 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: The agency provided an employee listing for all IYP-NW Shelter, Family Action and SNAP staff that evidences the minimum wage was increased to $19 per hour effective October 1, 2023.	**No recommendation or corrective action.**

2023-2024 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 5-15-16-2023-2024

CONCLUSION

CDS Family & Behavioral Health, Inc. - Interface N.W. (IYP – NW) has met the requirements for the CINS/FINS contract as a result of full compliance with --- applicable indicators of the Administrative and Fiscal Contract Monitoring Tool. Two of the fourteen compliance 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 recommendations or 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 and Behavioral Health - NW
CINS/FINS Program

Date: May 15-16, 2024

Compliance Monitoring Services Provided by

FOREFRONT

CINS/FINS Rating Profile

Standard 1: Management Accountability

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

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

Standard 2: Intervention and Case Management

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

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

Standard 3: Shelter Care & Special Populations

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

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

Standard 4: Mental Health/Health Services

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

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

Overall Rating Summary

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

Rating Definitions

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

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

Reviewers

Members

Keith Carr - Lead Reviewer Consultant-Forefront LLC/Florida Network of Youth and Family Services
Laura Moneyham, QI and Compliance Manager, Florida Network of Youth and Family Services
Robert Ashley, Assitant Shelter Manager, Anchorage Children's Home
Jessica Gibson, Operations Regional Monitor, North Region, Florida Department of Juvenile Justice
Chrissy Baker, Residential Counselor, Lutheran Services FLorida - NW

Methodology

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

Persons Interviewed

X	Chief Executive Officer		Case Manager		Nurse – Full time
	Chief Financial Officer	X	Counselor Non-Licensed	X	Nurse – Part time
X	Chief Operating Officer		Advocate		# Case Managers
	Executive Director	X	Direct – Care Full time	1	# Program Supervisors
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	4	# Other (lis Direct Care Staff
	Counselor Licensed		Human Resources		

Documents Reviewed

	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
X	Continuity of Operation Plan	X	Fire Drill Log	8	# 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	5	# Youth Records (Closed)
X	Egress Plans	X	Program Schedules	4	# Youth Records (Open)
X	Fire Inspection Report		List of Supplemental Contracts		# 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
X	Medication Administration	X	Staff Interactions with Youth	X	Census Board

Surveys

3	# of Youth	7	# 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

CDS Family and Behavioral Health Services, Inc. is a private non-profit social services agency that is contracted through the Florida Network of Youth and Family Services (FNYFS) to provide Children in Need Services and Families in Need Services (CINS/FINS). The agency has offices across 3 locations in Florida; Central (Gainesville), Northwest (Lake City), and East (Palatka). The main headquarter is located in Gainesville. The CDS Family and Behavioral Health Services, Inc. - Northwest (CDS NW) location serves youth and families in Columbia, Dixie, Hamilton, Lafayette, and Suwannee Counties. The agency has built a new youth shelter for its CDS-Central service region that is scheduled to begin serving at-risk youth this calendar year. The new 9700 square feet facility is planned to open the Summer of 2024. The old shelter is planned to be used by another non-profit agency that provides services for individuals experiencing homelessness.

The following programmatic updates were provided by the agency:

1. The agency reported it has continued to partner with the Columbia County Library District for TWEEN groups. In addition, the agency partners with the following organizations: the Hanley Foundation for Substance Abuse groups, Another Way Domestic Violence Network, IFAS of UF and Gateway Community College.
2. In March, 2024 CDS Interface was awarded $1,500 from The American Legion Post in Lake City, Florida. The supplies purchased are for the upcoming Summer Enrichment Program.
3. The agency reported that it hired Brandi Bell, Residential Supervisor to the IYP-NW Team on 11/27/23. Additionally, IYP-NW Administrative Assistant Walter Disbrow received the “Employee of the Year Award” for IYP-C at the CDS Annual Meeting. Mr. Disbrow celebrated 24 years of service with IYP-NW. Further, Stephanie Douglas, LMHC, Senior Case Manager was awarded the Service of Excellence Award from the Florida Juvenile Justice Association.
4. The agency reported a new 12 passenger van was purchased on 3/4/24.
5. New fencing around the perimeter of the Shelter was successfully installed on 2/24 by All Florida Enterprise, LLC.
6. The agency reported that during this reporting period (1) IYP- NW staff was Terminated / Resigned and (1) IYP-NW staff was hired. Currently, IYP-C has 18 employees, this includes; 1 Regional Director, 1 Residential Supervisor, 1 Full Time Residential Counselor, 1 Senior YCW, 1 Residential Administrative Assistant, House Manager(position acquired by Regional Director) 1 Part Time Registered Nurse, 5 Full Time YCW’s, 0 Part Time YCW’s and 5 PRN YCW’s and 2 Community Counselors. We have 2 Part Time Youth Care Workers currently in background check status. When these two positions are filled we can then produce the best Program and participant management possible.
7. IYP-NW reported that the United Way of Suwannee Valley has provided seasonal activities, refreshments and interactive age appropriate supplies to the participants in shelter.
8. IYP-NW reported youth entering the program are continuing to be assigned Community Instruction on a case-by-case basis. Elementary-aged youth are going on-site to Summers Elementary on Tuesdays and Thursdays from 1PM-2PM. Middle and High School-aged youth are going Tuesdays and Thursdays between 9AM-10 AM to Pathways Alternative School for 1 hour a week to meet with a teacher face to face. Residential Supervisor is in constant contact with Meg Hanley, the Community Instruction Coordinator.

Narrative Summary

The services provided under the CINS/FINS contract with the FNYFS allow the agency to serve all eligible youth between the ages of ten to seventeen years old that are runaway, ungovernable and/or truant, locked out, homeless, abused, neglected, or possess other at-risk factors. The agency provides specialized services to eligible youth with other profiles such as Staff Secure shelter, Domestic Minor Sex Trafficking, Domestic Violence, Probation Respite, Family/Youth Respite Aftercare Services (FYRAC), and provides services for eligible youth through Stop Now and Plan (SNAP). The youth census during the onsite QI program review visit was four (4) CINS/FINS youth. The CDS organization is currently accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF).

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

Standard 1: There are seven indicators for Standard 1. Indicator 1.01 Background Screening of Employees/Volunteers was rated **Satisfactory**, Indicator 1.02 Provision of an Abuse Free Environment was rated **Satisfactory with Exception**, Indicator 1.03 Incident Reporting was rated **Satisfactory**, Indicator 1.04 Training Requirements was rated **Satisfactory**, Indicator 1.05 Analyzing and Reporting Information was rated **Satisfactory**, Indicator 1.06 Client Transportation was rated **Satisfactory**, 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 with Exceptions**, Indicator 2.03 Case/Service Plan was rated **Satisfactory with Exceptions**, Indicator 2.04 Case Management and Service Delivery was rated **Satisfactory**, Indicator 2.05 Counseling Services was rated **Satisfactory with Exceptions**, Indicator 2.06 Adjudication/Petition Process was rated **Satisfactory**, Indicator 2.07 Youth Records was rated **Satisfactory**, Indicator 2.08 Specialized Additional Program Services was rated **Satisfactory**, and Indicator 2.09 Stop Now and Plan (SNAP) was rated **Satisfactory**.

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 with Exceptions**, Indicator 3.03 Youth Room Assignment was rated **Satisfactory**, Indicator 3.04 Log Books was rated **Satisfactory with Exceptions**, 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 with Exceptions.**

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 with Exceptions**, 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**.

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

No indicators received a Limited or Failed rating.

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:	
	Indicate policy number, authorized signee, date(s) of last review/revision/approval: 1.01 Management Accountability Reviewed: 1/11/2024; revised: 7/23/2023.	

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

Total number of New Hire Employee/Intern/Volunteer Files: 10
Total number of 5 Year Re-screen Employee Files: 5
Staff Position(s) Interviewed *(No Staff Names)*: **direct care staff**
Type of Documentation(s) Reviewed: Reselect and Workplace Productivity Profile

All positions providing direct services to youth has successfully passed pre-employment suitability assessment on the initial attempt.	**Compliance**	Fifteen employee records were reviewed for pre-employment suitability. All fifteen employees were provided a pre-employment suitability assessment prior to working with the youth and passed the assessment on the initial attempt according to the documentation reviewed.	
For any applicant that did not pass the initial suitability assessment, there was evidence that the applicant retook the assessment and passed within five (5) business days of the initial attempt, not exceeding three (3) attempts within thirty (30) days.	**No eligible items for review**	The agency had no applicable employees who 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.	**No eligible items for review**	The agency did not have any applicable employees with a break in service for eighteen months or more.	

Background screening completed prior to hire/start date (or exemption obtained prior to working with youth if rated ineligible) for new hires, volunteers/interns, and contractors. *(Employees who have had a break in service and are in good standing may be reemployed with the same agency without background screening if the break is less than 90 days.)*	**Compliance**	Ten out of ten employee records included documentation the initial background screenings were completed prior to the staff's start date. The agency did not have any volunteers during the annual compliance review period.	
Five-year re-screening is completed every 5 years from the date of the last screening or prior to retained fingerprints expiration date.	**Compliance**	Five out of five employee records included documentation to indicate background re-screenings were completed prior to the fingerprints expiration dates.	
Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?	**Compliance**	The Annual Affidavit of Compliance with Level 2 Screening Standards was completed and sent to Background Screening Unit via email message on January 10, 2024.	
Proof of E-Verify for all new employees obtained from the Department of Homeland Security	**Compliance**	Fifteen out of fifteen employee records included documentation of E-Verify for all new employees obtained from the Department of Homeland Security.	
Additional Comments: **There are no additional comments for this indicator.**			
1.02: Provision of an Abuse Free Environment			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 1.02		**YES** If NO, explain here: The agency has policies 1.02 Provision of an Abuse Free Environment; Florida Abuse Reporting; Behavioral expectations for staff; Rule Violations Revised: 2/2022 and Reviewed by the agency 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.*			
Type of Documentation(s) Reviewed: code of conduct, abuse hotline number postings, employee handbook **Describe any Observations:** Youth interacting with staff were observed during the review. The staff and youth are respectful to each other. There were on concerns with the observations.			
Agency has a code of conduct of policy and there is evidence that staff are aware of agency's code of conduct.	**Compliance**	The agency maintains a Code of Conduct which prohibits the use of physical abuse, profanity, threats, or intimidation. The staff members must sign acknowledgement of the Code of Conduct upon hire. The Code of Conduct is located in the staff handbook.	
The agency has a process in place for reporting and documenting child abuse hotline calls.	**Compliance**	The agency has a process in place for reporting and documenting child abuse hotline calls. At the time of this review, there have been no abuse calls in last six months.	

