Florida Network for Youth and Family Services
Compliance Monitoring Report for

Family Resources, Inc. - Manatee (Bradenton)

1001 9th Avenue West
Bradenton, FL 34205

May 15-16, 2024

Compliance Monitoring Services Provided by

EXECUTIVE SUMMARY

Forefront LLC conducted a Quality Improvement (QI) monitoring visit on behalf of the Florida Network of Youth and Family Services (FNYFS) for the Family Resources Manatee (Bradenton) for the FY 2023-2024 at its program office located at 1001 9th Avenue West, Bradenton, Florida. Forefront LLC (Forefront) is an independent compliance monitoring firm that is contracted by FNYFS to perform onsite program reviews to assess the agency's adherence to fiscal, programmatic and overall contract requirements. Family Resources Manatee (Bradenton) 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 Peer Reviewers Crystal Blair-Gallon, Pierre Bandoo, Citizen Fernandez, and Minnie Jackson. Agency representatives from Family Resources Manatee (Bradenton) present for the entrance interview were Andrew Coble, Chief Operating Officer; Kelli Yeazell, Director of Community Programs; Mackenzie Tomasik, Clinical Director; Lashawna Randall, Residential Supervisor; and Elizabeth Eichelberger, Intern. The last onsite QI visit was conducted December 14-15, 2022.

In general, the Reviewer found that Family Resources Manatee (Bradenton) is in compliance with specific contract requirements. Family Resources Manatee (Bradenton) **received an overall compliance rating of 100% for achieving full compliance with all 11 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 05-15-2023-2024

Agency Name: Family Resources Manatee (Bradenton)	**Monitor Name: Marcia Tavares, Lead Reviewer**
Contract Type : CINS/FINS	**Region/Office: 1001 9th Avenue West, Bradenton, FL 34205**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): May 15-16, 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 The agency has a total of five peer reviewers and all five have participated in a peer review for the current FY. However, the agency is short of meeting its requirement of two staff members per contract (6 total) and must ensure appropriate staff is trained.	**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 five additional contracts for FY 2023-2024 was provided by the provider including funding sources and contract term dates for the following agencies: Florida Department of Health, Health and Human Services, Manatee County, School District of Manatee County, and City of Bradenton.	**No recommendation or Corrective Action**
Limits of Coverage a. Provider shall provide and maintain during this contract, the following minimum kinds of insurance: Worker's	☐	☐	☐	☒	☐	Documentation General Liability through Alliance of Nonprofits for Insurance, for limits of	**No recommendation or Corrective Action**

2023-2024 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 05-15-2023-2024

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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:
Compensation and Employer's liability insurance as required by Chapter 440, F.S. with a minimum of $100,000 per accident, $100,000 per person and $500,000 policy aggregate. Commercial General Liability with a limit of $500,000 per occurrence, and $1,000,000 policy aggregate. Automobile Liability Insurance shall be required and shall provide bodily injury and property damage liability covering the operation of all vehicles used in conjunction with performance of this contract, with a minimum limit for bodily injury of $250,000 per person; with a minimum limit for bodily injury of $500,000 per accident; with a minimum limit for property damage of $100,000 per accident and with a minimum limit for medical payments or $5,000-$10,000 per person. Florida Network is listed as payee or co-payee. **PTV**						coverage $1,000,000 each $3,000,000 aggregate and medical payments for $20,000, effective 6/01/23-6/01/24. Auto Insurance through Alliance of Nonprofits for Insurance, with combined single limit coverage for $1,000,000, effective 6/01/23-6/01/24. Workers Compensation through Florida Insurance Trust, with limits of $2,000,000 for each incident and $2,000,000 policy limit, effective 6/01/23-6/01/24. Directors and Officers liability policy through Alliance of Nonprofits for Insurance, with limits of $1,000,000, per occurrence and $2,000,000 policy limit, effective 6/01/23-6/01/24. Umbrella Liability Insurance through Alliance of Nonprofits for Insurance, with limits of $4,000,000 each and aggregate, effective 6/01/23-6/01/24.	

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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:
						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 This item is not applicable due to the Chief Operating Officer reporting that there are no corrective action items cited by any external funders.	**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. Agency maintains a Fiscal Policies and Procedures Manual that is consistent with GAAP and provides for limited internal controls. Policies and procedures were last reviewed July 2020. Various policies were reviewed that cover the agency's budget process, capital assets, petty cash, required vendor information, cost allocation, bank reconciliation, general ledger, internal controls and purchasing.	**No recommendation or Corrective Action**

2023-2024 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
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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:
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: A review of the Family Resources Inc. General Ledger (GL) revealed it is structured to track all funding sources and there is a separate GL for the Bradenton program location.	**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**	☐	☐	☐	☐	☒	Interview: The agency does not use petty cash. The residential supervisor has an agency credit card for purchases. The policy states supervisors have a spending limit up to $500 on agency cards. Receipts for purchases are submitted to the accounting/finance department for reconciliation with the credit card statements. Credit card statements are paid monthly by the accounting/ finance department.	**No recommendation or Corrective Action**
d. Financial records and reports are current. Includes bank statements reconciled within 6 weeks of receipt. Vendor invoices past 6 months. Invoices are submitted on a monthly basis with supporting documentation.	☐	☐	☒	☐	☐	Documentation The agency provided bank statements for Truist Operation account and corresponding reconciliation reports completed within ten days of the close	**No recommendation or Corrective Action**

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(Disbursements/invoices are approved & monitored by management). **ON SITE**						of the statement. Checks are cut weekly to pay vendor invoices. Disbursements and invoices are reported to the CEO for signature monthly by the Director of Finance.	
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**	☐	☐	☐	☐	☒	Interview with the COO indicated there are no purchases requiring an Information Resources Request to DJJ and no purchases made with funds from the Florida Network of Youth and Family Services.	**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 Proof of biweekly payroll tax payments was reviewed for the most recent six months, from the agency's payroll company, Dominion Payroll, who processes payroll, submits payroll taxes, and issues W-2's.	**No recommendation or Corrective Action**

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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-February 29, 2024 for the CINS/FINS Program was reviewed. The provider has a monthly process for reviewing the budget at Board meetings 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 A Single Audit was completed for the period ending June 30, 2023 and 2022. The audit was completed by Assurance Dimensions, Certified Public Accountants and was dated October 26, 2023. Per the auditors, there was no management letter or deficiency control letter issued as there were no matters required to be reported in these letters.	**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: confidentiality – release of information; record retention; system monitoring; protection from viruses; system abuse; system back-up; and disaster preparedness.	**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 direct care staff was provided showing name of staff, position title, cost center, and pay rate. All direct care staff was observed to be paid at least $19 per hour.	**No recommendation or Corrective Action**

CONCLUSION

Family Resources Manatee (Bradenton) has met the requirements for the CINS/FINS contract as a result of full compliance with 11 applicable indicators of the Administrative and Fiscal Contract Monitoring Tool. Three of the 14 indicators were not applicable because: 1) the program does not have any corrective action items cited by an external funder, 2) petty cash is not used in the shelter program, and 3) no equipment was purchased with Florida Network funds requiring an Information Resources Request. Consequently, **the overall compliance rate for this contract monitoring visit is 100%.** There are no corrective actions cited or recommendations made 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 Family Resources, Inc. - Bradenton (Manatee Shelter)
CINS/FINS Program

May 15-16, 2024

Compliance Monitoring Services Provided by

FOREFRONT

CINS/FINS Rating Profile

Standard 1: Management Accountability

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

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

Standard 2: Intervention and Case Management

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

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

Standard 3: Shelter Care & Special Populations

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

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

Standard 4: Mental Health/Health Services

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

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

Overall Rating Summary

Percent of indicators rated Satisfactory: 96.43 %
Percent of indicators rated Limited: 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
Crystal Blair-Gallon– Regional Monitor, Department of Juvenile Justice
Pierre Bandoo – Crosswinds Youth Services
Citizen Fernandez – Lutheran Services Florida Miami Bridge
Minnie Jackson – Nehemiah Educational and Economic Development

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
X	Chief Operating Officer		Advocate		# Case Managers
	Executive Director	X	Direct – Care Full time	1	# Program Supervisors
X	Program Director		Direct – Part time		# Food Service Personnel
	Program Manager		Direct – Care On-Call		# Healthcare Staff
	Program Coordinator		Intern		# Maintenance Personnel
X	Clinical Director		Volunteer	1	# Other (listed Vice President Impact
	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
X	CCC Reports	X	Grievance Process/Records	5	# Health Records
X	Logbooks		Key Control Log	5	# MH/SA Records
	Continuity of Operation Plan	X	Fire Drill Log	9	# Personnel /Volunteer Records
X	Contract Monitoring Reports	X	Medical and Mental Health Alerts	9	# Training Records
	Contract Scope of Services	X	Precautionary Observation Logs	20	# Youth Records (Closed)
X	Egress Plans	X	Program Schedules	7	# 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	X	Staff Supervision of Youth
X	Program Activities	X	Tool Inventory and Storage	X	Facility and Grounds
	Recreation	X	Toxic Item Inventory & Storage	X	First Aid Kit(s)
	Searches		Discharge	X	Group
X	Security Video Tapes		Treatment Team Meetings	X	Meals
	Social Skill Modeling by Staff	X	Youth Movement and Counts	X	Signage that all youth welcome
	Medication Administration	X	Staff Interactions with Youth	X	Census Board

Surveys

5	# of Youth	6	# 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

Family Resources Inc. is sub-contracted with the Florida Network of Youth and Family Services (Florida Network) to provide temporary residential and non-residential services to youth and families through the Children In Need of Services/Families In Need of Services (CINS/FINS) program. The central office is located in Pinellas Park, Florida and CINS/FINS SafePlace2B has three shelters located in Clearwater, St. Petersburg, and Bradenton, Florida. Family Resources, Inc. Safe Place 2B (Bradenton - Manatee shelter) is located at 1001 9th Avenue West, Bradenton, Florida 34205.

Family Resources, Inc. serves both male and female youth between the ages of ten to seventeen years that are locked out, runaway, ungovernable and/or truant, homeless, abuse, neglected, or at-risk. The program is also contracted to provide services for Staff Secure Shelter and is a provider for youth referred through the Juvenile Justice Court System for domestic violence, probation respite, domestic minor sex trafficking, and Family/Youth Respite Aftercare Services (FYRAC). The Bradenton program is also contracted to provide Intensive Case Management (ICM) and SNAP Clinical Group services for youth 12-17 years of age.

