Florida Network for Youth and Family Services
Compliance Monitoring Report for

Family Resources, Inc.

1615 Union Street
Clearwater, Fl 33755

March 6-7, 2024

Compliance Monitoring Services Provided by

FOREFRONT

EXECUTIVE SUMMARY

Forefront LLC conducted a Quality Improvement (QI) monitoring visit on behalf of the Florida Network of Youth and Family Services (FNYFS) for the Family Resources, Inc. - Safe Place 2B for the FY 2023-2024 at its program office located at 1615 Union Street Clearwater, FL 33755. 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, Inc. is contracted with the Florida Network of Youth and Family Services (FNYFS) to provide direct services to Children/Families in Need of Services (CINS/FINS). The services to be provided are identified in Contract Section A - Descriptions and Specifications and Section B - Delivery and Performance and are funded with General Revenue Funds effective from July 2023 through June 30, 2024.

The review was conducted by Andrea Haugabook, Consultant for Forefront LLC and Jasmine Thompson, Charles Harris, Jr., Sawida Hollist, Lisa Bragano. Agency representatives from Family Resources, Inc. present for the entrance interview were: Andy Coble, Jarma Morgan, Kelli Yeazell, Nicole Leslie and Makenzie Tomasik. The last onsite QI visit was conducted April 26-27, 2023.

In general, the Reviewer found that Family Resources, Inc. - Safe Place 2B is in compliance with specific contract requirements. **Family Resources, Inc. (Clearwater) - Safe Place 2B received an overall compliance rating of 100% for achieving full compliance with 13 indicators** of the CINS/FINS Monitoring Tool. There were no corrective actions as a result of the monitoring visit.

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

2023-2024 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 3-06-07-2023-2024

Agency Name: Family Resources, Inc. (Clearwater) - Safe Place 2B	**Monitor Name: Andrea Haugabook, Lead Reviewer**
Contract Type: CINS/FINS	**Region/Office: 1615 Union Street Clearwater, FL 33755**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): March 6-7, 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.	☐	☐	☒	☐	☐	The agency has five peer reviewers. There are two agency peer reviewers (the Clinical Director and Residential Manager) designated for this location. Additionally, two of the five peer reviewers need to complete a refresher before being put into the review schedule.	
Additional Contracts a. Provider shall provide a listing of all current federal, state, or local government contracts, as well as other contracts entered into with for profit and not-for-profit organizations. Such a listing shall identify the awarding entity and contract start & end dates. **PTV**	☐	☐	☒	☐	☐	The agency received continued funding from the Juvenile Welfare Board and the community counseling program is only funded by the Florida Network of Youth and Family Services.	
Limits of Coverage a. Provider shall provide and maintain during this contract, the following minimum kinds of insurance: Worker's Compensation and Employer's liability insurance as required by Chapter 440, F.S. with a minimum of $100,000 per accident, $100,000 per person and $500,000 policy aggregate. Commercial General Liability with a limit of $500,000 per occurrence, and $1,000,000	☐	☐	☒	☐	☐	The agency has a certificate of insurance with Wallace Welch & Willingham, Inc., which covers the following minimum kinds of insurance: Worker's Compensation and Employer's liability insurance (06/01/2023-06/01/2024) with a minimum of $200,000 per accident,	

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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**						$200,000 per person and $200,000 policy aggregate. Commercial General Liability (06/01/2023-06/01/2024) with a limit of $1,000,000 per occurrence, and $3,000,000 policy aggregate, $500,000 damage to rented premises. Automobile Liability Insurance (06/01/2023-06/01/2024), with a combined single limit for each accident of $1,000,000. The Florida Network of Youth and Family Services is listed as a certificate holder on the certificate of insurance reviewed on-site.	
External/Outside Contract Compliance a. Provider has corrective action item(s) cited by an external funding source (Fiscal or Non-Fiscal). **ON SITE**	☐	☐	☐	☐	☒	This item is not applicable due to the Chief Operating Officer reporting that there are no corrective action items cited by any external funders.	
Fiscal Practice a. Agency must have employee and fiscal policy/procedures manuals that are in compliance with GAAP and provide sound internal controls. Agency maintains fiscal files that are audit ready. **PTV**	☐	☐	☒	☐	☐	The agency has employee and fiscal policy/procedures manuals that comply with GAAP and provide sound internal controls. Various policies were reviewed that cover the agency's budget process, capital assets, general ledger, internal controls and	

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	Unacceptable	**Conditionally Unacceptable**	**Fully Met**	**Exceeded**	**Not Applicable**		
						purchasing. An interview with the Director of Finance confirms the agency maintains fiscal files that are audit ready.	
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**	☐	☐	☒	☐	☐	A review of the agency's general ledger confirms that it is set up to track the activity of the Florida Network of Youth and Family Services grant separately from all other revenue sources.	
c. Petty cash ledger system is balanced, and all cash disbursements are compliant with financial policies and allowable under the contract. (Disbursements/invoices are approved & monitored by management.) –**ON SITE**	☐	☐	☒	☐	☐	The agency does not use petty cash. Interview with the director of finance indicated, 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.	

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d. Financial records and reports are current. Includes bank statements reconciled within 6 weeks of receipt. Vendor invoices past 6 months. Invoices are submitted on a monthly basis with supporting documentation. (Disbursements/invoices are approved & monitored by management). **ON SITE**	☐	☐	☒	☐	☐	The Director of Finance provided bank statements for the past six months which have all been reconciled within ten days of the close of the statement. The Director of Finance indicated that checks are cut weekly to pay vendor invoices. Disbursements and invoices are reported to the CEO monthly by the Director of Finance and she reviews and signs the report.	
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 Director of Finance 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 funds.	
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**	☐	☐	☒	☐	☐	Proof of payroll tax payments was reviewed for the most recent six months, from the agency's payroll company who submits payroll reports, taxes, and issues W-2's.	

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	Unacceptable	**Conditionally Unacceptable**	**Fully Met**	**Exceeded**	**Not Applicable**		
g. Budget to actual reports prepared and reviewed by appropriate management. Variance from the budget are investigated and explained. **PTV/ON SITE**	☐	☐	☒	☐	☐	The most recent six months of budget to actual reports were reviewed by the Director of Finance, Chief Executive Officer and Chief Operating Officer on a monthly basis. Additionally, reviews are conducted by the Board of Director at agency board meetings.	
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**	☐	☐	☒	☐	☐	A Single Audit was performed for the period ending June 30, 2023. Assurance Dimensions, Certified Public Accountants, conducted the audit and the agency has no deficiencies to require a corrective action plan. The annual financial audit was completed within 120 days after the previous fiscal year/calendar year and a copy was provided to the Network.	

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	Unacceptable	**Conditionally Unacceptable**	**Fully Met**	**Exceeded**	**Not Applicable**		
i. Agency maintains confidentiality policy with written policies and procedures to ensure the security and privacy of all employee and client data. Personal information is not easily accessible. Agency maintains a backup system in case of accidental loss of financial information. Security procedures are in place to protect laptops. Obsolete documents are shredded, and computer hard drives are wiped prior to discarding. **ON SITE**	☐	☐	☒	☐	☐	The agency has a confidentiality policy with written policies and procedures to ensure the security and privacy of all employee and client data. The policy on record retention was reviewed. Personal information is not easily accessible and personal information is only accessible electronically to key individuals in the agency. The agency maintains a backup system in case of accidental loss of financial information. Security procedures are in place to protect laptops. Documents are scanned and maintained in an electronic format. Computer hard drives are wiped prior to discarding.	
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**	☐	☐	☒	☐	☐	The Director of Finance provided a spreadsheet of all direct care staff which included: employee ID, name, job, cost center, location and payrate. The listing shows all direct care workers are earning a minimum of $19.00 per hour as of October 1, 2023.	

CONCLUSION

Family Resources, Inc. - Clearwater has met the requirements for the CINS/FINS contract as a result of full compliance with 13 applicable indicators of the Administrative and Fiscal Contract Monitoring Tool. One of the fourteen indicators was not applicable because the program maintains no inventory over $1000 nor has it purchased computer equipment requiring an IRR form. Consequently, **the overall compliance rate for this contract monitoring visit is 100%.** There are no corrective actions cited and no recommendation is 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's findings.

SUMMARY OF RECOMMENDATIONS

Recommendation
None

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. - Clearwater
CINS/FINS Program

Date: March 6-7, 2024

Compliance Monitoring Services Provided by

FOREFRONT

CINS/FINS Rating Profile

Standard 1: Management Accountability

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

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

Standard 2: Intervention and Case Management

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

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

Standard 3: Shelter Care & Special Populations

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

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

Standard 4: Mental Health/Health Services

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

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

Overall Rating Summary

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

Rating Definitions

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

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

Reviewers

Members

Andrea Haugabook - Lead Reviewer Consultant-Forefront LLC/Florida Network of Youth and Family Services
Charles Harris – Safe Children Coalition
Jasmine Thompson – Bethel Community
Sawida Hollist - Bethel Community
Lisa Bragano - Hillsborough County Children's Services

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		Case Manager		Nurse – Full time
	Chief Financial Officer	X	Counselor Non-Licensed	X	Nurse – Part time
X	Chief Operating Officer		Advocate		# Case Managers
	Executive Director	X	Direct – Care Full time		# Program Supervisors
	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 by title): Director, Residential Supervisor, Vice President of Impact
	Counselor Licensed		Human Resources		

Documents Reviewed

	Accreditation Reports	X	Table of Organization		Visitation Logs
X	Affidavit of Good Moral Character		Fire Prevention Plan		Youth Handbook
X	CCC Reports	X	Grievance Process/Records	4	# Health Records
X	Logbooks		Key Control Log	9	# MH/SA Records
	Continuity of Operation Plan	X	Fire Drill Log	10	# Personnel /Volunteer Records
	Contract Monitoring Reports	X	Medical and Mental Health Alerts	10	# Training Records
	Contract Scope of Services		Precautionary Observation Logs	7	# Youth Records (Closed)
X	Egress Plans	X	Program Schedules	8	# Youth Records (Open)
X	Fire Inspection Report	X	List of Supplemental Contracts		# Other: ___
	Exposure Control Plan		Vehicle Inspection Reports		

Observations During Review

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

Surveys

1	# of Youth	1	# of Direct Staff	1	# 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 community counseling 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 shelters are located in Clearwater, St. Petersburg, and Bradenton, Florida. SafePlace2B Clearwater shelter is located at 1615 Union Street, Clearwater. Family Resources serves both male and female youth between the ages of ten to seventeen years that are locked out, runaway, ungovernable and/or truant, homeless, abused, 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, Family/Youth Respite Aftercare Services (FYRAC), and Stop Now And Plan (SNAP) services. The SNAP in schools program covers the same district schools as the St. Petersburg shelter. 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 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 - The program reports that they are close to being fully staffed.

The shelter staff report directly to the Residential Supervisor, who has been in her role for the past three years. The Residential Supervisor reports directly to the COO. The Community Counseling team is led by the Clinical Director, who is new to this role since September of 2023 and reports directly to the COO.

Funding/Finance

The Clearwater programs have not received any new funding. The community counseling program remains 100% funded by the Florida Network of Youth and Family Services. The shelter was awarded continued funding this FY through the Juvenile Welfare Board. The Clearwater shelter currently receives Basic Center funding through 9/30/24.

The agency's audit management letter was received in October 2023 for the FY22-23 financial audit.

Governance and Community

There has been no change in the position of Board Chair for the last year. 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

The Clearwater shelter does not have any corrective action plans with other funding agencies.

Major Challenges

None at this time.

Narrative Summary

Family Resources, Inc. - Clearwater, provides both residential and community counseling CINS/FINS services for youth and their families in Pinellas County and the surrounding areas. The program is under the leadership of a chief executive officer (CEO), a chief operating officer (COO), vice president of impact (VP), a director of client success for community services, and a residential supervisor. Community counseling program has a new clinical director who has developed a masters' level intern program. The shelter has a part-time nurse. The shelter is licensed for 12 beds by the Department of Children and Families effective through December 31, 2024.

