Florida Network for Youth and Family Services
Compliance Monitoring Report for

Children's Home Society
WaveCREST Shelter

4520 Selvitz Road,
Fort Pierce, FL 34981

May 8-9, 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 Children's Home Society WaveCREST (CHS WaveCREST) for the FY 2023-2024 at its program office located at 4520 Selvitz Road, Fort Pierce, Florida. 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. CHS WaveCREST 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 Marcia Tavares, Consultant for Forefront LLC and Nicos Antonakos, Lashonda Chavis, Ivonne Medrano, and Myiah White. Agency representatives from CHS WaveCREST present for the entrance interview were Sabrina Barnes, Executive Director; Lauren Fuentes, Vice President Child and Family Welfare; Duane Gross, Residential Director; Kristi Walsh, Community Counseling Supervisor; Ashton Lopez, Residential Supervisor; Tracy Avant, Residential Shift Leader; and Esther Samuelson, Residential Counselor. Also present via TEAMS were Lauren Zamjahn, Director of Out of Home Placement; Solange Knowles, QI Specialist; and Loni Lauer, Talent General Manager. The last onsite QI visit was conducted March 8 -9, 2023.

In general, the Reviewer found that CHS WaveCREST is in compliance with specific contract requirements. CHS WaveCREST **received an overall compliance rating of 100% for achieving full compliance with all 13 applicable indicators** of the CINS/FINS Monitoring Tool. There were no corrective actions or recommendations made 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 05-08-2023-2024

Agency Name: CHS WaveCREST	**Monitor Name: Marcia Tavares, Lead Reviewer**
Contract Type: CINS/FINS	**Region/Office: 4520 Selvitz Road, Fort Pierce, FL**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): May 8-9, 2024**

Major Programmatic Requirements	Explain Rating: Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable	Ratings Based Upon: I = Interview; O = Observation; D = Documentation; PTV = Submitted Prior To Visit (List Who and What)	Notes: Explain Unacceptable or Conditionally Acceptable:
I. Administrative and Fiscal							
DJJ 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.	☐	☐	☒	☐	☐	Documentation: Duane Gross and Kristi Walsh are the only two peer reviewers for the Treasure Coast contract; however, Mr. Gross also works at the West Palm Beach location which currently has one Peer. The provider indicated they intend to have Carlene Pierre and Jean Christiansen Goggin trained in the near future. Ms. Walsh has participated in a QI Review for the current fiscal year.	**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**	☐	☐	☒	☐	☐	Documentation: A list of three additional contracts for FY 2023-2024 was provided by the provider. The list includes the funding sources and contract term dates with United Way of Martin County, Children's Services Council, and Communities Connected for Kids.	**No recommendation or Corrective Action.**
Limits of Coverage	☐	☐	☐	☒	☐	Documentation: General Liability through Alliance of	**No recommendation or Corrective Action.**

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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**						Nonprofits for Insurance, for limits of coverage $1,000,000 each $3,000,000 aggregate and medical payments for $5000, effective 7/01/23-7/01/24 Auto Insurance through Alliance of Nonprofits for Insurance, with combined single limit coverage for $1,000,000, effective 7/01/23-7/1/24 Workers Compensation through United Wisconsin Insurance Co, with limits of $1,000,000 for each incident and $1,000,000 policy limit, effective 7/01/23-7/01/24 Directors and Officers liability policy through Alliance of Nonprofits for Insurance, with limits of $1,000,000, per occurrence, effective 7/01/23-7/1/24 Umbrella liability coverage through Alliance of Nonprofits for Insurance,	

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						with limits of $5,000,000, each and aggregate, effective 7/01/23-7/1/24 The Florida Network of Youth and Family Services, Inc. is listed as certificate holder on the certificate of coverage.	
External/Outside Contract Compliance a. Provider has corrective action item(s) cited by an external funding source (Fiscal or Non-Fiscal). **ON SITE**	☐	☐	☐	☐	☒	Interview: During the Entrance Conference, the provider indicated that there are no outstanding corrective action item(s) cited by any external funding source.	**No recommendation or Corrective Action.**
Fiscal Practice a. Agency must have employee and fiscal policy/procedures manuals that are in compliance with GAAP and provide sound internal controls. Agency maintains fiscal files that are audit ready. **PTV**	☐	☐	☒	☐	☐	Documentation: Fiscal Policies and Procedures are maintained in the agency's Accounting Policies and Procedures Manual. The Accounting Policies and Procedures were last reviewed on December 1, 2019 and are in progress of review effective 4/18/2024. The procedures reviewed appear to be consistent with GAAP and provide for limited internal controls. Procedures are included for	**No recommendation or Corrective Action.**

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						accounts receivable, accounts payable, cash management, contributions, purchasing, travel, and Payroll. Fiscal files are located in the agency's corporate office.	
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**	☐	☐	☒	☐	☐	Documentation: General Ledger for July 1, 2023 – March 2024. The agency maintains a detailed general ledger with corresponding source documents. General ledger is structured to track all funding sources and there is a separate GL for the WaveCREST shelter (3623-2002 account) and CINS/FINS community counseling program (3624-1603 account).	**No recommendation or Corrective Action.**
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**	☐	☐	☒	☐	☐	Observation/Documentation: No change in practice was reported for the agency since the last onsite program review in February 2023. Petty cash is maintained and reconciled by the Secretary monthly or	**No recommendation or Corrective Action.**

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						as needed. The reconciliation is accompanied by a log including the date, vendor, amount, account, and sub-account for each activity. Policies and procedures are maintained in the Fiscal Manual under the Cash Management section. The maximum petty cash account for WaveCREST shelter is $400. The funds are kept locked up in the Administrative Secretary's office. Requests for petty cash are informal but are accompanied by an up-to-date log of activities and receipt that is maintained by the custodian.	
d. Financial records and reports are current. Includes bank statements reconciled within 6 weeks of receipt. Vendor invoices past 6 months. Invoices are submitted on a monthly basis with supporting documentation. (Disbursements/invoices are approved & monitored by management). **ON SITE**	☐	☐	☒	☐	☐	Documentation: Reviewed Reconciliation Statements and corresponding general ledger entries for accounts payable and payroll accounts held with Fifth Third Bank for the period October 2023-March 2024. Bank reconciliations are	**No recommendation or Corrective Action.**

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						processed by the finance department in the corporate office. Successful bank reconciliations were conducted timely, and all of the reconciliation worksheets prepared by the accounting analyst were reviewed by the accounting manager.	
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**	☐	☐	☒	☐	☐	Documentation: Agency maintains an inventory list of equipment for the CINS/FINS programs reflecting purchase dates from 2009 to 2019. No new purchases were made for the review period.	**No recommendation or Corrective Action.**
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**	☐	☐	☒	☐	☐	Documentation: Quarter 3 (July-September 2023) 941 quarterly Federal Tas Return, and biweekly payroll summaries for October 2023-March 2024 were reviewed. These reports demonstrate submission of payroll taxes and deposits biweekly.	**No recommendation or Corrective Action.**

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Major Programmatic Requirements	Explain Rating: Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable	Ratings Based Upon: I = Interview; O = Observation; D = Documentation; PTV = Submitted Prior To Visit; (List Who and What)	Notes: Explain Unacceptable or Conditionally Acceptable:
g. Budget to actual reports prepared and reviewed by appropriate management. Variance from the budget are investigated and explained. **PTV/ON SITE**	☐	☐	☒	☐	☐	Documentation: Budget to Actual report for July 1, 2023-March 2024 for the CINS/FINS Program was reviewed. The report captures the monthly variance, year-to-date, and annual budget. A net deficit was observed for the shelter program and surplus for community counseling per the report. The provider has a monthly process for reviewing and explaining variances.	**No recommendation or Corrective Action.**
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**	☐	☐	☒	☐	☐	Documentation: The provider submitted a copy of the Financial audit conducted for the year ending June 30, 2023 and 2022 for the review. The audit was completed by RSM US, LLP and was dated December 15, 2023. No management letter or deficiency control letter was issued.	**No recommendation or Corrective Action.**

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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**	☐	☐	☒	☐	☐	Documentation reviewed included policy and procedures regarding the following: CHS1017/Confidentiality and Access to Client Information and Records; CHS1032/Board Member Confidentiality; CHS5100/Cyber Security and Awareness Training Practice; CHS5002/Password Utilization; CHS5004/Equipment and Property Assignment Policy; CHS5105/Business Continuity and Disaster Recovery Plan; CHS5007/Electronic Document Retention Practice; and Accounting Manual/Record Retention Policy.	**No recommendation or Corrective Action.**
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**	☐	☐	☒	☐	☐	Documentation: A salary list of all CINS/FINS staff was provided, effective 8/30/2023, showing position title, annual salary, and pay rate. All direct care staff was observed to be paid at least $19 per hour.	**No recommendation or Corrective Action.**

CONCLUSION

CHS WaveCREST has met the requirements for the CINS/FINS contract as a result of full compliance with 13 applicable indicators of the Administrative and Fiscal Contract Monitoring Tool. One of the 14 indicators was not applicable because the program indicated there are no outstanding corrective action item(s) cited by any external funding source. Consequently, **the overall compliance rate for this contract monitoring visit is 100%.** There are no corrective actions or recommendations 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.

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 Children's Home Society - WaveCREST
Residential Program

May 8-9, 2024

Compliance Monitoring Services Provided by

FOREFRONT

CINS/FINS Rating Profile

Standard 1: Management Accountability

1.01 Background Screening of Employees/Volunteers	Limited
1.02 Provision of an Abuse Free Environment	Limited
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: 71.43 %
Percent of Indicators rated Limited: 28.57 %
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)	Not Applicable

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

Standard 3: Shelter Care & Special Populations

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

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

Standard 4: Mental Health/Health Services

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

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

Overall Rating Summary

Percent of indicators rated Satisfactory: 92.86 %
Percent of indicators rated Limited: 7.14 %
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

Marcia Tavares - Lead Reviewer Consultant-Forefront LLC/Florida Network of Youth and Family Services
Nicos Antonakos – Regional Monitor, Department of Juvenile Justice
Lashonda Chavis – Lutheran Services Florida Miami Bridge
Ivonne Medrano – Prevention Central
Myiah White – Urban League of Palm Beach

Methodology

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

Persons Interviewed

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

Documents Reviewed

	Accreditation Reports	X	Table of Organization		Visitation Logs
X	Affidavit of Good Moral Character	X	Fire Prevention Plan	X	Youth Handbook
	CCC Reports	X	Grievance Process/Records	5	# Health Records
X	Logbooks		Key Control Log	4	# MH/SA Records
	Continuity of Operation Plan	X	Fire Drill Log	11	# Personnel /Volunteer Records
X	Contract Monitoring Reports	X	Medical and Mental Health Alerts	8	# Training Records
	Contract Scope of Services	X	Precautionary Observation Logs	13	# Youth Records (Closed)
X	Egress Plans	X	Program Schedules	5	# Youth Records (Open)
X	Fire Inspection Report	X	List of Supplemental Contracts		# Other: ___
	Exposure Control Plan	X	Vehicle Inspection Reports		

Observations During Review

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

Surveys

7	# of Youth	12	# of Direct Staff		# of Other		

Comments

A Quality Improvement Program Review was conducted for FY 2023-2024.

Monitoring Purpose

The purpose of this monitoring is to provide an annual quality improvement program review. This is to verify the agency adheres to all current CINS/FINS standards and contract compliance requirements for residential and/or community counseling services.