The program is designated by the National Safe Place Program as a Safe Place provider who is responsible for building a network of safe place sites in the community to provide help and access to run away and homeless youth. The shelter holds a license from the Department of Children and Families, which is effective through May 31, 2024. The agency is currently accredited by the Council of Accreditation (COA) effective through December 31, 2024.

The following programmatic updates were provided by the agency:

Staffing

Shelter staff report directly to the Residential Supervisor, Lashawnna Randall, who has been in her role for the past eight months. Lashawnna reports directly to our COO, Andy Coble. The Community Counseling team is led by the Clinical Director, Mackenzie Tomasik, who joined the agency in September 2023. Mackenzie also reports directly to the COO, Andy Coble.

There are many new faces on the youth care team and the program reported close to being fully staffed as there were two candidates in the hiring process for both full time positions. There are three vacancies for part time roles on Friday -Saturday shifts.

Program updates

The program has fully transitioned to electronic client records through Lauris since the last audit. The community counseling program recently transitioned in April of 2024 and are in the testing phase before full implementation before the end of the FY.

Facility

The shelter facility received a new roof since the last review. The agency purchased a new building in summer 2023 and relocated its counseling office from the previous rental office.

Funding/Finance

The Manatee programs have not received any new funding. It's counseling program remains 100% funded by the Florida Network. The Manatee shelter currently receives basic center funding through 9/30/24.
The agency's Audit Management Letter was completed and received in October 2023 for our FY22-23 Financial Audit.

Governance and Community

Family Resources' Board Chair recently transitioned to Brock Ball. Since the last audit, the board has added four new members: Jennifer Gilray from Manatee County Schools, Brock Ball from the private business sector in Pinellas County, Christina Hurt from the Bank of Tampa, and Pat Gerard who is a former county commissioner of Pinellas County.

External Corrective Action Plans (CAP)

The Manatee shelter does not have any CAP with any other funding agencies.

Major Challenges

The program did not report any current major challenges.

Narrative Summary

Family Resources Inc. (Bradenton) is under the leadership of a CEO, a Chief Operating Officer, Vice President of Impact, and Finance Director. Other staff consist of a residential supervisor, director of client success and community services, a Clinical Director who oversees three community counselors, and the residential counselor and case manager. The residential component also includes several youth development specialists, administrative assistant, cook, and a vacant part-time nurse position. The shelter is in its inaugural year of transitioning to the Lauris electronic record system and still uses paper logbooks. All personnel functions are currently contracted to HR Puzzle. During the past year, the agency began using Smart Sheets, a cloud based, automated work management software that organizes agency data, projects, and systems across the organization on a single platform.

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

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

Standard 3: There are seven indicators for Standard 3.
Indicator 3.01 Shelter Environment was rated **Satisfactory with 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.**
Indicator 3.05 Behavior Management Strategies was rated **Satisfactory.**
Indicator 3.06 Staffing and Youth Supervision was rated **Limited.**
Indicator 3.07 Video Surveillance System was rated **Satisfactory.**

Standard 4: There are five indicators for Standard 4.
Indicator 4.01 Healthcare Admission Screening was rated **Satisfactory**.
Indicator 4.02 Suicide Prevention was rated **Satisfactory.**
Indicator 4.03 Medications was rated **Satisfactory.**
Indicator 4.04 Medical/Mental Health Alert Process was rated **Satisfactory**.
Indicator 4.05 Episodic/Emergency Care was rated **Satisfactory.**

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

Standard 1:
Indicator1.04 - Limited
One community counseling staff hired did not complete all pre-service training requirements prior to assignment of their first case. NetMIS information shows case assignment of 10/2/2023, prior to staff completing all required pre-service training.

One staff, date of hire (DOH) 10/2/2023, completed the DOJ Civil Rights training on 2/10/2024, exceeding the 30 days required timeframe.

One staff hired on 2/1/2023 did not complete Diversity, Fire Safety Equipment, and Adolescent Development within 90 days of hire. A second staff hired on 5/30/2023 did not complete 2-day Managing Aggressive Behavior (MAB) training and Diversity within 90 days of hire. A third staff hired on 10/30/2023 did not complete Diversity and Universal Precautions within 90 days of hire. The fourth staff hired on 10/2/2023 did not complete a total of 12 Training Topics (9 DJJ SkillPro and 3 other topics) within 90 days of hire.

One staff was late completing the annually required Florida Network Youth Suicide Prevention Training.

Standard 3:
Indicator3.06 - Limited
During the review period, the program did not always provide a minimum of two staff on shifts as follows: only one staff was on duty for 2nd shift on the following dates: 11/3, 11/4, 11/18, 11/19, 12/29, 12/17, 12/30, 1/20, 1/21, 1/28, 2/16, 2/18, 4/27. Only one staff was on duty for 3rd shift the following dates: 11/3, 11/4, 11/7, 11/10, 11/11, 11/17, 11/18, 11/24, 11/25, 12/1, 12/2, 12/8, 12/9, 12/15, 12/16, 12/22, 12/23, 12/29, 12/30, 1/3, 2/3, 2/17, 2/24, 3/2, 3/3, 3/16, 4/6, 4/12, 4/13, 4/19, 4/20, 4/26, 4/27.

On April 21st, between 2am-4am, staff conducted an improper check at 2:30am, 2:45am and 3:59am. Checks are documented within 15 minutes but staff did not open room to verify youth status. The finding was reported and accepted by Central Communications Center.

CINS/FINS QUALITY IMPROVEMENT TOOL

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

Standard One – Management Accountability

1.01: Background Screening of Employees, Contractors and Volunteers		Satisfactory with Exception
Provider has a written policy and procedure that meets the requirement for Indicator 1.01	**YES**	
	If NO, explain here:	
	The provider has the required policy and procedure, 1.01 Background Screening of Employees and Volunteers, that was approved by the Chief Operating Officer (COO) July 2023.	

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

Total number of New Hire Employee/Intern/Volunteer Files: 8 staff and 1 intern
Total number of 5 Year Re-screen Employee Files: No applicable re-screened staff for review period
Staff Position(s) Interviewed *(No Staff Names)*: **COO**
Type of Documentation(s) Reviewed: Staff roster, Department of Juvenile Justice Background Screening results, Berke Pre-Employment assessment tool, E-Verify, Annual Affidavit of Compliance with Level 2 Screening Standards

All positions providing direct services to youth has successfully passed pre-employment suitability assessment on the initial attempt.	**Compliance**	The program continues to use the Berke pre-employment assessment tool. The tool was administered prior to hiring eight new direct care staff who were hired during the review period. Six of the eight staff obtained passing scores of medium to high on the Berke; however, two staff received a low score.	
For any applicant that did not pass the initial suitability assessment, there was evidence that the applicant retook the assessment and passed within five (5) business days of the initial attempt, not exceeding three (3) attempts within thirty (30) days.	**Compliance**	Two of eight staff received a low score on the Berke Assessment. The two staff were hired prior to the effective date of this requirement and a letter was maintained for each staff showing the COO approved their hire based on further interview, as previously required.	
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 eight applicable new hires were initiated prior to hire/start dates with eligibility documented on the DJJ background screening results. There were no exemptions required. There was one intern utilized during the review period. The intern's eligible background screening was completed prior to volunteer service start date.	
Five-year re-screening is completed every 5 years from the date of the last screening or prior to retained fingerprints expiration date.	**No eligible items for review**	Per interview with COO, Family Resources Bradenton did not have any staff who met the requirement for background re-screening since the last onsite QI review. A review of the Clearinghouse Roster showed all staff have valid retained prints in the Clearinghouse.	
Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?	**Compliance**	The program emailed its Annual Affidavit of Compliance with Level 2 Screening Standards to the Background Screening Unit January 16, 2024 prior to the January 31st deadline. An email from DJJ on 1/17/24 confirmed receipt of the information.	
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 all eight new hires.	
Additional Comments: **There are no additional comments for this indicator.**			
1.02: Provision of an Abuse Free Environment			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 1.02	**YES** If NO, explain here: The provider has the required policy and procedure, 1.02 Provision of an Abuse Free Environment, that was approved by the COO July 2023.		
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Staff Position(s) Interviewed *(No Staff Names)* **: Residential Supervisor and Vice President of Impact** **Type of Documentation(s) Reviewed: Grievances, Grievance log, program logbook, youth and staff surveys, client handbook, Code of Conduct, abuse reports** **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 agency has a code of conduct that all staff sign at hire; prohibiting the use of physical abuse, profanity, and threats. Once signed by staff the code of conduct form is maintained in their personnel files.	

The agency has a process in place for reporting and documenting child abuse hotline calls.	**Compliance**	Postings of the Abuse Hotline Number were observed. The agency has a process in place for reporting and documenting abuse hotline calls. Once an abuse call is made, staff complete a form and document the filing of abuse, neglect or exploitation reports in the client file and document any action steps taken detailing time, date and person spoken with (Operator Number Identification). The call to the CCC is then documented in the logbook. A review of the logbook showed the agency reported three calls to the abuse hotline during the past six months. None of the abuse allegations were institutional.	
Youth were informed of the Abuse and Contact Number	**Compliance**	Per the Shelter Supervisor and Vice President of Impact, youth are informed of the abuse hotline during orientation. The abuse hotline number was observed posted on a wall in a very visible area to youth in the shelter.	
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**	During the shelter tour it was observed that the program has an accessible grievance box that is locked and located in the dayroom. The Shelter Supervisor has a key to the box, and it is checked daily.	
Shelter only: Grievances are maintained on file at minimum for 1 year.	**Compliance**	The Vice President of Impact maintains records of grievances in a file for a minimum of one year.	
Shelter only: There are formal grievance procedures for youth, including grievance forms, and a locked box which are easily accessible to youth in a common area.	**Compliance**	The agency's grievance box is locked and affixed to the wall, located in the day room next to the activity board and easily accessible to youth. Blank grievance forms are in a document tray located directly above the grievance box accessible to youth to complete and submit as needed.	
Shelter only: There is evidence that grievance boxes are checked by management or a designated supervisor at least daily as evidenced in the program logbook.	**Exception**	The current program logbook was reviewed to determine if the agency is consistently documenting the daily checks of the grievance box by management in the logbook. There was no indication by the agency that there was another method in which the program was documenting the grievance box checks at least five times per week, Monday-Friday, with the exception of holidays.	At the time of the review, there was evidence demonstrating that the grievance box checks were not completed and documented in the program logbook for 12 of the 60 days reviewed. Dates reviewed that were not checked are: 12/1, 1/18, 1/26, 2/26, 2/27, 2/28, 2/29, 3/1, 3/15. 3/22, 4/8, and 4/16.