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

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

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

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

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

NONE

CINS/FINS QUALITY IMPROVEMENT TOOL

Quality Improvement Indicators and Results: Please select the appropriate outcome for each indicator for each item within the indicator.	**Summary/Narrative Findings:** The narrative write-up is a thorough summary of each assigned QI indicator, explaining how finding(s) are determined.	**Deficiencies/Exceptions:** Please add additional detailed explanations for any items that have any deficiencies or exceptions.
Standard One – Management Accountability		
1.01: Background Screening of Employees, Contractors and Volunteers		**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 1.01	**YES**	
	If NO, explain here:	
	The agency has a policy, 1.01 Background screening of employees and volunteers last updated July 2023 and reviewed by COO.	

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

Total number of New Hire Employee/Intern/Volunteer Files: Six new hire and three intern files reviewed.
Total number of 5 Year Re-screen Employee Files: One re-screen file was reviewed.
Staff Position(s) Interviewed: Vice-president of Impact
Type of Documentation(s) Reviewed: Agency for Healthcare Administration (AHCA)/ Department of Juvenile Justice (DJJ) screening result, Department of Homeland Security E-Verify result summary and Berke suitability assessment results

All positions providing direct services to youth has successfully passed pre-employment suitability assessment on the initial attempt.	**Compliance**	Six new hire employee files reviewed all successfully passed the Berke pre-employment suitability assessment on the initial attempt.	
For any applicant that did not pass the initial suitability assessment, there was evidence that the applicant retook the assessment and passed within five (5) business days of the initial attempt, not exceeding three (3) attempts within thirty (30) days.	**Not Applicable**	This is not applicable due to all employees passing the assessment on the first attempt.	
Agency has evidence for employees who have had a break in service for 18 months or more, and/or when the agency had a change or update in the suitability assessment tool used was different from the employee's original assessment, that a new suitability assessment and background screening was completed as required.	**Not Applicable**	This is not applicable due to no employees having a break in service for 18 months or more.	
Background screening completed prior to hire/start date (or exemption obtained prior to working with youth if rated ineligible) for new hires, volunteers/interns, and contractors. *(Employees who have had a break in service and are in good standing may be reemployed with the same agency without background screening if the break is less than 90 days.)*	**Compliance**	Six new hire employee files and three intern files reviewed all contained completed background screening results prior to the date of hire or working with youth.	

Five-year re-screening is completed every 5 years from the date of the last screening or prior to retained fingerprints expiration date.	**Compliance**	One of one employee files reviewed contained proof of completion of a five year rescreen prior to the expiration date of the retained fingerprints.	
Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?	**Compliance**	The agency presented proof of a signed annual affidavit of compliance with level 2 screening standards emailed to the background screening unit on 01/16/2024.	
Proof of E-Verify for all new employees obtained from the Department of Homeland Security	**Compliance**	Proof of E-Verify was present in six of six new hire employee files reviewed.	
Additional Comments: **There are no additional comments for this indicator.**			
1.02: Provision of an Abuse Free Environment			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 1.02		**YES** If NO, explain here: The agency has a policy, 1.02-Provison of an Abuse Free Environment, reviewed 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): Shelter Supervisor, VP of Impact **Type of Documentation(s) Reviewed: Policy 1.02, grievance forms, youth survey, abuse hotline logbook** **Describe any Observations: Both Council on Accreditation (COA) 12/31/24, Child Caring Agency (CCA) 1/16/25 were additional accreditations held by the agency.**			
Agency has a code of conduct of policy and there is evidence that staff are aware of agency's code of conduct.	**Compliance**	The program has a code of conduct in place that prohibits the use of physical abuse, profanity, threats or intimidation in any form. This code of conduct serves as a set of ethical guidelines and standards that all individuals associated with the program, including staff members and participants are expected to adhere to as evidenced by a physical paper copy of the policy.	
The agency has a process in place for reporting and documenting child abuse hotline calls.	**Compliance**	The program has a well-defined process in place for reporting and documenting any abuse hotline calls. This process aids the timely and appropriate response to reports of abuse, as well as for maintaining accurate records for documentation and follow-up purposes. The program had six child abuse calls in the last six months.	
Youth were informed of the Abuse and Contact Number	**Compliance**	Yes, per the youth survey given, the youth in shelter can identify where the number is located and they were also notified, during orientation, of the number to call for the abuse hotline and the basis of calling.	

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**	To ensure an accessible and responsive grievance process for youth to provide feedback and address complaints, each youth can fill out a grievance form, available to them at any time. Evidenced by the policy clearly stating that each youth has access to submit their grievances. The youth survey also asks the youth 'What do you do if you have a complaint about something in the shelter?' in which the youth stated 'grievance form' and they also stated that they are aware of the grievance process further proving that the policy is being practiced.	
Shelter only: Grievances are maintained on file at minimum for 1 year.	**Compliance**	All grievance forms were accessible and on file.	
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 grievance box was viewed in the common area during the tour—demonstrating accessibility for the youth.	
Shelter only: There is evidence that grievance boxes are checked by management or a designated supervisor at least daily as evidenced in the program logbook.	**Compliance**	Grievance boxes are being checked by management, as demonstrated by their signature being on every form showing that it was reviewed/discussed within a timely manner. The forms on file, have a date in which it was reviewed. also evidenced by the program logbook.	
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**	Leadership has access to the grievances, as demonstrated by their signature being on every form showing that it was reviewed/discussed. All forms were reviewed within the 72 hour window, as demonstrated by the forms on file, showing the date in which it was reviewed.	

1.03: Incident Reporting			Satisfactory with Exception
Provider has a written policy and procedure that meets the requirement for Indicator 1.03	**YES**		
	If NO, explain here:		
	The agency has a policy, 1.03-Incident Reporting, reviewed 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): VP of Impact, Clinical Director
Type of Documentation(s) Reviewed: Central Communication Center reports, logbook, incident reports
Describe any Observations: Both signage and written communication with the youth and staff interactions were identified

During the past 6 months, the program notified the Department's CCC (Central Communication Center) no later than two hours after any reportable incident occurred or within two hours of the program learning of the incident	**Exception**	During the past 6 months, the program notified the Department's CCC (Central Communication Center) a total of 3 times, regarding three separate incidents. Two of three reportable incidents were called in to the CCC within the required two hours of the program learning of the incident.	One CCC incident was not reported within two hours of the program learning of the incident or no later than two hours after any reportable incident occurred. The youth reported he felt sick on 1/30/24 at 10:00pm and his mother was notified, however, she did not come pick up the youth until 1/31/24 at 11:00pm. A voicemail was left with CCC at 5:51am on 1/31/24 and the call was returned from the CCC at 8:36am, 01/31/2024. A CCC report was generated at that time. The program did not have an update from the youth's mother regarding the youth's medical status at the time the report was wade to the CCC. On 2/1/24 at 11:53am, the program notified the CCC of the youth's updated status.
The program completes follow-up communication tasks/special instructions as required by the CCC	**Compliance**	The program completes follow up communication tasks/special instructions, evidenced in both the log book and the CCC report that was provided.	
Agency internal incidents are documented on incident reporting forms and all CCC reportable incidents were consistently reported to CCC as required.	**Exception**	Out of the three incidents that occurred, one medical incident was not documented on the incident reporting forms as evidenced by being provided with the incidents that were accounted for.	One of the medical incidents that occurred on 1/31/24, was not documented on an incident reporting form, nor was it reported to the CCC within two hours of the program learning of the incident or no later than two hours after any reportable incident occurred.

Incidents are documented in the program logs and on incident reporting forms	**Compliance**	Incidents are documented in the program logs, as demonstrated by observing both the log book and the incident reports.	
All incident reports are reviewed and signed by program supervisors/ directors	**Exception**	The total Number of Incidents by type for review period were as follows: Two medical incidents were reviewed and one mental health and substance abuse. The incidents were reviewed and signed by the program supervisor.	Out of the three incidents that occurred, a medical incident that occurred on 1/31/24, was not accounted for with the other incident reports. It was however, reported in the logbook and CCC also has evidence of the incident-- the agency could not produce the report when asked.
1.04: Training Requirements (*Staff receives training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions*)			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 1.04		**YES**	
		If NO, explain here:	
		The agency has a policy, 1.04- Training Reports, last reviewed 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: Five **Total number of Annual In-Service Staff Files: Five** **Total number of Non-Licensed Mental Health Clinical Shelter Staff Files: Zero** **Annual Training Plan Timeframe (Program timeframe for annual trainings): Calendar year** **Staff Position(s) Interviewed (No Staff Names): Vice President of Impact** **Type of Documentation(s) Reviewed: Training plans, training certificate of completions** **Describe any Observations: Both leadership and staff had signage and supporting documentation to support the completion of training plans**			
First Year Direct Care Staff			
All direct care staff have completed new hire pre-service training requirements for safety and supervision as required.	**Compliance**	All direct care staff completed new hire pre-service training requirements for safety and supervision as required, as evidenced by the training plans and certificates of completion for each individual.	
All staff completed the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days from date of hire.	**Compliance**	All staff completed the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days from date of hire, as evidenced by the training plans and certificates of completion for each individual with the date of completion as well.	

All direct care CINS/FINS staff (full time, part time, or on-call) demonstrated a minimum of 80 hours of training or more for the first full year of employment.	**Compliance**	All direct care CINS/FINS staff demonstrated a minimum of 80 hours of training or more for the first full year of employment, as evidenced by the training plans and certificates of completion for each individual with the date of completion as well.	
All staff receives all mandatory training during the first 90 days of employment from date of hire.	**Compliance**	All staff receives all mandatory training during the first 90 days of employment from date of hire, as evidenced by the training plans and certificates of completion for each individual with the date of completion as well.	
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**	Staff that are 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, as evidenced by the training plans and certificates of completion for each individual with the date of completion as well.	
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**	New hires are within the first year of employment and still have time to complete the FL Statute 984 CINS Petition training.	
Non-licensed Mental Health Clinical Shelter Staff (within first year of employment)			
Documentation of non-licensed mental health clinical staff person's training in Assessment of Suicide Risk form or written confirmation by a licensed mental health professional of training (includes date, signature and license number of the licensed mental health professional supervisor).	**No eligible items for review**	There were no newly hired non-licensed mental health clinical staff.	
In-Service Direct Care Staff			
Direct care staff completes 24 hours of mandatory refresher Florida Network, Skill Pro, and job-related training annually (40 hours if the program has a DCF child caring license).	**Compliance**	Direct care staff completed 24 hours of mandatory refresher Florida Network, Skill Pro, and job-related training annually as evidenced by the training plans and certificates of completion for each individual with the date of completion as well.	
Required Training Documentation			
The agency has a training plan that includes all of the required training topics including the pre-service and in-service.	**Compliance**	The agency has a training plan that includes all of the required training topics including the pre-service and in-service for each staff member, as evidence by the training plans and certificates of completion for each individual with the date of completion as well.	

The agency has a designated staff member responsible to manage all employee's individual training files and completes routine tracking and reviews of staff files to ensure compliance.	**Compliance**	The agency has designated staff members responsible to manage employee's individual training files and completes routine tracking and reviews of staff files to ensure compliance as evidenced by the training plan logbook for each individual with the date of completion as well.	
The program maintains an individual training file or employee file AND a FLN Training Log (or similar document that includes all requirements) for each staff, which includes an annual employee training hours tracking form and related documentation, such as electronic record/transcript, training certificates, sign-in sheets, and agendas for each training attended.	**Compliance**	The program does maintain an individual training file or employee file AND a FLN Training Log 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 as evidenced by the training plan logbook for each individual.	
Additional Comments: **There are no additional comments for this indicator.**			
1.05 - Analyzing and Reporting Information			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 1.05		**YES** If NO, explain here: The agency has a policy, 1.05- Analyzing and Reporting Information, last reviewed 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, meeting minutes, group minutes, emails** **Describe any Observations: Agency dashboard, along with emails being sent, the data included the overall ratings for the shelter locations: Manatee Shelter, Clearwater Shelter, and the St. Pete shelter along with community counseling. Signage and verbal confirmations of compliance of the policy and follow ups were provided.**			
Case record review reports demonstrate reviews are conducted quarterly, at a minimum	**Compliance**	Case record review reports demonstrate reviews are conducted quarterly, as evidenced by meeting minutes, verbal review (per the staff being interviewed) and signage. The case record review reports were reviewed on the computer by the VP of impact.	