Youth were informed of the Abuse and Contact Number	**Compliance**	Three closed and two open youth records were reviewed. All the youth were informed of the Florida Abuse Hotline number. The Florida Abuse Hotline number is posted throughout the facility.	
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 agency maintains a written formal grievance process and includes procedures. All agency grievances are resolved and documented by the Program Director within seventy-two hours. Eight grievances were reviewed for the annual compliance review period. There were no issues or exceptions.	
Shelter only: Grievances are maintained on file at minimum for 1 year.	**Compliance**	The agency maintains a grievance system. The grievance forms completed by residents are maintained in a binder for a minimum of 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**	The agency maintains a written policy and procedures for the grievance process. The agency provides a program orientation to all eligible residents be informed of the grievance process and where grievances are to be submitted and how grievances will be resolved. Residents have multiple locations to access grievance forms and submit them as needed.	
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**	A review of existing grievances found the agency conducting checks of each grievance box located in the female and male living areas. A review of the agency logbooks indicated the grievance box is checked daily.	
Shelter only: All grievances are resolved within 72 hours and documented by program director/supervisor or escalated to higher leadership if grievance involves them directly.	**Exception**	A review of existing grievances found the agency is completing the grievances within seventy-two hours and is documented on the grievance form by the director/supervisor.	One youth reported on the surveys a grievance was written, but never dealt with. No date was provided. One youth reported the grievance process as poor.
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 1.03 Incident Reporting Procedure. The policy was revised 7/2023and reviewed and approved by the agency Chief Operating 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.*

Total number of New Hire Employee/Intern/Volunteer Files: 10 **Total number of 5 Year Re-screen Employee Files: 5** **Staff Position(s) Interviewed (No Staff Names): direct care staff** **Type of Documentation(s) Reviewed: Policy and Procedures, CCC reports, internal incident reports**			
During the past 6 months, the program notified the Department's CCC (Central Communication Center) no later than two hours after any reportable incident occurred or within two hours of the program learning of the incident	**Compliance**	The agency provided documentation of two incidents during the annual compliance review period which were reportable to the Florida Department of Juvenile Justice's (DJJ) Central Communication Center (CCC). Both incidents were reported within the required two hour time frame.	
The program completes follow-up communication tasks/special instructions as required by the CCC	**No eligible items for review**	The CCC did not provide any follow-up communication tasks or special instructions for incident reported in last six months.	
Agency internal incidents are documented on incident reporting forms and all CCC reportable incidents were consistently reported to CCC as required.	**Compliance**	All agency internal incidents were documented on incident reporting forms and all CCC reportable incidents were consistently reported to CCC as required.	
Incidents are documented in the program logs and on incident reporting forms	**Compliance**	All incidents were documented on the incident reporting forms and maintained in a binder at the agency. All incidents were reviewed with no exceptions in the program logs.	
All incident reports are reviewed and signed by program supervisors/ directors	**Compliance**	One Medical incident and one Mental Health and Substance Abuse Incident. There is evidence of each incident being reviewed and signed by the supervisor or designee.	
1.04: Training Requirements (*Staff receives training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions*)			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 1.04		**YES** If NO, explain here: The agency has three policies which outline the requirements of this indicator P1030-Training Policy revised 6/23 and 3/24, approved by 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.*			
Total number of New Hire Staff Files: 2 **Total number of Annual In-Service Staff Files: 6** **Total number of Non-Licensed Mental Health Clinical Shelter Staff Files: 0** **Annual Training Plan Timeframe (Program timeframe for annual trainings): The program uses 12 months from the date of hire to determine the annual time frame for new hires and transfers to the fiscal year beginning July 1 and ending June 30th thereafter.** **Staff Position(s) Interviewed (No Staff Names): Administrative Assistant** **Type of Documentation(s) Reviewed: Agency staff roster, Employee training files, Agency Training Policy** **Describe any Observations: The training files were extremely well organized with easy to navigate back-up documentation.**			

First Year Direct Care Staff			
All direct care staff have completed new hire pre-service training requirements for safety and supervision as required.	**Compliance**	Two staff files were reviewed for completion of the new hire pre-service requirements. Both staff members hired since the last QI review completed all required trainings prior to working independently with youth. One new staff member was late on 2 trainings required within the first 90 days, however there were extenuating circumstances due to a death in her family and she completed the trainings upon returning to work.	
All staff completed the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days from date of hire.	**Compliance**	Both staff members hired since the last QI review completed the DOJ Civil Rights and Federal Funds course in the DJJ SkillPro system in the first 30 days.	
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 staff member hired since the last QI review was hired on 6/13/2023 and completed 171 training hours. The other staff member hired since the last QI review was hired on 11/27/2023 and completed 116.5 hours of training.	
All staff receives all mandatory training during the first 90 days of employment from date of hire.	**Compliance**	Both staff members hired since the last QI review completed all mandatory training prior to working independently with youth. One new staff member was late on two trainings required within the first 90 days (MAB and ACEs), however there were extenuating circumstances due to a death in her family and she completed the trainings upon returning to work.	
Staff Required to Complete Data Entry for NIRVANA or access the Florida Department of Juvenile Justice Information System (JJIS)			
Any designated staff that is responsible for entering NIRVANA or ensuring accurate and complete data entry in the Florida Department of Juvenile Justice Information System (JJIS) have completed all of the required trainings.	**No eligible items for review**	Neither new staff member is responsible for entering data into NIRVANA or JJIS.	
Staff Participating in Case Staffing & CINS Petitions (within first year of employment)			
Documentation of instructor led FL Statute 984 CINS Petition Training by a local DJJ Attorney. *Effective for staff hired after 7/1/23*	**No eligible items for review**	Neither staff member hired since the last QI review participates in Case Staffings or CINS Petitions.	
Non-licensed Mental Health Clinical Shelter Staff (within first year of employment)			
Documentation of non-licensed mental health clinical staff person's training in Assessment of Suicide Risk form or written confirmation by a licensed mental health professional of training (includes date, signature and license number of the licensed mental health professional supervisor).	**No eligible items for review**	Neither of the two staff hired since the last QI review are non-licensed mental health clinical 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).*	**Compliance**	Five of the six staff member training files reviewed contained documentation of at least 40 in-service training hours in FY 23-24, with a range of 40.5 hours - 95.5 hours. One staff member had 38.5 in-service training hours documented and has until June 30, 2024 to complete the remaining 1.5 hours.	
Required Training Documentation			
The agency has a training plan that includes all of the required training topics including the pre-service and in-service.	**Compliance**	The agency's training policy, P1030, details the required training topics and timelines for pre-service and in-service training. Staff training files are overseen and managed by the program's Administrative Assistant and include a very detailed training plan which includes the training topic, number of credit hours, the due date and date completed, the number of credit hours earned and where the training was conducted (e.g. CDS in-person, DJJ SkillPro online, DCF online, etc.).	
The agency has a designated staff member responsible to manage all employee's individual training files and completes routine tracking and reviews of staff files to ensure compliance.	**Compliance**	The agency's Administrative Assistant manages the training files for all staff and tracks adherence to the training plan and any outliers.	
The program maintains an individual training file or employee file AND a FLN Training Log (or similar document that includes all requirements) for each staff, which includes an annual employee training hours tracking form and related documentation, such as electronic record/transcript, training certificates, sign-in sheets, and agendas for each training attended.	**Compliance**	The agency maintains individual training files for each employee with a training log for both pre-service and in-service training which includes tallies of the total number of pre-service or in-service trainings provided for the first year and by fiscal year thereafter. The file is sectioned and organized by the training type or platform (CDS, DCF, SkillPro, Bridge) and includes the electronic record/transcript and back-up documentation such as certificates, sign-in sheets and/or agendas for each training credited.	
Additional Comments: **There are no additional comments for this indicator.**			
1.05 - Analyzing and Reporting Information			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 1.05		**YES** If NO, explain here: The agency has three policies which outline the requirements of this indicator: Quality Improvement Program (P-1180) Rev 2/22, Data Integrity (P-1077) Rev 2/18, Risk Management Planning (P-1049) Rev 2/22. All policies noted above were reviewed and approved 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.*			

Staff Position(s) Interviewed *(No Staff Names)* **: Chief Operating Officer**
Type of Documentation(s) Reviewed: Quarterly Peer Review Analysis Report for FY 23/24 Q3 and Q4, Policies/Procedures (Quality Improvement Program (P-1180) Rev 2/22, Data Integrity (P-1077) Rev 2/18, Risk Management Planning (P-1049)), Executive Management Team (EMT) Meeting Minutes for 10/23/2023, 11/15/2023, 12/21/2023, 2/28/2024, and 3/38/2024, BOD Meeting Minutes for 8/10/2023, 9/12/2023, 10/12/2023, 1/11/2024, 2/8/2024, 3/14/2024.

Case record review reports demonstrate reviews are conducted quarterly, at a minimum	**Compliance**	Peer reviews are conducted quarterly for both Community Counseling and Shelter files. Results of the peer reviews are reviewed in the Executive Management Team (EMT) meetings, as evidenced by the 2/28/2024 EMT Meeting Minutes for the 2nd Qtr. Peer Review and the 11/15/2023 EMT Meeting Minutes for the 1st Qtr. Peer Review.	
The program conducts reviews of incidents, accidents, and grievances quarterly, at a minimum	**Compliance**	Incidents, accidents and grievances are reviewed monthly in the agency's EMT meetings that are attended by the CEO, COO, Regional Directors, CINS/FINs Managers and Shelter Managers for all three locations, as evidenced by a review of meeting minutes for the 11/15/2023 and 2/28/2024 EMT meetings.	
The program conducts an annual review of customer satisfaction data	**Compliance**	The program provided the FY 22-23 Annual Report of Satisfaction Survey Results for all three shelters and Community Counseling programs. 84.21% of respondents were satisfied with the services received and 15.79% of respondents were somewhat satisfied with services received for the Lake City Shelter location. 100% of respondents were satisfied with the services received for the Lake City Community Counseling location.	
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 FN outcome/performance data monthly, as evidenced by a review of their EMT meeting minutes for the following meetings: 3/28/24, 2/28/24, 12/21/24, 11/15, 2024, 10/23/24. The review includes CINS/FINS Contract Performance reports via NETMIS, the FN EOM report data, and medical error data.	
The program has a process in place to review and improve accuracy of data entry & collection	**Compliance**	A review of the Peer Review Analysis Reports for Quarter three and Quarter four FY 23/24 and EMT meeting minutes for the previous six months indicate that the agency has an effective process in place to review/improve data entry and collection.	
There is documentation that findings are regularly reviewed by management and communicated to staff and stakeholders.	**Compliance**	A review of EMT meeting minutes for the prior six months indicates that management at all levels of the agency regularly review quality improvement findings, contract performance, grievance, risk management etc.	