Strengths and Innovative Approaches

Children's Home Society WaveCREST (CHS WaveCREST) contracts with the Florida Network to operate the Child in Need of Services and Family in Need of Services (CINS/FINS) program in Fort Pierce, Florida. CINS/FINS funding allows the agency to provide residential, community counseling, and case management services the greater treasure coast area. WaveCREST is licensed for 12 beds and the program's license was renewed by the Department of Children and Families (DCF) and is valid until 2/27/2025. The agency also provides specialized services to youth who meet the criteria for Staff Secure shelter, Domestic Minor Sex Trafficking, and youth referred by the Juvenile Justice Court System for domestic violence, probation respite, and Family/Youth Respite Aftercare Services (FYRAC).

The following programmatic updates were provided by the agency:

Staffing

During the past year, the organization made significant changes to leadership as it pertains to program leadership of its programs. CHS WaveCREST's program operations are now being overseen by the Director of Out of Home Care Programs. This Director reports to the VP of Child and Family Wellbeing who then reports to the Chief Program and Clinical Officer. Both the WaveCREST and Safe Harbor shelter programs are now being overseen by Duane Gross, Residential Program Manager. This change allows for more seamless sharing of ideas, expertise, resources and best practices, resulting in further strengthening of both programs. Additionally, Kristi Walsh now oversees the Community Counseling program in the Treasure Coast and Osceola County.

Program Updates

Over the last couple of years, CHS has been strategic in providing vertical alignment with its programs. This allows CHS to leverage expertise in other areas of the state in order to best provide services for each of its programs. Staff members have peers across the state who are doing the same work in order to maximize the quality of work CHS is providing in each region and county. CHS staff have already seen that, as a result of this implementation, staff are able to spend more time with children and families and realize successes quicker. In the summer of 2023, the agency finalized its last stage of alignment and all programs statewide have made this shift.

Facility

With new leadership, the program is not only focused on strengthening morale and program efficacy but is working to brighten the physical environment. Through local charitable giving projects, the provider has been able to update fixtures throughout the shelter, bring in newer furniture, decluttered spaces, brightened the walls and added recreation equipment for the youth. It is also continuing to explore future projects with local contractors.

Challenges

The nurse position, is the most challenging staffing/programmatic issue currently. Although the agency has posted the vacancy for the nurse position and has had some promising applicants, it has not been able to secure a new hire. This has led to training complications for new hires as well as corrective actions surrounding medication errors. The program has benefited from outside nursing training through the Network, however, this is not sustainable.

Narrative Summary

CHS WaveCREST provides residential and non-residential counseling and case management services across four counties-- Indian River, Okeechobee, Martin, and St. Lucie, in Circuit 19. CHS WaveCREST is managed by a Director of Out of Home Placement, and Residential Director, a Group Living Manager, and a Residential Supervisor. Day-to-day activities in the youth shelter are managed by the Residential Supervisor. The community counseling program is managed by a Community Counseling Supervisor. At the time of the onsite visit, the shelter youth census was eight youth.

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 **Limited**, Indicator 1.02 Provision of an Abuse Free Environment was rated **Limited**, 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,** Indicator 2.03 Case/Service Plan was rated **Satisfactory**, Indicator 2.04 Case Management and Service Delivery was rated **Satisfactory, i**ndicator 2.05 Counseling Services was rated **Satisfactory**, Indicator 2.06 Adjudication/Petition Process was rated **Satisfactory**, Indicator 2.07 Youth Records was rated **Satisfactory**, Indicator 2.08 Specialized Additional Program Services was rated **Satisfactory.**

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

Standard 4: There are five indicators for Standard 4. Indicator 4.01 Healthcare Admission Screening was rated **Satisfactory**, Indicator 4.02 Suicide Prevention was rated **Satisfactory with Exception**, 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):

Standard 1:
Indicator 1.01 - Limited
Two of seven new staff hired by the program (date of hire (DOH) 10/4/23 and DOH 11/11/23) scored Low on the Berke Assessment. Neither of the two staff who did not pass the pre-employment assessment retook the assessment and demonstrated a passing score prior to hire.

Indicator 1.02 - Limited
Grievance box checks were not documented for a total of 32 of the 59 days reviewed. Checks were not completed and documented for three of ten days from November 6-17; nine of ten days from December 11-22; three of nine days from January 15-26; five of ten days from February 5-16; six of ten days from March 18-29; and six of ten days from April 1-12**.**

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		Limited
Provider has a written policy and procedure that meets the requirement for Indicator 1.01	**NO**	
	If NO, explain here: Policy CHS/7101 does not address the retaking of the suitability assessment if an applicant does not pass the assessment and is considered for hire.	
	The provider has a policy and procedures CHS/7101 - Background Screening of Employees/ Volunteers, Annual Affidavit of Compliance with Good Moral Character & Annual Abuse Registry Clearance that was approved 2/17/2024 by the Director of Out of Home Programs (DOHP).	

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: 7 new hire
Total number of 5 Year Re-screen Employee Files: 4 rescreened staff
Staff Position(s) Interviewed *(No Staff Names)*: **Talent General Manager, Residential Program Manager**
Type of Documentation(s) Reviewed: Staff roster, Department of Juvenile Justice Background Screening results, Berke Pre-employment Assessment, E-Verify, Annual Affidavit of Compliance with Level 2 Screening Standards, Email sent to BSU for confirmation of receipt of Annual Affidavit.

All positions providing direct services to youth has successfully passed pre-employment suitability assessment on the initial attempt.	**Exception**	A total of seven new staff were hired since the last onsite QI review. All seven staff met the criteria for a pre-screening assessment. The agency uses the Berke Assessment and completed the screening prior to hire for all seven staff. Five of the seven staff received passing scores of medium or high on the assessment.	Two of seven new staff hired by the program (date of hire (DOH) 10/4/23 and DOH 11/11/23) scored Low on the Berke Assessment.
For any applicant that did not pass the initial suitability assessment, there was evidence that the applicant retook the assessment and passed within five (5) business days of the initial attempt, not exceeding three (3) attempts within thirty (30) days.	**Exception**	The two of new staff who scored Low on the Berke Assessment were required, effective July 2023, to retake the assessment until a passing score is obtained.	Neither of the two staff who did not pass the pre-employment assessment retook the assessment and demonstrated a passing score prior to hire.

Agency has evidence for employees who have had a break in service for 18 months or more, and/or when the agency had a change or update in the suitability assessment tool used was different from the employee's original assessment, that a new suitability assessment and background screening was completed as required.	**No eligible items for review**	None of the new hires were prior employees.	
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**	Background screenings for the seven new hires were initiated prior to hire dates with eligibility documented on the DJJ background screening results. There were no exemptions required. There were no new interns/volunteers utilized during the 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.	**Exception**	The program had four employees who met the criteria for re-screening during the review period. Two of the four staff were rescreened prior to the retained fingerprints expiration date.	Rescreening was not conducted for two staff prior to their retained prints expiration date. One staff's fingerprint expired 2/13/24 but there was no rescreening until 4/30/24. The second staff, with agency original DOH 9/15/18, transferred 11/11/23 to CINS/FINS from a DCF program; however, a DJJ screening was not done until 4/30/24. Additionally, a review of the DCF screening shows the staff's retained prints expired 8/30/23 but not rescreened until 9/6/23.
Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?	**Compliance**	The program emailed its Annual Affidavit of Compliance with Level 2 Screening Standards to the Background Screening Unit on January 16, 2024, prior to the January 31st deadline.	
Proof of E-Verify for all new employees obtained from the Department of Homeland Security	**Compliance**	Proof of employment authorization from the Department of Homeland Security was obtained through E-verify and maintained on file for the seven new hires.	
Additional Comments: **There are no additional comments for this indicator.**			
1.02: Provision of an Abuse Free Environment			**Limited**
Provider has a written policy and procedure that meets the requirement for Indicator 1.02		**YES**	
		If NO, explain here:	
		The provider has the required policy and procedures CHS/7102 - Providing an Abuse Free Environment, that was approved 2/17/2024 by the Director of Out of Home Programs (DOHP).	

Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Staff Position(s) Interviewed (No Staff Names): Shelter Supervisor **Type of Documentation(s) Reviewed: CHS Employee Handbook, code of conduct, client handbook, client grievance file, logbook, Eco Online incident report** **Describe any Observations: abuse hotline postings, grievance box, grievance forms**			
Agency has a code of conduct of policy and there is evidence that staff are aware of agency's code of conduct.	**Compliance**	The program has a code of conduct that prohibits the use of physical abuse, profanity, threats or intimidation. All new employees (full, part-time and relief) will have access to the electronic CHS Employee Handbook at the time of hire and will sign an acknowledgement of knowledge and agree to abide by all policies. Staff will comply with all rules of conduct as described in the CHS Employee Handbook. This includes clear prohibitions against using physical abuse, intimidation of any kind, profanity, threats, and/or excessive use of force. Youth are not deprived of basic needs, such as food, clothing, shelter, medical care and security.	
The agency has a process in place for reporting and documenting child abuse hotline calls.	**Compliance**	The program has a process in place for reporting and documenting any child abuse hotline calls. In addition to receipt of the employee handbook and acknowledgement of the information, staff are required to report allegations directly to the abuse hotline, document it on the agency's incident report form, and enter the incident into the agency's online database called Eco Online, formerly Airs Web. A review of the database report shows two non-institutional calls to the abuse hotline during the review period.	
Youth were informed of the Abuse and Contact Number	**Compliance**	Youth are informed of the abuse hotline and telephone number during orientation and are required to initial receipt of the information on the orientation checklist and information in the youth handbook. This was verified in the five residential youth records reviewed. There are also many postings throughout the shelter with information regarding the Florida Abuse Hotline.	
Grievance			
The program must have an accessible and responsive grievance process for youth to provide feedback and address complaints. Program director/ supervisor will have access to and manage grievances unless it is towards themselves.	**Compliance**	The program provides an accessible, as well as responsive grievance process for youth to provide feedback and address complaints. The direct care workers do not handle the complaint/grievance documents, only the supervisor.	

Shelter only: Grievances are maintained on file at minimum for 1 year.	**Compliance**	The program maintains copies of all grievances reported in a file exceeding 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**	Youth are informed of the grievance procedures and are required to initial receipt of the information on the orientation checklist and information in the youth handbook. The locked grievance box and grievance forms are available to youth in the common area. During the review period the program provided copies of three grievances reported by youth during the review period.	
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.	**Exception**	Grievance box checks were reviewed for the following random 2-week periods: November 6-17, 2023; December 11-22, 2023; January 15-26, 2024; February 5-16, 2024; March 18-29, 2024, and April 1-12. 2024 for a total of 60 days. Grievance box checks were observed for only 28 of the 60 days.	Grievance box checks were not documented for a total of 32 of the 59 days reviewed. Checks were not completed and documented for three of ten days from November 6-17; nine of ten days from December 11-22; three of nine days from January 15-26; five of ten days from February 5-16; six of ten days from March 18-29; and six of ten days from April 1-12.
Shelter only: All grievances are resolved within 72 hours and documented by program director/supervisor or escalated to higher leadership if grievance involves them directly.	**Compliance**	All three grievances reported were reviewed by the shelter supervisor and resolved within 72 hours. The shelter supervisor writes a statement of how the grievance is resolved on the grievance form, then sign and date the form. An incident report is also generated and is reviewed by the shelter manager and DOHP.	
1.03: Incident Reporting			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 1.03		**YES** If NO, explain here: The provider has the required policy and procedures CHS/7103 - Incident Reporting, that was approved 2/17/2024 by the Director of Out of Home Programs (DOHP).	