The program conducts reviews of incidents, accidents, and grievances quarterly, at a minimum	**Compliance**	The continuous quality improvement analysis provided the data for each program totals by quarters which consist of: Safe Place to Be Shelter (SP2B) Clearwater, SP2B St. Pete, SP2B Manatee, Clearwater counseling and St. Pete counseling. All of which is further demonstrated by incident type, total and the incident details. Some of incident types include: client injury, contraband, drug/alcohol use, elopement, falsification of records, facility incident, inappropriate behavior, medical emergency, medication errors, mental health emergency and physical aggression. All of which had the count of incidents and the details. The reportable accidents were also provided in a logbook with signage to back the information being provided on the documents and grievances are reviewed regularly and discussed as seen with both the logbook and grievance forms on file.	
The program conducts an annual review of customer satisfaction data	**Compliance**	Per the continuous quality improvement analysis, the data for client satisfaction is divided by programs with charts to support the reports, along with outcome data also being provided.	
The program demonstrates a monthly review of the statewide End-of-Month ("EOM") report generated by the Florida Network Office. This includes monthly data, fiscal year to date data, benchmarks for residential and community counseling, screening data, report card measures, follow-up reporting measures.	**Compliance**	The program demonstrates a monthly review of the statewide End-of-Month (EOM) report generated by the Florida Network Office. All of which is routinely reviewed with the Board of Directors, evidenced by the board of directors meeting minutes, which was observed both electronically and by a printout document. These documents are submitted and reviewed with the information attached from each program. This includes monthly data, fiscal year to date data, benchmarks for residential and community counseling, screening data, report card measures, follow-up reporting measures. All of which were written out in detail and charts with the information was also included to compare findings-- if applicable.	
The program has a process in place to review and improve accuracy of data entry & collection	**Compliance**	The program has a process in place to review and improve accuracy of data entry & collection, as evidenced by meeting minutes, charts supporting the evidence for each program which consist of: Safe Place to Be Shelter (SP2B) Clearwater, SP2B St. Pete, SP2B Manatee, Clearwater counseling and St. Pete counseling.	
There is documentation that findings are regularly reviewed by management and communicated to staff and stakeholders.	**Compliance**	There is documentation that findings are regularly reviewed by management and communicated to staff and stakeholders: yes, as it is demonstrated through the agency dashboard, along with emails being sent, with the information found. All of which was evidenced by the viewing of the agency dashboard and documents were provided that supported the reviews. Reviews are addressed both verbally and by signage.	

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**	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 provider's Executive Committee on the Board of Directors. As evidenced in the continuous quality improvement analysis, the data included the overall ratings for the shelter locations: Manatee Shelter, Clearwater Shelter, and the St. Pete shelter along with community counseling. All of which are reviewed verbally and by signage of the meeting minutes.	
There is evidence that strengths and weaknesses are identified, improvements are implemented or modified, and staff are informed and involved throughout the process.	**Compliance**	CQI and Meeting minutes further explain what is being discussed and statistics to back the findings, as far as fiscal year incident reports for each program totals by quarters which consist of: Safe Place to Be Shelter (SP2B) Clearwater, SP2B St. Pete, SP2B Manatee, Clearwater counseling and St. Pete counseling. All of which is further demonstrated by incident type, total and the incident details. Elevated reportable incidents are also included, along with the impact committee and their areas of focus, which consist of consumer impact, dashboards for data, effective communication and compelling storytelling of outcomes to stakeholders.	
Additional Comments: **There are no additional comments for this indicator.**			
1.06: Client Transportation			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 1.06		**YES** If NO, explain here: The agency has a policy, 1.10 Transportation Policy, last updated July 2023 by the COO.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Dates or Timeframe Reviewed: October 2023-March 2024 **Staff Position(s) Interviewed** *(No Staff Names)* **:** **Type of Documentation(s) Reviewed: Transportation Logs, Approved driver list, insurance certificate of coverage**			
Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	**Compliance**	The agency provided an approved list of drivers who are all approved by administrative personnel to drive client(s) in agency or approved vehicle.	
Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	**Compliance**	The agency provided proof of all driver's valid driver's license and documentation of coverage under the company insurance policy.	

Agency's Transportation policy prohibit transporting a client without maintaining at least one other passenger in the vehicle during the trip and include exceptions in the event that a 3rd party is NOT present in the vehicle while transporting	**Compliance**	The agency's transportation policy prohibits 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.	
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 consider the clients' history, evaluation, and recent behavior.	
The 3rd party is an approved volunteer, intern, agency staff, or other youth	**Compliance**	The agency's policy states, 3rd parties can be an approved volunteer, intern, agency staff, or other youth.	
The agency demonstrated evidence via logbook or other written verification that supervisor approval was obtained prior to all single youth transports.	**Compliance**	The agency demonstrates evidence in the logbook of supervisor approval prior to all single youth transports taking place. There were a total of 96 single transports reviewed in the logbook from October 2023 to March 2024 and each of the entries contained indication of a prior approval from the supervisor.	
There is documentation of use of vehicle that notes name or initials of driver, date and time, mileage, number of passengers, purpose of travel and location.	**Compliance**	The agency maintains a transportation log which documents: the name or initials of driver, date and time, mileage, number of passengers, purpose of travel and location.	

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

1.07 - Outreach Services		**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 1.07	**YES**	
	If NO, explain here:	
	The agency has a policy, 1.07- Outreach Services, last reviewed July 2023 by the COO.	

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

Staff Position(s) Interviewed (No Staff Names): COO
Type of Documentation(s) Reviewed: NETMIS information
Describe any Observations: The COO made the information accessible, by providing the information electronically and answering any questions regarding the information-- i.e.: does the program has designated staff that conducts outreach which is defined in their job description.

The program has a lead staff member designated to participate in local DJJ board, Circuit and Council meetings with evidence that includes minutes of the event or other verification of staff participation.	**Compliance**	Position title of lead staff reviewed: COO. However, there were no meetings/events in the year of 2023, per the email sent from DJJ Chief Probation Officer.	

The program maintains written agreements with other community partners which include services provided and a comprehensive referral process.	**Compliance**	The program maintains written agreements with other community partners which include services provided and a comprehensive referral process. This is evidenced by meeting minutes in NetMIS.	`
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 is maintaining documentation of outreach activities and all information is being entered into NetMIS which includes: the title, date, duration (hours), zip code, location description, estimated number of people reached, modality, target audience and topic. All of which is evidenced by the information entered into NetMIS.	
The program has designated staff that conducts outreach which is defined in their job description.	**Compliance**	The program has been taking a collaborative approach with providing outreach services. The COO, Vice President of Impact and Clinical Director all attend outreach meetings and events. It is a shared responsibility and there is evidence of consistent outreach occurring.	
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 agency has a policy, 2.01 Screening and Intake, last reviewed 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: Four **Total number of Closed (Residential & Community) Files: Six** **Staff Position(s) Interviewed** *(No Staff Names)* **: VP of Impact, Clinical Director** **Type of Documentation(s) Reviewed: Intake Forms which Include Referral Forms, Consent Forms, NIRVANAs, Initial Plans of Service, Agreement Forms** **Describe any Observations: The forms for the youth that were Residential had all been transitioned into the Lauris system and the Community Counseling forms were still in paper format. The Community Counseling Files were organized and easy to look through.**			
Shelter youth: Eligibility screening form is completed immediately for all shelter placement inquiries.	**Compliance**	Reviewed five residential files and each one had an eligibility screening form filled out completely. Three of the files showed in a short amount of time they were transferred from one shelter to the other. Hence the reason for multiple screenings being discovered during our observation.	
Community counseling: Eligibility screening form is completed within 3 business days of referral by a trained staff using the Florida Network screening form.	**Compliance**	Reviewed five community counseling files and all five files had their eligibility forms completed within three business days of referral by a trained staff using the Florida Network screening form.	

There is evidence all referrals for service is screened for eligibility and is logged in NetMIS within 72 hours of screening completion.	**Compliance**	Reviewed all ten files and after speaking with the VP of Impact, there was evidence of all referrals being screened for eligibility and logged in NetMIS within 72 hours of screening completion.	
Youth and parents/guardians receive the following in writing: a. Available service options b. Rights and responsibilities of youth and parents/guardians	**Compliance**	Ten of ten files contained evidence that youth and parents/ guardians' received the available service options and rights and responsibilities in writing.	
The following is also available to the youth and parents/guardians: a. Possible actions occurring through involvement with CINS/FINS services (case staffing committee, CINS petition, CINS adjudication) b. Grievance procedures	**Compliance**	Ten of ten files reviewed contained documentation that youth and parents were advised of the possible actions occurring through involvement with CINS/FINS services (case staffing committee, CINS petition, CINS adjudication) and the program's grievance procedures.	
During intake, all youth were screened for suicidality and correctly assessed as required if needed.	**Compliance**	Reviewed all ten files and they were all screened for suicidality. One of the youth was assessed after being screened. One student was not screened because he never completed his initial intake after enrolling on October 29, 2023 at 8:45am and then discharged 12 hours later on October 30, 2023 at 8:40am after being Baker Acted.	
Additional Comments: **There are no additional comments for this indicator.**			
2.02 - Needs Assessment			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 2.02		**YES**	
		If NO, explain here:	
		The agency has a policy, 2.02 Needs Assessment, last reviewed 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: Four **Total number of Closed (Residential & Community) Files: Six** **Staff Position(s) Interviewed** *(No Staff Names)* **: Vice President of Impact, Clinical Director** **Type of Documentation(s) Reviewed: NIRVANAs** **Describe any Observations: NIRVANAs were organized and completed whether they were in Lauris or in the individual files.**			
Shelter Youth: NIRVANA is initiated within 72 hours of admission	**Compliance**	Reviewed all ten files and only one file didn't have a NIRVANA due to that youth being discharged after not completing his initial intake. The nine files all had their NIRVANAs completed within the required time frame.	

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**	Reviewed five files that were non-residential and all of them show the NIRVANAs being initiated and completed within the time frame required.	
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**	Reviewed all ten files and only one file didn't have a supervisor signature due to the youth not completing a NIRVANA to begin with (after not completing his initial intake, after being discharged in a short amount of time, after being Bake Acted). The other nine files have signatures from the supervisor.	
(Shelter Only) NIRVANA Self-Assessment (NSR) is completed within 24 hours of youth being admitted into shelter. If unable to complete, there must be documentation in NetMIS and the youth's file explaining the barriers to completion.	**Exception**	Reviewed five files that were residential and only two files had an NSR completed within 24 hours after being admitted into the shelter. In one file, it was noted in their case notes that the youth refused to complete their paperwork. One file the youth was discharged from the program after being Baker Acted in a short amount of time (so he never completed his initial paperwork).	In one file, the youth did not complete a NSR after being enrolled into the shelter on September 10, 2023.
A NIRVANA Post-Assessment is completed at discharge for all youth who have a length of stay that is greater than 30 days.	**Exception**	Reviewed all ten files and only two files had a post-assessment completed at discharge and had a length of stay greater than 30 days. Four files are currently open. With one file, the youth was discharged after being Baker Acted within 24 hours and not completing his initial intake. One file showed that the youth wasn't in the shelter for more than 30 days. He was enrolled on February 15, 2024 and discharged on February 28, 2024.	In one file, the NIRVANA Post-Assessment was not found. The youth was enrolled on November 12, 2023 and discharged on December 21, 2023.
A NIRVANA Re-Assessment is completed every 90 days excluding files for youth receiving SNAP services.	**Compliance**	Reviewed all ten files and only one file had a reassessment completed in the time frame required to complete the NIRVANA Re-Assessment. The other eight files had not required the re-assessment due to four of the files are currently open and the four files discharge dates have not reached 90 days. One file was discharged within 24 hours after being Baker Acted.	

All files include the interview guide and/or printed NIRVANA.	**Compliance**	Reviewed all ten files and the five residential files had transitioned into Lauris and their printed NIRVANAs had been uploaded into the system. The five non-residential files had the printed NIRVANA in their files.	
Additional Comments: **There are no additional comments for this indicator.**			
2.03 - Case/Service Plan			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 2.03		**YES** If NO, explain here: The agency has a policy, 2.03 Case/Service Plan, last reviewed 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: Four **Total number of Closed (Residential & Community) Files: Six** **Staff Position(s) Interviewed (No Staff Names): Clinical Director, Vice President of Impact** **Type of Documentation(s) Reviewed: NIRVANA, Initial Plan of Service, Plan of Service Reviews** **Describe any Observations:**			
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**	Reviewed all ten files and after speaking with the VP of Impact, the case/service plan for the four residential files were located. One residential file did not have a case/service plan after not completing his initial screening, intake, and NIRVANA since he was discharged from the shelter within 24 hours after being Baker Acted. After receiving files from and speaking with the Clinical Director, the case/service plan for the five non-residential files were located.	
Case/Service plan is developed within 7 working days of NIRVANA	**Exception**	Reviewed all ten files and eight of the files had a developed case/service plan within seven working days of NIRVANA. One residential file did not have case/service plan after being discharged from the shelter within 24 hours after being Baker Acted and not completing his initial intake.	One non-residential file shows that she was enrolled on October 30, 2023 but the case/service plan was developed after the seven working day window of NIRVANA. The plan was completed on November 16, 2023.