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**	Three grievances were reported by youth during the review period. All three grievances were addressed by the shelter supervisor and were signed by the youth and shelter supervisor indicating acceptable solution and resolved within the 72 hour period.	
1.03: Incident Reporting			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 1.03		**YES** If NO, explain here: The provider has the required policy and procedure, 1.03, 1.03A Incident Reporting, CCC Incident Reporting, that was approved by the COO July 2023.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Staff Position(s) Interviewed *(No Staff Names)* **: Residential Supervisor and Vice President of Impact** **Type of Documentation(s) Reviewed: Incident Reports, Program Logbook, CCC Emails** **Describe any Observations: Posting 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**	In the last six months a total of six incidents were reported to and accepted by the CCC. All six of the incidents were reported within the two hour time frame. All six of the incidents were also documented in the program logbook.	
The program completes follow-up communication tasks/special instructions as required by the CCC	**Compliance**	All CCC incidents that required followed up documented it was completed and the report was successfully closed. All of the six incidents were closed by the CCC and no further follow ups were required.	
Agency internal incidents are documented on incident reporting forms and all CCC reportable incidents were consistently reported to CCC as required.	**Compliance**	All six incidents were documented on the agency incident reporting forms and reported to the CCC within the required 2 hour timeframe.	
Incidents are documented in the program logs and on incident reporting forms	**Compliance**	All of the six incidents were documented in the program logbook.	
All incident reports are reviewed and signed by program supervisors/ directors	**Compliance**	All of the six incidents were reviewed and signed by the shelter supervisor.	

1.04: Training Requirements (*Staff receives training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions*)			**Limited**
Provider has a written policy and procedure that meets the requirement for Indicator 1.04		**YES** If NO, explain here: The provider has the required policy and procedure, 1.03, 1.03A Incident Reporting, CCC Incident Reporting, that was approved by the COO July 2023.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of New Hire Staff Files: 4 **Total number of Annual In-Service Staff Files: 4** **Total number of Non-Licensed Mental Health Clinical Shelter Staff Files: 1** **Annual Training Plan Timeframe** (*Program timeframe for annual trainings*)**: 1 Year** **Staff Position(s) Interviewed** *(No Staff Names)* **: Residential Supervisor and Clinical Director** **Type of Documentation(s) Reviewed: Staff Training Files, interview w/staff**			
First Year Direct Care Staff			
All direct care staff have completed new hire pre-service training requirements for safety and supervision as required.	**Exception**	A review of four first year direct care staff training files were conducted. Three of the four staff were within the first six months of hire and one had already completed her first full year of hire. All of the four staff reviewed did not complete the new hire pre-service training requirements for safety and supervision within the first 90 days time frame.	One community counseling staff hired did not complete all pre-service training requirements prior to assignment of their first case. NetMIS information shows case assignment of 10/2/2023, prior to staff completing all required pre-service training.
All staff completed the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days from date of hire.	**Exception**	Training Files were reviewed for four first year direct care staff who had exceeded the first 90 days of hire. Three out of the four staff completed the DOJ Civil Rights training within 30 days of hire.	One staff, date of hire (DOH) 10/2/2023, completed the DOJ Civil Rights training on 2/10/2024, exceeding the 30 days required 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**	Three out of the four staff reviewed are still within their first year of hire. All four of the staff reviewed exceeded the required 80 hours of training.	

All staff receives all mandatory training during the first 90 days of employment from date of hire.	**Exception**	Training Files were reviewed for four first year direct care staff who had exceeded the first 90 days of hire. All of the four staff reviewed did not complete all mandatory training requirements due within the first 90 days time frame.	One staff hired on 2/1/2023 did not complete Diversity, Fire Safety Equipment, and Adolescent Development within 90 days of hire. A second staff hired on 5/30/2023 did not complete 2-day Managing Aggressive Behavior (MAB) training and Diversity within 90 days of hire. A third staff hired on 10/30/2023 did not complete Diversity and Universal Precautions within 90 days of hire. The fourth staff hired on 10/2/2023 did not complete a total of 12 Training Topics (9 DJJ SkillPro and 3 other topics) within 90 days of hire.
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 community counseling staff completed the required NIRVANA training. There were no applicable new staff who are responsible for JJIS data entry.	
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).	**Compliance**	One applicable residential counselor completed the required Assessment of Suicide Risk training with supporting documentation confirmed by the licensed clinical supervisor	
In-Service Direct Care Staff			
Direct care staff completes 24 hours of mandatory refresher Florida Network, SkillPro, and job-related training annually *(40 hours if the program has a DCF child caring license).*	**Exception**	Three youth care and one Residential Supervisor training file was reviewed for the completion of In-Service Direct Care Staff training. All of the four staff reviewed exceeded the 40 hours of mandatory refresher training. Three of the four staff completed mandatory refresher and annual trainings required.	One staff was late completing the annually required Florida Network Youth Suicide Prevention Training.

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**	Per the agency's policy 1.04, Family Resources, Inc has designed the Individual Training Plan form that specifically outlines the required training topics to meet the requirements of the indicator.	
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**	Per the agency's policy 1.04, supervisors will maintain an individual training file for each employee to include documentation of training, including certifications, re-certifications, examinations, practicum, and test results. Supervisors will review the training requirements with each employee and work with the employee to schedule time to meet these requirements. Employees are expected to take an active role in their staff development and training process by identifying training needs and interests and communicating these during individual supervision, staff meetings, and through the annual need's assessment survey.	
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**	All nine training records reviewed were maintained in a training binder/file that contained a log of training topics, dates, and hours completed. The training files also included some documentation such as training certificates, sign-in sheets, and training worksheets; however, some of the records were missing the Florida Network Bridge transcript as supporting documentation for trainings completed. Consequently, assistance was required to retrieve those transcripts from the Residential Supervisor. Two training records were viewed electronically because the agency is in the process of transitioning to electronic training records.	
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 procedure, 1.05 Analyzing and Reporting Information, that was approved by the COO July 2023.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			

Staff Position(s) Interviewed (No Staff Names): Vice President of Impact Type of Documentation(s) Reviewed: Agency CQI plan, Roll-up report showing metrics of different data collected (incidents/accidents, grievances, satisfaction surveys, records reviewed, outcomes (3rd Quarter CQI Analysis FY23-24), : Board meeting minutes, CQI and managers/staff meetings agenda/minutes, Peer Review Process, EOM emails, Manatee Campus Peer Review			
Case record review reports demonstrate reviews are conducted quarterly, at a minimum	**Compliance**	Each designated program staff completes the respective peer review form and submits them to their direct supervisor by the 15th of the designated month. The Supervisor ensures all peer review forms, along with their summary, are scanned to the designated OneDrive folder, or email, as requested by VP of Impact. Supervisors and directors share any important findings or trends during their monthly meetings including strengths, areas needing improvement, action plans, and status of prior action plans. This fiscal year, the shelter transitioned to electronic health records (Lauris). Peer reviews are conducted by the Clinical Director, Data Administrator, and VP of Impact. A total of 16 residential records were reviewed by the team between November 2023 and May 2024. Manatee Community Counseling conducts peer reviews by exchanging files. Fifteen records were peer reviewed for the community counseling program during the last two quarters.	
The program conducts reviews of incidents, accidents, and grievances quarterly, at a minimum	**Compliance**	The agency's Risk Management Committee tracks and monitors incidents, accidents, and grievances quarterly. The Risk Management Committee convenes each month following the conclusion of each quarter to facilitate a comprehensive review of incidents from the preceding quarter. Program staff enters incidents, accidents, and grievances into the agency's SharePoint portal. Data is aggregated in terms of incident total by program, agency-wide incident totals by type, and incident type by program. The report also aggregates data for grievances. This information is published quarterly in the CQI Analysis report that is presented during directors and supervisory meetings and shared with staff during staff meetings.	
The program conducts an annual review of customer satisfaction data	**Compliance**	The agency continued its transition from Excel to Smartsheet for data tracking and benchmark reporting, New dashboards added this quarter include Client Satisfaction Surveys. Survey results are tracked monthly for the shelter and community counseling clients separately and compiled into quarterly and an annually on the CQI Analysis report that is presented during directors and supervisory meetings and shared with staff during staff meetings.	

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 COO and VP Impact and disseminated to supervisors to discuss with staff 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 Vice President of Impact reports findings for all benchmarks and CINS/ FINS compliance at each meeting.	
The program has a process in place to review and improve accuracy of data entry & collection	**Compliance**	Progress on meeting outcomes and objectives is monitored on a monthly basis through data collections reports. These reports are reviewed by program supervisory staff and are available for review. Meeting minutes showed evidence of the collection, data entry, and distribution of information.	
There is documentation that findings are regularly reviewed by management and communicated to staff and stakeholders.	**Compliance**	Emails, CQI Analysis Reports, and Meeting minutes were provided as evidence by the Vice President of Impact that findings are regularly reviewed by management and communicated to the staff and stakeholders.	
There is evidence the program demonstrates that program performance is routinely reviewed with the Board of Directors. All final reports that include a Limited or Failed score is submitted electronically or by mail to the providers Executive Committee on the Board of Directors.	**Compliance**	Copies of Board meeting minutes for meetings held between August 2023 - February 2024 show bi-monthly meetings of the Board of Directors and minutes that show the COO and/or VP Impact presents information about program performance to the board of directors. The last 3 meetings were held 8/17/23, 10/26/23, 12/13/23, and 2/15/24.	
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 VP Impact who oversees the development, implementation, documentation, evaluation, and promotion of continuous improvement practices and systems. Should a program fall below expectations in meeting an outcome or objective, action steps for immediate and sustained improvement are completed by program leadership and reviewed during monthly supervisor meetings, the CQI committee quarterly, and within executive leadership meetings when needed.	
Additional Comments: **There are no additional comments for this indicator.**			
1.06: Client Transportation			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 1.06		**YES** If NO, explain here: The provider has the required policy and procedure, 1.08 Agency Vehicles and 1.10 Transportation Policy that was approved by the COO July 2023.	

Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Dates or Timeframe Reviewed: November 2023 - April 2024 **Staff Position(s) Interviewed** *(No Staff Names)* **: Residential Supervisor** **Type of Documentation(s) Reviewed: HR Employee Files, Transportation Policy, Trip Plan/Van Mileage Log, Program Logbook** **Describe any Observations: Agency vehicle**			
Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	**Compliance**	The program maintains a list of staff who have a valid driver's license and clear motor vehicle check and are approved by Human Resources (HR) to transport youth in agency vehicles.	
Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	**Compliance**	Per interview with the shelter supervisor, approved drivers are confirmed by HR and covered under the agency's insurance policy.	
Agency's Transportation policy prohibit transporting a client without maintaining at least one other passenger in the vehicle during the trip and include exceptions in the event that a 3rd party is NOT present in the vehicle while transporting	**Compliance**	The agency's policy prohibits transporting a youth without another passenger in the vehicle. There are provisions in place in case a 3rd party is not present in the vehicle. The policy notes if a driver is transporting a single client in a vehicle, there is evidence that the program supervisor is aware (prior to the transportation) and consent is documented accordingly. The transporting employee shall check-in by phone at agreed upon intervals with the program supervisor, or designee, upon arrival and departure. Employee check-ins must be documented by manager or designee receiving the call.	
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 states in the event that a 3rd party cannot be obtained for transport, the agency's supervisor or managerial personnel considers the clients' history, evaluation and recent behavior when approving single youth transport.	
The 3rd party is an approved volunteer, intern, agency staff, or other youth	**Compliance**	Transportation logs for the agency's van were reviewed for the period November 2023 - April 2024. All non-single transports reviewed had a staff or youth listed as 3rd party.	

The agency demonstrated evidence via logbook or other written verification that supervisor approval was obtained prior to all single youth transports.	**Exception**	Review of transportation logs for the period of November 2023 - April 2024. Supervisor's approval is documented in the logbook and prior approval was evidenced for 23 out of the 25 single transports verified. This was verified by crosschecking each single transport from the Trip Plan/Van Mileage Log with the Logbook for evidence of supervisor's approval.	Two of the 25 single transports reviewed did not provide documentation of a supervisor's approval.
There is documentation of use of vehicle that notes name or initials of driver, date and time, mileage, number of passengers, purpose of travel and location.	**Compliance**	The program maintains a vehicle transportation log (Trip Plan/Van Mileage log) that documents the date, time, name of the driver and initials of staff passengers, location and purpose of travel, number of passengers, initials of passengers, mileage out/in, and return time. Each page of the log is also reviewed and signed by the supervisor	
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 procedure, 1.11 Outreach Services that was approved by the COO July 2023.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Staff Position(s) Interviewed *(No Staff Names)* **: Vice President of Impact and Shelter Supervisor** **Type of Documentation(s) Reviewed: Outreach Meeting Minutes and Outreach Emails, Attendance Sign In Sheets**			
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 Liaison is the designee for participation and attendance to the DJJ Board, Circuit and Council meetings. Evidence of meeting minutes and staff participation (sign in sheets, emails and screen shots of virtual meetings demonstrate staff participation.	

The program maintains written agreements with other community partners which include services provided and a comprehensive referral process.	**Compliance**	The agency maintains multiple interagency agreements that meet all contractual requirements. The agreements are held with a variety of community partners to provide a comprehensive referral process including mental health, substance abuse, medical services, and support services. Total of 14 MOU's - 3 - District (Educational), 3 - Police Departments, 2 - Healthy Teams (Life Skills/Educational), 1 - State Attorney's Office Circuit 12, 1 - Insight (Mental Health/Counseling), 1 - Manatee School For The Arts (Arts and Leisure), 1- Horizons Academy (Educational), 1 - BAYS - Bay Area Youth Services (Substance Abuse), 1- Starting Right Now - Human Trafficking.	
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 documentation of outreach activities that were entered into NetMIS. The report includes the title, date, duration (hours), zip code, location description, estimated number of people reached, modality, target audience and topic.	
The program has designated staff that conducts outreach which is defined in their job description.	**Compliance**	The program has a designated position that conducts outreach Community Liaison. However, the Chief Operating Officer (COO) and Chief Executive Officer (CEO) also attend outreach events and Circuit Meetings.	
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 procedure, 2.01.Eligibility Screening and Intake Assessment, that was approved by the COO July 2023.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open (Residential & Community) Files: Two opened community counseling and two opened residential youth records **Total number of Closed (Residential & Community) Files: Three closed community counseling and three closed residential youth records** **Staff Position(s) Interviewed** *(No Staff Names)* **: Clinical Director** **Type of Documentation(s) Reviewed: Youth records**			
Shelter youth: Eligibility screening form is completed immediately for all shelter placement inquiries.	**Compliance**	Eligibility screening was completed during intake for all five residential records reviewed.	

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 case files reviewed demonstrated screening form was completed by a trained staff within three business days 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 included evidence that the referrals for service were screened for eligibility and logged in Netmis within seventy-two hours of screening completion. The dates of the referrals were noted in the files.	
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 showed evidence that youth and parents received available service options and rights and responsibilities of youth and parents/guardians. The documents were dated and signed by youth and parents during intakes.	
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 ten files reviewed showed evidence that youth and parents were advised of possible action through involvement of the program and grievance procedures. Documents were noted in the file of the possible actions.	
During intake, all youth were screened for suicidality and correctly assessed as required if needed.	**Compliance**	All ten files reviewed were screened for suicidality and correctly assessed as required. Documentations in the files and any follow up needed was present, signed and dated by staff.	
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, 2.02.Network Inventory of Risks, Victories and Needs Assessment (NIRVANA) that was approved by the COO July 2023.	

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

Total number of Open (Residential & Community) Files: Two opened community counseling and two opened residential youth records
Total number of Closed (Residential & Community) Files: Three closed community counseling and three closed residential youth records
Staff Position(s) Interviewed *(No Staff Names)* **: Clinical Director**
Type of Documentation(s) Reviewed: Youth records

Shelter Youth: NIRVANA is initiated within 72 hours of admission	**Compliance**	All five residential files reviewed showed evidence of NIRVANA initiated within seventy-two hours of admission. Evidence of a completed NIRVANA was found in the youth files and noted in NetMIS.	
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 youth files reviewed showed evidence of NIRVANA initiated during intake and completed within two to three face to face contact.	
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 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**	The five residential records reviewed included NIRVANA Self-Assessment (NSR) that 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**	Five of the ten files reviewed were applicable for Post-Assessments. Post Assessments were completed in three of the five files. Two youth voluntarily withdrew from the program; therefore, the staff were unable to complete Post-Assessments and this was documented in the case notes of 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 ten files reviewed were in care for over 90 days.	
All files include the interview guide and/or printed NIRVANA.	**Compliance**	All ten files reviewed showed evidence of a printed NIRVANA in the file and was dated and signed by staff and supervisor.	
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, 2.03 Case/Service Plans, that was approved by the COO July 2023.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			

Total number of Open (Residential & Community) Files: Two opened community counseling and two opened residential youth records **Total number of Closed (Residential & Community) Files: Three closed community counseling and three closed residential youth records** **Staff Position(s) Interviewed** *(No Staff Names)* **: Clinical Director** **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 had service plans developed from information gathered during initial screening and assessment. The documents were placed in the youth's files, dated and signed by the staff.	
Case/Service plan is developed within 7 working days of NIRVANA	**Compliance**	All ten case/service plans reviewed were developed within 7 working days of completion of the NIRVANA.	
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**	All ten case/service plans reviewed contained individualized and prioritized goals identified by the NIRVANA and date plan was initiated; service type, frequency, location, person(s) responsible for completing goals; and target and completed dates for completion of goals. Signatures of youth, parent/ guardian, counselor, and supervisor were observed on all of the ten plans.	
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**	Six applicable records reviewed demonstrated timely reviews for progress every 30 days by the counselor during the required timeframes.	
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, 2.04; Case Management and Service Delivery that was approved by the COO July 2023.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			

Total number of Open (Residential & Community) Files: Two opened community counseling and two opened residential youth records **Total number of Closed (Residential & Community) Files: Three closed community counseling and three closed residential youth records** **Staff Position(s) Interviewed** *(No Staff Names)* **: Clinical Director** **Type of Documentation(s) Reviewed: Youth records**			
Counselor/Case Manager is assigned	**Compliance**	Each of the ten files demonstrated a counselor/case manager was assigned to work with the youth/family from case assignment 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**	As applicable, all 10 records were observed to demonstrate coordination of service plans, monitor progress in services, and provision of various types of support for youth and family. Eight applicable records demonstrated referrals for needed services. None of the ten records reviewed were court ordered or referred to the case staffing committee or required judicial/adjudication services. Case termination notes were completed for six applicable closed cases. Thirty and 60-day follow ups were conducted for four applicable closed cases.	
The program maintains written agreements with other community partners that include services provided and a comprehensive referral process	**Compliance**	The program has a list of community partners and a referral process. The agreements are held with a variety of community partners to provide a comprehensive referral process including mental health, substance abuse, medical services, and support services. Total of 14 MOU's - 3 - District (Educational), 3 - Police Departments, 2 - Healthy Teams (Life Skills/Educational), 1 - State Attorney's Office Circuit 12, 1 - Insight (Mental Health/Counseling), 1 - Manatee School For The Arts (Arts and Leisure), 1- Horizons Academy (Educational), 1 - BAYS - Bay Area Youth Services (Substance Abuse), 1- Starting Right Now - Human Trafficking.	
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, 2.05; Counseling Services that was approved by the COO July 2023.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open (Residential & Community) Files: Two open community counseling and two open residential youth record **Total number of Closed (Residential & Community) Files: Three closed community counseling and three closed residential youth record** **Staff Position(s) Interviewed** *(No Staff Names)* **: Clinical Director** **Type of Documentation(s) Reviewed: youth records; group meetings** **Describe any Observations: On 5-16-24 at 4pm, Peer Reviewer observed a group meeting conducted by primary prevention staff from Hope Family Services.**			
Shelter Program			
Shelter programs provides individual and family counseling	**Compliance**	All ten files reviewed showed evidence individual and family counseling was provided.	
Group counseling sessions held a minimum of five days per week	**Compliance**	The program's group sign in sheets for the review period were reviewed. It was evident from the documents presented the program is conducting groups five days per week consistently.	
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**	Group documentation reviewed included: a clear leader or facilitator, relevant topic - educational/informational or developmental, opportunity for youth to participate, and duration of 30 minutes or longer. Peer Reviewer observed a group meeting on May 16, 2024 being conducted by a guest staff from Hope Family Service. The group was at least thirty minutes long and the youth were gratefully participating during the meeting. There were three youth present and they were engaged in the meeting. The topic for the group was Teen Dating/ Violence. The items discussed included verbal, sexual, physical, mental and emotional behaviors.	
Documentation of groups must include date and time, a list of participants, length of time, and topic.	**Compliance**	Documents of groups, date and time were noted and list of participants, length of time and topic were also included.	