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

Staff Position(s) Interviewed *(No Staff Names)* **: Quality Management Specialist, Shelter Supervisor**
Type of Documentation(s) Reviewed: Program log books, and Eco Online internal incident reports for the past six months.
Describe any Observations: Postings of CCC telephone number

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 program documents all incidents, both reportable and non-reportable, in the electronic Eco Online system. The program had a total of five incidents which were reported to the CCC, including one contraband incident, one youth behavior incident, and two missed medication. All five incidents were reported to the CCC within two hours, as required.	
The program completes follow-up communication tasks/special instructions as required by the CCC	**Compliance**	All five CCC reports reviewed demonstrated follow-up communication tasks/ special instructions were completed by the program.	
Agency internal incidents are documented on incident reporting forms and all CCC reportable incidents were consistently reported to CCC as required.	**Exception**	Incident reports are documented electronically in the agency's online system which is an incident management and incident tracking software that simplifies incident reporting, investigations, and corrective action within a single, secure platform. All five incidents reviewed were recorded in the online system.	It was observed information regarding date/time of notification to authorities including CCC was not accurately documented in the online system for the five incidents when compared to the date/time noted in the program logbook and summary of CCC report generated by CCC. In addition, two of the five CCC incidents were not flagged in Eco Online as reported to CCC.
Incidents are documented in the program logs and on incident reporting forms	**Compliance**	All five CCC reports reviewed were documented in the program logbook.	
All incident reports are reviewed and signed by program supervisors/ directors	**Compliance**	All five incident reports recorded in Eco Online showed electronic documentation of supervisor's reviews.	
1.04: Training Requirements (*Staff receives training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions*)			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 1.04		**YES** If NO, explain here: The provider has a policy and procedures CHS/7104- Training Requirements that was approved 2/17/2024 by the Director of Out of Home Programs (DOHP).	

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: 4
Total number of Annual In-Service Staff Files:4
Total number of Non-Licensed Mental Health Clinical Shelter Staff Files: N/A
Annual Training Plan Timeframe (*Program timeframe for annual trainings*)**: Calendar year**
Staff Position(s) Interviewed *(No Staff Names)* **: Residential Manager/Shelter Supervisor**
Type of Documentation(s) Reviewed: Training logs, training certificates, training transcripts from Bridge and DJJ SkillPro.
Describe any Observations: reviewed 8 files, each staff had an individual binder well organized.

First Year Direct Care Staff			
All direct care staff have completed new hire pre-service training requirements for safety and supervision as required.	**Compliance**	All four new hire pre-service training requirements were reviewed, and it was verified that all pre-service training requirements were completed.	
All staff completed the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days from date of hire.	**Compliance**	All four first year direct care staff training records were reviewed. The four direct care staff completed the required Civil Rights training within the 30 day timeframe.	
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**	All direct care staff exceeded the 80 hours required for the first full year of employment.	
All staff receives all mandatory training during the first 90 days of employment from date of hire.	**Exception**	Two out of the four new hires completed all mandatory training within 90 days of employment.	One new hire did not complete the Universal Precaution within the ninety-day timeframe. A second new hire did not complete the CPR and First Aid within the ninety-day timeframe.
Staff Required to Complete Data Entry for NIRVANA or access the Florida Department of Juvenile Justice Information System (JJIS)			
Any designated staff that is responsible for entering NIRVANA or ensuring accurate and complete data entry in the Florida Department of Juvenile Justice Information System (JJIS) have completed all of the required trainings.	**Compliance**	One applicable staff member responsible for entering NIRVANA completed the required trainings prior to completing a NIRVANA assessment.	
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**	One applicable community counseling new hire staff member still has time remaining to complete the required training.	
Non-licensed Mental Health Clinical Shelter Staff (within first year of employment)			
Documentation of non-licensed mental health clinical staff person's training in Assessment of Suicide Risk form or written confirmation by a licensed mental health professional of training (includes date, signature and license number of the licensed mental health professional supervisor).	**No eligible items for review**	The program has not hired a non-licensed mental health clinical staff during the review period.	
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**	Four in-service staff training records were reviewed. All four required in-service trainings were completed by the agency's annual calendar training year.	
Required Training Documentation			
The agency has a training plan that includes all of the required training topics including the pre-service and in-service.	**Compliance**	The agency has a training plan that outlines all of the mandatory training topics, including pre-service and in-service. The training log in each file included shows all required and completed trainings.	
The agency has a designated staff member responsible to manage all employee's individual training files and completes routine tracking and reviews of staff files to ensure compliance.	**Compliance**	The agency's residential manager manages all staff training for the program and a training file is maintained for each staff.	
The program maintains an individual training file or employee file AND a FLN Training Log (or similar document that includes all requirements) for each staff, which includes an annual employee training hours tracking form and related documentation, such as electronic record/transcript, training certificates, sign-in sheets, and agendas for each training attended.	**Compliance**	The program maintains an individual training file or employee file with a training log, which tracks annual employee training hours, certificates of completion, sign-in sheets, and transcripts.	
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 provider has the required policy and procedures CHS/7105-Reporting and Analyzing Data/Information, that was approved 2/17/2024 by the Director of Out of Home Programs (DOHP).	
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): Senior Director of Quality and Compliance, Quality Management Specialist **Type of Documentation(s) Reviewed: Compliance and Quality Record Review Aggregation Tool, Quality Council Meeting - Quarterly, Quarterly Program Performance Meeting, Flash Report - Monthly, Quarterly Executive Director Report, Monthly Matrix, Quarterly Board Report, Program Performance Report (PPR), and Client Satisfaction Survey Email.**			

Case record review reports demonstrate reviews are conducted quarterly, at a minimum	**Compliance**	Record reviews were conducted for both the shelter and community counseling programs quarterly during the current fiscal year (FY). During the second and third quarters of the FY, the shelter completed a total of nine record reviews and community counseling completed twelve record reviews. Record reviews are documented on the Compliance and Quality Record Review Aggregation tool which includes 53 indicators relevant to CINS/FINS youth record requirements. Quality team member meets with program staff weekly or at staff meetings to reviewed deficiencies and create a plan of action. Action plans are tracked on the shared drive and reported through quality meetings with leadership.	
The program conducts reviews of incidents, accidents, and grievances quarterly, at a minimum	**Compliance**	Incidents and accidents are entered in real time into the agency's Eco Online electronic system. All staff has access to enter incidents in lieu of using a report form. The system tracks the types of incidents, status of reviews, and generates reports. Consumer grievances are submitted to program supervisors and entered into Eco Online. A review of the Eco Online report for the review period demonstrates the program collects detailed information for incidents, accidents, and grievances and communicate findings at monthly staff meetings.	
The program conducts an annual review of customer satisfaction data	**Compliance**	Consumer surveys are collected by program staff as well as electronically submitted through the agency's website. Surveys are monitored by quality management staff who generate reports to be reviewed at monthly program meetings, and quarterly quality council meetings. Evidence of consumer survey results is reported on quarterly program performance review (PPR) reports.	
The program demonstrates a monthly review of the statewide End-of-Month ("EOM") report generated by the Florida Network Office. This includes monthly data, fiscal year to date data, benchmarks for residential and community counseling, screening data, report card measures, follow-up reporting measures.	**Compliance**	EOM reports are emailed to the Program Director and disseminated to the management team. Data from the EOM report is reviewed at the monthly staff meetings. Monthly staff meeting agendas and minutes for the review period validates program review of the EOM reports on a regular basis with staff.	
The program has a process in place to review and improve accuracy of data entry & collection	**Compliance**	The agency has a robust quality management process and data collection system in place to monitor, analyze, and communicate information to the Board of Directors, local management team. Data collected is maintained on a dashboard accessible to the QM team and findings are regularly reported and reviewed with staff and stakeholders.	

There is documentation that findings are regularly reviewed by management and communicated to staff and stakeholders.	**Compliance**	The provider's quality management team has monthly and quarterly reporting timeframes to analyze data with reporting requirements to leadership, management, and staff. Evidence of quarterly quality council meetings, executive leadership meetings, and staff meeting minutes support regular communication to stakeholders.	
There is evidence the program demonstrates that program performance is routinely reviewed with the Board of Directors. All final reports that include a Limited or Failed score is submitted electronically or by mail to the providers Executive Committee on the Board of Directors.	**Compliance**	All final QI reports that include a limited or failed score are submitted electronically or by mail to the providers' executive committee. Two board meetings held on 9/8/23 and 12/1/23 during the FY were reviewed. The agenda includes an item for Risk and Audit information so that program performance is reviewed with the board of directors.	
There is evidence that strengths and weaknesses are identified, improvements are implemented or modified, and staff are informed and involved throughout the process.	**Compliance**	The agency has a Senior Director of Quality and Compliance who leads a quality management team in the development, implementation, documentation, evaluation, and promotion of continuous improvement practices and systems. The Quality Management team is responsible for oversight at the local level. Processes are in place and established in the agency's PQI plan to collect data and identify areas needing improvement. Should negative trends be observed, a corrective action will be implemented as a priority issue to be addressed and is monitored by the compliance staff as well as the program's management team.	
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 provider has the required policy and procedures CHS/7106-Client transportation, that was approved 2/17/2024 by the Director of Out of Home Programs (DOHP).	
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: December 2023-May 2024 **Staff Position(s) Interviewed** *(No Staff Names)* **: Residential manager/Director Contact** **Type of Documentation(s) Reviewed: Transportation records, Logbook, List of Approved Drivers**			

Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	**Compliance**	The agency maintains a list of 13 authorized drivers, and per the residential manager/director contact, all 13 staff members are approved by administration and are covered under the agency's insurance policy to drive agency vehicles.	
Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	**Compliance**	Florida Department of Highway Safety and Motor Vehicles driver's license checks evidenced all 13 approved drivers who are covered under the agency's company insurance policy have valid drivers licenses.	
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**	Per the program's transportation policy, the best practice to prevent situations that put youth or staff in danger of real or perceived harm, or allegations of inappropriate conduct by either staff or youth is to have a 3rd party present in the vehicle while transporting a client. However, in the event a 3rd party cannot be present, the policy includes exceptions and guidelines for staff to follow.	
In the event that a 3rd party cannot be obtained for transport, the agency's supervisor or managerial personnel consider the clients' history, evaluation, and recent behavior	**Compliance**	The agency's policy provides provision in the event a 3rd party cannot be obtained for the transport for the consideration of the client's history, evaluation and recent behavior.	
The 3rd party is an approved volunteer, intern, agency staff, or other youth	**Compliance**	The agency's policy does require the 3rd party to be an approved volunteer, intern, agency staff or other youth.	
The agency demonstrated evidence via logbook or other written verification that supervisor approval was obtained prior to all single youth transports.	**Compliance**	The program conducted 19 single transport during the review period. Evidence of supervisor's approval was documented in the program logbook for all 19 transportation events.	
There is documentation of use of vehicle that notes name or initials of driver, date and time, mileage, number of passengers, purpose of travel and location.	**Compliance**	The program maintains vehicle transportation logs each time the program vehicle is used for transporting youth. The logs are documented in the logbook binder, which includes transportation events and entry fields for the name of the driver, date and time, mileage and number of passengers, purpose of travel, and location.	
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 provider has the required policy and procedures CHS/7107-Outreach and Interagency Agreements, that was approved 2/17/2024 by the Director of Out of Home Programs (DOHP).	
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)* **: Supervisor over community counseling** **Type of Documentation(s) Reviewed: DJJ CAB agendas and minutes, NetMIS printout log, flyers for events.** **Describe any Observations: well organized**			
The program has a lead staff member designated to participate in local DJJ board, Circuit and Council meetings with evidence that includes minutes of the event or other verification of staff participation.	**Compliance**	The community counseling supervisor is the designated lead staff to attend the local DJJ council advisory board (CAB) meetings held via ZOOM. A total of five CAB meetings were reviewed during the review period November 2023 - April 2024. Staff provided meeting agenda and minutes documentation to support attendance to all five meetings. In addition, the staff is a board member on the DJJ council advisory board as a community leader.	
The program maintains written agreements with other community partners which include services provided and a comprehensive referral process.	**Compliance**	The program maintains written Interagency Agreements, in a binder, with other community partners which includes services provided and a comprehensive referral process. Services provided through these agreements include early prevention/other Intervention, medical, educational/recreation, clinical, and food. All agreements were up-to-date.	
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 program provided the NetMIS Outreach log for November 3 - May 9th, which documented 44 outreach activities/events including multiple staff members conducting the outreach activities. The NetMIS outreach log includes all required information.	
The program has designated staff that conducts outreach which is defined in their job description.	**Compliance**	The DOHP mentioned that all staff are required to conduct outreach as listed on their position description.	
Additional Comments: **There are no additional comments for this indicator.**			