Case plan/service plan includes: 1. Individualized and prioritized need(s) and goal(s) identified by the NIRVANA 2. Service type, frequency, location 3. Person(s) responsible 4. Target date(s) for completion and actual completion date(s) 5. Signature of youth, parent/guardian, counselor, and supervisor 6. Date the plan was initiated	**Exception**	Reviewed all ten files and one file was discharged from the shelter within 24 hours after being Baker Acted and never completed a case/service plan. One residential didn't have the signature of the parent/guardian due to the parent being unable to come to the shelter since they also had the P.O. at their house noted in the case notes on 2/24/2024. The other nine files showed all were in compliance with having individualized and prioritized needs and goals identified by NIRVANA. All nine files had a service type, frequency, location along with the person(s) responsible, along with the target date(s) of completion and actual date of completion. Two of the non-residential files don't have an actual completion date due to them currently being active in the program. Finally, all nine files have a clear date of when the plan was initiated.	One residential file is missing signatures from the youth, parent/guardian, and the supervisor. Another residential file is missing signatures from parent/guardian and the supervisor. On this file, it was shown that the parent/guardian signature was present on the plan of service review.
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**	Reviewed all ten files and seven of those files were reviewed for progress/revised by counselor and parent (if available) within the time frame required. In one file, the youth was discharged on February 28, 2024 after being enrolled on February 14, 2024. Another file showed that youth was discharged on October 30, 2023 after being enrolled on October 29, 2023.	
Additional Comments: **There are no additional comments for this indicator.**			
2.04 - Case Management and Service Delivery			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.04		**YES** If NO, explain here: The agency has a policy, 2.04 Case Management and Service Delivery, last reviewed 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: Four **Total number of Closed (Residential & Community) Files: Six** **Staff Position(s) Interviewed** *(No Staff Names)* **: COO, Clinical Director** **Type of Documentation(s) Reviewed: Case Management Notes, Files, Case Staffing Agendas, Meeting Notes, Official Letters for Case Staffing to Parents** **Describe any Observations: During the transition of the clinical director joining Family Resources, paperwork for certain cases were harder to find due to the transition and the clinical director playing catch up with getting the information needed for certain files before she started working at Family Resources.**			
Counselor/Case Manager is assigned	**Compliance**	Reviewed all ten cases and all of those cases were assigned a counselor/case manager.	

The Counselor/Case Manager completes the following as applicable: 1. Establishes referral needs and coordinates referrals to services based upon the on-going assessment of the youth's/family's problems and needs 2. Coordinates service plan implementation 3. Monitors youth's/family's progress in services 4. Provides support for families 5. Monitoring progress of court ordered youth in shelter 6. Makes referrals to the case staffing to address problems and needs of the youth/family 7. Accompanies youth and parent/guardian to court hearings and related appointments 8. Refers the youth/family for additional services when appropriate 9. Provides case monitoring and reviews court orders 10. Provides case termination notes 11. Provides follow-up after 30 days post discharge 12. Provides follow-up after 60 days post discharge	**Compliance**	Reviewed all ten files and all of those files are in compliance of what the counselor/case manager needed to complete for each case. One file had not been referred to any type of court or legal placement. In one file, the youth had been enrolled on October 29, 2023 at 8:45am and then discharged on October 30, 2023 at 8:40am after being Baker Acted and he never got to finish his initial intake. Two non-residential files have not completed their service plan despite attempts noted by the counselor/case manager in the case notes attempts to set up appointment days with them not showing up and not answering phone calls.	
The program maintains written agreements with other community partners that include services provided and a comprehensive referral process	**Compliance**	Reviewed all ten files and all files except one file are in compliance with having written agreements with other community partners that include services provided and a comprehensive referral process.	
Additional Comments: **There are no additional comments for this indicator.**			
2.05 - Counseling Services			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.05	**YES**		
	If NO, explain here:		
	The agency has a policy, 2.05 Counseling Services, last reviewed 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: Four
Total number of Closed (Residential & Community) Files: Six
Staff Position(s) Interviewed *(No Staff Names)* **: Counselor/Case Manager, Clinical Director**
Type of Documentation(s) Reviewed: Case Notes, Group Log Notes
Describe any Observations:

Shelter Program			
Shelter programs provides individual and family counseling	**Compliance**	Reviewed all ten files and each file had case notes showing that they would conduct individual and family counseling. One file does not have these notes due to being discharged within a few hours of being at the shelter on October 30, 2023.	
Group counseling sessions held a minimum of five days per week	**Compliance**	Reviewed all five residential files and the four files along with the group logs show they have participated in the group counseling five days a week.	
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**	Reviewed group logs provided by Family Resources showing how they have conducted their sessions and each one showed who the facilitator was, the topic of conversation, which participants had high participation versus low participation, and the length of the session and each one was 30 minutes or longer.	
Documentation of groups must include date and time, a list of participants, length of time, and topic.	**Compliance**	Reviewed group logs provided by Family Resources showing how they have conducted their sessions and each one showed who the facilitator was, the topic of conversation, which participants had high participation versus low participation, and the length of the session and each one was 30 minutes or longer.	
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**	Reviewed all ten files and every file, residential or non-residential, were in compliance with community counseling guidelines.	
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**	Reviewed all ten files and every file, residential or non-residential, were in compliance with counseling services. In one file, the youth was discharged after a short amount of time in the program after being Baker Acted. He never completed his initial intake. Two files don't have case/plan of service review-- in one file the client was discharged before the plan was due and the other client the file is open and it wasn't time to do a case/plan review.	
Maintain individual case files on all youth and adhere to all laws regarding confidentiality.	**Compliance**	Reviewed all ten files and all files are in compliance with maintaining the individual case files and they adhere to all laws regarding confidentiality.	

Case notes maintained for all counseling services provided and documents youth's progress.	**Compliance**	Reviewed all ten files and all files are in compliance with case notes maintained for all counseling services provided and documents youth's progress.	
On-going internal process that ensures clinical reviews of case records and staff performance.	**Compliance**	Four out of the ten files were selected and reviewed. Each of the four showed evidence of an on-going internal process ensuring clinical reviews of case records and staff performance.	
When an intake is conducted through virtual means, consent is confirmed by the counselor, documented in the file, and reviewed with the supervisor during supervision/case review. There is written documentation provided in the youths file for reasons why virtual sessions are in the best interest of the youth and family.	**No eligible items for review**	Reviewed all ten files and all of these files had intakes conducted in the facility at Family Resources.	
Additional Comments: **There are no additional comments for this indicator.**			
2.06 - Adjudication/Petition Process			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 2.06		**YES** If NO, explain here: The agency has a policy, 2.06 Adjudication/Petition Process, last reviewed by the COO in 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: Four **Total number of Closed (Residential & Community) Files: Six** **Staff Position(s) Interviewed** *(No Staff Names)* **: Clinical Director** **Type of Documentation(s) Reviewed: Case Staffing Log, Reviews of Case Staffing Meeting** **Describe any Observations: During the transition of the clinical director joining Family Resources, paperwork for certain cases were harder to find due to the transition and the clinical director playing catch up with getting the information needed for certain files before she started working at Family Resources.**			
Must include: a. DJJ rep. or CINS/FINS provider b. Local school district representative	**Compliance**	Out of the ten files, only three files were already in truancy court and were referred to Family Resources for services which then got them referred to Case Staffing to CINS/FINS. All three files are compliant in having DJJ rep or CINS/FINS provider and local school district representative.	
Other members may include: a. State Attorney's Office b. Others requested by youth/ family c. Substance abuse representative d. Law enforcement representative e. DCF representative f. Mental health representative	**Compliance**	Reviewed all three files and all of the files had a state attorney and mental health representative, but didn't have the other members present in court.	
The program has an established case staffing committee, and has regular communication with committee members	**Compliance**	The program has an established case staffing committee, and has regular communication with committee members.	

The program has an internal procedure for the case staffing process, including a schedule for committee meetings	**Compliance**	Reviewed the log books for case staffing with the schedule of who they would be speaking, who would be on the call, and what they would be talking about with each case.	
The youth and family are provided a new or revised plan for services	**Exception**	Reviewed all three files and one file had proof of the youth and family being provided a new revised plan for services.	Two clients didn't have a new or revised plan. The clinical director stated that this occurred during the transition of when the clinical director started working these cases.
Written report is provided to the parent/guardian within 7 days of the case staffing meeting, outlining recommendations and reasons behind the recommendations	**Exception**	Reviewed all three files and one file had proof of a written report being provided to the parent/guardian within seven days of the case staffing meeting, outlining recommendations and reasons behind the recommendations.	Two client files didn't have a written report provided to the parent/guardian.
If applicable, the program works with the circuit court for judicial intervention for the youth/family	**Exception**	Reviewed all three files and one file shows the program is working with the circuit court for judicial intervention for the youth/family. The other two files doesn't show the program working with the circuit court for judicial intervention. There was a transition during this time where the Clinical Director is basically playing catch up with the files.	Two files do not show that the program was working with the circuit court for judicial intervention. Since hiring a new clinical director, the program is very involved with the circuit court for judicial intervention.
Case Manager/Counselor completes a review summary prior to the court hearing	**Compliance**	Reviewed all three files and one file shows a review summary prior to court. Two files do not show a review summary. The newly hired clinical director reported that she is still in the process of completing review summaries for these cases prior to the court hearing.	
Additional Comments: **There are no additional comments for this indicator.**			
2.07 - Youth Records			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.07		**YES** If NO, explain here: The agency has a policy, 2.07 Youth Records, last reviewed by the COO in 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, Vice President of Impact** **Type of Documentation(s) Reviewed: Youth files** **Describe any Observations: Files were kept in a room that is locked and the cabinets were secured and locked. There was an additional lock to keep the cabinets secure. It was clear that the files were confidential with the stickers on the file cabinets.**			
All records are clearly marked 'confidential'.	**Compliance**	All the cabinets had confidential stickers on them and there was a confidential stamp on all of the files.	

All records are kept in a secure room or locked in a file cabinet that is marked "confidential"	**Compliance**	All records are secured in the cabinets and locked all the time and marked confidential.	
When in transport, all records are locked in an opaque container marked "confidential"	**Compliance**	The Clinical Director mentioned that the files are rarely if ever transported from the facility, but that there is a black box they use that has confidential marked on it. The majority of the time that box is at a different location before they have at Family Resources to prepare the transport.	
All records are maintained in a neat and orderly manner so that staff can quickly and easily access information	**Compliance**	All records are organized and easy to access when needed.	
Additional Comments: **There are no additional comments for this indicator.**			
2.08 - Specialized Additional Program Services			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.08		**YES** If NO, explain here: The agency has a policy, 2.08 Specialized Additional Program Services, last reviewed 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.*			
Total number of Open Files: Zero **Total number of Closed Files: Zero** **Staff Position(s) Interviewed** *(No Staff Names)* **: COO, Vice President of Impact** **Type of Documentation(s) Reviewed:** **Describe any Observations: The COO and the VP of Impact confirmed that in the last six months there were no files to review for this policy for Specialized Additional Program Services.**			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? **(If no, select rating "No eligible items for review")**	**No eligible items for review**	The agency had no cases in the last six months or since the last onsite QI review was conducted.	
Staff Secure policy and procedure outlines the following: a. In-depth orientation on admission b. Assessment and service planning c. Enhanced supervision and security with emphasis on control and appropriate level of physical intervention d. Parental involvement e. Collaborative aftercare	**No eligible items for review**	The agency has a policy that addresses the necessary requirements of staff secure policies and procedures outlined by the Florida Network.	

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 had no cases in the last six months or since the last onsite QI review was conducted.	
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 had no cases in the last six months or since the last onsite QI review was conducted.	
Agency provides a written report for any court proceedings regarding the youth's progress	**No eligible items for review**	The agency had no cases in the last six months or since the last onsite QI review was conducted.	