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**	There was evidence that the community counseling program provides therapeutic community-based services designed to provide the intervention necessary to stabilize the family whenever needed. Services are provided in the youth's home, a community location, or the local provider's counseling office. None of the records indicated services were provided virtually.	
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**	The program has an internal process that ensures clinical reviews of case records and staff performance. Interview with the Clinical Director supported practice of reviewing all open cases to provide oversight on coordination of services.	
Maintain individual case files on all youth and adhere to all laws regarding confidentiality.	**Compliance**	All ten youth records were maintained in individual case files with adherence to all laws regarding confidentiality.	
Case notes maintained for all counseling services provided and documents youth's progress.	**Compliance**	All ten files reviewed had evidence in the case notes of maintaining counseling services and documents of the youth's progress.	
On-going internal process that ensures clinical reviews of case records and staff performance.	**Compliance**	Treatment team meets weekly and includes the Clinical Director. The team discuss progress of youth and case files are reviewed and documented. Reviewer saw the documents in the youth's records.	
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 ten files reviewed had a virtual intake.	
Additional Comments: **There are no additional comments for this indicator.**			
2.06 - Adjudication/Petition Process			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.06		**YES** If NO, explain here: The provider has the required policy and procedure, 2.06; Adjudication/Petition that was approved by the COO July 2023.	

Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open (Residential & Community) Files: None **Total number of Closed (Residential & Community) Files: Three closed non-residential files were reviewed.** **Staff Position(s) Interviewed** *(No Staff Names)* **: Clinical Director** **Type of Documentation(s) Reviewed: Youth's case staffing records**			
Must include: a. DJJ rep. or CINS/FINS provider b. Local school district representative	**Compliance**	Case staffing sign in sheet for all three files reviewed included Department of Juvenile Justice or Children In Need of Service/Families in Need of Services provider and a local school district representative present.	
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**	All three case staffings included a mental health representative. Other members requested by the youth/family is encouraged.	
The program has an established case staffing committee, and has regular communication with committee members	**Compliance**	The program had evidence of an established case staffing committee and regular communication with committee members. The evidence included letters, minutes, time and dates of the program case staffing in the three files reviewed. The committee members were identified.	
The program has an internal procedure for the case staffing process, including a schedule for committee meetings	**Compliance**	The case staffing meetings occur monthly and additional meetings may 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**	Evidence supported the youth and family for the three records reviewed were provided a new or revised plan for services as a result of the case staffing.	
Written report is provided to the parent/guardian within 7 days of the case staffing meeting, outlining recommendations and reasons behind the recommendations	**Compliance**	A review of the three case staffing records revealed a report was provided immediately after the case staffing to the youth/family outlining 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**	None of the three records reviewed required court/judicial intervention.	
Case Manager/Counselor completes a review summary prior to the court hearing	**No eligible items for review**	None of the three records reviewed required court/judicial intervention.	
Additional Comments: **There are no additional comments for this indicator.**			
2.07 - Youth Records			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 2.07		**YES** If NO, explain here: The provider has the required policy and procedure, 2.07; Youth Records that was approved by the COO July 2023.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Staff Position(s) Interviewed *(No Staff Names)* **: Clinical Director, Shelter Supervisor** **Type of Documentation(s) Reviewed: ten youth files** **Describe any Observations: Observed youth files, transport container and filing cabinets**			
All records are clearly marked 'confidential'.	**Compliance**	All ten case records reviewed were marked confidential.	
All records are kept in a secure room or locked in a file cabinet that is marked "confidential"	**Compliance**	All records are kept in a secure room and locked in a file cabinet that is marked "confidential. Evidence of the secured files was provided and viewed by the Peer Reviewer.	
When in transport, all records are locked in an opaque container marked "confidential"	**Exception**	The program has a locked container to transport records offsite. The container is opaque and has a combination lock for secure transport of the records.	Upon observation, the container did not have "confidential " marked on the container. When this information was brought to the attention to the Clinical Director, a correction was made and a label "Confidential" was placed on the transport's container.
All records are maintained in a neat and orderly manner so that staff can quickly and easily access information	**Compliance**	All files were observed to be clearly divided into sections which were consistent in their organization among residential and community counseling files. Each client case record includes: chronological sheet and youth demographic data, program information, correspondence, service/treatment plans, needs information, case management information and other materials relevant to the case.	
Additional Comments: **There are no additional comments for this indicator.**			

2.08 - Specialized Additional Program Services			Satisfactory with Exception
Provider has a written policy and procedure that meets the requirement for Indicator 2.08		**YES** If NO, explain here: The provider has the required policies and procedures, 2.08/Specialized Additional Program Services, 2.09a Special Populations, and 2.09b FYRAC, that were approved by the COO July 2023.	
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)* **: Clinical Director**			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? **(If no, select rating "No eligible items for review")**	**No eligible items for review**	The agency has not served any youth who met the criteria for staff secure in the last 6 months or since the last onsite 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	**Compliance**	A review of the current staff secure policy and procedures indicate protocols are in place to provide the following as required: In-depth orientation on admission; assessment and service planning; enhanced supervision and security with emphasis on control and appropriate level of physical intervention; parental involvement; and collaborative aftercare.	
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**	The agency has not served any youth who met the criteria for staff secure in the last 6 months or since the last onsite QI review.	
Staff Assigned: a. One staff secure bed and assigned staff supervision to one staff secure youth at any given time b. Program assign specific staff during each shift to monitor location/ movement of staff secure youth c. Agency clearly documents the specific staff person assigned to the staff secure youth in the logbook or any other means on each shift	**No eligible items for review**	The agency has not served any youth who met the criteria for staff secure in the last 6 months or since the last onsite QI review.	
Agency provides a written report for any court proceedings regarding the youth's progress	**No eligible items for review**	The agency has not served any youth who met the criteria for staff secure in the last 6 months or since the last onsite QI review.	

Domestic Minor Sex Trafficking (DMST)			
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Staff Position(s) Interviewed *(No Staff Names)* **: Clinical Director**			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	**No eligible items for review**	The agency has not served any youth who met the criteria for Domestic Minor Sex Trafficking (DMST) in the last 6 months or since the last onsite QI review.	
Agency has evidence that the FNYFS was contacted for approval prior to admission for all Domestic Minor Sex Trafficking (DMST) placements.	**No eligible items for review**		
There is evidence the youth was entered into NetMIS as a Special Populations youth at admission and a Human Trafficking Screening Tool (HTST) was completed.	**No eligible items for review**		
Services provided to these youth specifically designated services designed to serve DMST youth	**No eligible items for review**		
Did the placement of DMST youth require additional supervision for the safety of the youth or the program? If so, did the agency provide the appropriate level of supervision and safety measures?	**No eligible items for review**		
Length of Stay: a. Youth in program do not have length of stay in DMST placement that exceeds seven (7) days b. Agency has approval for stays and support beyond seven (7) days for DMST placements that are obtained on a case-by-case basis? (If applicable.)	**No eligible items for review**		
Agency has evidence that staff assigned to DMST youth under this provision are to enhance the regular services available through direct engagement in positive activities designed to encourage the youth to remain in shelter	**No eligible items for review**		
All other services provided to DMST youth are consistent with all other general CINS/FINS program requirements	**No eligible items for review**		
Domestic Violence			

Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: 0 **Total number of Closed Files: 3** **Staff Position(s) Interviewed** *(No Staff Names)* **: Clinical Director**			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	**Yes**	Three youth records were reviewed. All three youth charts were closed. None of the present youth on site were DV youth.	
Youth admitted to DV Respite placement have evidence in the file of a pending DV charge	**Compliance**	Three youth records all had indications that the placement was being sought out due to need for DV respite pending charges.	
Data entry into NetMIS within (3) business days of intake and discharge	**Compliance**	All three youth charts reviewed demonstrated data entry was entered into NetMIS timely.	
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**	None of the three DV youth placement exceeded 21 days. Two of the youth were at the shelter for longer than 21 days; however, there was an indication in the chart showing the files transitioned to CINS/FINS on the 21st day.	
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**	Three of three youth charts and service plans reviewed indicated goals that focused on the following areas: plans for managing emotions, family coping skills, and/or other interventions to reduce the propensity for violence in the homes.	
All other services provided to Domestic Violence Respite youth are consistent with all other general CINS/FINS program requirements	**Compliance**	Services documented in the three youth charts reviewed were found to be consistent with other general CINS/FINS program requirements.	
Probation Respite			
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Staff Position(s) Interviewed *(No Staff Names)* **: Clinical Director**			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	**No eligible items for review**	The agency has not served any youth who met the criteria for probation respite services 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.*			
Total number of Open Files: 2 **Total number of Closed Files: 1** **Staff Position(s) Interviewed** *(No Staff Names)* **: Clinical Director**			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	**Yes**	Three cases, two open and one closed, were reviewed for 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.	**Compliance**	All three youth were referred due to truancy.	

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.	**Compliance**	All three records reviewed documented two direct contacts each month and two collateral contacts per week. The program documents contacts on a form and provided a description of the contact event.	
Assessments include a. NIRVANA at intake b. NIRVANA Re-Assessment every 90 days c. Post NIRVANA at discharge as aligned with timeframe requirements	**Compliance**	Three youth records reviewed had NIRVANA completed at intake. Two closed youth charts reviewed had applicable post discharge NIRVANA completed.	
Service/case plan demonstrates a strength-based, trauma-informed focus	**Exception**	All three ICM records reviewed each had one goal related to school attendance. Other needs identified for skills that are lacking were identified but were not addressed.	Other needs identified on the NIRVANA assessment for all three youth were not discussed and included on the service plans.
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	**No eligible items for review**	Virtual services were not indicated or provided for the youth records reviewed.	
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)* **: Clinical Director**			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	**No eligible items for review**	The agency has not served any youth who met the criteria for Family and Youth Respite Aftercare Services (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)			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 2.09		**YES** If NO, explain here: The provider has the required policies and procedures, 2.10 SNAP Intake Requirements, 2.11 SNAP Group Delivery, 2.12 SNAP Fidelity Adherence, 2.13 SNAP Discharge Requirements, and 2.14 SNAP for Schools and Communities, that were approved by the COO in January 2024.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: 1 open SNAP 12-17 youth record **Total number of Closed Files: 2 closed SNAP 12-17 youth records** **Staff Position(s) Interviewed** *(No Staff Names)* **: SNAP Program Manager** **Type of Documentation(s) Reviewed: youth records**			
SNAP Clinical Groups Under 12			
Youth are screened to determine eligibility of services.	**Not Applicable**	The program does not provide SNAP U12 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.	**Compliance**	All three youth were screened using NetMIS and Brief SNAP screening forms to determine eligibility.	
The Consent to Treatment and Participation in Research Form is completed and located within the file.	**Compliance**	Each youth record contained a printed Consent to Treatment and Participation in Research Form is completed and located within the file.	
The NIRVANA was completed at initial intake, or within two sessions.	**Compliance**	Each youth record contained a printed NIRVANA assessment that was completed at intake.	
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.	**Compliance**	HIT forms were completed and contained in all three youth records.	
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.	**Compliance**	Social Skills Improvement System (SSIS) Student forms were completed and contained in all three youth records.	
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.	**Compliance**	Social Skills Improvement System (SSIS) Teacher/Adult forms were completed and contained in all three youth records.	
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 provider does not provide SNAP for Schools and Communities services.	