2.01 - Screening and Intake			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 2.01		**YES** If NO, explain here: The provider has the required policy and procedures CHS/7201, Screening Eligibility for Services and Intake Assessment, that was approved 2/17/2024 by the DOHP.	
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 open residential, 2 open community counseling **Total number of Closed (Residential & Community) Files: 3 closed residential, 3 closed community counseling** **Staff Position(s) Interviewed (No Staff Names): Community Counseling Manager** **Type of Documentation(s) Reviewed: youth records**			
Shelter youth: Eligibility screening form is completed immediately for all shelter placement inquiries.	**Compliance**	All five residential files reviewed demonstrated eligibility screening is completed immediately for all 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**	All five community counseling files reviewed demonstrated eligibility screening is completed within three business days of referral by a trained staff using the Florida Network screening form.	
There is evidence all referrals for service is screened for eligibility and is logged in NetMIS within 72 hours of screening completion.	**Compliance**	All ten files reviewed demonstrated evidence all referrals for service is screened for eligibility and is logged in NetMIS within 72 hours of screening completion.	
Youth and parents/guardians receive the following in writing: a. Available service options b. Rights and responsibilities of youth and parents/guardians	**Compliance**	All ten files reviewed demonstrated youth and parents/guardians receive the available service options and rights and responsibilities of youth and parents/guardians in writing during intake.	
The following is also available to the youth and parents/guardians: a. Possible actions occurring through involvement with CINS/FINS services (case staffing committee, CINS petition, CINS adjudication) b. Grievance procedures	**Compliance**	All files demonstrated the program provided the CINS/FINS parent brochure and grievance procedures during intake. An acknowledgement of review of this information is included in each youth record.	
During intake, all youth were screened for suicidality and correctly assessed as required if needed.	**Compliance**	All ten youth files reviewed evidenced all youth were screened for suicidality and four applicable residential youth were assessed further due to having a hit on the suicide screening.	

Additional Comments: **There are no additional comments for this indicator.**			
2.02 - Needs Assessment			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.02		**YES** If NO, explain here: The provider has the required policy and procedure, CHS/7202 Needs Assessment, that was approved 2/17/2024 by the DOHP.	
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 open residential, 2 open community counseling **Total number of Closed (Residential & Community) Files: 3 closed residential, 3 closed community counseling** **Staff Position(s) Interviewed (No Staff Names): Community Counseling Manager** **Type of Documentation(s) Reviewed: youth records**			
Shelter Youth: NIRVANA is initiated within 72 hours of admission	**Compliance**	All five residential records reviewed demonstrated 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**	All five community counseling files reviewed demonstrated NIRVANA was initiated at intake and completed within two to three face-to-face contacts after the initial intake.	
Supervisor signatures is documented for all completed NIRVANA assessments and/or the chronological note and/or interview guide that is located in the youths' file.	**Compliance**	All ten youth files reviewed included a supervisor's signature on the 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.	**Compliance**	All five residential files reviewed demonstrated NIRVANA Self-Assessments were completed within 24 hours of youth being admitted into 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**	Two applicable youth files, with length of stay greater than 30 days, included NIRVANA post assessments they were completed and documented in the files.	
A NIRVANA Re-Assessment is completed every 90 days excluding files for youth receiving SNAP services.	**No eligible items for review**	None of the files reviewed were eligible for a NIRVANA re-assessment because the length of stay did not meet the 90 day requirement.	
All files include the interview guide and/or printed NIRVANA.	**Compliance**	All 10 files included the interview guide and printed NIRVANA for all youth	

Additional Comments: **There are no additional comments for this indicator.**			
2.03 - Case/Service Plan			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.03		**YES** If NO, explain here: The provider has the required policy and procedure, CHS/7203 Case Plans Implementation, Review, and Revision, that was approved 2/17/2024 by the DOHP.	
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 open residential, 2 open community counseling **Total number of Closed (Residential & Community) Files: 3 closed residential, 3 closed community counseling** **Staff Position(s) Interviewed (No Staff Names): Community Counseling Manager** **Type of Documentation(s) Reviewed: youth records**			
The case/service plan is developed on a local provider-approved form or through NETMIS and is based on information gathered during the initial screening, intake, and NIRVANA.	**Compliance**	All ten files reviewed demonstrated the case/service plan is developed on a local provider-approved form and is based on information gathered during the initial screening, intake, and NIRVANA.	
Case/Service plan is developed within 7 working days of NIRVANA	**Compliance**	The case and service plans were created immediately in all 10 files	
Case plan/service plan includes: 1. Individualized and prioritized need(s) and goal(s) identified by the NIRVANA 2. Service type, frequency, location 3. Person(s) responsible 4. Target date(s) for completion and actual completion date(s) 5. Signature of youth, parent/guardian, counselor, and supervisor 6. Date the plan was initiated	**Compliance**	Case plans in all 10 files included: Individualized and prioritized need(s) and goal(s) identified by the NIRVANA, Service type, frequency, location, Person(s) responsible, Target date(s) for completion and actual completion date(s), Signature of youth, parent/guardian, counselor, and supervisor and Date the plan was initiated	
Case/service plans are reviewed for progress/revised by counselor and parent (if available) every 30 days for the first three months and every 6 months after	**Compliance**	All applicable case plans were observed to be reviewed for progress and revised by the counselor and parent every 30 days for the first three months.	
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 provider has the required policy and procedure, CHS/7204 Case Management Services - Family Involvement, that was approved 2/17/2024 by the DOHP.	
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 open residential, 2 open community counseling **Total number of Closed (Residential & Community) Files: 3 closed residential, 3 closed community counseling** **Staff Position(s) Interviewed (No Staff Names): Community Counseling Manager** **Type of Documentation(s) Reviewed: youth records**			
Counselor/Case Manager is assigned	**Compliance**	In all 10 cases a counselor/case manager was assigned to work with the youth and family from the beginning to termination.	
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 ten records reviewed demonstrated coordination of service plan implementation based on the youth's/family's problems and needs. It was also evident the case worker monitored youth's/family's progress in services, provided support for families when needed, and referred the youth/family for additional services when appropriate. None of the ten files reviewed were referred for case staffing or required court intervention. Case termination notes were present in the six closed files. Thirty and 60 day follow ups were completed timely in a total of five applicable files.	
The program maintains written agreements with other community partners that include services provided and a comprehensive referral process	**Compliance**	If applicable, referral were made for youth and/family to local community agencies. The program maintains agreements with a variety of community partners that include services provided and a comprehensive referral process.	
Additional Comments: **There are no additional comments for this indicator.**			

2.05 - Counseling Services			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 2.05		**YES** If NO, explain here: The provider has the required policy and procedure, CHS/7205 Counseling Services, that was approved 2/17/2024 by the DOHP.	
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 open residential, 2 open community counseling **Total number of Closed (Residential & Community) Files: 3 closed residential, 3 closed community counseling** **Staff Position(s) Interviewed (No Staff Names): Community Counseling Manager** **Type of Documentation(s) Reviewed: youth records**			
Shelter Program			
Shelter programs provides individual and family counseling	**Compliance**	Residential youth received individual and family counseling as evidenced by the clinical notes in the five residential youth records reviewed.	
Group counseling sessions held a minimum of five days per week	**Compliance**	A random selection of weekly sessions during the review period was conducted to assess group counseling practice. The program maintains a group binder that includes documentation of groups provided, including sign-in sheets. It was observed that the program conducts groups a minimum of five days for each of the weeks reviewed.	
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**	Each of the group counseling sessions reviewed included documentation of a clear leader or facilitator, relevant topic, opportunity for youth to participate, completed worksheets which are kept in the youth files, and per the residential manager, all groups are held 30 minutes or longer.	
Documentation of groups must include date and time, a list of participants, length of time, and topic.	**Compliance**	Group sessions are documented on a group form that documented date and time, list of youth participating, and topic.	
Community Counseling			

Community counseling programs provide therapeutic community-based services designed to provide the intervention necessary to stabilize the family. Services are provided in the youth's home, a community location, the local provider's counseling office or virtually if written documentation is provided in the youth's file for reasons why it is in the best interest of the youth and family.	**Compliance**	All five youth who participated in the community counseling program were provided community-based services directly or through referrals. The goal of the services are to provide the intervention necessary to stabilize the family. Services were provided in an approved location.	
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**	In all 10 files 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	
Maintain individual case files on all youth and adhere to all laws regarding confidentiality.	**Compliance**	All of the youth records reviewed were maintained in individual youth files with adherence to all laws regarding confidentiality, and are stored securely.	
Case notes maintained for all counseling services provided and documents youth's progress.	**Compliance**	Case notes reviewed in all of the records appear to be well kept and updated throughout the entire time the youth are in the residential and/or community counseling program.	
On-going internal process that ensures clinical reviews of case records and staff performance.	**Compliance**	All cases reviewed undergo a process that ensures clinical reviews of case records and staff performance. In addition peer record reviews are conducted monthly for a sample of case records and deficiencies are identified and addressed by management.	
When an intake is conducted through virtual means, consent is confirmed by the counselor, documented in the file, and reviewed with the supervisor during supervision/case review. There is written documentation provided in the youths file for reasons why virtual sessions are in the best interest of the youth and family.	**No eligible items for review**	None of the intakes for the records reviewed were conducted through virtual means.	
Additional Comments: **There are no additional comments for this indicator.**			
2.06 - Adjudication/Petition Process			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.06		**YES** If NO, explain here: The provider has the required policy and procedure, CHS/7206 Case Staffing Committee - CINS Petition, Adjudication Process, that was approved 2/17/2024 by the DOHP.	