Domestic Minor Sex Trafficking (DMST)

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

Total number of Open Files: Zero
Total number of Closed Files: Zero
Staff Position(s) Interviewed *(No Staff Names)* **: COO and Vice President of Impact**
Type of Documentation(s) Reviewed:
Describe any Observations: The COO and the VP of Impact confirmed that in the last six months there were no files to review for this policy Specialized Additional Program Services.

Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	**No eligible items for review**	The agency had no cases in the last six months or since the last onsite QI review was conducted.	
Agency has evidence that the FNYFS was contacted for approval prior to admission for all Domestic Minor Sex Trafficking (DMST) placements.	**No eligible items for review**	The agency had no cases in the last six months or since the last onsite QI review was conducted.	
There is evidence the youth was entered into NetMIS as a Special Populations youth at admission and a Human Trafficking Screening Tool (HTST) was completed.	**No eligible items for review**	The agency had no cases in the last six months or since the last onsite QI review was conducted.	
Services provided to these youth specifically designated services designed to serve DMST youth	**No eligible items for review**	The agency had no cases in the last six months or since the last onsite QI review was conducted.	
Did the placement of DMST youth require additional supervision for the safety of the youth or the program? If so, did the agency provide the appropriate level of supervision and safety measures?	**No eligible items for review**	The agency had no cases in the last six months or since the last onsite QI review was conducted.	

Length of Stay: a. Youth in program do not have length of stay in DMST placement that exceeds seven (7) days b. Agency has approval for stays and support beyond seven (7) days for DMST placements that are obtained on a case-by-case basis? (If applicable.)	**No eligible items for review**	The agency had no cases in the last six months or since the last onsite QI review was conducted.	
Agency has evidence that staff assigned to DMST youth under this provision are to enhance the regular services available through direct engagement in positive activities designed to encourage the youth to remain in shelter	**No eligible items for review**	The agency had no cases in the last six months or since the last onsite QI review was conducted.	
All other services provided to DMST youth are consistent with all other general CINS/FINS program requirements	**No eligible items for review**	The agency had no cases in the last six months or since the last onsite QI review was conducted.	
Domestic Violence			
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: Zero **Total number of Closed Files: Zero** **Staff Position(s) Interviewed** *(No Staff Names)* **: COO and Vice President of Impact** **Type of Documentation(s) Reviewed:** **Describe any Observations: The COO and the VP of Impact confirmed that in the last six months there were no files to review for this policy Specialized Additional Program Services.**			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating “No eligible items for review”)	**No eligible items for review**	The agency had no cases in the last six months or since the last onsite QI review was conducted.	
Youth admitted to DV Respite placement have evidence in the file of a pending DV charge	**No eligible items for review**	The agency had no cases in the last six months or since the last onsite QI review was conducted.	
Data entry into NetMIS within (3) business days of intake and discharge	**No eligible items for review**	The agency had no cases in the last six months or since the last onsite QI review was conducted.	
Youth length of stay in DV Respite placement does not exceed 21 days. If more than 21 days, documentation exists in youth file of transition to CINS/FINS or Probation Respite placement, if applicable.	**No eligible items for review**	The agency had no cases in the last six months or since the last onsite QI review was conducted.	
Case plan in file reflects goals for aggression management, family coping skills, or other intervention designed to reduce propensity for violence in the home	**No eligible items for review**	The agency had no cases in the last six months or since the last onsite QI review was conducted.	
All other services provided to Domestic Violence Respite youth are consistent with all other general CINS/FINS program requirements	**No eligible items for review**	The agency had no cases in the last six months or since the last onsite QI review was conducted.	
Probation Respite			

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

Total number of Open Files: Zero
Total number of Closed Files: Zero
Staff Position(s) Interviewed *(No Staff Names)* **: COO and Vice President of Impact**
Type of Documentation(s) Reviewed:
Describe any Observations: The COO and the VP of Impact confirmed that in the last six months there were no files to review for this policy Specialized Additional Program Services.

Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	**No eligible items for review**	The agency had no cases in the last six months or since the last onsite QI review was conducted.	
All probation respite referrals are submitted to the Florida Network.	**No eligible items for review**	The agency had no cases in the last six months or since the last onsite QI review was conducted.	
All Probation Respite Referral come from DJJ Probation and there is evidence that the youth is on Probation regardless of adjudication status.	**No eligible items for review**	The agency had no cases in the last six months or since the last onsite QI review was conducted.	
Data entry into NetMIS and JJIS within (3) business days of intake and discharge	**No eligible items for review**	The agency had no cases in the last six months or since the last onsite QI review was conducted.	
Length of stay is no more than fourteen (14) to thirty (30) days. Any placement beyond thirty (30) days contains evidence in the file that the JPO was contacted in writing to request the need of an extension no later than the 25th day the youth was admitted into the program.	**No eligible items for review**	The agency had no cases in the last six months or since the last onsite QI review was conducted.	
All case management and counseling needs have been considered and addressed	**No eligible items for review**	The agency had no cases in the last six months or since the last onsite QI review was conducted.	
All other services provided to Probation Respite youth are consistent with all other general CINS/FINS program requirements	**No eligible items for review**	The agency had no cases in the last six months or since the last onsite QI review was conducted.	

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: Zero
Total number of Closed Files: Zero
Staff Position(s) Interviewed *(No Staff Names)* **: COO and Vice President of Impact**
Type of Documentation(s) Reviewed:
Describe any Observations: The COO and the VP of Impact confirmed that in the last six months there were no files to review for this policy Specialized Additional Program Services.

Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	**No eligible items for review**	The agency had no cases in the last six months or since the last onsite QI review was conducted.	
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.	**No eligible items for review**	The agency had no cases in the last six months or since the last onsite QI review was conducted.	
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.	**No eligible items for review**	The agency had no cases in the last six months or since the last onsite QI review was conducted.	
Assessments include a. NIRVANA at intake b. NIRVANA Re-Assessment every 90 days c. Post NIRVANA at discharge as aligned with timeframe requirements	**No eligible items for review**	The agency had no cases in the last six months or since the last onsite QI review was conducted.	
Service/case plan demonstrates a strength-based, trauma-informed focus	**No eligible items for review**	The agency had no cases in the last six months or since the last onsite QI review was conducted.	
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**	The agency had no cases in the last six months or since the last onsite QI review was conducted.	
Family and Youth Respite Aftercare Services (FYRAC)			

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

Total number of Open Files: Zero
Total number of Closed Files: Zero
Staff Position(s) Interviewed *(No Staff Names)* **: COO and Vice President of Impact**
Type of Documentation(s) Reviewed:
Describe any Observations: The COO and the VP of Impact confirmed that in the last six months there were no files to review for this policy Specialized Additional Program Services.

Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	**No eligible items for review**	The agency had no cases in the last six months or since the last onsite QI review was conducted.	
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**	The agency had no cases in the last six months or since the last onsite QI review was conducted.	
Agency has evidence that all FYRAC referrals have documented approval from the Florida Network office	**No eligible items for review**	The agency had no cases in the last six months or since the last onsite QI review was conducted.	
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**	The agency had no cases in the last six months or since the last onsite QI review was conducted.	
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**	The agency had no cases in the last six months or since the last onsite QI review was conducted.	

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**	The agency had no cases in the last six months or since the last onsite QI review was conducted.	
Group Sessions: a. Focus on the same issues as individual/family sessions with application to youth pulling on similar experiences with other group members with the overall goal of strengthening relationships and prevention of domestic violence. b. Shall be no more than eight (8) youth at one (1) time and shall be for a minimum of sixty (60) minutes per session	**No eligible items for review**	The agency had no cases in the last six months or since the last onsite QI review was conducted.	
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**	The agency had no cases in the last six months or since the last onsite QI review was conducted.	
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**	The agency had no cases in the last six months or since the last onsite QI review was conducted.	

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**	The agency had no cases in the last six months or since the last onsite QI review was conducted.	
All data entry in NetMIS is completed within 3 business days as required.	**No eligible items for review**	The agency had no cases in the last six months or since the last onsite QI review was conducted.	
Additional Comments: **There are no additional comments for this indicator.**			
2.09- Stop Now and Plan (SNAP)			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.09		**YES** If NO, explain here: The agency had several policies: 2.10 SNAP Intake requirements, 2.11 SNAP Group delivery, 2.12 SNAP Fidelity Adherence Monitoring, 2.13 SNAP discharge Requirements, 2.14 SNAP for Schools and Community, all reviewed July 2023 by the COO.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: Four **Total number of Closed Files: One** **Staff Position(s) Interviewed** *(No Staff Names)* **:** **Type of Documentation(s) Reviewed: Youth Files**			
SNAP Clinical Groups Under 12			
Youth are screened to determine eligibility of services.	**Not Applicable**	The program does not provide SNAP Clinical Groups under 12.	
The NIRVANA was completed at initial intake, or within two sessions.	**Not Applicable**	The program does not provide SNAP Clinical Groups under 12.	
There is evidence of the completed Child Behavior Checklist (CBCL) by the caregiver (pre and post) and is located within the file.	**Not Applicable**	The program does not provide SNAP Clinical Groups under 12.	
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**	The program does not provide SNAP Clinical Groups under 12.	
There is evidence of the completed TOPSE is completed by the caregiver (pre and post) and is located within the file.	**Not Applicable**	The program does not provide SNAP Clinical Groups under 12.	
SNAP Clinical Groups Under 12 - Discharge			

There is evidence of the completed SNAP Discharge Report located within the file for any discharged youth.	**Not Applicable**	The program does not provide SNAP Clinical Groups under 12.	
There is evidence of the SNAP Boys/SNAP Girls Child Group Evaluation Form located in the file.	**Not Applicable**	The program does not provide SNAP Clinical Groups under 12.	
There is evidence of the SNAP Boys/SNAP Girls Parent Group Evaluation Form located in the file.	**Not Applicable**	The program does not provide SNAP Clinical Groups under 12.	
SNAP Clinical Groups for Youth 12-17			
Youth are screened to determine eligibility of services.	**Compliance**	Five of five SNAP youth files reviewed contained a completed screening to determine eligibility of services.	
The Consent to Treatment and Participation in Research Form is completed and located within the file.	**Compliance**	The Consent to Treatment and Participation in Research Form was completed and located within five of five SNAP files reviewed.	
The NIRVANA was completed at initial intake, or within two sessions.	**Compliance**	Five of five SNAP youth files reviewed contained a NIRVANA that was completed at initial intake, or within two sessions.	
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**	A completed 'How I Think Questionnaire' (HIT) form was located within each of the five SNAP files reviewed.	
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**	A completed Social Skills Improvement System (SSIS) Student form was located within the five SNAP youth files reviewed.	
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**	Completed Social Skills Improvement System (SSIS) Teacher/Adult form were located within the five SNAP youth files reviewed.	
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*)	**No eligible items for review**	The SNAP in schools files were previously reviewed during the onsite review at the North shelter.	

The program maintained evidence of a completed "Class Goal" Document for the class reviewed.	**No eligible items for review**	The SNAP in schools files were previously reviewed during the onsite review at the North shelter.	
The program maintained evidence of both pre AND post Measure of Classroom Environment (MoCE) completed documents for the class reviewed.	**No eligible items for review**	The SNAP in schools files were previously reviewed during the onsite review at the North shelter.	
The program maintained evidence of completed pre and post evaluation documents for the class reviewed.	**No eligible items for review**	The SNAP in schools files were previously reviewed during the onsite review at the North shelter.	
There is evidence of the fidelity adherence checklist maintained in the file for each class reviewed.	**No eligible items for review**	The SNAP in schools files were previously reviewed during the onsite review at the North shelter.	

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

3.01 - Shelter Environment		**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 3.01	**YES**	
	If NO, explain here:	
	The facility's policy is "3.01 - Shelter Environment" and was last reviewed by the COO in 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)* **: Shelter Supervisor**
Type of Documentation(s) Reviewed: DCF Child Care License, perpetual chemical inventory, MSDS, annual fire inspection, fire drill/emergency drill logs, fire safety equipment inspection report, Residential Group Care inspection report, youth daily schedule
Describe any Observations: The physical facility is warm and welcoming, and is clean and well-maintained.