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 provider has the required policy and procedure, 3.01 Shelter Environment, that was approved by the COO July 2023.		

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

Staff Position(s) Interviewed *(No Staff Names)* **: Residential Supervisor**
Type of Documentation(s) Reviewed: Weekly and perpetual chemical inventory, MSDS, Fire Drills, Emergency Drills, 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**	The shelter environment was inspected during both days of the onsite visit with the agency Residential Supervisor. During the tour it was observed all furnishings were well maintained. The program is bug free, has sufficient lighting throughout, and graffiti free on furniture and walls. Exterior areas are well-kept, free of debris, and grounds are free of hazards. A total of eight restrooms were observed and all are free of foul odors, leaks, dust, and mildew, and in good working order. Each of the six dorm rooms has a full bathroom with shower stall and/or a tub. All four of the garbage cans on the exterior had lids that were closed properly. Reviewer confirmed all doors were secured, in and out access is limited to staff members, and key control is monitored. The program had detailed maps and egress plans of the facility, general client rules, grievance forms, abuse hotline information, DJJ Incident Reporting number and other related notices posted. All interior areas (bedrooms, bathrooms, and common areas) do not contain contraband and are free from hazardous unauthorized metal/foreign objects	
Facility Inspection: a. All agency and staff vehicles are locked. b. Agency vehicles are equipped with major safety equipment including first aid kit, (all items in the first aid kit are current and do not have expired items; all expired items should be replaced regularly), fire extinguisher, flashlight, glass breaker and, seat belt cutter.	**Exception**	At the time of the onsite program review and tour of the facility, all agency and staff vehicles were locked. All two official agency vehicles were equipped with major safety equipment. All first aid kits had evidence of current medical supplies and had no expired items. Shelter main van is in compliance of fire extinguisher, all in one (flashlight, glass breaker and, seat belt cutter).	Outreach vehicle was missing all in one tool and fire extinguisher. Graffiti was observed on two seats in the main shelter van.

Facility Inspection: All chemicals are listed, approved for use, inventoried weekly and perpetually, stored securely and Material Safety Data Sheets (MSDS) are maintained on each item (minimum 1 time per week or per agency policy). A perpetual inventory will be the primary means of maintaining a current and real-time inventory. The weekly inventory will be conducted weekly at a minimum to ensure that a perpetual inventory is being maintained consistently and accurately. If more than one location is used to store chemicals, there is an inventory wherever chemicals are stored that is current and well maintained unless previously approved by the Network.	**Compliance**	Reviewed weekly chemical inventory November 2023 - April 2024 and found all chemicals were inventoried weekly and a perpetual inventory was conducted after each chemical use. In addition, Residential Supervisor also maintains a storage of overstock chemicals in an office and conducts a weekly chemical inventory.	
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**	Both sets of washers and dryers were operational and both dryer vents were lint free. Signage is hanging in laundry room reminding staff and youth to clean after each use. The agency has evidence of a current DCF license that is effective through May 31st 2024. Each bedroom has a nice decorative theme. Staff secures youth belongings in closest called confidential closet near dining 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**	Logbook and fire drill logs confirmed each shift conducted monthly drills in compliance with requirements. Additionally, all three shifts conducted a mock drill at least quarterly. The annual fire inspection was overdue upon initial review; however, program supervisor was able to arrange for a Fire Inspection during the review on 5-15-24. Fire Department completed inspection 5/15/24 at 15:52 and reported two indicators violations, the fire alarm panel and fire sprinkler system. Re-inspection is scheduled to be conducted on or after 6/12/24. Kitchen overhead hood and fire extinguishers all updated.	No evidence, at time of review, of annual fire inspection.

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**	Agency has a current Satisfactory Food Service inspection report from the Department of Health and food menus are posted in dining hall area and signed by Licensed Dietician 6/19/2023. Kitchen is well maintain; all cold food was properly stored, leftovers marked and labeled, and dry storage area was clean. Refrigerators/Freezers were clean and maintained optimal temperatures with thermometers to monitor temperature. All small appliances appeared 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**	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. Daily programming activity calendar is posted in the common area dining hall on a bulletin board. At least one hour of physical activity (titled fitness group) is provided daily at 4pm. The schedule is Included in youth handbook and posted on the weekly activity bulletin board. Youth are provided the opportunity to participate in a variety of faith-based activities. Daily programming includes opportunities for youth to complete homework and access program approved books for reading. Youth are allowed quiet time to read.	
Additional Comments: **There are no additional comments for this indicator.**			
3.02 - Program Orientation			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 3.02		**YES** If NO, explain here: The provider has the required policy and procedure, 3.02 Program Orientation, that was approved by the COO July 2023.	

Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: 2 open residential youth record **Total number of Closed Files: 3 closed residential youth records** **Staff Position(s) Interviewed** *(No Staff Names)* **:Residential Supervisor** **Type of Documentation(s) Reviewed: Youth Files, Residential Youth Handbook, Youth Intake form through Lauris online system**			
Youth received a comprehensive orientation and handbook provided within 24 hours	**Compliance**	Five youth records reviewed and it was confirmed that each youth received a comprehensive orientation and handbook within twenty-four hour of admission.	
Orientation includes the following: a. Youth is given a list of contraband items b. Disciplinary action is explained c. Dress code explained d. Review of access to medical and mental health services e. Procedures for visitation, mail and telephone f. Grievance procedure g. Disaster preparedness instructions h. Physical layout of the facility i. Sleeping room assignment and introductions j. Suicide prevention- alerting staff of feelings or awareness of others having suicidal thoughts	**Compliance**	All five youth orientation included a list of contraband items, disciplinary actions, dress code, review of access to medical and mental health services, procedures for visitation, mail, telephone, grievance procedure, disaster preparedness instructions, physical layout of the facility, sleeping room assignments and introductions, and suicide prevention.	
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**	Present in all five youth records reviewed was documentation of each component of orientation which included orientation topics and dates of presentation, as well as signatures of the youth and staff involved.	
Additional Comments: **There are no additional comments for this indicator.**			
3.03 - Youth Room Assignment			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 3.03		**YES** If NO, explain here: The provider has the required policy and procedure, 3.03 Youth Room Assignment, that was approved by the COO July 2023.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			

Total number of Open Files: 2 open residential youth record **Total number of Closed Files: 3 closed residential youth records** **Staff Position(s) Interviewed** *(No Staff Names)* **:Residential Supervisor** **Type of Documentation(s) Reviewed: Youth Files, Residential Youth Handbook, Youth Intake form through Lauris online system**			
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**	A review of all five records indicated there is a process currently in place that includes a review of available information about the youth's history, status and exposure to trauma, Initial collateral contacts, Initial interactions with and observations or the youth, The program also separates younger youth from older youth and violent youth from non-violent youth, as well as youth susceptible to victimization, Presence of medical, mental or physical disabilities, suicide risk, sexual aggression and predatory behavior, acute health symptoms requiring quarantine or isolation are also reviewed with the youth and documented.	
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**	A review of all five records indicated 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.	
Additional Comments: **There are no additional comments for this indicator.**			
3.04 - Log Books			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 3.04		**YES** If NO, explain here: The provider has the required policy and procedure, 3.04 Log Book, that was approved by the COO July 2023.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Dates or Timeframe Reviewed: November 2023 through April 2023 **Staff Position(s) Interviewed** *(No Staff Names)* **: Residential Supervisor, Direct Care Staff** **Type of Documentation(s) Reviewed: logbooks**			
Log book entries that could impact the security and safety of the youth and/or program are highlighted	**Compliance**	A review of the program's logbook entries was conducted for entries from October 1st 2023 - March 31st. In reviewing the program's logbook, entries that could impact the security and safety of the youth and/or program were highlighted according to the policy and procedure.	

All entries are brief, legibly written in ink and include: • Date and time of the incident, event or activity • Names of youth and staff involved • Brief statement providing pertinent information • Name and signature of person making the entry	**Compliance**	All entries were brief, legibly written in ink and include the date and time of the event, names of youth and staff involved, brief statement providing vital information and name and signature of person making the entry.	
Recording errors are struck through with a single line. The staff person must initial and date the correction. The use of whiteout and erasures is prohibited.	**Compliance**	All overwriting and recording errors were struck through with a single line, signed by staff with initials and included dates of correction. The staff person initials and date the correction. No use of whiteout was found.	
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**	In reviewing logbook entries, the residential supervisor reviewed the logbook weekly and notated the dates reviewed, signed, and documented any correction, recommendations or follow-up that was needed.	
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**	Logbook entries document staff notating logbook review of the previous two shifts, that are signed, and dated into the logbook indicating the dates reviewed.	
At the beginning of their shift, oncoming supervisor and shelter counselor reviews the logbook of all shifts since their last log entry and makes a signed and dated entry and into log book indicating the dates reviewed.	**Compliance**	The program logbooks reviewed revealed the oncoming supervisor and shelter counselor reviewed the logbook since their last log entry, signed and dated the logbook with the dates reviewed.	
In reviewing logbook entries, Logbook entries include: a. Supervision and resident counts b. Visitation and home visits	**Compliance**	The staff documents youth movement throughout the shift, and document when youth leave for a home visit, and return, as well as document any shelter visitors.	
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 procedure, 3.05 Behavior Management Strategies, that was approved by the COO July 2023.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			

Staff Position(s) Interviewed *(No Staff Names)* **: Residential Supervisor and Direct Care Staff** **Type of Documentation(s) Reviewed: Program Behavior Management provided to staff and residents** **Describe any Observations: engagement of youth observed at random times during onsite two day program review**			
The program has a detailed written description of the BMS and it is explained during program orientation	**Compliance**	The agency has a process which includes providing documentation and full explanation of its Behavior Management System (BMS). The plan has a detailed written description of the BMS and it is explained to the youth during program orientation process and is in the client handbook.	
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**	Observations of the direct care staff's engagement and interactions with the current clients in the youth shelter were conducted during the onsite program review. Reviewer conducted observations of daily activities including observations of agency providing clients meals, groups, free time, and recreation during the onsite program review. Observations included assessing the direct care staff's ability to implement the programs BMS. Further observations of consequences applied by program staff for youth that violated program rules were observed to determine if responses to these behaviors are applied logically and consistently.	
Program's use of the BMS			
All staff are trained in the theory and practice of administering BMS rewards and consequences	**Compliance**	The program has a detailed written description of the (BMS). All direct care staff must complete a training session on understanding and proper use of the program's BMS per Residential Supervisor. All staff are trained in the theory and practice of administering the BMS and applicable consequences.	
There is a protocol for providing feedback and evaluation of staff regarding their use of BMS rewards and consequences	**Compliance**	The program reported residential supervisor monitors BMS providing feedback and evaluation of staff regarding their use of BMS rewards and consequences	