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

Total number of Open (Residential & Community) Files: 1 open residential record
Staff Position(s) Interviewed *(No Staff Names)* **: Group Living Manager**
Type of Documentation(s) Reviewed: Youth file

Must include: a. DJJ rep. or CINS/FINS provider b. Local school district representative	**Compliance**	The program had one applicable case staffing that was held during the review period. Documentation in the file indicated a DJJ representative, CINS/FINS provider, and local school district representative was present at the staffing.	
Other members may include: a. State Attorney's Office b. Others requested by youth/ family c. Substance abuse representative d. Law enforcement representative e. DCF representative f. Mental health representative	**Compliance**	Per the program's policy and procedure, other members of the committee may include: State Attorney's Office; others requested by youth/ family; substance abuse representative; law enforcement representative; DCF representative; and mental health representative. No additional members were requested to be present for the staffing reviewed.	
The program has an established case staffing committee, and has regular communication with committee members	**Compliance**	The program has an established case staffing committee in the event the youth/family is not in agreement with services or treatment; the youth/family will not participate in the services selected; or the program receives a written request from a parent/guardian or any other member of the committee.	
The program has an internal procedure for the case staffing process, including a schedule for committee meetings	**Compliance**	The case staffing meetings will be held if requested, including emergency case staffing. Members of the committee are notified via email when a case staffing is scheduled to be convened.	
The youth and family are provided a new or revised plan for services	**Compliance**	As a result of the case staffing, documentation supported the youth and family were provided a revised case plan.	
Written report is provided to the parent/guardian within 7 days of the case staffing meeting, outlining recommendations and reasons behind the recommendations	**Compliance**	Written report was provided to the parent or guardian within 48 hours of case staffing, outlining the reasons behind the recommendations of the committee.	
If applicable, the program works with the circuit court for judicial intervention for the youth/family	**No eligible items for review**	Court intervention was not required for the case staffed.	

Case Manager/Counselor completes a review summary prior to the court hearing	**No eligible items for review**	Court intervention was not required for the case staffed.	
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 provider has the required policy and procedure, CHS/7207 Youth Records and Case Management Services, that was approved 2/17/2024 by the DOHP.	
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): Community Counseling Manager **Type of Documentation(s) Reviewed: Policy and Procedure, Client Case Files** **Describe any Observations: File cabinet, record storage/transport container, and file room**			
All records are clearly marked 'confidential'.	**Compliance**	All 10 files reviewed were stamped CONFIDENTIAL.	
All records are kept in a secure room or locked in a file cabinet that is marked "confidential"	**Compliance**	All community counseling files reviewed onsite were kept in a secure travel case marked with confidential. All shelter records were observed to be kept in a secure room and locked in a file cabinet that is marked "confidential".	
When in transport, all records are locked in an opaque container marked "confidential"	**Compliance**	The program has a container that is used to transport records off site. The storage container is marked confidentiality and equipped with a lock. Program laptops are encrypted and password protected for confidentiality and safety.	
All records are maintained in a neat and orderly manner so that staff can quickly and easily access information	**Compliance**	All files are maintained in a neat and orderly manner, and are easily accessible when needed.	
Additional Comments: **There are no additional comments for this indicator.**			
2.08 - Specialized Additional Program Services			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.08		**YES** If NO, explain here: The provider has the required policy and procedure, CHS/7211 Specialized Additional Program Services, that was approved 2/17/2024 by the DOHP.	
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.*			
Staff Position(s) Interviewed *(No Staff Names)* **: Residential Program Manager**			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? **(If no, select rating "No eligible items for review")**	**No eligible items for review**	CHS WaveCREST has not served any youth who met the criteria for Staff Secure services 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.*			
Staff Position(s) Interviewed *(No Staff Names)* **: Residential Program Manager**			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	**No eligible items for review**	The provider has not served any youth who met the criteria for Domestic Minor Sex Trafficking (DMST) services 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 Closed Files: 3 closed DV Respite youth records **Staff Position(s) Interviewed (No Staff Names): Shelter Counselor** **Type of Documentation(s) Reviewed: Youth records, NetMIS**			
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 total of three closed residential DV youth records were reviewed.	

Youth admitted to DV Respite placement have evidence in the file of a pending DV charge	**Compliance**	All three records reviewed have face sheets in their files with documentation to show the three youth have pending DV charge and were referred to the shelter for DV respite.	
Data entry into NetMIS within (3) business days of intake and discharge	**Compliance**	The three youth records were reviewed in NetMIS and data entry was verified to be completed within three business days of intake and discharge.	
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**	One of the three youth had a placement in DV Respite for 21 days. Documentation in the youth's file showed the youth was terminated from DV and transitioned to CINS/FINS.	
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**	The case plans for the three youth reflected goals for anger management and family coping skills.	
All other services provided to Domestic Violence Respite youth are consistent with all other general CINS/FINS program requirements	**Compliance**	All three files reviewed demonstrated youth participated in services consistent with other general CINS/FINS population while in care.	
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.*			
Staff Position(s) Interviewed *(No Staff Names)* **: Residential Program Manager**			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	**No eligible items for review**	The program has not served any youth who met the criteria for Probation Respite in the last 6 months or since the last onsite 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 program 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.*			
Staff Position(s) Interviewed *(No Staff Names)* **: Residential Program Manager**			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	**Not Applicable**	CHS WaveCREST does not have a contract to provide ICM services.	
Youth receiving services were deemed chronically truant and/or runaway and require more intensive and lengthy services. The youth was determined to be eligible because they have gone through petition and/or case staffing and was in need of case management services.	**Not Applicable**		
Services for youth and family include: a. Two (2) direct contacts per month b. Two (2) collateral contacts per week c. Direct and collateral contacts not obtained must have documentation to support attempts made to obtain them. All reasonable attempts (at minimum of three) must be made to reach all contacts (direct and collateral) and documented in the case file and NetMIS.	**Not Applicable**		
Assessments include a. NIRVANA at intake b. NIRVANA Re-Assessment every 90 days c. Post NIRVANA at discharge as aligned with timeframe requirements	**Not Applicable**		

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

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

2.09- Stop Now and Plan (SNAP)			Not Applicable
Provider has a written policy and procedure that meets the requirement for Indicator 2.09		**N/A** If NO, explain here: CHS WaveCREST not contracted to provide SNAP services.	
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)* **: Residential Program Manager**			
SNAP Clinical Groups Under 12			
Youth are screened to determine eligibility of services.	**Not Applicable**	CHS WaveCREST is not contracted to provide SNAP services.	
The NIRVANA was completed at initial intake, or within two sessions.	**Not Applicable**		
There is evidence of the completed Child Behavior Checklist (CBCL) by the caregiver (pre and post) and is located within the file.	**Not Applicable**		
There is evidence of the completed Teacher Report Form (TRF) is completed by the teacher (pre and post) and is located within the file.	**Not Applicable**		
There is evidence of the completed TOPSE is completed by the caregiver (pre and post) and is located within the file.	**Not Applicable**		
SNAP Clinical Groups Under 12 - Discharge			
There is evidence of the completed SNAP Discharge Report located within the file for any discharged youth.	**Not Applicable**		
There is evidence of the SNAP Boys/SNAP Girls Child Group Evaluation Form located in the file.	**Not Applicable**		
There is evidence of the SNAP Boys/SNAP Girls Parent Group Evaluation Form located in the file.	**Not Applicable**		
SNAP Clinical Groups for Youth 12-17			
Youth are screened to determine eligibility of services.	**Not Applicable**		
The Consent to Treatment and Participation in Research Form is completed and located within the file.	**Not Applicable**		
The NIRVANA was completed at initial intake, or within two sessions.	**Not Applicable**		
There is evidence of the completed 'How I Think Questionnaire' (HIT) form located within the file or evidence of at least three (3) documented attempts in the youths' file to obtain this information.	**Not Applicable**		

There is evidence of the completed Social Skills Improvement System (SSIS) Student form located within the file or evidence of at least three (3) documented attempts in the youths' file to obtain this information.	**Not Applicable**		
There is evidence of the completed Social Skills Improvement System (SSIS) Teacher/Adult form located within the file or evidence of at least three (3) documented attempts in the youths' file to obtain this information.	**Not Applicable**		
SNAP for Schools & Communities			
The program demonstrated all of the required weekly attendance sheets that included youth names and/or identifying numbers completed with the teacher and trained SNAP Facilitator signatures. (*This must include a total of 13 attendance sheets for a full cycle*)	**Not Applicable**		
The program maintained evidence of a completed "Class Goal" Document for the class reviewed.	**Not Applicable**		
The program maintained evidence of both pre AND post Measure of Classroom Environment (MoCE) completed documents for the class reviewed.	**Not Applicable**		
The program maintained evidence of completed pre and post evaluation documents for the class reviewed.	**Not Applicable**		
There is evidence of the fidelity adherence checklist maintained in the file for each class reviewed.	**Not Applicable**		
Additional Comments: **There are no additional comments for this indicator.**			
3.01 - Shelter Environment			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 3.01	**YES**		
	If NO, explain here:		
	The program has the required policy and procedures CHS/7301 Shelter Environment, approved on 4/29/2024 by the DOHP.		

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: Program Director, Residential Director
Type of Documentation(s) Reviewed: Weekly and perpetual chemical inventory, MSDS, Fire Drills, Emergency Drills, Palm Beach County Fire Inspection, Fire equipment inspection, Department of Health Inspections, activity and program schedule.
Describe any Observations: Tour of facility, postings, inspection of agency vehicle, chemical storage.

Facility Inspection: a. Furnishings are in good repair. b. The program is free of insect infestation. c. Bathrooms and shower areas are clean and functional, free of foul odors, leaks, dust, and mildew and in good working order. d. There is no graffiti on walls, doors, or windows. e. Lighting is adequate for tasks performed there. f. Exterior areas are free of debris; grounds are free of hazards. g. Dumpster and garbage can(s) are covered. h. All doors are secure, in and out access is limited to staff members and key control is in compliance. i. Detailed map and egress plans of the facility, general client rules, grievance forms, abuse hotline information, DJJ Incident Reporting Number and other related notices are posted. j. Interior areas (bedrooms, bathrooms, common areas) do not contain contraband and are free from hazardous unauthorized metal/foreign objects.	**Compliance**	A tour of the program's interior and exterior areas was completed with the Residential Director. The program's one vehicle was also inspected during the tour as well. Furnishing was in good condition in the common area, bedrooms, and bathroom areas. The program was observed to be free of insect infestation. The bathrooms and shower areas were clean and free of foul odors. There was one bathroom shower that was observed not being utilized due to cracked shower floor in the male bathroom. The program was free of graffiti on walls, doors, and windows. The exterior grounds were free of hazards and free of debris. The program had old furniture in an outside area awaiting trash pickup. The program dumpster was closed and covered upon inspection. All facility doors were secure, in and out access was limited to staff members, and facility keys were locked in a locked box. If a visitor does come into the facility, a doorbell must be rung, and staff will allow visitors in the building. The program posted an egress plan near the front door, two in the male hall, two in the girl's hall, and near the administrative offices. Agency also posted general client rules, abuse hotline information and DJJ incident reporting number in the common area and bedrooms as well as gender/sexual orientation diversity material throughout the facility. The lighting in the program was operational and adequate for the daily functions in the shelter. The program had one van which included a fire extinguisher, seat belt cutter, knife for life, and window breaker.	
Facility Inspection: a. All agency and staff vehicles are locked. b. Agency vehicles are equipped with major safety equipment including first aid kit, (all items in the first aid kit are current and do not have expired items; all expired items should be replaced regularly), fire extinguisher, flashlight, glass breaker and, seat belt cutter.	**Compliance**	During tour of exterior of the facility, all staff vehicles were locked. The program has one van which included a fire extinguisher, seat belt cutter, knife for life, and window breaker. Agency first aid kit bags were equipped with major safety materials and were up to date.	