There is evidence the program demonstrates that program performance is routinely reviewed with the Board of Directors. All final reports that include a Limited or Failed score is submitted electronically or by mail to the providers Executive Committee on the Board of Directors.	**Compliance**	A review of meeting minutes for Board of Director meetings for 3/14/24, 2/8/24, 1/11/24, 10/12/23, 9/12/23 indicate that agency leadership regularly reviews contract performance, monthly deliverables and quality improvement results with the Board of Directors. An email from January 2024 was provided as evidence that final reports are provided to the Board of Directors.	
There is evidence that strengths and weaknesses are identified, improvements are implemented or modified, and staff are informed and involved throughout the process.	**Compliance**	A review of the 12/21/23 EMT meeting minutes demonstrate that issues are identified and strategies are implemented to address them. In this example contract performance measures for shelter and community counseling were reviewed at the halfway point in the fiscal year and strategies (e.g. increased outreach, timely screening, and double-booking screening appointments to address no-shows) were initiated.	
Additional Comments: **There are no additional comments for this indicator.**			
1.06: Client Transportation			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 1.06		**YES** If NO, explain here: The agency has a policy 1.06 Vehicles Use and Safety Inspection. The policy was reviewed and approved on 1/11/2024;and revised: 1/2024 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.*			
Dates or Timeframe Reviewed: November 2023 to May 2024 **Staff Position(s) Interviewed** *(No Staff Names)* **:** **Type of Documentation(s) Reviewed: Policy and Procedures, travel logs, agency logbooks** **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's written policy and procedures were reviewed and found to be compliant with all requirements pertaining to driver eligibility. The program provided a list of four staff members authorized to transport clients in the agency's vehicle.	
Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	**Compliance**	The agency maintains a transportation binder at the facility. All approved driver's for the agency have a valid driver's license and copies were found in the binder for review. All drivers are covered under the company insurance policy.	

Agency's Transportation policy prohibit transporting a client without maintaining at least one other passenger in the vehicle during the trip and include exceptions in the event that a 3rd party is NOT present in the vehicle while transporting	**Compliance**	A review of the agency written policy and procedures indicated the program director must be notified prior to the practice of the individual staff transporting a single client.	
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**	A review of the agency written policy and procedures indicated in the event a third party cannot be obtained for transport, the agency's supervisor or managerial personnel consider the clients' history, evaluation, and recent behavior prior to the transport.	
The 3rd party is an approved volunteer, intern, agency staff, or other youth	**No eligible items for review**	The agency did not have any circumstances where a third party could transport the youth.	
The agency demonstrated evidence via logbook or other written verification that supervisor approval was obtained prior to all single youth transports.	**Compliance**	Logbook reviews were conducted between November 2023 and May 2024. A total of 274 transports were reviewed. The program is not documenting the supervisory approval on the transport form, however all supervisory approvals are being completed and are documented in the program logbooks. All of the single transports were documented in the logbook with prior supervisory approval. The agency maintains Vehicle Travel Logs for each transport. There is a section to indicate the number of youth being transported and a section for supervisory approval signature.	
There is documentation of use of vehicle that notes name or initials of driver, date and time, mileage, number of passengers, purpose of travel and location.	**Compliance**	A review of the transport documentation revealed the name of driver, date and time, mileage, number of passengers, purpose of travel and location are being documented on the Vehicle Travel Logs and in the agency logbook.	
Additional Comments: **There are no additional comments for this indicator.**			
1.07 - Outreach Services			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 1.07		**YES** If NO, explain here: The agency has three policies which outline the requirements of this indicator 1.07 Outreach Plan for Targeting Youth for Program Services revised 4/2022 and reviewed and approved by the agency 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.*			
Type of Documentation(s) Reviewed: Policy and Procedures, Outreach participation documentation **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**	Position title of lead staff designated to participate in local DJJ Board, Circuit or Council included the agency's Regional Director, Residential Supervisor and Counselor/Case Manager.	
The program maintains written agreements with other community partners which include services provided and a comprehensive referral process.	**Compliance**	There was evidence the program maintains written agreements with community partners which include services provided and a comprehensive referral process.	
The program will maintain documentation of outreach activities and enter into NetMIS the title, date, duration (hours), zip code, location description, estimated number of people reached, modality, target audience and topic.	**Compliance**	The agency provided the documentation printed from NetMIS which included the title, date, duration (hours), zip code, location description, estimated number of people reached, modality, target audience, and topic(s) covered.	
The program has designated staff that conducts outreach which is defined in their job description.	**Compliance**	Include all position(s) and name of position title for staff members with established roles to conduct outreach include the Regional Director, Residential Supervisor and Counselor/Case Manager.	
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** N/A The agency has two policies that meet the indicator; policy #1112/Screening Process (1/24) and policy #1151/Intake Assessment (7/23) were both approved 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.*			
Total number of Open (Residential & Community) Files: 4 **Total number of Closed (Residential & Community) Files: 6** **Staff Position(s) Interviewed** *(No Staff Names)* **: Residential Counselor, Community Counselor** **Type of Documentation(s) Reviewed: 5 Residential Files, 5 Community Counseling Files** **Describe any Observations: All files were well organized and contained detailed legends indicating location of all documents within the file.**			
Shelter youth: Eligibility screening form is completed immediately for all shelter placement inquiries.	**Compliance**	A randomly selected sample of five open and closed residential client files were reviewed onsite. All five files contained documentation of eligibility screening being completed for shelter placement inquiries.	

Community counseling: Eligibility screening form is completed within 3 business days of referral by a trained staff using the Florida Network screening form.	**Compliance**	A randomly selected sample of five open and closed community counseling files were reviewed onsite. All five files contained evidence of eligibility screening forms being completed within three business days of a referral.	
There is evidence all referrals for service is screened for eligibility and is logged in NetMIS within 72 hours of screening completion.	**Compliance**	A randomly selected sample of ten open and closed residential and community counseling client files were reviewed onsite. All ten files contained evidence that referrals for service are screened for eligibility and entered into NetMIS within 72 hours.	
Youth and parents/guardians receive the following in writing: a. Available service options b. Rights and responsibilities of youth and parents/guardians	**Compliance**	A randomly selected sample of ten open and closed residential and community counseling files were reviewed onsite. All ten files contained evidence that youth and parents/guardian received a.) Available service options and b.) Rights and responsibilities of youth and parents/guardian.	
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**	A randomly selected sample of ten open and closed residential and community counseling files were reviewed onsite. All ten files contained evidence that youth and parents/guardian received information regarding a.) CINS/FINS services and b.) Grievance procedures.	
During intake, all youth were screened for suicidality and correctly assessed as required if needed.	**Compliance**	A randomly selected sample of ten open and closed residential and community counseling files were reviewed onsite. All ten files contained documentation that youth were screened for suicidality and assessed as required during intake.	
Additional Comments: **There are no additional comments for this indicator.**			
2.02 - Needs Assessment			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 2.02		**YES** If NO, explain here: The agency has a policy P-1019 Needs Assessment. Revised 2/2024. The policy was reviewed and approved 1/11/2024 by 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: 5 **Total number of Closed (Residential & Community) Files: 5** **Staff Position(s) Interviewed** *(No Staff Names)* **: Residential and Community Counselor, Administrative Assistant** **Type of Documentation(s) Reviewed: Residential and Community Counseling Files**			

Shelter Youth: NIRVANA is initiated within 72 hours of admission	**Compliance**	A randomly selected sample of five open and closed residential files were reviewed onsite. All five files contained documentation that indicated the Nirvana was initiated within 72 hours of admission.	
Non-Residential youth: NIRVANA is initiated at intake and completed within 2 to 3 face-to-face contacts after the initial intake **OR** updated, if most recent assessment is over 6 months old	**Compliance**	A randomly selected sample of five open and closed community counseling files were reviewed onsite. All five files contained documentation that indicates Nirvana is initiated at intake and completed within 2-3 face-to-face visits. There were no applicable files to review for documentation indicating Nirvana is updated after six months.	
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**	A randomly selected sample of ten open and closed residential and community counseling client files were reviewed onsite. All ten files contained supervisor signatures on completed Nirvana assessments.	
(Shelter Only) NIRVANA Self-Assessment (NSR) is completed within 24 hours of youth being admitted into shelter. If unable to complete, there must be documentation in NetMIS and the youth's file explaining the barriers to completion.	**Exception**	A randomly selected sample of five open and closed residential files were reviewed onsite. Four of the five files contain Nirvana Self-Assessments (NSR) that were completed within 24 hours after coming into shelter.	One of the five randomly selected residential files reviewed, contained a completed Nirvana Self-Assessment that was not dated, therefore it could not be determined if the NSR was completed within the 24 hours after 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 randomly selected sample of ten open and closed residential and community counseling client files were reviewed onsite. Two of the residential files and three of community counseling files contained Nirvana Post-Assessments as needed. The remaining five files did not require Post-Assessments.	
A NIRVANA Re-Assessment is completed every 90 days excluding files for youth receiving SNAP services.	**No eligible items for review**	The sample review during the program review did not include any eligible client files for this measure.	
All files include the interview guide and/or printed NIRVANA.	**Compliance**	A randomly selected sample of ten open and closed residential and community counseling client files were reviewed onsite. All ten files contained the printed Nirvana.	
Additional Comments: **The residential counselor was hired on 4/13/22. This counselor has not completed Nirvana training as required by the Florida Network Quality**			
2.03 - Case/Service Plan			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 2.03		**YES** If NO, explain here: The agency has a P-1162 Individual Plan. The plan was revised 7/2023. The plan was reviewed and approved on 1/12/2024 by 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: 5 **Total number of Closed (Residential & Community) Files: 5** **Staff Position(s) Interviewed** *(No Staff Names)* **: Community Counselor, Residential Counselor** **Type of Documentation(s) Reviewed: Client Files**			
The case/service plan is developed on a local provider-approved form or through NETMIS and is based on information gathered during the initial screening, intake, and NIRVANA.	**Compliance**	A randomly selected sample of ten open and closed residential and community counseling client files were reviewed onsite. All ten files contained documentation that the case plan was developed on an approved form and was based on information gathered during screening, intake, and the Nirvana Assessment.	
Case/Service plan is developed within 7 working days of NIRVANA	**Compliance**	All ten of the randomly selected residential and community counseling files reviewed onsite contained case plans that were 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**	Nine of the ten randomly selected residential and community counseling files reviewed contained case plans that prioritized needs/goals; included service type, frequency, location, person responsible; contained youth, parent/guardian, counselor, supervisor signatures; and documented the date the plan was initiated.	One of the five randomly selected residential files reviewed had a service plan that was not signed by the youth.
Case/service plans are reviewed for progress/revised by counselor and parent (if available) every 30 days for the first three months and every 6 months after	**Exception**	Six of the ten randomly selected residential and community counseling files contained documentation of being reviewed for progress every 30 days. Two of the ten randomly selected files did not apply to this indicator.	Two of the ten randomly selected files had case plans that did not have documentation to indicate that the case plans had been reviewed every 30 days. Both of the files were residential youth (one closed and one open).
Additional Comments: **There are no additional comments for this indicator.**			
2.04 - Case Management and Service Delivery			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.04		**YES** If NO, explain here: The agency has a policy called P-1163 Case Management, Counseling, and Service Delivery. The revised 1/2024; Approved 1/12/2024 by 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: 4 **Total number of Closed (Residential & Community) Files: 6** **Staff Position(s) Interviewed** *(No Staff Names)* **: Community Counselor, Residential Counselor, Administrative Assistant** **Type of Documentation(s) Reviewed: Client files, Follow Up Binders**			
Counselor/Case Manager is assigned	**Compliance**	A review of ten client file records resulted in all 10 files reviewed having a counselor/case manager assigned.	
The Counselor/Case Manager completes the following as applicable: 1. Establishes referral needs and coordinates referrals to services based upon the on-going assessment of the youth's/family's problems and needs 2. Coordinates service plan implementation 3. Monitors youth's/family's progress in services 4. Provides support for families 5. Monitoring progress of court ordered youth in shelter 6. Makes referrals to the case staffing to address problems and needs of the youth/family 7. Accompanies youth and parent/guardian to court hearings and related appointments 8. Refers the youth/family for additional services when appropriate 9. Provides case monitoring and reviews court orders 10. Provides case termination notes 11. Provides follow-up after 30 days post discharge 12. Provides follow-up after 60 days post discharge	**Compliance**	All 10 client records were reviewed and demonstrated evidence that each file included documentation that the counselor/case manager assigned completed all of the applicable requirements. The staff member provided referral needs and coordinated referrals to services based upon the on-going assessment of the youth's/family's problems and needs. Further the staff member coordinated service plan implementation, monitored youth's/family's progress during service delivery sessions, provided support for families, provided ongoing case monitoring, and made referrals for the youth/family for additional services as needed. All three applicable cases demonstrated the monitoring of progress for court ordered youth in the shelter. No case were applicable for the case manager to make a referrals to the case staffing to address problems and needs of the youth/family as needed. All applicable case demonstrated the case manager accompanies youth and parent/guardian to court hearings and related appointments. All six applicable cases had evidence of the case termination summary as required. All six applicable cases had evidence of the 30 day follow-ups and four applicable cases had evidenced of 60 day follow-ups completed as required.	
The program maintains written agreements with other community partners that include services provided and a comprehensive referral process	**Compliance**	The agency provided written agreements with other community-based entities partners. The agency has evidence of agreements with other local community partners and reported on their respective referral processes when services are needed.	
Additional Comments: **There are no additional comments for this indicator.**			

