Florida Network for Youth and Family Services
Compliance Monitoring Report for

Lutheran Services Florida NW – HOPE House

5127 Eastland Street
Crestview, FL 32539

March 20-21, 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 Lutheran Services Florida NW HOPE House (LSF NW HOPE House) for the FY 2023-2024 at its program office located at 5127 Eastland Street, Crestview, FL 32539. Forefront LLC (Forefront) is an independent compliance monitoring firm that is contracted by the FNYFS to perform onsite program reviews to assess the agency's adherence to fiscal, programmatic and overall contract requirements. LSF NW HOPE House 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 compliance monitoring review was conducted by Keith Carr, Consultant for Forefront LLC. Agency representatives from LSF NW HOPE House present for the entrance interview were Sherri Kirkpatrick, Regional Director and LSF NW HOPE House Residential, Community Counseling and Administrative staff members. The last onsite QI visit was conducted in 2023.

In general, the Reviewer found that LSF NW HOPE House is in compliance with specific contract requirements. LSF NW HOPE House **received an overall compliance rating of 100% for achieving full compliance with 12 of the 14 compliance indicators** of the CINS/FINS Monitoring Tool. There were no recommendations or 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 3-20-21-2024

Agency Name: Lutheran Services Florida-NW HOPE House	**Monitor Name: Keith Carr, Lead Reviewer**
Contract Type : CINS/FINS	**Region/Office: 5127 Eastland Street , Crestview, FL 32539**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): March 20-21, 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.	☐	☐	☒	☐	☐	Interview/Documentation: The program currently has two staff members certified as DJJ QI Peer reviewers for this location that cover the LSF NW HOPE House programs: Cyndy Freshour and Chrissy Baker. The staff have participated and/or are scheduled for peer reviews this fiscal year.	**No recommendation or Corrective Action.**
Additional Contracts a. Provider shall provide a listing of all current federal, state, or local government contracts, as well as other contracts entered into with for profit and not-for-profit organizations. Such a listing shall identify the awarding entity and contract start & end dates. **PTV**	☐	☐	☒	☐	☐	Documentation: A list of additional grant contracts for FY 2023-2024 was provided by the provider. The list includes fund identification number, program name, funding source name, contract period start and end dates and contract amount.	**No recommendation or Corrective Action.**
Limits of Coverage a. Provider shall provide and maintain during this contract, the following minimum kinds of insurance: Worker's Compensation and Employer's liability insurance as required by Chapter 440, F.S. with a minimum of	☐	☐	☒	☐	☐	Documentation: The provider has a policy with Market Global Reinsurance Company for General Liability insurance with limits	**No recommendation or Corrective Action.**

2023-2024 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 3-20-21-2024

Agency Name: Lutheran Services Florida-NW HOPE House	**Monitor Name: Keith Carr, Lead Reviewer**
Contract Type : CINS/FINS	**Region/Office: 5127 Eastland Street , Crestview, FL 32539**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): March 20-21, 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:
$100,000 per accident, $100,000 per person and $500,000 policy aggregate. Commercial General Liability with a limit of $500,000 per occurrence, and $1,000,000 policy aggregate. Automobile Liability Insurance shall be required and shall provide bodily injury and property damage liability covering the operation of all vehicles used in conjunction with performance of this contract, with a minimum limit for bodily injury of $250,000 per person; with a minimum limit for bodily injury of $500,000 per accident; with a minimum limit for property damage of $100,000 per accident and with a minimum limit for medical payments or $5,000-$10,000 per person. Florida Network is listed as payee or co-payee. **PTV**						of coverage of $1,000,000 each/$3,000,000 aggregate and $10,000 each for medical expenses. Additional policies with this carrier include Professional Liability insurance provides limits of coverage of $1,000,000 each/$3,000,000 aggregate and Abuse/Molestation insurance provides limits of coverage of $1,000,000 each/$3,000,000 aggregate. The provider has a policy with Florida Insurance Trust for Automobile insurance that provides limits of coverage of $1,000,000 combined for each accident. The provider has a policy with Century Surety Company for Excess/Umbrella Liability insurance which provides limits of coverage of $1,000,000 each/aggregate. Coverage for the above policies is in	

2023-2024 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 3-20-21-2024

Agency Name: Lutheran Services Florida-NW HOPE House	**Monitor Name: Keith Carr, Lead Reviewer**
Contract Type : CINS/FINS	**Region/Office: 5127 Eastland Street , Crestview, FL 32539**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): March 20-21, 2024**