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**	During the tour, chemical inventory was observed in a locked cabinet. The program maintains the cleaning supplies in stock log weekly that consists of dates, quantity, and number of items purchased. Program also maintains a binder with MSDS sheets for chemicals used which includes name of product, SDS number of products, and recommended use, manufacturer, importer, supplier, telephone emergency numbers, hazards identification information, information on ingredients first aid measures, etc. Program does not maintain a perpetual inventory which indicates when chemicals are being used and by staff signing and out.	Chemical Inventory is conducted weekly but staff is not maintaining a perpetual inventory of chemicals used on a regular basis.
Facility Inspection: Washer/dryer are operational & general area/lint collectors are clean. Agency has a current DCF Child Care License which is displayed in the facility. Each youth has own individual bed with clean covered mattress, pillow, sufficient linens and blanket. Youth have a safe, lockable place to keep personal belongings, if requested.	**Compliance**	The dormitory has a laundry room equipped with one washer and dryer. The machines were clean and dryer was free of lint. The agency received relicensing of its Child Caring License on February 28, 2024 and license is effective until February 27, 2025. The female and male bedrooms had adequate and clean bedding which were newly donated. Each bed contained sufficient linens and a pillow. During the tour it was observed that youth photos are taken to be placed on box to keep personal items locked in laundry room. According to residential manager, valuable items are kept in a safe located in the pantry area.	
Additional Facility Inspection Narrative (if applicable)			

Fire and Safety Health Hazards: a. Annual facility fire inspection was conducted, and the facility is in compliance with local fire marshal and fire safety code within jurisdiction. b. Agency completes a minimum of 1 fire drill on each shift monthly (within 2 minutes or less). c. Completes 1 mock emergency drill per shift per quarter. d. All annual fire safety equipment inspections are valid and up to date (extinguishers, sprinklers, alarm system and kitchen overhead hood, including fire extinguishers in all vehicles).	**Exception**	All fire and safety inspections were up to date and current during review. The annual inspection was completed by St. Lucie County Fire District Marshall's office on February 29, 2024. Fire safety inspections were conducted October 2023 by Pye Barker on each fire extinguisher for an annual inspection and all fire extinguishers are valid for one year from the inspection date. The agency's fire alarm system was inspected by Pye Barker fire and safety and it received a passed inspection on 2/14/2024. Agency also had the restaurant system semiannual inspection completed on 12/13/2023 and passed inspection. Fire extinguishers are located in the girl' and boy's hallways, kitchen, den hall, administrative office area, and van. The facility is not required to have a sprinkler system in the kitchen. Monthly fire drills were conducted on each shift with evacuation time less than two minutes between November 2023 through May 1, 2024. During the same period, the program conducted mock episodic and emergency drills quarterly except for the first and third shift missing some drills.	Episodic/emergency drills were missing quarterly during the past six months for the 1st and 3rd shift. There was one drill that was missed for the first shift and two missing drills for the third shift quarterly.
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 had a current satisfactory food service inspection report from the Department of Health on February 6, 2024, and food menus were posted in the kitchen and are current. Menus are signed by a licensed dietician annually. Agency has cold food stored in refrigerator/ freezer and in pantry but none were labeled with dates. QI reviewer interviewed Department of Health Inspector who states is it not required in this county for food is labeled before it is utilized, but it has to be labeled with dates once it has been opened. Agency does have label in freezer items sections in areas of pork/seafood, chicken, and beef. The residential manager reports agency does label food and date food once it opened. Refrigerator/freezer were clean and maintained at required temperature - fridge temperature: 37F and freezer temperature: 11F. All appliances were operable and clean.	
Additional Fire and Safety Health Hazards Narrative (if applicable)			

Youth Engagement			
a. Youth are engaged in meaningful, structured activities (e.g., education, recreation, counseling services, life and social skill training) seven days a week during awake hours. Idle time is minimal. b. At least one hour of physical activity is provided daily. c. Youth are provided the opportunity to participate in a variety of faith-based activities. Non-punitive structured activities are offered to youth who do not choose to participate in faith-based activities. d. Daily programming includes opportunities for youth to complete homework and access a variety of age appropriate, program approved books for reading. Youth are allowed quiet time to read. e. Daily programming schedule is publicly posted and accessible to both staff and youth.	**Compliance**	During the review staff was observed being engaged in meaningful structured activities with youth who were out of school. The program has a monthly recreational schedule and a daily program schedule. According to staff and residential manager, youth are provided a client handbook with all daily activities weekdays (Mon-Fri) and holiday/weekend. Daily schedules and recreational weekly activities are posted in the common area, kitchen and staff area. Youth participate in outside physical activities daily if the weather permits. Youth have homework time, computer time, reading time, letter writing time, and journal time on the schedule between 3pm to 5pm. Youth also have counseling sessions scheduled weekly at a minimum and group sessions five times a week. During the interview with the residential manager, the program has weekly opportunities for youth to participate in faith-based activities. The program has faith-based organization/church onsite each Tuesday to conduct a group. Youth have an option to attend based on their preference or spiritual beliefs. Youth who do not participate in faith-based groups may participate in other structured activities.	
Additional Comments: **There are no additional comments for this indicator.**			
3.02 - Program Orientation			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 3.02		**YES** If NO, explain here: The program has the required policy and procedures CHS/7302 Program Orientation, approved 4/29/2024 by the DOHP.	
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 open residential files **Total number of Closed Files: 3 closed residential files** **Staff Position(s) Interviewed** *(No Staff Names)* **: Residential Manager, Shift Leader** **Type of Documentation(s) Reviewed: Intake Forms in five youth files**			
Youth received a comprehensive orientation and handbook provided within 24 hours	**Compliance**	All five residential files reviewed included an orientation checklist showing orientation was completed on the intake date. Youth all signed an acknowledgement of receipt of the resident handbook.	

Orientation includes the following: a. Youth is given a list of contraband items b. Disciplinary action is explained c. Dress code explained d. Review of access to medical and mental health services e. Procedures for visitation, mail and telephone f. Grievance procedure g. Disaster preparedness instructions h. Physical layout of the facility i. Sleeping room assignment and introductions j. Suicide prevention- alerting staff of feelings or awareness of others having suicidal thoughts	**Compliance**	In the five files reviewed, the orientation process for shelter services consisted of a completion of the checklist which list the orientation information each client was informed about during the intake. Staff and client initialed acknowledging that that youth was given a list of contraband items which are not allowed in program, disciplinary action is explained, dress code explained, review of access to medical and mental health services, procedures for visitation, information regarding mail and telephone usage, grievance procedure, tour of facility, bed assignment, and disaster preparedness instructions.	
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**	All components of the orientation included on the orientation checklist reviewed in all five files were initialed by the youth and staff.	
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 program has the required policy and procedures CHS/7303 Youth Room Assignment - Classification, that was approved 4/29/2024 by the DOHP.	

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 open residential files
Total number of Closed Files: 3 closed residential files
Staff Position(s) Interviewed *(No Staff Names)* **: Residential Manager, Shift Leader**
Type of Documentation(s) Reviewed: Intake forms in five youth files

A process is in place that includes an initial classification of the youths, to include:			
a. Review of available information about the youth's history, status and exposure to trauma b. Initial collateral contacts, c. Initial interactions with and observations or the youth d. Separation of younger youth from older youth, e. Separation of violent youth from non-violent youth f. Identification of youth susceptible to victimization g. Presence of medical, mental or physical disabilities h. Suicide risk i. Sexual aggression and predatory behavior j. Acute health symptoms requiring quarantine or isolation	**Compliance**	The youth room assignment was written on the CINS/FINS intake screening form that includes information gathered during the intake process to determine room assignment. The program takes into consideration the demographic information of a youth such as the age, trauma experiences, general alerts, triggers of a youth, and if a youth is susceptible to being victimized.	
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 has a general alert form completed at intake which lists youth special needs and risks such as risk of suicide, mental health, substance abuse, physical health or security risk factors. The program also has a census board which consists of the youth's name, age, room, case status, intake date, alerts, medication times and follow ups, and allergies restrictions.	
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 program has the required policy and procedures CHS/7304 Logbooks - Electronic Logbook, approved 4/29/2024 by the DOHP.	
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: Log book was reviewed during the period of 11/1/2023 to 4/30/2024 **Staff Position(s) Interviewed** *(No Staff Names)* **: Residential Manager** **Type of Documentation(s) Reviewed: Observed two randomly selected consecutive weeks four of the past six months** **Describe any Observations: Program uses manual logbook**			
Log book entries that could impact the security and safety of the youth and/or program are highlighted	**Compliance**	Logbook entries reviewed highlighted critical incidents and important issues which could impact security and safety of the youth and/or program.	

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**	Staff entries were brief and legibly written in ink and included date and time of incident, event or activity, names of youth and staff involved, brief statement providing pertinent information, and name/signature of person making entries in the logbook.	
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**	No observations were made of any white-out being used in the log book review. Errors were observed to be struck through with staff initials.	
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**	During observation of the log book for the following periods supervisory reviews of the logbook were conducted as follows: November 1-14: reviews were completed on 11/6/23, 11/8/2023, and 11/15/2023; December 1-14: reviews were completed on 12/1/2023 and 12/8/2023; January 1-14: reviews were completed weekly on 1/5/2024 where supervisor encourage staff to write legible and 1/12/2024 - no issues noted; February 2024: supervisor completed log book reviews on 2/2/2024 and encouraged staff continue the great work and on 2/20/2024, encouraged staff to highlight important information.	
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**	In observation of log book for oncoming staff, it was observed November 2023 to April 2024, shelter staff reviewed log books and wrote review of two previous shifts. Staff also are logging head counts, stating keys are placed in locked box, overall impressions on shift, signing in and out, house meetings and indicating when critical incidents happen with highlights. Program staff also uses codes when documenting in log book, i.e., SI-means sign in, SO-means sign out, K-means Keys, PC-means phone call, etc.	
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**	In observation of the logbook, at the beginning of the shift, oncoming supervisor reviewed logbook of all shift and enters dates and signatures in the log; however, no reviews of the logbook were documented by the shelter counselor.	During review of the log book, there was no logbook review documented, indicating the shelter counselor reviews the logbook at the beginning of each shift.
Logbook entries include: a. Supervision and resident counts b. Visitation and home visits	**Compliance**	It was observed logbook entries included supervision and resident counts as well as visitation and home visits.	
Additional Comments: **There are no additional comments for this indicator.**			

3.05 - Behavior Management Strategies			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 3.05		**YES** If NO, explain here: The provider has the required policy and procedures CHS/7305-Behavior Management Strategies/Interventions that was approved 4/29/2024 by the DOHP.	
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)* **: Group Living Manager** **Type of Documentation(s) Reviewed: Training log, youth handbook**			
The program has a detailed written description of the BMS and it is explained during program orientation	**Compliance**	The agency provides the resident handbook to youth upon admission which describes the Behavior Management Plan. This system is also reviewed during the orientation process, and the youth initials, to confirm that it was reviewed, and signs off on their understanding of the behavior system.	
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**	BMS is a daily point system and rewards program that is designed to teach and correct, not punish. Points range from 0-80 points and youth can also earn bonus points daily. The BMS captures each youth's daily behavior and each youth will have a Service Plan Goal Conference to review daily behavior. A variety of positive incentives are used including "cash in" points at the Point Store which could be candy, snacks, personal items, or toys. The BMS protocol appears to promote safety, fairness, intent to encourage positive reinforcement and behavior modification with privileges/incentives and consequences. Each youth's daily target skills sheet is provided to their counselor to address any behavior. Disciplinary actions do not deny the youth of any of their basic rights.	
Program's use of the BMS			