2.05 - Counseling Services			Satisfactory with Exception
Provider has a written policy and procedure that meets the requirement for Indicator 2.05		**YES** If NO, explain here: The agency has policies which P-1163 Case Management, Counseling, and Service Delivery. Revised 1/2024; Approved 1/12/2024 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.*			
Total number of Open (Residential & Community) Files: 4 **Total number of Closed (Residential & Community) Files: 6** **Staff Position(s) Interviewed** *(No Staff Names)* **: Residential and Community Counselor** **Type of Documentation(s) Reviewed: Client Files, Group Logs**			
Shelter Program			
Shelter programs provides individual and family counseling	**Compliance**	The residential shelter has proof of providing individual and family counseling services documented in each client file.	
Group counseling sessions held a minimum of five days per week	**Exception**	The agency has evidence of conducting group counseling sessions at a minimum of 5 days per week for the majority of the weeks for the period of the review. Group logs were reviewed from November 15, 2023 until May 15-16, 2024.	Documentation of group five days a week was not available for the weeks of December 31, January 7, January 14, January 28, February 4, March 17, March 31, April 7, April 14, April 21, and April 28 (with weeks running Sunday through Saturday).
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**	The agency has evidence of conducting groups which have clearly defined group facilitators, relevant topics, opportunities for youth to participate, and each session was 30 minutes or longer.	
Documentation of groups must include date and time, a list of participants, length of time, and topic.	**Compliance**	The agency has evidence of the five residential client files which were reviewed and included documentation of time, participants, and topics.	
Community Counseling			

Community counseling programs provide therapeutic community-based services designed to provide the intervention necessary to stabilize the family. Services are provided in the youth's home, a community location, the local provider's counseling office or virtually if written documentation is provided in the youth's file for reasons why it is in the best interest of the youth and family.	**Compliance**	Five Community Counseling files were reviewed, two open and three closed. The agency provides therapeutic community-based services designed to provide the intervention necessary to stabilize the family. Services are provided in the office, in the home, and/or in the school or virtually with written documentation in the client file for the reasons why it is in the best interest of the youth and family.	
Counseling Services			
There is evidence the program completes review of all case files for coordination between presenting problem(s), psychosocial assessment, case/service plan, case/service plan reviews, case management, and follow-up.	**Compliance**	Two open Community Counseling files and three closed Community Counseling files were reviewed. There is evidence in the files through case notes that 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.	
Maintain individual case files on all youth and adhere to all laws regarding confidentiality.	**Compliance**	Five files were reviewed, two open and three closed. The agency maintains individual case files on all youth and adhere to all laws regarding confidentiality.	
Case notes maintained for all counseling services provided and documents youth's progress.	**Compliance**	Case notes are maintained in all five files for counseling services provided and documents the youth's progress.	
On-going internal process that ensures clinical reviews of case records and staff performance.	**Compliance**	The agency has an on-going internal process that ensures clinical reviews of case records and staff performance. Each file is reviewed by a Supervisor and there is evidence the agency documents the review and any needed follow-up.	
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 reported there were no youth and families which required services to be delivered virtually.	
Additional Comments: **There are no additional comments for this indicator.**			
2.06 - Adjudication/Petition Process			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.06		**YES** If NO, explain here: P-1159 Case Staffing Committee: Parent/Guardian Request. Revised 2/2008; Approved 1/12/2024 by Chief Operations Officer. P- 1160 Case Staffing Committee: Plan of Services. Revised 2/2008; Approved 1/12/2024 by 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: None.			
Must include: a. DJJ rep. or CINS/FINS provider b. Local school district representative	**Compliance**	The agency has a current process which incudes documentation of CINS FINS or DJJ provider and school district representative.	
Other members may include: a. State Attorney's Office b. Others requested by youth/ family c. Substance abuse representative d. Law enforcement representative e. DCF representative f. Mental health representative	**Compliance**	When appliable, the agency's current process involves members in the case staffing committee which includes DCF, mental health, substance abuse, State Attorney's Office and others requested by youth/family.	
The program has an established case staffing committee, and has regular communication with committee members	**Compliance**	The agency has an established case staffing committee and the agency has regular communication with committee members.	
The program has an internal procedure for the case staffing process, including a schedule for committee meetings	**Compliance**	The agency's internal process for participating in case staffing was provided for review and the agency reported on the frequency on the upcoming schedule of committee meetings.	
The youth and family are provided a new or revised plan for services	**No eligible items for review**	There were no youth cases which met the case staffing criteria during the period of review.	
Written report is provided to the parent/guardian within 7 days of the case staffing meeting, outlining recommendations and reasons behind the recommendations	**No eligible items for review**	There were no youth cases which met the case staffing criteria during the period of review.	
If applicable, the program works with the circuit court for judicial intervention for the youth/family	**No eligible items for review**	There were no youth cases which met the case staffing criteria during the period of review.	
Case Manager/Counselor completes a review summary prior to the court hearing	**No eligible items for review**	There were no youth cases which met the case staffing criteria during the period of review.	
Additional Comments: **There are no additional comments for this indicator.**			
2.07 - Youth Records			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.07		**YES** If NO, explain here: The agency has a policy titled P-1046 Youth Case Record. This policy was revised 7/2023. The policy was last reviewed and approved on 1/12/2024 by Chief Operations Officer.	

Doc **ument Source: Please provide a detailed explanation of any sources used to complete this indicator.** *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Staff Position(s) Interviewed *(No Staff Names)* **: Residential and Community Counselor, Administrative Assistant, SNAP Supervisor** **Type of Documentation(s) Reviewed: Client files, file cabinets, file transport containers.**			
All records are clearly marked 'confidential'.	**Compliance**	A review of a total of ten client file records indicated all ten records were marked "confidential".	
All records are kept in a secure room or locked in a file cabinet that is marked "confidential"	**Compliance**	All client files are kept in a secure cabinet in the office with the Administrative Assistant and are maintained in a locked cabinet marked "confidential".	
When in transport, all records are locked in an opaque container marked "confidential"	**Compliance**	When staff members need to transport client files they are locked in a opaque container marked "confidential" or transported in a locked suitcase marked "confidential".	
All records are maintained in a neat and orderly manner so that staff can quickly and easily access information	**Compliance**	All records are maintained in an organized manner and are generally neat and have no tears, fading or mis-aligned formatting.	
Additional Comments: **There are no additional comments for this indicator.**			
2.08 - Specialized Additional Program Services			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.08		**YES NO (explain below)** If NO, explain here: P-1248 Staff Secure Shelter Services. Revised 09/2021. P- 1249 Staff Secure Shelter: Program Overview. Revised 01/2023. P-1267 Domestic Violence Respite. Revised 07/2023. P 1279 Probation Respite. Revised 07/2023. P- 1282 Domestic Minor Sex Trafficking. Revised 07/2023. P- 1283 Family Youth Respite Aftercare (FYRAC) Non-Residential Services. Revised 07/2023. P-1301 Specialized Additional Program Services. Revised 07/2023. All policies were approved on 1/12/2024.	
Staff Secure			
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: 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.	

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**		
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**		
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 provides a written report for any court proceedings regarding the youth's progress	**No eligible items for 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: 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.	
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**		
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**		
Services provided to these youth specifically designated services designed to serve DMST youth	**No eligible items for review**		
Did the placement of DMST youth require additional supervision for the safety of the youth or the program? If so, did the agency provide the appropriate level of supervision and safety measures?	**No eligible items for review**		

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**		
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**		
All other services provided to DMST youth are consistent with all other general CINS/FINS program requirements	**No eligible items for 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: 4** **Staff Position(s) Interviewed** *(No Staff Names)* **: Residential Counselor** **Type of Documentation(s) Reviewed: 4 residential DV respite youth files**			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	**Yes**	A review of four randomly selected client files were reviewed for this program service. All four client files are closed and were served during the six-month review cycle.	
Youth admitted to DV Respite placement have evidence in the file of a pending DV charge	**Compliance**	All four client files reviewed contained evidence of a completed DV referral for a pending DV charge.	
Data entry into NetMIS within (3) business days of intake and discharge	**Compliance**	All four client files reviewed contained evidence of initial intake information and discharge information being entered within.	
Youth length of stay in DV Respite placement does not exceed 21 days. If more than 21 days, documentation exists in youth file of transition to CINS/FINS or Probation Respite placement, if applicable.	**Compliance**	All four files did not have a shelter stay the exceeded 21 days. All files reviewed were discharged prior to the aforementioned time frame.	
Case plan in file reflects goals for aggression management, family coping skills, or other intervention designed to reduce propensity for violence in the home	**Compliance**	All four client files contained evidence of the client's case plan which contains goals which address aggression management, family coping skills or other anger reduction interventions and methods designed to lower the chances of the reoccurrence of violence in the home.	
All other services provided to Domestic Violence Respite youth are consistent with all other general CINS/FINS program requirements	**Compliance**	All four files contained evidence of the services provided to clients include service delivery consistent with all other general CINS FINS program requirements.	