Major Programmatic Requirements	**Explain Rating**					**Ratings Based Upon:** **I = Interview** **O = Observation** **D = Documentation** **PTV = Submitted Prior To Visit** **(List Who and What)**	**Notes** **Explain Unacceptable or Conditionally Acceptable:**
	Unacceptable	**Conditionally Unacceptable**	**Fully Met**	**Exceeded**	**Not Applicable**		
						effect for the current FY 6/01/2023-6/01/2024. The certificate does list the Florida Network on the consolidate certificate of liability as a certificate holder.	
External/Outside Contract Compliance a. Provider has corrective action item(s) cited by an external funding source (Fiscal or Non-Fiscal). **ON SITE**	☐	☐	☐	☐	☒	Documentation/Interview: N/A – Regional Director indicated that there are no outstanding corrective action item(s) cited by an external funding source.	**Not Applicable.**
Fiscal Practice a. Agency must have employee and fiscal policy/procedures manuals that are in compliance with GAAP and provide sound internal controls. Agency maintains fiscal files that are audit ready. **PTV**	☐	☐	☒	☐	☐	Documentation: The provider has several policies that address general accounting practices which are maintained by the Chief Financial Officer for the agency. Fiscal policies and procedures are contained in the agency's Financial Services Policy and Procedures Manual. The procedures appear to be consistent with GAAP and provide for limited internal controls. Provider provided 45 policies which include procedures for general ledger, cost	**No recommendation or Corrective Action.**

2023-2024 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 3-20-21-2024

Agency Name: Lutheran Services Florida-NW HOPE House	**Monitor Name: Keith Carr, Lead Reviewer**
Contract Type : CINS/FINS	**Region/Office: 5127 Eastland Street , Crestview, FL 32539**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): March 20-21, 2024**

Major Programmatic Requirements	**Explain Rating**					**Ratings Based Upon:** **I = Interview** **O = Observation** **D = Documentation** **PTV = Submitted Prior To Visit** **(List Who and What)**	**Notes** **Explain Unacceptable or Conditionally Acceptable:**
	Unacceptable	**Conditionally Unacceptable**	**Fully Met**	**Exceeded**	**Not Applicable**		
						accounting, payroll, petty cash, computer backup, and other relevant financial processes.	
b. Agency maintains a general ledger and the corresponding source documents. A general ledger must be set up to track the activity of the grant separately (standard account numbers / separate funds for each revenue source, etc.). **PTV**	☐	☐	☒	☐	☐	Documentation: Detailed General Ledger for the current FY2023-2024 for July 2023 – Feb 2024. Provider maintains a detailed general ledger that includes breakdown of GL code, GL title, effective date, Doc number, ID number, Name of funding source, transaction description, fund code, year code, program code, location code, and debit and credit columns. Ledgers included current balances and differences.	**No recommendation or Corrective Action.**
c. Petty cash ledger system is balanced and all cash disbursements are compliant with financial policies and allowable under the contract. (Disbursements/invoices are approved & monitored by management.) –**ON SITE**	☐	☐	☒	☐	☐	Observation/Documentation: The agency utilizes a system of managing petty cash. Petty cash is stored in a secure locked location and must be verified and approved by management on a monthly basis. At the time of this program review, the agency's Administrative Assistant is	**No recommendation or Corrective Action.**

2023-2024 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 3-20-21-2024

Agency Name: Lutheran Services Florida-NW HOPE House	**Monitor Name: Keith Carr, Lead Reviewer**
Contract Type : CINS/FINS	**Region/Office: 5127 Eastland Street , Crestview, FL 32539**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): March 20-21, 2024**