All staff are trained in the theory and practice of administering BMS rewards and consequences	**Compliance**	All staff are trained on BMS as part of the pre-service training and refreshers are provided to staff regularly.	
There is a protocol for providing feedback and evaluation of staff regarding their use of BMS rewards and consequences	**Compliance**	Staff are trained in the use of BMS and are monitored by the Group Living Manager who provides feedback and evaluation individually regarding the use of BMS rewards and consequences.	
Supervisors are trained to monitor the use of rewards and consequences by their staff	**Compliance**	Training documentation showed all supervisory staff are trained in the BMS to monitor the use of rewards and consequences by their staff.	
Additional Comments: **There are no additional comments for this indicator.**			
3.06 - Staffing and Youth Supervision			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 3.06		**YES** If NO, explain here: The program has the required policy and procedures CHS/7306 Staffing and Youth Supervision, approved on 4/29/2024 by the DOHP.	
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: Logbook and staff schedules for the period November 2023-April 2024; Video Surveillance dates/times: April 12th 12am-2am; April 17th 2am-4am; April 21st 4am-6am; April 27th 1am-3am; May 6th, 3am-5am. **Staff Position(s) Interviewed** *(No Staff Names)* **: Shift Leader and Residential Manager** **Type of Documentation(s) Reviewed: Staff Schedules and Logbooks** **Observation: Video surveillance system**			
The program maintains minimum staffing ratios as required by Florida Administrative Code and contract. • 1 staff to 6 youth during awake hours and community activities • 1 staff to 12 youth during the sleep period	**Compliance**	A review of staff schedules, logbook entries, and observation of staff present during the review indicated the program maintains the required staffing ratios of one staff to six youth during awake time and during sleeping hours, at least one staff to 12 youth.	
All shifts must always provide a minimum of two direct care staff present that have met the minimum training requirements	**Compliance**	Staff schedules for November 2023 - April 2024 showed at least two staff on all shifts. The program census holds up to twelve (12) youth and there was always two staff on schedule. All staff met the minimum training requirements to work on schedule with youth.	

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**	Background screening and training records for four new and four in-service staff demonstrate staff included on the staff schedule are trained and background screened to work on schedule with youth.	
The staff schedule is provided to staff or posted in a place visible to staff	**Compliance**	The program manager develops a staff schedule on a two week basis and the schedule is posted in the staff's office.	
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**	During interview with the residential manager and shift leader, it was reported the program has an On-call/Staff phone list in case coverage is needed.	
Staff observe youth at least every 15 minutes while they are in their sleeping room, either during the sleep period or at other times, such as during illness or room restriction	**Compliance**	During the review of camera surveillance on bed checks, it was observed staff completed bed checks every 10 minutes for the following timeframes: April 12th, 12am-2am; April 17th, 2am - 4am; April 21st, 4am-6am; April 27th, 1am-3am; and May 6th, 3am-5am.	

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

3.07 - Video Surveillance System		**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 3.07	**YES**	
	If NO, explain here:	
	The program has the required policy and procedures CHS/7307 Video Surveillance System, approved on 4/29/2024 by the DOHP.	

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: Logbook and staff schedules for the period November 2023-April 2024; Video Surveillance dates/times: April 12th 12am-2am; April 17th 2am-4am; April 21st 4am-6am; April 27th 1am-3am; May 6th, 3am-5am.
Staff Position(s) Interviewed *(No Staff Names)* **: Residential Manager**
Type of Documentation(s) Reviewed: Logbook
Observation: Program Surveillance Camera system

Surveillance System			
The agency, at a minimum, shall demonstrate: a. A written notice that is conspicuously posted on the premises for the purpose of security b. System can capture and retain video photographic images which must be stored for a minimum of 30 days c. System can record date, time, and location; maintain resolution that enables facial recognition d. Back-up capabilities consist of cameras' ability to operate during a power outage e. Have cameras placed in interior (e.g. intake office, counseling office, cafeteria, day room) and exterior (e.g. entrance/exit, recreation area, parking lot) general locations of the shelter where youth and staff congregate and where visitors enter and exit; to include locations where youth searches are conducted. Cameras are never placed in bathrooms or sleeping quarters. f. All cameras are visible	**Compliance**	It was observed during the tour of facility, that the program has a posting near each camera stating " Smile you are on camera". Cameras are present in the interior areas of the facility such as intake office, youth common area, counseling office, kitchen area, and mainly in the areas where youth and staff congregate and where visitors enter and exits. Program also has cameras on the exterior areas of the parking lot and on the sides of the facility. The program has three cameras that views the back yard area which consists of the basketball court and large recreational area. Program staff conducts youth searches in the lobby area in camera view once youth enters the facility. The program cameras are visible throughout the facility and no cameras are placed in bathrooms or bedrooms. The camera system can record date, time, location and maintain resolution that enables facial recognition. It also captures and retains video feeds for a minimum of 30 days. Per the residential supervisor, the system has back-up capabilities in the event of power outage.	
A list of designated personnel who can access the video surveillance system is maintained (includes off-site capability per personnel)?	**Compliance**	The Residential Manager maintains a list of designated personnel who can access the video surveillance system which includes the Senior Vice President, the Program Director, and the Residential Manager.	
Supervisory review of video is conducted a minimum of once every 14 days and timeframes reviewed are noted in the logbook.	**Compliance**	Supervisory reviews of the cameras were observed to be completed as required during the periods selected between November 2023 through February 2024. Logbook documentation supported camera reviews as follows: November 1-14, supervisory review of cameras was completed on 11/8/23 and 11/15/2023; December 1-14, supervisory review of cameras was completed on 12/1/2023 and 12/8/2023; January 1, 2024, supervisory review of cameras was completed weekly on 1/5/2024 and 1/12/2024; and in the month of February 2024, supervisor completed camera reviews on 2/2/2024 and 2/14/2024.	
The reviews assess the activities of the facility and include a review of random sample of overnight shifts	**Compliance**	Supervisory camera reviews documented in the logbook consisted of review times during activities of the facility and a random sample of overnight 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 a process to allow access to footage of surveillance video for third party review by downloading on a USB and sending video file link to a drop box for third party requests.	
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 program reported instances where surveillance services were malfunctioning and in need of repairs. Emails with repair request being made to have camera serviced were observed for the following dates: 11/18/2023, 3/11/2024, and 3/27/24 with efforts made to complete repairs promptly.	
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 program has the required policy and procedures CHS/7401 Healthcare Admission Screening, approved on 4/29/2024 by the DOHP.	
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 open residential files **Total number of Closed Files: 3 closed residential files** **Staff Position(s) Interviewed** *(No Staff Names)* **: Residential Shift Lead** **Type of Documentation(s) Reviewed: A total of five youth records were reviewed, healthcare screening.**			
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**	Reviewed documentation validated each of the five reviewed youth had a healthcare screening completed on the youth's date of admission. The screening included screening for current medications, existing acute and/or chronic medical conditions, allergies, recent injuries and/or illnesses, the presence of pain or any other physical distress, as well as noted observations of illness, injury, pain, physical distress, movement difficulty, scars, tattoos, and any other skin markings, as well as whether any acute health symptoms required quarantine or isolation.	
Referral and Follow-Up			

Youth with chronic medical conditions have a referral to ensure medical care (e.g. diabetes, pregnancy, seizure disorder, cardiac disorders, asthma, tuberculosis, hemophilia, head injuries, etc.)	**No eligible items for review**	A referral for medical care is required for any youth with a chronic medical condition including diabetes, current pregnancy, seizure or cardiac disorders, asthma, tuberculosis, hemophilia, or any head injury in the preceding two weeks. Reviewed documentation indicated none of the reviewed records were applicable for a youth with a chronic conditions.	
When needed, the parent is involved with the coordination and scheduling of follow-up medical appointments	**No eligible items for review**	If any chronic conditions are identified that indicate a need for medical follow-up, staff will document discussion of this need with the parent/ guardian in the medical section of the youth's file. Youth will be transported by parent/ guardian to any scheduled medical appointments.	
All medical referrals are documented on a daily log.	**No eligible items for review**	None of the reviewed records were applicable for a youth with a medical referral.	
The program has a thorough referral process and a mechanism for necessary follow-up medical care as required and/or needed	**Compliance**	The program maintains a policy, procedure and process for referring youth for follow-up medical care as required. If a youth has not been treated for a condition, the intake staff will follow-up with the parent/ guardian, to have the parent schedule a medical examination as soon as possible and document communication. If needed, parent will be provided with a list of area medical facilities that provide care, taking into consideration the medical insurance information attained during intake.	
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 program has the required policy and procedures CHS/7402 Identification of Suicide Risk in Shelter Prevention, approved on 4/29/2024 by the DOHP.	
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 open residential files **Total number of Closed (Residential & Community) Files:2 closed residential files** **Staff Position(s) Interviewed** *(No Staff Names)* **: Residential Shift Lead, Residential Shelter Program Manager** **Type of Documentation(s) Reviewed:. Four residential youth records, Suicide screening results, Suicide Risk Assessment, Observation Logs**			
Suicide Risk Screening and Approval (*Residential and Community Counseling*)			

Suicide risk screening occurred during the initial intake and screening process. Suicide screening results reviewed and signed by the supervisor and documented in the youth's case file.	**Exception**	Four residential youth records were reviewed, and documentation in each indicated a suicide risk screening was conducted during the initial intake and screening. There were no applicable community counseling youth which required an assessment of suicide risk during the annual review period. Suicide screening results are to be reviewed and signed by the supervisor and documented in each youth's case record. Three of four reviewed records included a supervisor's signature showing the screening results were reviewed by the supervisor.	Three of four reviewed records included a supervisor's signature showing the screening results were reviewed by the supervisor. However, one reviewed record did not include the supervisor's signature indicating the assessment had been reviewed.
The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	**Compliance**	Documentation verified the program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services.	
Supervision of Youth with Suicide Risk *(Shelter Only)*			
Youth are placed on the appropriate level of supervision based on the results of the suicide risk assessment.	**Compliance**	Three of the four reviewed records demonstrated youth were placed on sight-and-sound supervision until the youth were assessed by a licensed professional or a non-licensed professional under the supervision of a licensed professional. One youth did not have a suicide risk requiring the youth to be placed on sight-and sound supervision.	
Staff person assigned to monitor youth maintained one-to-one supervision or constant supervision and documented his/her observations of the youth's behavior at 30 minute or less intervals	**Compliance**	All three applicable youth were placed on an appropriate level of supervision based upon the results of the suicide risk assessment, and each documented the direct care staff assigned to monitor the youth documented the youth's behavior in thirty minutes intervals.	
Documentation includes the time of day, behavioral observations, any warning signs observed, and the observers' initials and was maintained in either an observation log or in the shelter daily log.	**Compliance**	Documentation also included the time of day, behavioral observations, any warning signs observed, and the observers' initials.	
Supervision level was not changed/reduced until a licensed professional or a non-licensed mental health professional under the supervision of a licensed professional completed a further assessment OR Baker Act by local law enforcement	**Compliance**	Three applicable youth records documented the supervision level was not changed until a licensed professional or a non-licensed mental health professional under the supervision of a licensed professional completed a further assessment.	
There was evidence that documentation was reviewed by supervisory staff each shift. If program uses an observation log, completed logs are maintained in the youth's file.	**Compliance**	Three reviewed youth observation logs included documentation that supervisory staff reviewed the logs. The observation logs were completed and maintained in the youth's record.	
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**	There were no applicable community counseling youth which required an assessment of suicide risk during the annual review period.	
During the intake, if the appropriate staff is unavailable, youth identified for suicide risk was immediately referred by the provider and the parent/guardian is notified of the suicide risk findings disclosed and advised that an Assessment of Suicide Risk should be completed ASAP by a licensed professional.	**No eligible items for review**		
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 program has the required policy and procedures CHS/7403 Medications, approved on 4/29/2024 by the DOHP.	