Probation Respite			
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: None. **Total number of Closed Files:** **Staff Position(s) Interviewed** *(No Staff Names)* **:**			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	**No eligible items for review**	The agency has not served this program type since the last QI review.	
All probation respite referrals are submitted to the Florida Network.	**No eligible items for review**		
All Probation Respite Referral come from DJJ Probation and there is evidence that the youth is on Probation regardless of adjudication status.	**No eligible items for review**		
Data entry into NetMIS and JJIS within (3) business days of intake and discharge	**No eligible items for review**		
Length of stay is no more than fourteen (14) to thirty (30) days. Any placement beyond thirty (30) days contains evidence in the file that the JPO was contacted in writing to request the need of an extension no later than the 25th day the youth was admitted into the program.	**No eligible items for review**		
All case management and counseling needs have been considered and addressed	**No eligible items for review**		
All other services provided to Probation Respite youth are consistent with all other general CINS/FINS progr+A244:D245am requirements	**No eligible items for review**		
Intensive Case Management (ICM)			
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
N/A			
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**		

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: 1
Total number of Closed Files: 1
Staff Position(s) Interviewed *(No Staff Names)* **: Community Counselor**
Type of Documentation(s) Reviewed: 2 FYRAC community counseling files

Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	**Yes**	The agency has provided Family and Youth Respite Aftercare Services (FYRAC) services to two clients cases in the last 6 months.	
Youth is referred by DJJ for a domestic violence arrest on a household member, and/or the youth is on probation regardless of adjudication status and at risk of violating.	**Compliance**	Both client files have evidence of being referred by DJJ for a domestic violence arrest on or the client is on probation regardless of adjudication status and at risk of violating the requirements of their probation agreement.	
Agency has evidence that all FYRAC referrals have documented approval from the Florida Network office	**Compliance**	The agency has evidence of all FYRAC referrals being documented with approval from the FNYFS to provide services.	

Intake and initial assessment sessions meets the following criteria: a. Services shall be documented through the signature of the youth and his/her parent/guardian as well as orientation to the program which is kept in the youths file. b. The initial assessment shall be face-to-face, in person or through virtual means, to include a gathering of all family history and demographic information, as well as the development of the service plan. c. For youth on probation, a copy of the youths Community Assessment Tool (CAT) to assist with development of the family service plan.	**Compliance**	The 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. All files have evidence of the aforementioned items.	
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	**Compliance**	A review of the files indicates that both have evidence of Life Management Sessions that meet the requirement of supportive individual and family sessions that are supportive and a minimum of 60 minutes.	
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	**Compliance**	The agency provides individual sessions to youth and families which focus on strengths and weaknesses; triggers and coping strategies; and symptoms leading to anger and violence reduction/safety plans in each session.	
Group Sessions: a. Focus on the same issues as individual/family sessions with application to youth pulling on similar experiences with other group members with the overall goal of strengthening relationships and prevention of domestic violence. b. Shall be no more than eight (8) youth at one (1) time and shall be for a minimum of sixty (60) minutes per session	**No eligible items for review**	The agency reported the limited number of clients reduced the opportunities to conduct group sessions.	
There is evidence of completed 30 and/or 60 day follow-ups and is documented in NetMIS following case discharge.	**Compliance**	The review of both client files indicates evidence of completed 30 and/or 60 day follow-ups and that sessions are documented in NetMIS following case discharge.	

Youth and family participate in services for thirteen (13) sessions or ninety (90) consecutive days of services, or there is evidence in the youth's file that an extension is granted by DJJ circuit Probation staff	**Compliance**	There is evidence in both client files that indicates participation in 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.	
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**	The agency reported that they do not provide virtual services to the youth and their families.	
All data entry in NetMIS is completed within 3 business days as required.	**Compliance**	There is evidence in both client files that all data is entered into NetMIS is entered in three days.	
Additional Comments: **There are no additional comments for this indicator.**			
2.09- Stop Now and Plan (SNAP)			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.09		**YES** If NO, explain here: SNAP Screening and Intake P-1299 6/2023 and Snap Discharge Requirements P-1300 7/2023 were last reviewed 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.*			
Total number of Open Files: 1 **Total number of Closed Files: 2** **Staff Position(s) Interviewed** *(No Staff Names)* **: Residential Staff.**			
SNAP Clinical Groups Under 12			
Youth are screened to determine eligibility of services.	**Compliance**	A total of three clients were reviewed and all youth are screened to determine eligibility of services.	
The NIRVANA was completed at initial intake, or within two sessions.	**Compliance**	Two of the three clients files contained evidence of NIRVANA being completed at intake, or in two sessions. One of the three files did not have a completed Nirvana Assessment. It is documented that the assessment was initiated on 12/12/23 and the student's portion was completed. The remainder could not be completed due to the family's lack of participation in services.	
There is evidence of the completed Child Behavior Checklist (CBCL) by the caregiver (pre and post) and is located within the file.	**Compliance**	There is evidence in all three client files of the completed Child Behavior Checklist (CBCL) by the caregiver (pre and post) and is located within the file.	

There is evidence of the completed Teacher Report Form (TRF) is completed by the teacher (pre and post) and is located within the file.	**Compliance**	There is evidence of two of the three completed Teacher Report Form (TRF) areas completed by the teacher (pre and post) and is located within the file. One of three files reviewed did not contain the Pre Teacher Report Form. It is documented in the file that the form was not received by the teacher after six attempts by the SNAP Supervisor.	
There is evidence of the completed TOPSE is completed by the caregiver (pre and post) and is located within the file.	**Compliance**	The TOPSE is completed by the caregiver (pre and post) and is located in all three client files.	
SNAP Clinical Groups Under 12 - Discharge			
There is evidence of the completed SNAP Discharge Report located within the file for any discharged youth.	**Compliance**	There is evidence of a SNAP Discharge Report located in the file for all discharged clients.	
There is evidence of the SNAP Boys/SNAP Girls Child Group Evaluation Form located in the file.	**Compliance**	There is evidence of the SNAP Boys/SNAP Girls Child Group Evaluation Form located in the file.	
There is evidence of the SNAP Boys/SNAP Girls Parent Group Evaluation Form located in the file.	**Compliance**	There is evidence of the SNAP Boys/SNAP Girls Parent Group Evaluation Form located in the file.	
SNAP Clinical Groups for Youth 12-17			
Youth are screened to determine eligibility of services.	**Not Applicable**		
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*)	**Compliance**	A total of two SNAP in School files were reviewed and all files contained evidence that all 13 weekly sessions were completed and maintained within the class file.	
The program maintained evidence of a completed "Class Goal" Document for the class reviewed.	**Compliance**	Both SNAP in School client files contained evidence of a completed "Class Goal" form for the class which was reviewed.	
The program maintained evidence of both pre AND post Measure of Classroom Environment (MoCE) completed documents for the class reviewed.	**Compliance**	Both client files contained proof of completed pre and post Measures of Classroom Environment (MoCE) documents which were completed for the class reviewed.	
The program maintained evidence of completed pre and post evaluation documents for the class reviewed.	**Compliance**	Both agency files have evidence of completed pre and post evaluation documents for the class reviewed.	
There is evidence of the fidelity adherence checklist maintained in the file for each class reviewed.	**Compliance**	Both agency files have evidence of adherence to checklist and confirmation of items maintained in the file for each class reviewed.	
Additional Comments: **There are no additional comments for this indicator.**			
3.01 - Shelter Environment			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 3.01		**YES** If NO, explain here: The agency has multiple policies associated with the youth shelter. The agency policy number is P-1293 and is called Shelter Environment; the agency policy number is P-1165 and is called Maintenance Plan and Safety Inspection. The policies were 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.*			
Staff Position(s) Interviewed *(No Staff Names)* **: Regional Director, Residential Supervisor** **Type of Documentation(s) Reviewed: Evacuation plans, facility tour, logbook, inspections**			

Facility Inspection: a. Furnishings are in good repair. b. The program is free of insect infestation. c. Bathrooms and shower areas are clean and functional, free of foul odors, leaks, dust, and mildew and in good working order. d. There is no graffiti on walls, doors, or windows. e. Lighting is adequate for tasks performed there. f. Exterior areas are free of debris; grounds are free of hazards. g. Dumpster and garbage can(s) are covered. h. All doors are secure, in and out access is limited to staff members and key control is in compliance. i. Detailed map and egress plans of the facility, general client rules, grievance forms, abuse hotline information, DJJ Incident Reporting Number and other related notices are posted. j. Interior areas (bedrooms, bathrooms, common areas) do not contain contraband and are free from hazardous unauthorized metal/foreign objects.	**Compliance**	All furnishings appeared to be in good repair. The program was free from insect infestation. There was no evidence of any insect droppings or infestation in the shelter. During the time of the review, both male and female bathrooms were observed. Each bathroom had a shower, toilet, and sink. Both were in functional order and free of leaks. The living areas had no visible graffiti. All places had adequate lighting. The outside areas were well maintained. The grounds are free of hazards and well-maintained. The dumpster was covered at the time of observation. All doors are in good working order and secure. It was observed that the staff members used their keys to enter particular doors that were not accessible to the youth. The exit plans were located in several different areas in the shelter living area and throughout the facility. The youth rules and expectations are listed in the male and female living areas. On the wall of each dorm is a grievance form that the youth fill out and place in the grievance boxes, and the abuse hotline number is located. The DCF license and DJJ incident reporting number is located in the youth care worker's office on the wall. The shelter is licensed for 12 beds, with a renewal date of May 2, 2024.	
Facility Inspection: **a. All agency and staff vehicles are locked.** **b. Agency vehicles are equipped with major safety equipment including first aid kit, (all items in the first aid kit are current and do not have expired items; all expired items should be replaced regularly), fire extinguisher, flashlight, glass breaker and, seat belt cutter**	**Compliance**	The program has a 2024 Ford Transit 350 15 passenger van with a first aid kit in the front storage compartment. The fire extinguisher, flashlight, glass breaker, and seat belt cutter were all present. All the doors were locked upon entering and locked once finished. All safety and first aid were current.	