Major Programmatic Requirements	**Explain Rating**					**Ratings Based Upon:** **I = Interview** **O = Observation** **D = Documentation** **PTV = Submitted Prior To Visit** **(List Who and What)**	**Notes** **Explain Unacceptable or Conditionally Acceptable:**
	Unacceptable	**Conditionally Unacceptable**	**Fully Met**	**Exceeded**	**Not Applicable**		
						the steward of the agency's petty cash. When this staff member is not available the Regional Director and Residential Supervisor are the only other staff members with access to the petty cash drawer. The petty cash on hand, checks, and receipts were reconciled onsite on the second day of review by the Administrative Assistant and was verified to be consistent with March 2024 petty cash reconciliation documentation onsite.	
d. Financial records and reports are current. Includes bank statements reconciled within 6 weeks of receipt. Vendor invoices past 6 months. Invoices are submitted on a monthly basis with supporting documentation. (Disbursements/invoices are approved & monitored by management). **ON SITE**	☐	☐	☒	☐	☐	Documentation: Reviewed Bank Statements and Bank Reconciliations for months September 2023-January 2023 for one account with Ameris Bank. Bank reconciliations are conducted each month for the activities and bank statements for the preceding month and are reviewed by two parties. Invoices are submitted on a monthly basis with supporting documentation.	**No recommendation or Corrective Action.**

2023-2024 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 3-20-21-2024

Agency Name: Lutheran Services Florida-NW HOPE House	**Monitor Name: Keith Carr, Lead Reviewer**
Contract Type : CINS/FINS	**Region/Office: 5127 Eastland Street , Crestview, FL 32539**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): March 20-21, 2024**

Major Programmatic Requirements	**Explain Rating**					**Ratings Based Upon:** **I = Interview** **O = Observation** **D = Documentation** **PTV = Submitted Prior To Visit** **(List Who and What)**	**Notes** **Explain Unacceptable or Conditionally Acceptable:**
	Unacceptable	**Conditionally Unacceptable**	**Fully Met**	**Exceeded**	**Not Applicable**		
e. Agency maintains inventory in accordance with a written policy and FNYFS contractual requirements. If over $1,000 inventory has DJJ Property Inventory Number/Tag. In the event the provider has purchased computer equipment an Informational Resources Request (IRR) has been submitted to DJJ. **PTV/ON SITE**	☐	☐	☐	☐	☒	Documentation/Interview: N/A – The agency has not purchased any items with FNYFS funds since the last time on-site.	**Not Applicable.**
f. Agency submits payroll taxes and deposits (and retirement deposits as applicable), Employee IRS Form W-2 and Independent Contractors IRS Form 1099 forms prior to federal requirements. **ON SITE**	☐	☐	☒	☐	☐	Documentation: Provider submitted evidence of payroll taxes and deposits for first and second quarters for FY2024. A Deposit Recap report showed funds deposited every two weeks via EFT or check and showed all payments made.	**No recommendation or Corrective Action.**
g. Budget to actual reports prepared and reviewed by appropriate management. Variance from the budget are investigated and explained. **PTV/ON SITE**	☐	☐	☒	☐	☐	Documentation: Agency provided a detailed CINS/ FINS Budget Report which included months July 2023-Feb 2024. The report tracks all budget categories by current period actual and current period contract separately. Variances if applicable are identified.	**No recommendation or Corrective Action.**

2023-2024 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 3-20-21-2024

Agency Name: Lutheran Services Florida-NW HOPE House	**Monitor Name: Keith Carr, Lead Reviewer**
Contract Type : CINS/FINS	**Region/Office: 5127 Eastland Street , Crestview, FL 32539**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): March 20-21, 2024**

Major Programmatic Requirements	**Explain Rating**					**Ratings Based Upon:** **I = Interview** **O = Observation** **D = Documentation** **PTV = Submitted Prior To Visit** **(List Who and What)**	**Notes** **Explain Unacceptable or Conditionally Acceptable:**
	Unacceptable	**Conditionally Unacceptable**	**Fully Met**	**Exceeded**	**Not Applicable**		
h. A Single Audit is performed as part of the annual audit if expenses are greater than $750,000. The agency must submit a Corrective Action Plan for findings cited in the management letter and single audit. An annual financial audit was completed within 120 days after the previous fiscal year/calendar year and that a copy was provided to the Network unless and extension has been requested and approved in writing. Copy of Audit is submitted to the FNYFS by December 31st. **Can obtain from FNYFS**	☐	☐	☒	☐	☐	Documentation: Financial audit was conducted for the fiscal year beginning June 30, 2022 – 2021 by RSM US LLP. A letter dated December 22, 2022, stated no corrective action was needed. A copy was submitted directly to the Florida Network of Youth and Family Services. The agency reported that the auditors are still working on the FY2023 audit. As of March 2024, this is the most recent Financial Audit report provided by the agency. They report that they will submit the Audit report for 2023 once completed.	**No recommendation or Corrective Action.**
i. Agency maintains confidentiality policy with written policies and procedures to ensure the security and privacy of all employee and client data. Personal information is not easily accessible. Agency maintains a backup system in case of accidental loss of financial information. Security procedures are in place to protect laptops. Obsolete documents are shredded and computer hard drives are wiped prior to discarding. **ON SITE**	☐	☐	☒	☐	☐	Documentation: The agency maintains a procedure manual with several sections (Information Technology, Risk Prevention and Management) to address security and privacy of employee and client data. The agency provided 7 Policies and Procedures for review including: Confidentiality of Clients, Records Retention, IT Disposal of Hardware, IT Security,	**No recommendation or Corrective Action.**