Supervisors are trained to monitor the use of rewards and consequences by their staff	**Compliance**	The program reported residential supervisor monitors behavior grading sheets to evaluate all staff regarding their use of BMS rewards and consequences.	
Additional Comments: **There are no additional comments for this indicator.**			
3.06 - Staffing and Youth Supervision			**Limited**
Provider has a written policy and procedure that meets the requirement for Indicator 3.06		**YES** If NO, explain here: The provider has the required policy and procedure, 3.06 Staffing And Youth Supervision, that was approved by the COO July 2023.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Dates or Timeframe Reviewed: November 2023 through April 2023 **Staff Position(s) Interviewed** *(No Staff Names)* **: Residential Supervisor and direct care staff** **Type of Documentation(s) Reviewed: Video camera surveillance and staff schedule** **Describe any Observations: 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 and youth census for November 2023 through April 2023 confirmed that the agency scheduled the minimum staff members required to the ratios for each work shift.	
All shifts must always provide a minimum of two direct care staff present that have met the minimum training requirements	**Exception**	The staff schedules reviewed for the period November 2023 through April 2023 revealed that the agency does not consistently provide a minimum of two direct care staff on each shift as required.	During the review period, the program did not always provide a minimum of two staff on shifts as follows: only one staff was on duty for 2nd shift on the following dates: 11/3, 11/4, 11/18, 11/19, 12/29, 12/17, 12/30, 1/20, 1/21, 1/28, 2/16, 2/18, 4/27. Only one staff was on duty for 3rd shift the following dates: 11/3, 11/4, 11/7, 11/10, 11/11, 11/17, 11/18, 11/24, 11/25, 12/1, 12/2, 12/8, 12/9, 12/15, 12/16, 12/22, 12/23, 12/29, 12/30, 1/3, 2/3, 2/17, 2/24, 3/2, 3/3, 3/16, 4/6, 4/12, 4/13, 4/19, 4/20, 4/26, 4/27.

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**	A review of the documentation confirmed all direct care workers, supervisors, and clinical staff members working in the shelter November 2023 through April 2023 are background screened. A review of training files indicated staff were generally provided all required trainings.	
The staff schedule is provided to staff or posted in a place visible to staff	**Compliance**	During the tour of the facility, it was observed that the staff schedule is posted on staff YDS workstation visible to staff.	
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**	A roster of staff phone numbers for on call and overtime rotation near staff YDS workstation.	
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	**Exception**	Program documentation of bed checks in the logbook and video review of randomly selected bed Check dates and times was conducted to assess 15-minute bed checks were completed as required. The following dates and times were reviewed: 1) April 20th, 12am-2am, in compliance but only 1 staff on duty with census of 8 youth 2) April 21st, 2am-4am, improper check at 2:30am, 3:45am and 3:59am. Check is documented within 15 minutes but staff did not open room to verify youth status. Two staff on duty with census 10 youth. 3) April 24th, 4am-6am, in compliance. Two staff on duty with census of 7 youth 4) May 2nd, 1am-3am, in compliance. Two staff on duty with census of 6 youth 5) May 6th, 3am-5am, in compliance. Two staff on duty with census 7 youth. The program was advised to report the improper bed check on 4/21/2024 to CCC. The report falls under youth supervision and was accepted, report #0924.	On April 21st, between 2am-4am, staff conducted an improper check at 2:30am, 2:45am and 3:59am. Checks are documented within 15 minutes but staff did not open room to verify youth status.
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 provider has the required policy and procedure, 3.07 Video Surveillance System, that was approved by the COO July 2023.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			

Dates or Timeframe Reviewed: Last 30 days of video surveillance footage and last six months of staffing schedules **Staff Position(s) Interviewed** *(No Staff Names)* **: Residential Supervisor and direct care staff** **Type of Documentation(s) Reviewed: video surveillance footage and staffing schedules**			
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**	During the tour it was observed that the program has a written notice that is posted around the campus for the purpose of security. The Residential Supervisor confirmed during video review that the video surveillance system can capture and retain video photographic images which must be stored for 30 days. It was observed the program's video surveillance system can record date, time, and location, and maintain resolution that enables facial recognition. In addition, the back-up battery capabilities consist of cameras' ability to operate during a power outage. All 27 cameras are positioned in interior and exterior common locations of the shelter where youth and staff congregate and where visitors enter and exit, including locations where youth searches are conducted. No cameras were placed in bathrooms or dorms.	
A list of designated personnel who can access the video surveillance system is maintained (includes off-site capability per personnel)?	**Compliance**	The program maintains a list of designated management who can access the video surveillance system. In addition, the program has the capability off-site for designated management.	
Supervisory review of video is conducted a minimum of once every 14 days and timeframes reviewed are noted in the logbook.	**Compliance**	A review of the agency's practice regarding video surveillance was conducted to determine the agency's adherence to this indicator. In reviewing the logbook for supervisory review of the camera it confirmed a minimum of once every 14 days and timeframes reviewed are noted in the logbook (not counting holidays).	
The reviews assess the activities of the facility and include a review of random sample of overnight shifts	**Compliance**	A review of seven randomly selected dates were identified to determine the agency's protocol of the requirements of this indicator. All seven dates reveled the reviews assess the activities of the facility and include 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 agency has a policy and process for providing requested video recordings when an investigation is pursued after an allegation of an incident within 24-72 hours of request by respectful party.	

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**	Management documents via email to Iron Shield Security any camera service order/requests within 24 hours of discovery of camera malfunctioning or being inoperable. All efforts made to obtain repairs are documented and maintained.	
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 provider has the required policy and procedure, 4.01 Healthcare Admission Screening, that was approved by the COO July 2023.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: 1 open residential record **Total number of Closed Files: 4 closed residential records** **Staff Position(s) Interviewed** *(No Staff Names)* **: Residential Supervisor** **Type of Documentation(s) Reviewed: Residential Intake Form**			
Preliminary Healthcare Screening			
Screening includes : a. Current medications b. Existing (acute and chronic) medical conditions c. Allergies d. Recent injuries or illnesses e. Presence of pain or other physical distress f. Observation for evidence of illness, injury, physical distress, difficulty moving, etc. g. Observation for presence of scars, tattoos, or other skin markings h. Acute health symptoms requiring quarantine or isolation	**Compliance**	The program's Residential Intake Screening form in all five records reviewed included current medications, existing (acute and chronic) medical conditions, recent injuries or illnesses, presence of pain or other physical distress as well as observation for presence of scars, tattoos, or other skin markings, and acute health symptoms requiring quarantine or isolation.	
Referral and Follow-Up			
Youth with chronic medical conditions have a referral to ensure medical care (e.g. diabetes, pregnancy, seizure disorder, cardiac disorders, asthma, tuberculosis, hemophilia, head injuries, etc.)	**No eligible items for review**	Five of five youth records were reviewed. None of the records indicated having a chronic medical condition that required follow up care.	

When needed, the parent is involved with the coordination and scheduling of follow-up medical appointments	**Compliance**	The policy reviewed outlines the process for including parents in the coordination and scheduling of follow-up medical appointments. The residential manager and confirmed this by outlining current practice of how they would address any medical conditions presented by the youth.	
All medical referrals are documented on a daily log.	**Compliance**	The policy reviewed indicates that all medical referrals, follow up or care is documented in the log book and client case file.	
The program has a thorough referral process and a mechanism for necessary follow-up medical care as required and/or needed	**Compliance**	The program has a thorough referral process in place as the nurse that is currently being used, reviews the notes from admission and follows up with any needed action.	
Additional Comments: **There are no additional comments for this indicator.**			
4.02 - Suicide Prevention			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 4.02		**YES** If NO, explain here: The provider has the required policy and procedure, 4.02 Suicide Prevention, that was approved by the COO July 2023.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open (Residential & Community) Files: Two **Total number of Closed (Residential & Community) Files: Four** **Staff Position(s) Interviewed** *(No Staff Names)* **: Residential Supervisor** **Type of Documentation(s) Reviewed: Suicide Risk Assessments / Policy**			
Suicide Risk Screening and Approval (*Residential and Community Counseling*)			
Suicide risk screening occurred during the initial intake and screening process. Suicide screening results reviewed and signed by the supervisor and documented in the youth's case file.	**Compliance**	All six youth records reviewed demonstrated that the suicide risk screening was completed at time of intake and all questions were asked and documented. Suicide Risk Assessments were conducted during the initial intake and screening process. Suicide screening results were reviewed and signed by the supervisor and documented in the youth's case file.	
The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	**Compliance**	The program utilizes an Assessment of Suicide Risk that 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 residential records reviewed reflected that youth were placed on the appropriate level of supervision based on the results of the suicide risk assessment.	
Staff person assigned to monitor youth maintained one-to-one supervision and documented his/her observation of the youth's behavior at 30 minute or less intervals	**Compliance**	All three records showed staff person assigned to monitor youth, maintained one-to-one supervision and documented observation of the youth's behavior every 30 minutes or less.	
Documentation includes the time of day, behavioral observations, any warning signs observed, and the observers' initials and was maintained in either an observation log or in the shelter daily log.	**Compliance**	The program utilizes a sight and sound sheet separate from the daily communication log that included 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.	
Supervision level was not changed/reduced until a licensed professional or a non-licensed mental health professional under the supervision of a licensed professional completed a further assessment OR Baker Act by local law enforcement	**Compliance**	All three records reviewed reflected that 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.	
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**	The three records reflected evidence that documentation was reviewed by supervisory staff each shift. Completed observation logs were maintained in the youth records.	
Youth with Suicide Risk *(Community Counseling Only)*			
Youth identified for suicide risk during intake was immediately assessed by a licensed professional or non-licensed professional (under the direct supervision of a licensed mental health professional) and the parents and supervisor were both notified of the results.	**Compliance**	Three community counseling records were reviewed and youth identified for suicide risk during intake were 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.	
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.	**Compliance**	All three youth identified for suicide risk were immediately referred by the provider and the parent/guardian was notified of the suicide risk findings and an Assessment of Suicide Risk was completed by a licensed professional.	