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**	The chemicals are located in the laundry room and kitchen pantry behind a locked door. MSDS notebook and MSDS sheets for all chemicals are located in the laundry room on the wall. MSDS were accurate and complete.	The agency does not have evidence of maintaining a perpetual inventory of chemicals. The inventory sheet in use does not reflect when chemicals are returned. The Regional Director was able to demonstrate the individually proportioned use of one of the chemicals however; this practice is not carried over to the full inventory of chemicals that are in use.
Facility Inspection: Washer/dryer are operational & general area/lint collectors are clean. Agency has a current DCF Child Care License which is displayed in the facility. Each youth has own individual bed with clean covered mattress, pillow, sufficient linens and blanket. Youth have a safe, lockable place to keep personal belongings, if requested.	**Compliance**	The shelter has one laundry room with one washer and one dryer. The dryer was lint-free. The shelter has a current DCF License which is valid until May 1, 2025 and is displayed in the intake office. The youth have their bed with clean, covered mattresses, pillows, lining, and blankets. Youth also have a safe place in the Staff office to store their necessary valuables.	
Additional Facility Inspection Narrative (if applicable)			

Fire and Safety Health Hazards: a. Annual facility fire inspection was conducted, and the facility is in compliance with local fire marshal and fire safety code within jurisdiction. b. Agency completes a minimum of 1 fire drill on each shift monthly (within 2 minutes or less). c. Completes 1 mock emergency drill per shift per quarter. d. All annual fire safety equipment inspections are valid and up to date (extinguishers, sprinklers, alarm system and kitchen overhead hood, including fire extinguishers in all vehicles).	**Compliance**	The shelter completed all fire drills within the past six months. The shifts and dates are as followed: 1st Shift: 11.6.23 / 12.6.23 / 1.5.24 / 2.4.24 / 3.5.24 / 4.4.24 2nd Shift: 11.8.23 / 12.8.23 / 1.7.24 / 2.6.24 / 3.7.24 / 4.6.24. As applicable 3rd Shift: 11.5.23 / 12.5.23 / 1.4.24 / 2.3.24 / 3.4.24 / 4.3.24. An annual facility fire inspection was conducted, and the facility is in compliance with local fire marshal and fire safety code within jurisdiction. All annual fire safety equipment inspections are valid and up to date (extinguishers, sprinklers, alarm system and kitchen overhead hood, including fire extinguishers in all vehicles). The agency conducted Mock drills. The shifts and dates are as follows: 1st Shift: 1.6.24 / 2.7.24 / 3.5.24 / 4.5.24 2nd Shift: 1.16.24 / 2.12.24 / 3.13.24 / 4.18.24 As applicable 3rd Shift: 1.28.24 / 2.28.24 / 3.28.24 / 4.29.24.	
Fire and Safety Health Hazards: a. Agency has a current Satisfactory Residential Group Care inspection report from the Department of Health. b. Agency has a current Satisfactory Food Service inspection report from the Department of Health and food menus are posted, current and signed by Licensed Dietician annually. c. All cold food is properly stored, marked and labeled and dry storage/pantry area is clean and food is properly stored. d. Refrigerators/Freezers are clean and maintained at required temperatures and all small and medium sized appliances are operable and clean for use as needed.	**Compliance**	The agency has a current Residential Group Care/Food service inspection that was issued on September 24, 2023. All food was observed to be properly stored and organized in a clean operable in the refrigerator/freezers or pantry. The temperature for the refrigerators was 36 degrees and the freezer was at 12 degrees.	
Additional Fire and Safety Health Hazards Narrative (if applicable)			
Youth Engagement			

a. Youth are engaged in meaningful, structured activities (e.g., education, recreation, counseling services, life and social skill training) seven days a week during awake hours. Idle time is minimal. b. At least one hour of physical activity is provided daily. c. Youth are provided the opportunity to participate in a variety of faith-based activities. Non-punitive structured activities are offered to youth who do not choose to participate in faith-based activities. d. Daily programming includes opportunities for youth to complete homework and access a variety of age appropriate, program approved books for reading. Youth are allowed quiet time to read. e. Daily programming schedule is publicly posted and accessible to both staff and youth.	**Compliance**	The shelter has a daily activity schedule for the youth, which is located in the kitchen, living area, boys dorm and girls dorm. The youth are engaged in activities from 6:00 am to 9:30 pm. Youth have access to youth faith-based activities. This reviewer observed the clients at lunch, and staff engaging with the youth. The schedule has one hour of physical activity. There are 30 minutes of homework/study hours for the youth in the program.	
Additional Comments: **There are no additional comments for this indicator.**			
3.02 - Program Orientation			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 3.02		**YES** If NO, explain here: The agency policy number is P-1114 Admission/ Intake and Participant. 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: 2 **Total number of Closed Files: 3** **Staff Position(s) Interviewed** *(No Staff Names)* **: None** **Type of Documentation(s) Reviewed: Orientation Check List, Orientation Packet**			
Youth received a comprehensive orientation and handbook provided within 24 hours	**Exception**	Of the five files that were reviewed, four files received a comprehensive orientation and handbook which was provided within 24 hours.	Of the five files reviewed, one file was missing the youth's signature on the orientation packet and orientation check list.

Orientation includes the following: a. Youth is given a list of contraband items b. Disciplinary action is explained c. Dress code explained d. Review of access to medical and mental health services e. Procedures for visitation, mail and telephone f. Grievance procedure g. Disaster preparedness instructions h. Physical layout of the facility i. Sleeping room assignment and introductions j. Suicide prevention- alerting staff of feelings or awareness of others having suicidal thoughts	**Compliance**	A review of five youth files revealed that all youth files include documentation of completion of orientation including the following: a. Youth is given a list of contraband items b. Disciplinary action is explained c. Dress code explained d. Review of access to medical and mental health services e. Procedures for visitation, mail and telephone f. Grievance procedure g. Disaster preparedness instructions h. Physical layout of the facility i. Sleeping room assignment and introductions j. Suicide prevention- alerting staff of feelings or awareness of others having suicidal thoughts	
Documentation of each component of orientation, including orientation topics and dates of presentation, as well as signatures of the youth and staff involved is maintained in the individual youth record	**Compliance**	Documentation of each component of orientation as well as the signatures of the staff and youth involved was located in all five files reviewed.	
Additional Comments: **There are no additional comments for this indicator.**			
3.03 - Youth Room Assignment			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 3.03		**YES** If NO, explain here: The agency policy number is 3.03 Sleeping Arrangements. 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: 2 **Total number of Closed Files: 3** **Type of Documentation(s) Reviewed: Youth records, orientation and intake documentation**			

A process is in place that includes an initial classification of the youths, to include:			
a. Review of available information about the youth's history, status and exposure to trauma b. Initial collateral contacts, c. Initial interactions with and observations or the youth d. Separation of younger youth from older youth, e. Separation of violent youth from non-violent youth f. Identification of youth susceptible to victimization g. Presence of medical, mental or physical disabilities h. Suicide risk i. Sexual aggression and predatory behavior j. Acute health symptoms requiring quarantine or isolation	**Compliance**	Five youth records were reviewed for initial classification. Two records were open and three were closed. All five records included documentation of all required youth room assignment elements.	
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**	The program maintains an alert board where all alerts are updated on a regular basis. The alert board consists of special needs, risks, risk of suicide, mental health, substance abuse, physical health, and any security factors.	
Additional Comments: **There are no additional comments for this indicator.**			
3.04 - Log Books			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 3.04		**YES** If NO, explain here: The agency policy number is P-1149 and is called Shelter Environment. 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.*			
Dates or Timeframe Reviewed: Six months **Staff Position(s) Interviewed** *(No Staff Names)* **: Regional Director, Residential Supervisor** **Type of Documentation(s) Reviewed: written logbook**			
Log book entries that could impact the security and safety of the youth and/or program are highlighted	**Compliance**	Evidence shows that the log book entries that could impact the security and safety of the youth and/ or program are highlighted.	
All entries are brief, legibly written in ink and include: • Date and time of the incident, event or activity • Names of youth and staff involved • Brief statement providing pertinent information • Name and signature of person making the entry	**Compliance**	Evidence shows the daily logbook entries which that include date, time, youths name, staffs name, and a brief statement providing pertinent information. Each entry has a signature of initial of the person making the entry.	

Recording errors are struck through with a single line. The staff person must initial and date the correction. The use of whiteout and erasures is prohibited.	**Compliance**	A random review of log book entries for the past six months showed one strike-through of a recording error on 2/10/24 at 7:55pm. It was properly documented with a single line and the staff person initialed and dated the correction. There was no evidence of the use of whiteout and erasures.	
The program director or designee reviews the facility logbook(s) every week and makes a note chronologically in the logbook indicating the dates reviewed and if any correction, recommendations and follow-up are required and sign/date the entry	**Compliance**	Evidence shows the Regional Director reviews the facility logbook every week and makes a chronological note in the logbook indicating the dates reviewed and if any correction, recommendations and follow-up are required.	
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**	Evidence shows all staff reviews the logbook of the previous two shifts and makes an entry signed and dated into the logbook indicating the dates reviewed.	
At the beginning of their shift, oncoming supervisor and shelter counselor reviews the logbook of all shifts since their last log entry and makes a signed and dated entry and into log book indicating the dates reviewed.	**Exception**	Entries were reviewed from 3/20/24 to 4/4/24. The supervisor reviews of all logbook pages are not consistent since the last time on duty. All pages which have reviewed by supervisor have proof of date and signature as required. Sample review period assessed onsite found documentation on some pages and other were not found.	The logbook lacks documentation indicating that the oncoming supervisor and shelter counselor have reviewed the logbook.
Logbook entries include: a. Supervision and resident counts b. Visitation and home visits	**Compliance**	The written log was observed to have resident counts, visitation and offsite visits in the logs.	
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: P-1123 Behavior Management System revised 1/21 and P-1128 Rule Violations revised 1/2016. Both reviewed and approved by CC 1/11/24.		
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.			
Staff Position(s) Interviewed *(No Staff Names)* **:** COO, Shelter Director, Shelter Counselor **Type of Documentation(s) Reviewed: P-1123 (Behavior Management System), P-1128 (Rule Violation), and Participant "FACE BOOK" (Facilitating Activity & Communication Effectively)**			