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 open residential file
Total number of Closed Files:2 closed residential files
Staff Position(s) Interviewed *(No Staff Names)* **: Residential Shift Lead, Residential Shelter Program Manager, Residential Supervisor**
Type of Documentation(s) Reviewed three residential youth records, monthly staff meeting agendas, Medication Distribution Log, alerts, medication errors, training records, Medical and Mental Health Assessment screening
Describe any Observations: Observations and an informal interview with the Residential Shift Lead validated the program stores medications in the Pyxis Med-Station Medication Cabinet. Secured refrigerator used to store medications requiring refrigeration. Medication in separate cubby spaces. Pyxis keys in secured safe.

The agency has a Registered Nurse (RN) and/or a Licensed Practical Nurse (LPN) that is being supervised by RN and all of their credentials have been verified.	**No eligible items for review**	The registered nurse (RN) retired from the program in December 2023; program is in the process of hiring a new RN. An offer was made to a potential candidate; however, the offer was declined.	
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**	Since departure in December 2023, a RN is not on-site to conduct in-person medication training certifications, demonstrate competency, or maintain annual re-certifications. Untrained staff are not approved to distribute medication to youth. The residential manager indicated the Florida Network was contacted to arrange for annual medication re-certification training in the interim.	
The agency held at least quarterly staff meetings conducted by RN and/or Shelter Manager to review and assess: a. strategies implemented to reduce medication errors shelter wide b. analyze factors that contributed to medication errors c. allow staff the opportunity to practice and role-play solutions	**Compliance**	A review of monthly staff meeting agendas for the last six months verified starting administration staff reviewed medication practice and strategies including the Pyxis med-station usage, medication management, and medication refills.	
The agency has strategies implemented to ensure medications are provided within the 2-hour time frame.	**Compliance**	The provider has strategies in place to ensure medications are provided within the two-hour time frame by setting medication alarm clocks to remind staff to distribute medication.	
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 approved Pyxis med-station users were clearly identified and designated on the staff schedule.	
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**	Documentation and an informal interview with the Residential Shift Lead verified there is a clear method of communicating which youth are on medication with the times and dosage easily discernable by all staff on each shift. Communication of medication is provided by an alert board in the mail room, an alert board in the room where the Pyxis med-station is located, and in the youth's record.	

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 program has a delivery process of medications which is consistent with the FNYFS Medication Management and Distribution Policy. The program has an internal quality assurance process which ensures the appropriate medication management, and distribution methods are in place, and tracks medication errors. The Pyxis Med-Station alerts staff to discrepancies with red error messages on the screen and the user must enter correct counts before the Med-Station will allow access to the medications. In addition, the program's system is able to identify systemic issues and implement migration strategies, as needed. Any medication discrepancies are to be cleared after each shift. Reviewed documentation indicated there were two instances of medication errors reported during the annual review period. Documentation verified one staff which committed the medication error was retrained by the RN, and the other staff was removed from administrating medications until a retraining can be conducted. There were no staff members who were responsible for three medication errors within a one-year time frame.	
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**	Three reviewed youth records verified upon admission, the youth and parent/guardian were interviewed about the youth's current medications as part of the Medical and Mental Health Assessment screening and were reviewed by administration staff 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**	Observations and an informal interview with the Residential Shift Lead validated the program stores medications in the Pyxis Med-Station Medication Cabinet. The Pyxis machine is stored in the locked office which is inaccessible to youth and in accordance with Florida Statute 499.0121. Narcotics and controlled medication are stored in the locked Med-Station. Counts are conducted and documented as required. Oral medications are stored separately from injectable or topical medications within the Pyxis machine. The provider has a secured refrigerator with a temperature range between 36-46 degrees Fahrenheit used to store medications requiring refrigeration. At the time of the annual review, the provider did not have any medication requiring refrigeration. In the event the Pyxis machine will not open to access a medication, the provider will contact the manufacturer to reset the Pyxis. If the reset does not work, the provider has special keys stored in a secured safe which open the top cover, and the back panel to access the medication.	
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 provider has a minimum of two trained Super Users of the Pyxis Med-Station. Reviewed documentation and an informal interview with the Residential Shift Lead verified only designated staff have user permissions to access the secured medications and limited access to controlled substances. A review of Medication Distribution Logs verified they are used for distribution of medication by non-licensed and licensed staff. The provider verifies medication using one of three methods listed in the FNYFS Policies & Procedures Manual. In cases when nurse is on duty the 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. At the time of the review, the provider did not have a Registered Nurse on-site. The provider does not accept youth currently prescribed injectable medications, except for epi-pens. A review of eight non-licensed staff training records verified they have received training in the use of epinephrine auto-injectors provided by a registered nurse.	

The medication distribution log documentation includes: a. the time of medication administration b. evidence of youth initials that the dosage was given c. evidence of staff initials that the dosage was given	**Compliance**	A review of one open record and two closed records of youth receiving medication was conducted. Documentation verified a Medication Distribution Log was used for the distribution of medication by non-licensed and licensed staff for all three reviewed youth. Documentation included the time of administration on the Medication Distribution Log, youth and staff initials, and the dosage given.	
There is evidence that staff provide youth with medications within one hour of the scheduled time of delivery as ordered by the medication. Documentation is provided for instances this does not occur within the required timeframe.	**Compliance**	A review of three youth records verified staff assisted youth with medications within one hour of the scheduled time of delivery.	
During the review period, there were no instances where youth missed their medication due to failure to open the pyxis machine.	**Compliance**	During the review period, there were no instances where youth missed their medication due to failure to open the pyxis machine.	
If applicable: Any staff member deemed responsible for a medication error, there was evidence that the staff member received refresher training from an RN and demonstrated competency prior to being assigned future medication administration responsibilities. There is evidence that any staff member deemed responsible for 3 errors within a 1-year time frame, had their certification suspended and was not recertified until the completion of the full **in-person** medication administration training, demonstrating competency and re-certification from an RN.	**Compliance**	Reviewed documentation indicated there were two instances of medication errors reported during the annual review period. Documentation verified one staff which committed the medication error was retrained by the RN, and the other staff was removed from administrating medications until a retraining can be conducted. There were no staff members who were responsible for three medication 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**	Narcotics and controlled medication are stored in the locked Med-Station. Counts are conducted and documented as required. Perpetual inventories with running balances are maintained for all controlled substances. The program maintains a list of designated staff who have access to the secured medication. Shift-to-shift counts are conducted and documented for controlled substances. Non-controlled medication and over-the-counter medications which are accessed regularly are inventoried weekly. The provider does not have syringes and sharps on-site.	

There are monthly reviews of the Pyxis reports to monitor medication management practice.	**Compliance**	The provider conducts monthly reviews of the Pyxis Reports to monitor medication management practices.	
Medication discrepancies are cleared after each shift.	**Compliance**	Any discrepancies found with the Pyxis Med-Station are cleared each shift prior to giving medications. Instructions for clearing/ printing discrepancies are posted for reference. Staff will print discrepancies, sign, and place in a binder. Staff also print the Patient Order Report from the Pyxis Med-Station when assigned medication prior to giving medication for the shift. Staff sign the report and place it in the binder.	
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 program has the required policy and procedures CHS/7404 Medical, Mental Health Alert Process, approved on 4/29/2024 by the DOHP.	
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 open residential files **Total number of Closed Files:3 closed residential files** **Staff Position(s) Interviewed** *(No Staff Names)* **: Residential Shift Lead, Residential Shelter Program Manager, Residential Supervisor** **Type of Documentation(s) Reviewed: provider's alert system** **Describe any Observations: Observations and an informal interview with the Residential Shift Lead verified the provider has a food allergy alert board in the kitchen, a mental health/medical alert board in the mail room, a medication alert board where the Pyxis med-station is located, on the General Alert form located in the youth's record, and in the logbooks.**			
Youth with a medical, mental health, or food allergy was appropriately placed on the program's alert system	**Compliance**	A review of two open and three closed files for medical, mental health, or food allergies was conducted. Each of the reviewed records verified the youth were placed on the provider's alert system. The alert system included precautions concerning prescribed medications, medical, and mental health conditions.	
Alert system includes precautions concerning prescribed medications, medical/mental health conditions	**Compliance**	Alert system includes precautions concerning prescribed medications, medical/mental health conditions.	

Staff are provided sufficient training, information and instructions to recognize/respond to the need for emergency care for medical/mental health problems	**Compliance**	A review of eight staff training records verified staff are provided sufficient training, information and instructions to recognize/respond to the need for emergency care for medical/mental health problems.	
A medical and mental health alert system is in place that ensures information concerning a youth's medical condition, allergies, common side effects of prescribed medications, foods and medications that are contraindicated, or other pertinent mental health treatment information, is communicated to all staff	**Compliance**	The provider has a food allergy alert board in the kitchen, a mental health/medical alert board in the mail room, a medication alert board where the Pyxis med-station is located, on the General Alert form located in the youth's record, and in the logbooks.	
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 program has the required policy and procedures CHS/7405 Episodic Emergency Care, approved on 4/29/2024 by the DOHP.	
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 Closed Files: 2 closed residential files **Staff Position(s) Interviewed** *(No Staff Names)* **: Residential Shift Lead, Residential Shelter Program Manager, Residential Supervisor** **Type of Documentation(s) Reviewed: Two closed records for youth applicable for off-site emergency care were reviewed. Episodic/Emergency Care Log** **Describe any Observations: Observations verified the knife-for-life was located in a wall-mounted box in the mail room area, there was one first aid kit in the day room, and one first aid kit in the kitchen area. In addition, there were two first aid kits used during transportation.**			
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**	Two closed records for youth applicable for off-site emergency care were reviewed. Each reviewed record included an incident report in the youth records. Upon youth return back to the program, the youth record included a receipt of medical clearance, discharge instructions with any required follow-up. Both youth records included notification to the parent/guardian regarding the need for off-site emergency care. Staff are required to document all episodic and emergency care on the program's Episodic/Emergency Care Log to include the youth's name, date, destination, whether the parent/guardian was notified, whether the youth was transported by the parent/guardian or program staff, and whether the youth was returned to the program. One reviewed youth was transported for off-site care by the parent/guardian and one youth was transported by emergency medical services from the program.	
All staff are trained on emergency medical procedures	**Compliance**	A review of eight staff training records verified all were trained on emergency medical procedures.	
The program has a Knife-for-life and wire cutters accessible to staff in a secure location(s)	**Compliance**	Observations verified the knife-for-life was located in a wall-mounted box in the mail room area, there was one first aid kit in the day room, and one first aid kit in the kitchen area. In addition, there were two first aid kits used during transportation.	
Additional Comments: **There are no additional comments for this indicator.**			