2023-2024 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 3-20-21-2024

Agency Name: Lutheran Services Florida-NW HOPE House	**Monitor Name: Keith Carr, Lead Reviewer**
Contract Type : CINS/FINS	**Region/Office: 5127 Eastland Street , Crestview, FL 32539**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): March 20-21, 2024**

Major Programmatic Requirements	**Explain Rating**					**Ratings Based Upon:** **I = Interview** **O = Observation** **D = Documentation** **PTV = Submitted Prior To Visit** **(List Who and What)**	**Notes** **Explain Unacceptable or Conditionally Acceptable:**
	Unacceptable	**Conditionally Unacceptable**	**Fully Met**	**Exceeded**	**Not Applicable**		
						Data Backup Retention and Recovery, Access to Case Records, and Case Record Keeping. The agency CEO oversees authority for administration for these policies and the Senior Director of Information Technology is responsible for maintaining policies are current.	
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**	☐	☐	☒	☐	☐	As of October 2023, all direct staff member salaried employees have a minimum of $19 per hour pay rate. Agency provided payroll and hour pay rate documentation.	**No recommendation or Corrective Action.**

CONCLUSION

Lutheran Services Florida NW HOPE House has met the requirements for the CINS/FINS contract as a result of full compliance with --- applicable indicators of the Administrative and Fiscal Contract Monitoring Tool. Two of fourteen indicators were not applicable because 1) the provider does not have any outstanding corrective action item(s) cited by an external funding source, and 2) does not have any current inventory purchased with DJJ/FN Funds. Consequently, **the overall compliance rate for this contract monitoring visit is 100%.** There are no corrective actions or recommendations cited as a result of the contract monitoring visit. Overall, the provider is performing satisfactorily in meeting the fiscal and administrative terms of its contract. In addition, the majority of indicators reviewed were carried out in a manner which meets the standard described in the report findings.

SUMMARY OF RECOMMENDATIONS

No Corrective Actions or Recommendations.

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 Lutheran Services Florida NW - HOPE House
CINS/FINS Program

Date: March 20-21, 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	Limited
2.02 Needs Assessment	Satisfactory
2.03 Case/Service Plan	Satisfactory
2.04 Case Management & Service Delivery	Satisfactory
2.05 Counseling Services	Satisfactory
2.06 Adjudication/Petition Process	Satisfactory
2.07 Youth Records	Satisfactory
2.08 Special Populations	Satisfactory
2.09 Stop Now and Plan (SNAP)	Not Applicable

Percent of indicators rated Satisfactory: 88.89 %
Percent of indicators rated Limited: 11.11 %
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: 96.43 %
Percent of indicators rated Limited: 3.57 %
Percent of indicators rated Failed: 0 %

Rating Definitions

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

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

Reviewers

Members

Keith Carr - Lead Reviewer Consultant-Forefront LLC/Florida Network of Youth and Family Services
Patrick M McKinstry – Regional Monitor, Department of Juvenile Justice
Gina Dozier – Chief Operating Officer, Capital City Youth Services, Inc.
Krissy Botzong – Quality Improvement Director, Anchorage Children's Home Agency

Methodology

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

Persons Interviewed

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

Documents Reviewed

X	Accreditation Reports	X	Table of Organization		Visitation Logs
X	Affidavit of Good Moral Character	X	Fire Prevention Plan	X	Youth Handbook
X	CCC Reports	X	Grievance Process/Records	5	# Health Records
X	Logbooks		Key Control Log	5	# MH/SA Records
X	Continuity of Operation Plan	X	Fire Drill Log	8	# Personnel /Volunteer Records
	Contract Monitoring Reports	X	Medical and Mental Health Alerts	8	# Training Records
X	Contract Scope of Services	X	Precautionary Observation Logs	4	# Youth Records (Closed)
X	Egress Plans	X	Program Schedules	6	# Youth Records (Open)
X	Fire Inspection Report	X	List of Supplemental Contracts	3	# Other: ___
X	Exposure Control Plan	X	Vehicle Inspection Reports		