The program has a detailed written description of the BMS and it is explained during program orientation	**Compliance**	The program utilizes the "FACEBOOK"-Facilitating Activity & Communication Effectively model. Per policy and interview with Shelter Director, A "FACEBOOK" is provided to each youth upon admission.	
Behavior Management Strategies must include:			
a. BMS is designed to teach youth new behaviors and help youth understand the natural consequences for their actions b. Behavioral interventions are applied immediately, with certainty, and reflect the severity of the behavior c. BMS uses a wide variety of awards/incentives to encourage participation and completion of the program d. Appropriate consequences and sanctions are used by the program and consequences for behavior are logical and designed to promote skill-building for the youth e. Counseling, verbal intervention and de-escalation techniques are used prior to physical intervention (Only techniques approved by the Florida Network and DJJ are used if physical intervention is required) f. Only staff discipline youth. Group discipline is not imposed g. Room restriction is not used as part of the system or for youth who are physically and/or emotionally out of control h. Youth should never be denied basic rights such as meals, clothing, sleep, services, exercise, or correspondence privileges	**Compliance**	The agency's BMS (Facilitating Activity & Communication Effectively) utilizes a range of rewards and incentives selected by youth. The program utilizes a point store with items requested by youth and an opportunity to select movies on Friday night with special snacks. Youth on "Achievement Level" have access to additional incentives such as 1:1 computer time, movie on tablet, lunch with staff, furlough, and additional options in point store. Social skills are modeled and reinforced through the point/phase system. At the end of each day, staff meet individually with youth to review their behavior and skills demonstrated throughout the day. The "FACEBOOK' notebook provided to youth clearly describes the 3 different phases of the BMS and behavioral expectations to be demonstrated in each phase, the behaviors to be demonstrated throughout the day (morning routine, breakfast, am school, lunch time, group, outdoor activities, dinner, bedtime, etc...) and opportunities to earn points. Behavioral expectations are clearly articulated and movement through the levels is logical, step-wise and designed to promote adaptive skill-building. Verbal intervention, counseling and de-escalation are utilized prior to physical interventions and only staff discipline youth. Group discipline is not utilized. Room restriction is not utilized and youth are not denied basic rights as a consequence.	
Program's use of the BMS			
All staff are trained in the theory and practice of administering BMS rewards and consequences	**Compliance**	A review of 4 YCW staff records indicate that staff received BMS training prior to working independently and received refresher training by the former Residential Supervisor at least annually.	
There is a protocol for providing feedback and evaluation of staff regarding their use of BMS rewards and consequences	**Compliance**	The Regional Director reported that BMS implementation is a frequent topic of discussion in monthly staff meetings, although the specific topic is not documented.	
Supervisors are trained to monitor the use of rewards and consequences by their staff	**Compliance**	An interview with the Regional Director and new Residential Supervisor indicate that the Residential Supervisor is still in training and the Regional Director monitors staff implementation of the BMS. As her training progresses, she will begin to assume that responsibility.	

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: Multiple Policies: The agency policy number is P-1121 and is called Supervision and Staffing Ratio/ Scheduling; the agency policy number is P-1133 Bed Time Supervision and Bed Checks. The policies were 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.*			
Dates or Timeframe Reviewed: 4/22/24 2am- 3am, 5/1/24 1am- 2am, 4/5/24 2am-3am **Staff Position(s) Interviewed** *(No Staff Names)* **: Regional Director, Residential Supervisor** **Type of Documentation(s) Reviewed: Staff Schedules, Written Log book, overtime/holdover list, video surveillance**			
The program maintains minimum staffing ratios as required by Florida Administrative Code and contract. • 1 staff to 6 youth during awake hours and community activities • 1 staff to 12 youth during the sleep period	**Compliance**	It was reviewed in the logbook that the staff to youth ratios of one to six during awake hours and one to twelve during the sleep period, are being followed. There are two staff on overnights.	
All shifts must always provide a minimum of two direct care staff present that have met the minimum training requirements	**Compliance**	Eight of eight employee files reviewed contained evidence of completed background screenings prior to hire/start date and evidence of proper training for all youth care workers, supervision staff, and treatment staff.	
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**	Total number of two new hire staff files and six annual in-service staff files were reviewed to assess the agency's adherence to the requirements of this measure. At the time of this onsite programs review, all staff members background screening and training requirements meet ratio and training requirements for staffing and engaging youth.	
The staff schedule is provided to staff or posted in a place visible to staff	**Compliance**	The staff schedule was observed posted in the youth care specialist office on the wall.	
There is a holdover or overtime rotation roster which includes the telephone numbers of staff who may be accessed when additional coverage is needed	**Compliance**	The holdover/overtime list was observed and it included telephone numbers of staff who may be accessed when additional coverage is needed. Callouts/overtime is written in on the schedule that is posted.	

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**	A review of the Video Surveillance review form, indicated that staff observed youth sleeping in their rooms every 15 minutes. Dates reviewed are as follows: 4/22/24 2am- 3am all checks were completed. 5/1/24 1am- 2am All checks were completed. 4/5/24 2am-3am All checks were completed.	
Additional Comments: **There are no additional comments for this indicator.**			
3.07 - Video Surveillance System			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 3.07		**YES** If NO, explain here: The agency policy number is P-1280 and is called Video Surveillance system. 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.*			
Dates or Timeframe Reviewed: Six Months **Staff Position(s) Interviewed** *(No Staff Names)* **: Regional Director, Residential Supervisor** **Type of Documentation(s) Reviewed: Log Books, List of personnel designated to review the video surveillance system** **Describe any Observations: Posted "Notice of security cameras in use" signs**			
Surveillance System			
The agency, at a minimum, shall demonstrate: a. A written notice that is conspicuously posted on the premises for the purpose of security b. System can capture and retain video photographic images which must be stored for a minimum of 30 days c. System can record date, time, and location; maintain resolution that enables facial recognition d. Back-up capabilities consist of cameras' ability to operate during a power outage e. Have cameras placed in interior (e.g. intake office, counseling office, cafeteria, day room) and exterior (e.g. entrance/exit, recreation area, parking lot) general locations of the shelter where youth and staff congregate and where visitors enter and exit; to include locations where youth searches are conducted. Cameras are never placed in bathrooms or sleeping quarters. f. All cameras are visible	**Compliance**	A sign is place in the intake office stating "Notice security cameras in use." The camera system can capture videos and pictures that can be retained for up to 30 days. The system can record date, time and location. The facility has a backup generator that allows the system to work if there is a power outage. All cameras are located in areas where staff and clients congregate and where visitors enter and exit. The searches are conducted where they are visible on camera.	

A list of designated personnel who can access the video surveillance system is maintained (includes off-site capability per personnel)?	**Compliance**	The Regional Director provided a list of designated personnel who can access the video surveillance system. The Regional Director, Residential Supervisor and IT Coordinator are all designated personnel.	
Supervisory review of video is conducted a minimum of once every 14 days and timeframes reviewed are noted in the logbook.	**Exception**	The camera review sheet shows evidence of video review being conducted a minimum of once every 14 day.	Documentation of camera reviews is missing from the logbook.
The reviews assess the activities of the facility and include a review of random sample of overnight shifts	**Compliance**	The Residential Supervisor reviews and assess the activities of the facility and includes a review of random sample of overnights shifts.	
Grant the requesting of video recordings to yield a result within 24-72 hours from program quality improvement visits and when an investigation is pursued after an allegation of an incident	**Compliance**	The program has the capability to provide video recordings upon request within 24-72 hours from the program's quality improvement visit and when an investigation is pursued after an allegation of an incident. In addition, there is a system access request form on file.	
Camera service order/requests will be made within 24 hours of discovery of camera malfunctioning or being inoperable. All efforts made to obtain repairs are documented and maintained	**Compliance**	The Residential Supervisor reported that all cameras are in working condition. It was also reported that any service order/ requests will be made within 24 hours of discovery of camera malfunctioning or being inoperable.	
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 P-1117. Preliminary Physical Health Screening, approved by the CEO, January 2024.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: 2 **Total number of Closed Files: 4** **Staff Position(s) Interviewed** *(No Staff Names)* **: Residential staff members.** **Type of Documentation(s) Reviewed: Client files.**			
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**	The agency has policy regarding primary healthcare screening requirements. A total of six client file records were reviewed for primary healthcare screenings and observations recorded included current medications, existing medical conditions, allergies, recent injuries and illnesses, presence of pain or other physical distress, observations for evidence of illness, injury, pain or physical distress, difficulty moving, presence of scars, tattoos, or other skin markings and acute healthcare symptoms requiring quarantine or isolation. The majority of files are reviewed and signed off by the RN.	
Referral and Follow-Up			
Youth with chronic medical conditions have a referral to ensure medical care (e.g. diabetes, pregnancy, seizure disorder, cardiac disorders, asthma, tuberculosis, hemophilia, head injuries, etc.)	**No eligible items for review**	At the time of the QI program review, none of the youth reviewed were applicable to requiring a referral for medical care for chronic conditions. The agency has policy and procedures to ensure residents with chronic medication and numerous health conditions have a referral for medical care, as required.	
When needed, the parent is involved with the coordination and scheduling of follow-up medical appointments	**No eligible items for review**	The agency policy requires the parent be involved with the coordination and scheduling of follow-up medical appointments when necessary. None of the client file records reviewed were in need of follow-up for medical appointments.	
All medical referrals are documented on a daily log.	**No eligible items for review**	Of the six youth records were reviewed, none were applicable for 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 agency has procedures that include a thorough referral process and a mechanism for necessary follow-up medical care for youth admitted with chronic medical conditions which includes a consultation with the parent/guardian, youth's physician if the parent/guardian is unavailable, or 9-1-1 if an emergency, and documented on the Medical Health Follow-Up Form. When warranted, the agency initiates Medical/Mental Health Alerts to keep staff members informed of a resident's current status.	
Additional Comments: **There are no additional comments for this indicator.**			
4.02 - Suicide Prevention			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 4.02		**YES** If NO, explain here: The agency has a policy P-1247. Suicide Prevention which was approved by the CEO, October 2022.	

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: 2 **Total number of Closed (Residential & Community) Files: 4** **Staff Position(s) Interviewed** *(No Staff Names)* **: Licensed Clinician** **Type of Documentation(s) Reviewed: Client files.**			
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**	A total of five client file records were reviewed. All five youth had a suicide risk screening occur during the initial intake and screening process. Suicide screening results were reviewed and signed by the supervisor and or Licensed Clinician and are documented in the resident's case file in all five records reviewed.	
The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	**Compliance**	The program's suicide risk assessment has been previously approved by the Florida Network of youth and Family Services.	
Supervision of Youth with Suicide Risk *(Shelter Only)*			
Youth are placed on the appropriate level of supervision based on the results of the suicide risk assessment.	**Compliance**	Five residential client file records were reviewed and all five youth were assessed by a non-licensed professional under the direct supervision of a licensed professional within twenty-four hours from the suicide risk screening results, or the morning of the first business day. All five residential clients were placed on the appropriate level of supervision based on the results of the suicide risk assessment.	
Staff person assigned to monitor youth maintained one-to-one supervision or constant supervision and documented his/her observations of the youth's behavior at 30 minute or less intervals	**Compliance**	The residential direct care staff members assigned to monitor the youth documented the resident's behavior at thirty minute, or less, intervals and included the time of day, behavioral observations, any warning signs observed, and the observers' initials are documented in all five residential client file records reviewed.	
Documentation includes the time of day, behavioral observations, any warning signs observed, and the observers' initials and was maintained in either an observation log or in the shelter daily log.	**Compliance**	The residential direct care staff members assigned to monitor the residents have evidence of documenting the resident's behavior at thirty minute, or less, intervals and included the time of day, behavioral observations, any warning signs observed, and the observers' initials in all five residential client records on observation logs.	