Facility Inspection: a. Furnishings are in good repair. b. The program is free of insect infestation. c. Bathrooms and shower areas are clean and functional, free of foul odors, leaks, dust, and mildew and in good working order. d. There is no graffiti on walls, doors, or windows. e. Lighting is adequate for tasks performed there. f. Exterior areas are free of debris; grounds are free of hazards. g. Dumpster and garbage can(s) are covered. h. All doors are secure, in and out access is limited to staff members and key control is in compliance. i. Detailed map and egress plans of the facility, general client rules, grievance forms, abuse hotline information, DJJ Incident Reporting Number and other related notices are posted. j. Interior areas (bedrooms, bathrooms, common areas) do not contain contraband and are free from hazardous unauthorized metal/foreign objects.	**Compliance**	All furnishings throughout the shelter were well maintained and in good repair (furniture is wood and upholstered). Wood was in good condition, and there were no stains or tears observed on the upholstery. There was no insect infestation observed during the facility walk-through. There were seven bathroom/shower areas, and each was observed to be clean and sanitary. All the shower curtains appeared to be new and without mold or mildew. There was no graffiti observed on any surface in the shelter. All areas of the shelter had either sufficient natural light or overhead lighting appropriate for tasks performed. All bedrooms have wall lamps and windows with mini blinds. There is overhead lighting in the common area, and the dining area has windows with mini blinds and overhead lighting. No debris was observed in the outdoor area. Fallen leaves are in the process of being raked and removed by volunteers. The fenced area behind the facility where youth have outdoor time was observed with no hazards. Bikes are stored on the far end of the outdoor space and were maintained in good condition. The basketball court was well maintained. The dumpster is located in front of the facility and is kept out of sight behind gates. The lid of the dumpster was observed to be closed. All doors in the facility are secured by key card, except for doors from the outside into lobby areas. Staff was observed to use key card access to enter and exit through all secure entrances. Maps/egress routes were observed in every room in the facility, and client rules were posted in the common area, dining room and lobby. Grievance forms/boxes were located in the common area and lobby. Phone numbers for the Abuse Hotline and DJJ Incident Reporting were posted in the common area, along with other pertinent notices. Four bedrooms, each with three beds, and seven bathrooms were observed to be free of hazardous/unauthorized metal/foreign objects, and no contraband was evident in any of the bedrooms, bathrooms, common area, or dining room.	
Facility Inspection: a. All agency and staff vehicles are locked. b. Agency vehicles are equipped with major safety equipment including first aid kit, (all items in the first aid kit are current and do not have expired items; all expired items should be replaced regularly), fire extinguisher, flashlight, glass breaker and, seat belt cutter.	**Compliance**	All agency and staff vehicles were locked. The one van used by the facility is equipped with major safety equipment, including an extensive first aid kit with all current, non-expired items, a flashlight, and a currently tagged fire extinguisher. The combination glass breaker/seatbelt cutter is on the keyring holding the van key.	

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**	The perpetual inventory of chemicals was observed. A box of cleaning supplies was delivered during the review after the initial facility walk-through, and all items in the box had been added to the perpetual inventory when the reviewer returned to check the inventory sheets. The closet near the entrance to the dining room is the only location where chemicals are stored. The Material Data Safety Sheets are stored in a binder located in a lower cabinet behind the desk in the common area, and is easily accessed by staff. All chemicals observed in the closet had an associated MSDS.	
Facility Inspection: Washer/dryer are operational & general area/lint collectors are clean. Agency has a current DCF Child Care License which is displayed in the facility. Each youth has own individual bed with clean covered mattress, pillow, sufficient linens and blanket. Youth have a safe, lockable place to keep personal belongings, if requested.	**Compliance**	The facility has two washers and two dryers. One dryer that was not in use had no lint in the collector. The second dryer still had clothes/towels in it and some lint in the collector. Staff removed the lint from the current load. A current DCF Child Care License is posted in the facility, with an effective date of January 17, 2024. Each youth bed was properly equipped with mattress cover, sheets, linens, pillow(s), and blanket. Each room is decorated according to a theme, and comforters and pillow cases coordinate with the theme of the room. Each youth is provided with a locker and keyed padlock to secure their personal items in a closet located off the common 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).	**Compliance**	The date of the current satisfactory fire inspection is September 27, 2023. Fire drills have been recorded for each shift and all evacuations were done in under two minutes. Fire drills in January were dated as follows: first shift January 4, 2024, second shift January 12, 2024, and third shift January 19, 2024. Mock emergency drills were also conducted on the dates listed above, and included incidents of injury to a youth and weather-related emergencies. Fire protection equipment inspection was done December 8, 2023, and all fire extinguishers throughout the facility were tagged as follows: kitchen, common area, back exit extinguishers are all due May 2027; the second common area, bathroom, hall, and back extinguishers are all due May 2024; the van extinguisher is due May 2029; the front extinguisher is due May 2035.	

Fire and Safety Health Hazards: a. Agency has a current Satisfactory Residential Group Care inspection report from the Department of Health. b. Agency has a current Satisfactory Food Service inspection report from the Department of Health and food menus are posted, current and signed by Licensed Dietician annually. c. All cold food is properly stored, marked and labeled and dry storage/pantry area is clean and food is properly stored. d. Refrigerators/Freezers are clean and maintained at required temperatures and all small and medium sized appliances are operable and clean for use as needed.	**Compliance**	The most recent Residential Group Care Inspection report is dated April 18, 2023 (the permit expires September 20, 2024). A satisfactory Food Service inspection was done on the same date (April 18, 2023). Weekly menus are posted in the common area and have been initialed by the Licensed Dietician, whose license is valid through May 31, 2025. All food is properly labeled and stored. Individual packages of meat were observed in the freezer in labeled freezer bags. Other frozen food was in original, unopened packaging. The food in the refrigerator was well organized and all dates were current. Dry storage was also well organized and all dates were current. Both the refrigerator and freezer appeared to be clean and sanitary. The refrigerator temperature was 38 degrees Fahrenheit, and the freezer was 0 degrees Fahrenheit. All small appliances were observed to be clean and in good working condition.	
Additional Fire and Safety Health Hazards Narrative (if applicable)			
Youth Engagement			
a. Youth are engaged in meaningful, structured activities (e.g., education, recreation, counseling services, life and social skill training) seven days a week during awake hours. Idle time is minimal. b. At least one hour of physical activity is provided daily. c. Youth are provided the opportunity to participate in a variety of faith-based activities. Non-punitive structured activities are offered to youth who do not choose to participate in faith-based activities. d. Daily programming includes opportunities for youth to complete homework and access a variety of age appropriate, program approved books for reading. Youth are allowed quiet time to read. e. Daily programming schedule is publicly posted and accessible to both staff and youth.	**Compliance**	The daily schedule requires youth to be engaged in appropriate activities throughout the day. They are provided time for counseling, group work, homework, self-care, and recreation. There is minimal idle time available for youth. There are separate daily schedules for weekdays and weekends. The daily schedule allows thirty minutes in the morning for physical activity and at least thirty minutes late in the afternoon for physical activity. According to the Shelter Supervisor, youth are typically engaged in physical activity for at least one hour each afternoon, weather permitting. The daily schedule for weekends indicates that youth may request to participate in faith based activities. This item is highlighted in yellow at the bottom of the weekend schedule. The daily schedule is posted in the common area and is easily visible by youth and staff.	
Additional Comments: **There are no additional comments for this indicator.**			
3.02 - Program Orientation			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 3.02		**YES** If NO, explain here: The facility's policy is "3.02 Program Orientation" and was last reviewed by the COO in 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: One
Total number of Closed Files: Four
Staff Position(s) Interviewed *(No Staff Names)* **: Shelter Supervisor, Vice President of Impact, Clinical Manager**
Type of Documentation(s) Reviewed: client files
Describe any Observations:

Youth received a comprehensive orientation and handbook provided within 24 hours	**Exception**	Three client files were reviewed and were found to be in compliance. A fourth client file was reviewed and it was discovered that the youth had been Baker Acted within 24 hours of initial intake, so no orientation took place.	One client file did not have documentation that a comprehensive orientation and handbook were provided within 24 hours.
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**	Four client files were reviewed and were found to be in compliance. A fifth client file was reviewed and it was discovered that the youth had been Baker Acted within 24 hours of initial intake, so no orientation took place.	
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**	Four client files were reviewed and were found to be in compliance. A fifth client file was reviewed and it was discovered that the youth had been Baker Acted within 24 hours of initial intake, so no orientation was applicable in this case.	

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

3.03 - Youth Room Assignment		**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 3.03	**YES**	
	If NO, explain here:	
	The facility's policy is "3.03 Youth Room Assignment" and was last reviewed by the COO in 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: One **Total number of Closed Files: Four** **Staff Position(s) Interviewed (No Staff Names): Clinical Manager** **Type of Documentation(s) Reviewed: client files, log books** **Describe any Observations: It seems that documentation is not consistent between client files; documents that appear in one client's file may not appear in another client's file. In addition, clients who move between Family Resources' shelters do not always have complete documentation for their current placement.**			
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	**Exception**	A review of five client files (one open, four closed), indicated that the facility routinely reviews youth's history, status, and exposure to trauma. The facility also routinely collects collateral contacts for all clients. The facility assesses clients' ages and history of violent behaviors and assigns rooms appropriately accordingly. The facility routinely documents medical, mental and physical disabilities, and evaluates for suicide risk and any health symptoms requiring quarantine or isolation. One youth's file did not have full documentation, as the youth was Baker Acted within 24 hours of arrival at the facility.	One of the client files reviewed had no documentation of staff's initial interaction with and observation of a youth entering care at this shelter. Another file had no documentation that the youth was or was not susceptible to victimization or that the youth was evaluated for sexually aggressive or predatory behavior. This client was transferred from another Family Resources shelter and a new room assignment intake was not done.
An alert is immediately entered into the program's alert system when a youth is admitted with special needs and risks such as risk of suicide, mental health, substance abuse, physical health or security risk factors	**Compliance**	All of the client files reviewed indicated that alerts for special needs were immediately entered into the program's alert system.	
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 facility's policy is "3.04 Log Book" and was last reviewed by the COO in 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: July 2023 - present **Staff Position(s) Interviewed** *(No Staff Names)* **:** **Type of Documentation(s) Reviewed: Logbooks** **Describe any Observations:**			
Log book entries that could impact the security and safety of the youth and/or program are highlighted	**Compliance**	Two logbooks were observed: 11/21/23 - present and 7/2/23 - 11/21/23. Staff making entries into the logbooks are identified and have signed a form attached to the first page of each book. Logbook entries detailed pertinent information about each youth, including the youth's alert level(s). Entries for 11/24/23, 11/26/23, 12/4/23, 12/6/23, 1/19/24, 1/23/24, 2/3/24, 2/14/24, 3/1/24, 3/4/24 were observed that detailed safety and security issues impacting youth and/or program.	
All entries are brief, legibly written in ink and include: • Date and time of the incident, event or activity • Names of youth and staff involved • Brief statement providing pertinent information • Name and signature of person making the entry	**Compliance**	Entries were observed to be regularly written in ink and were clearly and legibly written. Late entries observed for 11/29/23, 12/4/23, 1/8/24, 2/5/24, and 3/3/24 were clearly marked as late. All entries were observed to have recorded the dates and times of incidents, as well as staff and youth names, a brief statement of the occurrence, and a clear staff name/signature.	
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**	Errors were observed to be struck through with one single line and initialed by staff. Errors were observed on 11/24/23, 11/26/23, 11/29/23, 12/4/23, 12/6/23, 12/7/23, 1/12/24, 1/17/24, 1/18/24, 2/4/24, 2/7/24, 2/11/24, 3/3/24. This is not an exhaustive list. No areas of white-out or erasures were observed in either logbook.	
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**	It was observed that the Shelter Supervisor reviews the week's log entries and notes any special concerns. These notes are highlighted in blue in the logbooks. Supervisory reviews were done typically every two to four days: some selected dates observed were 11/22/23, 11/25/23, 11/27/23, 12/8/23, 12/12/23, 12/13/23, 1/2/23, 1/3/23, 1/4/23, 2/5/23, 2/9/23, 3/1/23, 3/5/23. The Shelter Supervisor also documents routine camera reviews.	
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**	It was observed that staff routinely document that the notes from the previous two shifts were reviewed at the start of each shift. Some observed dates for these entries are: 11/22/23, 11/28/23, 12/4/23, 12/8/23, 12/12/23, 1/8/24, 1/15/24, 2/9/24, 2/14/24, 3/1/24, and 3/5/24.	
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**	It was observed on 11/22/23, 11/28/23, 12/04,23, 12/8/23, 12/12/23, 01/08/24, 01/15/24, 02/9/24, 02/14/24, 03/1/24, and 03/05/24 that at the beginning of the shift, oncoming supervisor and shelter counselor review the logbook of all shifts since their last log entry and makes a signed and dated entry into the log book indicating the dates reviewed.	