Information on resources available in the community for further assessment was provided to the parent/guardian and is documented in the youth's file and signed by the parent/guardian OR a written follow-up notification was sent by certified mail if the parent/guardian was not present during the screening and was notified by telephone.	**Compliance**	Three community counseling records were reviewed and information on resources available in the community for further assessment was provided to the parent/guardian and documented in the youth's records. Written follow-up notification was sent by certified mail if the parent/guardian was not present during the screening and was notified by telephone.	
If the parent/guardian cannot be contacted, all efforts to contact them are documented in the case file.	**Compliance**	Three community counseling records reviewed showed evidence in the notes of attempts to contact parent/guardians. All efforts to contact parent/guardians were documented in the case files.	
When the screening was completed during school hours on school property, the appropriate school authorities were notified.	**No eligible items for review**	Three community counseling records were reviewed and none of the suicide screenings were completed during school hours or on school property.	
Additional Comments: **There are no additional comments for this indicator.**			
4.03 - Medications			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 4.03		**YES** If NO, explain here: The provider has the required policy and procedure, 4.03 Medications, that was approved by the COO July 2023.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: 0 **Total number of Closed Files: 3 closed residential youth record** **Staff Position(s) Interviewed** *(No Staff Names)* **: Residential Supervisor** **Type of Documentation(s) Reviewed: MARS log, list of staff authorized to assist in distribution of medications, staff training logs** **Observation: Pyxis Medication Station, medication room**			
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**	This program location does not currently have a nurse on staff; however, as needed, the program has access to the nurse from another program location to assist with training needs. The program currently does not have any youth on medication.	

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**	**S**taff training records were reviewed for all non-nursing staff designated to assist with the self-administration of medication. Documentation of in-person self-administration of medication distribution training provided by a registered nurse, staff competency to assist with self-administration of medication distribution, and maintenance of annual medication training re-certification was provided for review by the Residential Supervisor.	
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**	Monthly staff meetings were conducted by RN and/or Shelter Manager to review and assess strategies implemented to reduce medication errors shelter wide, analyze factors that contributed to medication errors, and allow staff the opportunity to practice and role-play solutions. Sign-in sheets for monthly staff meetings were reviewed. The Residential Supervisor stated that monthly staff meetings related to medication instead of quarterly staff meeting helps eliminate medication errors.	
The agency has strategies implemented to ensure medications are provided within the 2-hour time frame.	**Compliance**	In review of the program process and interview with the Residential Supervisor, staff utilize alarms for all medication times on their phones to ensure medications are provided within the 2-hour time frame.	
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**	The monthly staff schedule clearly identified staff responsible for medication that is shift specific with an "M" next to their name**.**	
The agency has clear methods of communicating which youth are on medications with the times and dosage easily discernable by all staff on each shift.	**Compliance**	The agency has a census board in the staff office which documents specific medications with times and dosage each youth are on if applicable.	
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**	Reviewer was unable to observe medication pass as the program had no youth currently on medication at the time of the review. Interview with the Residential Supervisor validated the medication delivery process is consistent with the FNYFS medication management and distribution policy. The program utilizes staff meetings and shift change briefings to disseminate any changes or reminders needed on the medication process.	
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**	The program does not currently have a registered nurse, however, they have a form labeled Nurse Review of the Healthcare Admission Screening. This form is currently being reviewed by one of the program supervisors within the three day window. Medication forms are reviewed by the residential supervisor by the next business day.	
Medication Storage			
a. All medications are stored in a Pyxis ES Medication Cabinet that is inaccessible to youth (when unaccompanied by authorized staff) b. Pyxis machine is stored in accordance with guidelines in FS 499.0121 and policy section in Medication Management c. Oral medications are stored separately from injectable epi-pen and topical medications d. Medications requiring refrigeration are stored in a secure refrigerator that is used only for this purpose, at temperature range 2-8 degrees C or 36-46 degrees F. (If the refrigerator is not secure, the room is secure and inaccessible to youth.) e. Narcotics and controlled medications are stored in the Pyxis ES Station f. Pyxis keys with the following labels are accessible to staff in the event they need to access medications if there is a Pyxis malfunction: a TOP COVER b BACK PANEL- LEFT TALL CABINET LOCK- LEFT, c BACK PANEL- RIGHT TALL CABINET LOCK- RIGHT	**Compliance**	The agency stores all medications in the Pyxis medication cabinet that is kept behind a locked door in the staff office. The program did not have any topical or epi-pen medications at the time of the review but their policy and practice is to store these in a separate location of the Pyxis. The program keeps a medication refrigerator in the same room which is also locked and was checked and noted to be in compliance with the correct temperature range. At the time of the review the program did not have any medications that were in need of refrigeration. The keys to the Pyxis have labels and are kept in the supervisor's office	
Medication Distribution			

a. Agency maintains a minimum of 2 site-specific System Managers for the Pyxis ES Station b. Only designated staff delineated in User Permissions have access to secured medications, with limited access to controlled substances (narcotics) c. A Medication Distribution Log shall be used for distribution of medication by non-licensed and licensed staff d. Agency verifies medication using one of three methods listed in the FNYFS Policies & Procedures Manual e. When nurse is on duty, medication processes are ALWAYS conducted by the nurse or when the nurse is not onsite, then the designated staff who has been trained by a licensed Registered Nurse provides the medication. f. Agency does not accept youth currently prescribed injectable medications, except for epi-pens h. Non-licensed staff have received training in the use of epinephrine auto-injectors provided by a registered nurse	**Compliance**	The program has a minimum of two site-specific System Managers for the Pyxis ES Station. A list of trained staff are maintained in a binder and it matches the staff who have access to the Pyxis. Only designated staff with user permissions have access to secured medications, with limited access to controlled substances (narcotics). A Medication Distribution Log is used for distribution of medication by non-licensed and licensed staff . The agency does not currently have a nurse and they do not accept youth with injectable medications except for epi-pens.	
The medication distribution log documentation includes: a. the time of medication administration b. evidence of youth initials that the dosage was given c. evidence of staff initials that the dosage was given	**Compliance**	The program currently does not have any youth on medication. A review of the medication distribution log for three youth previously on medication included the time of medication being administered, evidence of youth initials that the dosage was given and evidence of staff initials that the dosage was given.	
There is evidence that staff provide youth with medications within one hour of the scheduled time of delivery as ordered by the medication. Documentation is provided for instances this does not occur within the required timeframe.	**Compliance**	Medication distribution log for three closed records reviewed showed compliance with the required timeframe for medication distribution.	
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 the pyxis machine failed to open.	

If applicable: Any staff member deemed responsible for a medication error, there was evidence that the staff member received refresher training from an RN and demonstrated competency prior to being assigned future medication administration responsibilities. There is evidence that any staff member deemed responsible for 3 errors within a 1-year time frame, had their certification suspended and was not recertified until the completion of the full **in-person** medication administration training, demonstrating competency and re-certification from an RN.	**No eligible items for review**	During the review period there were no medication errors.	
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**	As reviewed in the MARS for three closed youth records who were prescribed medications, the MARS indicates a perpetual count that is completed by staff on each shift to document the running balances of the medication and shift-to-shift counts verified by a witness. Over the counter medications are inventoried on a weekly basis. The program does not use syringes or medical sharps.	

There are monthly reviews of the Pyxis reports to monitor medication management practice.	**Compliance**	The program supervisor reviews the Pyxis reports weekly to ensure there are no discrepancies.	
Medication discrepancies are cleared after each shift.	**Compliance**	The program provided shift meeting notes of shift to shift clearance of medication discrepancies.	
Additional Comments: **There are no additional comments for this indicator.**			
4.04 - Medical/Mental Health Alert Process			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 4.04		**YES** If NO, explain here: The provider has the required policy and procedure, 4.04 Medical / Mental Health, that was approved by the COO July 2023.	
Total number of Open Files: 1 **Total number of Closed Files: 4** **Staff Position(s) Interviewed** *(No Staff Names)* **: Residential Supervisor** **Type of Documentation(s) Reviewed: youth records, Staff training log, agency policy and procedure** **Describe any Observations: Census Board**			
Youth with a medical, mental health, or food allergy was appropriately placed on the program's alert system	**Compliance**	Five files showed evidence of alerts being used on the Residential Intake form and for open files on the spine of the folder. One closed file had no indications for alerts so was N/A. For open youth, the program utilizes a census board where the alerts are also noted.	
Alert system includes precautions concerning prescribed medications, medical/mental health conditions	**Compliance**	The alert system uses color codes which are notated on the second page of the Residential Intake Form. There are specific alerts for medications and medical/mental health conditions. Specifically, the program uses a blue dot for medical issues, a red dot for medications, a red check for mental health, and a red "C" for controlled medications.	
Staff are provided sufficient training, information and instructions to recognize/respond to the need for emergency care for medical/mental health problems	**Compliance**	During orientation staff are provided sufficient training, information and instructions to recognize/respond to the need for emergency care for medical/mental health problems. All four new hire training records reviewed supported staff received the necessary training.	

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 program notes any alerts on the Residential Intake Form and the file utilizing a color coding system. Alerts are 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.	
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 provider has the required policy and procedure, 4.05 Episodic / Emergency Care, that was approved by the COO July 2023.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: 0 **Total number of Closed Files: 5** **Staff Position(s) Interviewed** *(No Staff Names)* **: Residential Supervisor** **Type of Documentation(s) Reviewed: Episodic Log and Incident Reports, Training Files** **Describe any Observations: N/A**			
Off Site Emergency Care			
a. If off-site emergency medical or dental care was provided, an incident report was submitted for the medical or dental care b. Upon youth return, there is a verification receipt of medical clearance via discharge instructions with follow-up is present in file c. Youth's parent/guardian was notified d. A daily log is maintained for emergency care provided	**Compliance**	The program maintains a binder labeled "Episodic Emergency Care Log For Off-Site Emergencies". One of five records reviewed, a youth was taken off-site for a medical emergency. Upon return of the youth, verification of medical clearance via discharge instructions with follow-up is present in the youth records. The youth's parent / guardian was notified and a daily log is being maintained for emergency care.	
All staff are trained on emergency medical procedures	**Compliance**	All staff records reviewed reflects staff have been trained on emergency medical procedures.	
The program has a Knife-for-life and wire cutters accessible to staff in a secure location(s)	**Compliance**	The program maintains the Knife-for-Life and wire cutters in a case inside the office located near the common area.	
Additional Comments: **There are no additional comments for this indicator.**			