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	**Exception**	It was confirmed by onsite review of client file records in this sample that the supervision level was not changed/reduced until a licensed mental health professional completed a further assessment or Baker Act by local law enforcement in all five applicable records.	Agency operating standards for Logbook color codes for all logged entries for youth placed on, stepped down and all associate Suicide Risk are required to be highlighted in Blue in the program logbook. In one of the five files reviewed, Suicide Risk are marked in Yellow.
There was evidence that documentation was reviewed by supervisory staff each shift. If program uses an observation log, completed logs are maintained in the youth's file.	**Compliance**	There was evidence that documentation was reviewed by supervisory staff each work shift, and the completed observation log forms were maintained in the resident's file in all five client file records.	
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 agency reported that no Community Counseling youth screened for suicide risk responded with a positive response to one of the five suicide risk screening questions. The agency clinician reported no youth have indicated positive to these questions in over a year.	
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**		
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**		
If the parent/guardian cannot be contacted, all efforts to contact them are documented in the case file.	**No eligible items for review**		
When the screening was completed during school hours on school property, the appropriate school authorities were notified.	**No eligible items for review**		
Additional Comments: **There are no additional comments for this indicator.**			

4.03 - Medications			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 4.03		**YES** If NO, explain here: The agency has multiple applicable policies; P-1120 Medication Provisions, Storage, Access, Inventory, and Disposal and P-1117 which was approved by the CEO, January 2024.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: 2 **Total number of Closed Files: 2** **Staff Position(s) Interviewed** *(No Staff Names)* **:** **Type of Documentation(s) Reviewed: Youth files.** **Describe any Observations: Med pass reviewed with two youth for morning medication distribution. Practice was executed as required and no deficiencies.**			
The agency has a Registered Nurse (RN) and/or a Licensed Practical Nurse (LPN) that is being supervised by RN and all of their credentials have been verified.	**Compliance**	At the time of this onsite QI program review, the agency has a Registered Nurse (RN) with verified credentials who is on-site a limited amount of time each month.	
The agency has evidence of the following for all non-nursing shelter staff designated to assist with the self-administration of medication: a. Documentation of in-person self-administration of medication distribution training provided by a Registered Nurse b. Evidence demonstrating their competency to assist with self-administration of medication distribution c. Maintenance of their annual medication training re-certification	**Compliance**	The agency does have an RN on staff. The RN provides this training to all staff in the facility. Documentation reviewed for four staff showed evidence of medication distribution training to assist with the self-administration process of medication to current residents.	
The agency held at least quarterly staff meetings conducted by RN and/or Shelter Manager to review and assess: a. strategies implemented to reduce medication errors shelter wide b. analyze factors that contributed to medication errors c. allow staff the opportunity to practice and role-play solutions	**Compliance**	The program conducts monthly meeting at each staff 'Youth Shelter' staff meeting to discuss aspects of the agency's performance related to medication distribution. Meeting minutes indicate general overview of medication practice and any issues that must be addressed. The RN provides assistance as needed on all items and intervention discussed on an as needed basis.	

The agency has strategies implemented to ensure medications are provided within the 2-hour time frame.	**Compliance**	The RN Residential Supervisor and Lead Staff are is responsible for ensuring medications are provided in the two-hour timeframe. The medication distribution session occurs a minimum of three sessions per day (7am, 4pm and 9pm). The agency's practice ensures medication can be given no more than on hour prior of post the prescribed time.	
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**	All non-licensed staff members are clearly identified and designated as staff members on the schedule and shift change report/shift responsibility form for assisting with the self-administration of medications on each shift, as required.	
The agency has clear methods of communicating which youth are on medications with the times and dosage easily discernable by all staff on each shift.	**Compliance**	The agency has clear methods of communicating which residents are on medications with the time and dosage clearly marked by all staff on each work shift. During shift change, staff members going off shift check with staff members coming on-shift regarding which youth need medications and at what time. Medication needs are also documented on the client board with the resident name, time, 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.	**Compliance**	The agency's long-time and highly experienced RN has implemented a internal quality assurance process to ensure appropriate medication management and distribution methods to track medication errors and identify system issues and implement mitigation strategies, as appropriate.	
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 total of four client file records were reviewed for the admission/intake process. Upon admission, the resident and parent/guardian were interviewed by residential staff members via the Health Admission Screening form. Each file has evidence the verifies that this process was completed in all four resident files upon admission to the program. Documentation reviewed showed the on-shift certified supervisor or higher level staff reviewed all medication forms either on the same day or 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**	All medications are stored in a Pyxis ES Medication Cabinet that is inaccessible to youth (when unaccompanied by authorized staff). The Pyxis machine is stored in separate locked room in accordance with guidelines in FS 499.0121 and policy section in Medication Management. The program had no injectable or topical medications at the time of the review, but the program has policy and procedure regarding medications which states oral medications are to stored separately from injectable epi-pen and topical medications. 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. The refrigerator is secure and the same located room which is secure and inaccessible to residents. Narcotics and controlled medications are stored in the Pyxis medication cabinet. Observation of Pyxis keys showed key with the following labels are accessible to staff in the event they need to access medications if there is a Pyxis medication cabinet 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 2 site-specific System Managers for the Pyxis ES Station for each shift. Only designated staff delineated in User Permissions have access to secured medications, with limited access to controlled substances (narcotics). A Medication Distribution Log shall is used for distribution of medication by non-licensed and licensed staff. The program verifies medication using one of three methods listed in the FNYFS Policies & Procedures Manual, as required. When the RN is on duty, medication processes are administered by the RN or when the RN is not onsite, then the designated staff member who has been trained by a licensed RN provides the medication. The program does not accept youth currently prescribed injectable medications, except for epi-pens. Non-licensed staff have received training in the use of epi-pen auto-injectors provided via the RN.	

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**	The agency's medication distribution log documentation was reviewed and had evidence to include the time that the medication was distributed to the resident, evidence of resident's initials that the dosage was given, and evidence of staff initials that the dosage was provided to the residents.	
There is evidence that staff provide youth with medications within one hour of the scheduled time of delivery as ordered by the medication. Documentation is provided for instances this does not occur within the required timeframe.	**Compliance**	The agency's practice ensures medication can be given no more than one hour prior or post the prescribed time. The agency has implemented a process that requires supervisor follow-up within the appropriate timeframe to ensure medications are provided within a required hour before or not to exceed an hour after the timeframe.	
During the review period, there were no instances where youth missed their medication due to failure to open the pyxis machine.	**Compliance**	A review of the last six months of documentation related to incidents of monthly pyxis logs confirmed there were no instances where youth missed their medication due to failure to open the Pyxis medication cabinet, during the review period.	
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**	The agency's RN is responsible for corrective action follow-up measures associated with any staff member which has committed and medication error. At the time of this QI program review, there is no staff member deemed responsible for 3 errors within a one-year time frame.	
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**	The agency had evidence of operating proper measures associated with handling controlled substances. The agency has a perpetual inventory with running balances which is maintained, as well as a shift-to-shift counts that are verified by a witness and documented. At the time of the QI program review, the over-the counter medications are inventoried weekly for medications accessed regularly. The program does not maintain any syringes or sharps at the youth shelter, as it relates to medications.	

There are monthly reviews of the Pyxis reports to monitor medication management practice.	**Compliance**	The agency provided documentation of monthly reviews of the Pyxis medication cabinet reports to monitor medication distribution practice on an on-going basis.	
Medication discrepancies are cleared after each shift.	**Compliance**	At the time of this onsite QI program review, the agency a Pyxis reports do not indicate the occurrence of any medication discrepancies. If and when discrepancies occur, they are required to be cleared prior to the end of each work shift.	
Additional Comments: **There are no additional comments for this indicator.**			
4.04 - Medical/Mental Health Alert Process			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 4.04		**YES** If NO, explain here: The agency has a policy P-1119 Medical and Mental Health Alert Process, which was approved by the CEO, Nov 2016.	
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: 2 **Total number of Closed Files: 4** **Staff Position(s) Interviewed** *(No Staff Names)* **: Residential staff members.** **Type of Documentation(s) Reviewed: Client files.**			
Youth with a medical, mental health, or food allergy was appropriately placed on the program's alert system	**Compliance**	Two open and four closed records were reviewed for the medical and mental health alert process. All five residents reviewed had a medical or mental health condition or food allergy, and each of the resident was appropriately placed on the program's alert system.	
Alert system includes precautions concerning prescribed medications, medical/mental health conditions	**Compliance**	The agency alert system includes proper alerts and precautions concerning prescribed medications, acute medical and mental health conditions.	
Staff are provided sufficient training, information and instructions to recognize/respond to the need for emergency care for medical/mental health problems	**Compliance**	A review of client file and general alert system documentation indicated staff members are provided sufficient information/instructions to recognize and respond to the need for emergency care for medical and mental health problems associated with each resident.	

A medical and mental health alert system is in place that ensures information concerning a youth's medical condition, allergies, common side effects of prescribed medications, foods and medications that are contraindicated, or other pertinent mental health treatment information, is communicated to all staff	**Compliance**	A medical and mental health alert system is operational in the agency's residential program which ensures information concerning a youth's medical condition, allergies, common side effects of prescription medications that are contraindicated, or other pertinent mental health treatment information is communicated to all staff in a timely manner.	
Additional Comments: **There are no additional comments for this indicator.**			
4.05 - Episodic/Emergency Care			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 4.05		**YES** If NO, explain here: The agency has a policy P-1166 Episodic Emergency Care, which was approved by the CEO, February 2022.	
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: **Total number of Closed Files: 1** **Type of Documentation(s) Reviewed: Client file.**			
Off Site Emergency Care			
a. If off-site emergency medical or dental care was provided, an incident report was submitted for the medical or dental care b. Upon youth return, there is a verification receipt of medical clearance via discharge instructions with follow-up is present in file c. Youth's parent/guardian was notified d. A daily log is maintained for emergency care provided	**Compliance**	The program had one client file record applicable to episodic or emergency care during the last six-month review period. The client file record indicated the resident received off-site emergency medical care. An incident report was submitted for medical care. The resident was eligible for return upon completion of medical care. There is a verification receipt of medical clearance via discharge instructions with follow-up in the client file. The parent/guardians were notified in the client record, as the parent/guardians transported the youth for medical care.	
All staff are trained on emergency medical procedures	**Compliance**	A review of training documentation indicated all staff members are trained on the proper procedure for medical emergencies. The agency also completes medical emergency drills for all staff on a routine basis. A review of mock emergency drill records indicated the most recent set of drills was conducted in April 2024.	
The program has a Knife-for-life and wire cutters accessible to staff in a secure location(s)	**Compliance**	The agency had two first aid kits and one knife-for-life. The knife-for-life is located in a secure area in the shelter accessible to all staff members. The agency has one large transportation van which contain a first aid kit.	
Additional Comments: **There are no additional comments for this indicator.**			