Logbook entries include: a. Supervision and resident counts b. Visitation and home visits	**Compliance**	Census counts were observed for each day, and evening bed checks were routinely documented. Family visits and the arrival/departure dates and times and family member picking up each youth for home visits was documented. Also documented are any communications between the facility and relatives pertaining to anticipated check out and return dates for youth in care.	
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 facility's policy is "3.05/3.05A Behavior Management Strategies" and was last reviewed by the COO in 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)* **: COO, Clinical Manager** **Type of Documentation(s) Reviewed:** **Describe any Observations:**			
The program has a detailed written description of the BMS and it is explained during program orientation	**Compliance**	The program has a detailed written description of the BMS and it is explained during program orientation.	
Behavior Management Strategies must include:			

a. BMS is designed to teach youth new behaviors and help youth understand the natural consequences for their actions b. Behavioral interventions are applied immediately, with certainty, and reflect the severity of the behavior c. BMS uses a wide variety of awards/incentives to encourage participation and completion of the program d. Appropriate consequences and sanctions are used by the program and consequences for behavior are logical and designed to promote skill-building for the youth e. Counseling, verbal intervention and de-escalation techniques are used prior to physical intervention (Only techniques approved by the Florida Network and DJJ are used if physical intervention is required) f. Only staff discipline youth. Group discipline is not imposed g. Room restriction is not used as part of the system or for youth who are physically and/or emotionally out of control h. Youth should never be denied basic rights such as meals, clothing, sleep, services, exercise, or correspondence privileges	**Compliance**	The program uses positive incentives largely based on verbal encouragement, support and reinforcement, as well as levels of performance. These levels designate each out as being "orientation," "citizenship," "leadership," and "ownership," with "ownership" being the least successful of the levels. Youth discuss disciplinary levels as a group each day, and areas for growth are shared by staff for each of the youth in care. Youth can be rewarded for their efforts in meeting their personal objectives and for making positive contributions to the shelter experience. Youth are given verbal redirection when behavior does not meet the facility's requirements, and are given multiple methods for reaching behavioral expectations, depending on the circumstances of the violations. The log book describes that application of behavioral interventions. Entries on 9/4/23, 10/3/23, 10/12/23, 10/22/23, and 11/15/23 all describe level changes or natural consequences for behavior. The facility has a step by step procedure for processing violations, which are outlined in the policy manual as well as in the orientation materials given to each youth upon arrival at the facility. Youth are never denied regular meals or snacks, clothing, sleep, physical or mental health services, educational services, exercise, correspondence privileges, contact with parents or guardians, their attorney of record, juvenile probation officer, or clergy.	
Program's use of the BMS			
All staff are trained in the theory and practice of administering BMS rewards and consequences	**Compliance**	Training on the facility's behavior management system is part of each staff member's onboarding requirements.	
There is a protocol for providing feedback and evaluation of staff regarding their use of BMS rewards and consequences	**Compliance**	The facility uses the grievance process to determine if consequences have been applied appropriately. Staff are counseled on use of the behavior management system if youth have lodged a grievance.	
Supervisors are trained to monitor the use of rewards and consequences by their staff	**Compliance**	Supervisors complete worksheets on each shift detailing the level-based interventions occurring during every shift.	
Additional Comments: **There are no additional comments for this indicator.**			

3.06 - Staffing and Youth Supervision			Satisfactory with Exception
Provider has a written policy and procedure that meets the requirement for Indicator 3.06	**YES**		
	If NO, explain here:		
	The facility's policy is "3.06 Staffing and Youth Supervision" and was last reviewed by the COO in 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: September - December 2023 and January - March 2024
Staff Position(s) Interviewed *(No Staff Names)* **: COO, Clinical Manager, VP of Impact**
Type of Documentation(s) Reviewed: log books, staff schedules, bed check logs, video camera footage
Describe any Observations: Third shift staffing levels are a known issue and are being addressed.

The program maintains minimum staffing ratios as required by Florida Administrative Code and contract. • 1 staff to 6 youth during awake hours and community activities • 1 staff to 12 youth during the sleep period	**Compliance**	Staff schedules for September - December 2023 and January - March 2024 were reviewed. A random sampling of dates are documented here: 9/1/23 - 4 youth present/2 staff on schedule for all shifts; 9/16/23 4 youth present/1 staff scheduled for 1st shift, 2 staff scheduled for shifts 2 and 3; 9/22/23 - 5 youth present/1 staff scheduled for each shift; 10/11/23 - 8 youth present/2 staff scheduled for each shift; 10/26/23 - 5 youth present/2 staff scheduled for shifts 1 and 2, 1 staff scheduled for shift 3; 11/22/23 - 5 youth present/2 staff scheduled for shifts 1 and 2, 1 staff scheduled for shift 3; 11/25/23 - 3 youth present/2 staff scheduled for shift 1, 1 staff scheduled for shifts 2 and 3; 12/1/23 - 5 youth present/1 staff scheduled for each shift; 12/20/23 - 1 youth present/2 staff scheduled for shift 1, 3 staff scheduled for shift 2, 2 staff scheduled for shift 3; 1/8/24 - 12 youth present/2 staff scheduled for shift 1, 3 staff scheduled for shift 2, 2 staff scheduled for shift 3; 1/20/24 - 4 youth present/2 staff scheduled for shift 1, 1 staff scheduled for shifts 2 and 3; 2/4/24 - 5 youth present/2 staff scheduled for shifts 1 and 2, 1 staff scheduled for shift 3; 2/23/24 - 5 youth present/2 staff scheduled for shifts 1 and 3, 3 staff scheduled for shift 2; 3/2/24 - 5 youth present/2 staff scheduled for shift 1, 1 staff scheduled for shifts 2 and 3; 3/7/24 - 7 youth present/2 staff scheduled for shifts 1 and 2, 1 staff scheduled for shift 3.	
All shifts must always provide a minimum of two direct care staff present that have met the minimum training requirements	**Exception**	A random sample of sixteen dates from September - December 2023 and January - March 2024, was reviewed on the staff schedule and in the program's log book to verify the number of direct care staff present that have met the minimum training requirements.	Although staff to youth ratios are routinely maintained, there are times when the facility does not have two staff on the premises. The overnight shifts on 9/30/23, 10/21/23, 10/22/23, 10/27/23, and 10/29/23 had only one staff member on site, as evidenced by the staff schedule, the bed check log, and the logbook.

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**	All staff caring for youth and included in ratio are background screened and properly trained according to their roles.	
The staff schedule is provided to staff or posted in a place visible to staff	**Compliance**	The staff schedule is posted in the common area behind the staff desk.	
There is a holdover or overtime rotation roster which includes the telephone numbers of staff who may be accessed when additional coverage is needed	**Compliance**	The facility maintains a list with phone numbers of staff available to cover when needed.	
Staff observe youth at least every 15 minutes while they are in their sleeping room, either during the sleep period or at other times, such as during illness or room restriction	**Exception**	The logbook documents each day that overnight bed checks were done. The bed check log supports the logbook documentation and includes daytime checks when youth are ill/sleeping. Times are documented in real time, and were verified by review of video footage for 3/1/24 at 11 pm and 3:15 am, for 3/6/24 at 12:30 am and 4:00 am, and 3/7/24 at 10:15 pm, 2/19/24 at 11:45 pm and 2:45 am, and 2/13/24 at 1:15 am and 3:45 am. Each bedroom has three beds lined up against one wall; beds are placed approximately four feet apart and are easily observable from each bedroom door. This facility also uses the couches in the common area for sight and sound checks or ill youth, and lists "couch" on the bed check log.	On 3/5/24, there are gaps in bed checks from 5:37 am to 6:04 am and from 6:22 am to 6:51 am, and a note was made that the gap in bed checks was due to a parent bringing a client clothes.

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 facility's policy is "3.07 Video Surveillance System," and was last reviewed by the COO in 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: September 1, 2023 to March 1, 2024
Staff Position(s) Interviewed *(No Staff Names)* **: Shelter Supervisor, COO**
Type of Documentation(s) Reviewed: Log books, video footage
Describe any Observations:

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**	Notices that recording is in progress are posted in several areas of the shelter. Cameras are located in multiple areas of the shelter, both in the interior and exterior of the building. This facility also has a dedicated camera for medication administration. Cameras are readily visible in the shelter, and no cameras are located in bathrooms or sleeping areas. Per the COO, video footage is maintained for 30 days, and the system records date and time; the COO reports that staff are easily able to identify the location of the footage. There is limited back up for the surveillance system in the event of a power outage.	
A list of designated personnel who can access the video surveillance system is maintained (includes off-site capability per personnel)?	**Compliance**	Although all staff can view the video, administrative staff are the only staff permitted to access functions. Administrative staff include the CEO, COO, VP of Impact, and Shelter Supervisor.	
Supervisory review of video is conducted a minimum of once every 14 days and timeframes reviewed are noted in the logbook.	**Compliance**	Entries in the log book were observed that indicated the camera footage is reviewed every 14 days and documentation is made of the date and times reviewed.	
The reviews assess the activities of the facility and include a review of random sample of overnight shifts	**Compliance**	The following dates observed in the log book from September 1, 2023 to March 1, 2024 that indicate that reviews of camera footage was completed: 9/1/23 (8/30/23) from 5:30 pm to 7:30 pm, 9/12/23 (9/9/23) from 6:30 am to 9:30 am, 10/3/23 (10/1/23) from 11:30 am to 1:30 pm, 10/24/23 (10/16/23) from 10 pm to 12 am, 11/1/23 (10/31/23) from 6:30 am to 8:30 am, 11/17/23 (11/13/23) from 8 pm to 10 pm.	
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 policy for release of video recordings is outlined in the facility's policy manual. This policy matches the Florida Network policy.	

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**	According to the COO, as soon as an inoperable camera is identified, a repair order is initiated. The longest period of time a camera has been inoperable is four days.	
Additional Comments: **There are no additional comments for this indicator.**			
4.01 - Healthcare Admission Screening			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 4.01		**YES** If NO, explain here: The agency has a policy, 4.01 Health Care Admission Screening, reviewed and approved by COO. in 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: Five **Total number of Closed Files: Four** **Staff Position(s) Interviewed (No Staff Names):** **Type of Documentation(s) Reviewed: Client files and log book** **Describe any Observations:**			
Preliminary Healthcare Screening			
Screening includes : a. Current medications b. Existing (acute and chronic) medical conditions c. Allergies d. Recent injuries or illnesses e. Presence of pain or other physical distress f. Observation for evidence of illness, injury, physical distress, difficulty moving, etc. g. Observation for presence of scars, tattoos, or other skin markings h. Acute health symptoms requiring quarantine or isolation	**Compliance**	Reviewed five files (four closed and one open). All five files had a residential intake form present that contained the preliminary healthcare screening. Three closed files indicated that the youth was on medications while two youth files indicated that the youth were not on medications. One of the four youth files reviewed had an existing medical condition. Three closed files indicated that the youth had an allergy, while one closed and one open file indicated that the youth did not have an allergy. One out of the five files indicated that the youth had a recent illness or injury (S.T.I. and bladder infection). That youth was on medication to help manage and follow up was made with mother which was documented in the log book on 11/13/2023.	
Referral and Follow-Up			
Youth with chronic medical conditions have a referral to ensure medical care (e.g. diabetes, pregnancy, seizure disorder, cardiac disorders, asthma, tuberculosis, hemophilia, head injuries, etc.)	**No eligible items for review**	The agency has not had any cases of youth with chronic medical conditions in the last six months or since the last on-site QI review.	

When needed, the parent is involved with the coordination and scheduling of follow-up medical appointments	**Compliance**	Only one of the five files reviewed needed parent involvement with the coordination and scheduling of follow-up medical appointments. Follow-up was captured for the one required case on 11/13/2023 in the log book.	
All medical referrals are documented on a daily log.	**Compliance**	Medical referrals were documented in the log book and met the standard.	
The program has a thorough referral process and a mechanism for necessary follow-up medical care as required and/or needed	**Compliance**	The program does have a thorough procedure in place to manage necessary follow-up and medical care which is written in their policy and executed in the log book and client files.	
Additional Comments: **There are no additional comments for this indicator.**			
4.02 - Suicide Prevention			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 4.02		**YES** If NO, explain here: The agency has a policy, 4.02 Suicide Prevention, last reviewed and approved January 2024 by the COO.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open (Residential & Community) Files: Three **Total number of Closed (Residential & Community) Files: Six** **Staff Position(s) Interviewed** *(No Staff Names)* **: Clinical Director** **Type of Documentation(s) Reviewed: Client files** **Describe any Observations:**			
Suicide Risk Screening and Approval (*Residential and Community Counseling*)			
Suicide risk screening occurred during the initial intake and screening process. Suicide screening results reviewed and signed by the supervisor and documented in the youth's case file.	**Exception**	Nine files were reviewed-- five residential and four community counseling, four opened and five closed files. All nine files reviewed provided documentation of the suicide risk screening being conducted during the initial intake and screening process and contained signature lines for staff and supervisors.	One open community counseling file had a completed risk screening conducted on 1/3/2024 and was not signed by the supervisor until the Clinical Director signed while the review team was onsite. One closed Residential file had a risk screening conducted on 8/20/2023 at the South Shelter, the youth was transferred to North Shelter with a new risk screening being conducted and the 8/20 risk screening did not have a supervisor's signature.
The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	**Compliance**	The program's suicide risk assessment has been approved by the Florida Network.	
Supervision of Youth with Suicide Risk *(Shelter Only)*			

Youth are placed on the appropriate level of supervision based on the results of the suicide risk assessment.	**Compliance**	Five files were reviewed, four closed and one open. All youth were placed on the appropriate level of supervision.	
Staff person assigned to monitor youth maintained one-to-one supervision or constant supervision and documented his/her observations of the youth's behavior at 30 minute or less intervals	**Compliance**	Five file were reviewed. Two of the files had documentation of a staff maintaining and documenting the one-to-one supervision at 30 minute intervals. Three of the reviewed file did not require a higher level of supervision based on the risk screening.	
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 organization utilizes a red observation log that is implemented when a youth is placed on a higher level of observation. The observation log includes the time of day, behavior of the youth, any warning signs and the staff's initials.	
Supervision level was not changed/reduced until a licensed professional or a non-licensed mental health professional under the supervision of a licensed professional completed a further assessment OR Baker Act by local law enforcement	**Compliance**	Two of the five files reviewed required a change in the supervision level. One youth was kept on a one-to-one until he was Baker Acted less than 24 hours of being admitted to the program. One youth was kept on a one-to-one until being removed by a licensed professional. Three of the files reviewed were not applicable as they did not require a change in supervision.	
There was evidence that documentation was reviewed by supervisory staff each shift. If program uses an observation log, completed logs are maintained in the youth's file.	**Compliance**	There was evidence that documentation was reviewed by supervisory staff each shift. The observation logs were in the electronic 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.	**No eligible items for review**	Four community counseling files were reviewed, three closed and one open. None of the files identified a risk of suicide of the youth.	

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**	Four community counseling files were reviewed, three closed and one open. None of the files identified a risk of suicide of the youth. The program's policy and interview with the Clinical Director indicated the youth would be immediately referred by the provider and the parent or guardian notified of the suicide risk finding disclosed and advised that an assessment of suicide risk should be completed ASAP 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**	There were no cases requiring further assessment. According to the program's policy, information on resources available in the community for further assessment shall be provided to the parent/guardian by the program staff.	
If the parent/guardian cannot be contacted, all efforts to contact them are documented in the case file.	**Compliance**	There were no cases requiring further assessment. The program's policy indicates if the parent or guardian cannot be contacted, all efforts to contact them are documented in the case file.	
When the screening was completed during school hours on school property, the appropriate school authorities were notified.	**Not Applicable**	Four of four youth files reviewed did not have screenings completed during school hours on school property.	
Additional Comments: **There are no additional comments for this indicator.**			

4.03 - Medications			Satisfactory with Exception
Provider has a written policy and procedure that meets the requirement for Indicator 4.03	**YES**		
	If NO, explain here:		
	The agency has a policy, 4.03 Medications Approved, last reviewed and approved January 2024 by the COO.		

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

Total number of Open Files: Four
Total number of Closed Files: Zero
Staff Position(s) Interviewed *(No Staff Names)* **: Residential Nurse, Lead YDS**
Type of Documentation(s) Reviewed: Medication Logs, Log book, Training Logs
Describe any Observations:

The agency has a Registered Nurse (RN) and/or a Licensed Practical Nurse (LPN) that is being supervised by RN and all of their credentials have been verified.	**Compliance**	The Shelter has one RN nurse that comes in on Mondays and Tuesdays.	
The agency has evidence of the following for all non-nursing shelter staff designated to assist with the self-administration of medication: a. Documentation of in-person self-administration of medication distribution training provided by a Registered Nurse b. Evidence demonstrating their competency to assist with self-administration of medication distribution c. Maintenance of their annual medication training re-certification	**Compliance**	The Nurse trained all staff listed in the medication room as being able to assist in self-administration of medications. Certificates of successful completion of the training and competency are located in the staff training files. Monthly staff meetings have a medication refresher component that is listed on the meeting agenda.	
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**	Date(s) of quarterly meetings held: 11/7/2023, and 1/16/2024 staff meetings were held to allow the staff to role play, present any issues/concerns. Alexia is used and the med pass window of time is 30 minutes not an hour so if a medication is not passed within the 30 minute window there will be an additional 30 minutes to pass the medication and still be in compliance with the standard.	
The agency has strategies implemented to ensure medications are provided within the 2-hour time frame.	**Compliance**	In the interview with the nurse she explained that instead of the 2-hour time frame their practice is a one hour time frame to allow an additional hour to provide the medication if needed.	

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**	In the interview with the nurse it was indicated that the staff that is responsible for shift medication pass is highlighted in blue and upon observation of the schedule writer could confirm that each shift had a staff highlighted in blue. Reviewer observed in the medication room a white board that reflected which youth were on medications and at which time the medication were to be administered.	
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**	Reviewer observed a medication book that contained the medication logs for each youth on medications. There were tabs present to divide each youth and the medication logs were organized behind each youth's tab based on time the medication was to be administered. The white board in the medication room listed each youth that was on medication and the time the youth were to receive the medication.	
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**	Interview with the shelter nurse educated the reviewer that there are reports run to monitor the time of medications pass, controlled medication discrepancies. Nurse was able to provide reports to confirm the practice.	
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.	**Exception**	Four open files were reviewed. All four files had documentation in the form of an electronic progress note written by the shelter's RN within three business days that an interview was conducted about the youth's current medications as part of the Medical and Mental Health Assessment. Two of the four files showed evidence of a supervisor or higher level staff conducting a review of medications forms by the next business day.	Two youth files were missing the signature of the supervisor on the residential intake form.
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	**Exception**	It was observed that all medications were properly stored in the Pyxis ES Medication Cabinet and is inaccessible to the youth. Upon observation all oral medications were stored in the Pyxis and no injectable or topical medications were present. Pyxis keys are located in the medication room in a drawer. All keys were labeled.	It was observed that the medication fridge is not in working order. During an interview with the nurse and lead YDS it was stated that the fridge went out around the 18th of Feb. and a new fridge was being procured. There are currently no youth in shelter requiring refrigerated medications.
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 agency maintains a minimum of 2 site-specific System Managers for the Pyxis ES Station, only designated staff delineated in User Permissions have access to secured medications, with limited access to controlled substances (narcotics). A Medication Distribution Log shall be used for distribution of medication by non-licensed and licensed staff. The agency verifies medication using one of three methods listed in the FNYFS Policies & Procedures Manual. The nurse is on duty every Monday and Tuesday and medication processes are ALWAYS conducted by the nurse on those days. All other days, medication processes are conducted by the designated staff who has been trained by a licensed Registered Nurse. The agency does not accept youth currently prescribed injectable medications, except for epi-pens and Non-licensed staff have received training in the use of epinephrine auto-injectors provided by a registered nurse.	

The medication distribution log documentation includes: a. the time of medication administration b. evidence of youth initials that the dosage was given c. evidence of staff initials that the dosage was given	**Compliance**	A review of the agency's medication distribution logs showed they include: 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	
There is evidence that staff provide youth with medications within one hour of the scheduled time of delivery as ordered by the medication. Documentation is provided for instances this does not occur within the required timeframe.	**Compliance**	The agency documents that staff provides youth with medications within one hour of the scheduled time of delivery as ordered by the medication. The agency has several practices in place to ensure staff adhere to the timeframe for medication distribution, including alarms, reminders from Alexa, and written documentation. There is no instances where medication distribution did not occur within the required timeframe.	
During the review period, there were no instances where youth missed their medication due to failure to open the pyxis machine.	**Compliance**	During the review period, there were no instances where youth missed their medication due to failure to open the pyxis machine.	
<u>If applicable:</u> 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 instances of medication error requiring a refresher training from the registered nurse.	
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**	Observed medication logs. Two controlled medications were present and both had double signatures each shift for perpetual inventory balances. In an interview with the RN., it was stated that OTC medications are not generally stocked and are only presented by Legal Guardians with a doctor's note. The RN. noted that there are also no syringes or sharps.	

There are monthly reviews of the Pyxis reports to monitor medication management practice.	**Compliance**	The nurse conducts monthly reviews of the Pyxis reports to monitor medication management practice.	
Medication discrepancies are cleared after each shift.	**Exception**	Observation at the time of the review showed there were no discrepancies found. RN stated that she will be training medication staff on clearing discrepancies at next training.	During the interview with the RN. she stated that the discrepancies are cleared on Mondays and Tuesdays when she comes to work and not after each shift.
Additional Comments: **There are no additional comments for this indicator.**			
4.04 - Medical/Mental Health Alert Process			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 4.04		**YES** If NO, explain here: The agency has a policy, 4.04 Medical and Mental Health Alerts, reviewed and approved by COO. on 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: One **Total number of Closed Files: Four** **Staff Position(s) Interviewed** *(No Staff Names)* **: Lead YDS and Clinical Director** **Type of Documentation(s) Reviewed: Client files, log book, Census Board** **Describe any Observations:**			
Youth with a medical, mental health, or food allergy was appropriately placed on the program's alert system	**Exception**	Five files were reviewed, one open and four closed. One of the youth did not have a medical, mental health or allergy. Three of the four youth that did have a medical, mental health or allergy were placed appropriately on the program's alert system.	One youth file reviewed was transferred from the south shelter and the residential intake form stated that the youth has a milk allergy but the north shelter intake note did not state the allergy nor did it have the alert code in the notes for food allergy.
Alert system includes precautions concerning prescribed medications, medical/mental health conditions	**Compliance**	The agency's alert system includes precautions concerning prescribed medications and medical/mental health conditions.	

Staff are provided sufficient training, information and instructions to recognize/respond to the need for emergency care for medical/mental health problems	**Compliance**	All staff are provided sufficient training in CPR/ First Aid, information and instructions to recognize/respond to the need for emergency care for medical/mental health problems.	
A medical and mental health alert system is in place that ensures information concerning a youth's medical condition, allergies, common side effects of prescribed medications, foods and medications that are contraindicated, or other pertinent mental health treatment information, is communicated to all staff	**Compliance**	A medical and mental health alert system is in place during intake, on the youth census board and in Lauris 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 with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 4.05		**YES** If NO, explain here: The agency has a policy, 4.05 Episodic/ Emergency Care, reviewed and approved by COO. in 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: One **Total number of Closed Files: One** **Staff Position(s) Interviewed (No Staff Names): Vice President of Impact** **Type of Documentation(s) Reviewed: Youth files, Incident reports, First Aid/ Episodic log, CCC reports, log books** **Describe any Observations: No entries in the logbook or on the episodic log meet the criteria as off-site emergency dental or medical care.**			
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	**No eligible items for review**	There were no instances of off-site emergency medical or dental care provided in the last six months or back to the date of the last QI review.	
All staff are trained on emergency medical procedures	**Compliance**	All staff are trained on emergency medical procedures.	
The program has a Knife-for-life and wire cutters accessible to staff in a secure location(s)	**Exception**	Knife for life is located in the drawer behind the staff desk. First Aid kits in the van and the dining area closet both are in acceptable expiration date range.	Wire cutters were missing per the staff interviewed.
Additional Comments: **There are no additional comments for this indicator.**			