Observations During Review

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

Surveys

7 # of Youth	**3** # of Direct Staff	**1** # of Community Counseling Staff

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 review is conducted 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

Lutheran Services Florida NW - (HOPE House) is part of the statewide, non-profit Lutheran Services Florida (LSF) agency that contracts with the Florida Network of Youth and Family Services (Florida Network) to operate Children In Need of Services/Families In Need of Services (CINS/FINS) residential and community counseling services to youth and families in Escambia County. Specifically, LSF HOPE House serves all eligible youth between the ages of ten to seventeen years old in its residential program and six to seventeen years old who are runaway, ungovernable and/or truant, locked out, homeless, abused, neglected, or possess other presenting problems. In addition to CINS/FINS, the agency provides services to special populations who meet the criteria for youth referred for domestic violence (DV) respite, probation (PR) respite, and Family and Youth Respite Aftercare services (FYRAC).

The following programmatic updates were provided by the agency:

The agency is Counsel on Accreditation (COA) accredited through February 28, 2026. There are no new CINS program initiatives. The agency reported it is focused on rebuilding and stabilizing its current array of services to children and families. The agency's Community Counseling services are provided primarily in office, however, Zoom and home visit options are utilized when clients cannot otherwise attend. Individual, Family and Group sessions are provided in the shelter. The agency continues to maintain paper files. The program benefits from supplemental funding through HHS to support a Life Skills Coach and a couple of YCS positions. This funding allows the team to more fully support those youth who are aging out of their childhood and have no other supports. In terms of the physical plant, the agency reported updates/improvements to the agency which include February 2023 repaired roof and ceiling; May 2023 repaired AC (backside); September 2023 repaired AC (driveway side); October 2023 replaced water pump on donation van; November - painted the day room and dining room. The agency reported it established new community partnerships (non-profit and corporate) with a former employee, that delivers faith-based services to the agency each week with the residents. Alateen visits weekly on Thursdays to do group with the residents. The local Fire Marshall in the region continues to partner with the agency on a Christmas gift drive for HOPE House residents with the contractors from the community. The agency also reports it has reconnected with Toys for Tots for Christmas gifts. The agency participates with local agencies in the community through active involvement in the Human Trafficking Task Force (4 counties), Suicide Prevention Coalition, Community Alliance FWB, Legislative Luncheon, State of Military Affairs Luncheon, Opioid Summit, Circuit 1 Alliance Provider Fair.

Narrative Summary

Lutheran Services Florida – (LSF) operates six emergency youth/crisis shelters in the State of Florida which are contracted with the Florida Network of Youth & Family Services, Inc. (FNYFS). LSF-NW HOPE House is contracted to provide Children In Need of Services and Families In Need of Services (CINS/FINS) in Circuit 1: which encompasses Okaloosa and Walton Counties. The LSF-NW HOPE House's shelter is licensed for eight beds and offers 24-hour availability, youth supervision, food and clothing, life skills education, crisis counseling, individual and family counseling, recreation and leisure activities, and case management services. Youth are provided educational services at their home schools and transportation is arranged and provided by local school bus and by LSF-NW HOPE House staff members as needed. LSF-NW HOPE House provides Community Counseling/non-residential counseling services in the aforementioned service regions. The services provided under the community counseling CINS/FINS contract with the FNYFS allow the agency to serve all eligible youth between the ages of ten to seventeen years old in its residential program and six to seventeen-years-old in their community counseling program who are runaway, ungovernable and/or truant, locked out and homeless. The program also serves youth which require temporary shelter due to abuse and neglect. The agency also provides specialized services to eligible youth with other profiles such as Staff Secure shelter, Domestic Minor Sex Trafficking, Domestic Violence, and Probation Respite, Family/Youth Respite Aftercare Services (FYRAC) and the Stop Now And Plan (SNAP) program. Lutheran Services Florida NW HOPE House residential program is led by a Regional Director, a Quality Services Manager and a Youth Care Specialist (YCS) III, a Licensed Clinician, Residential Youth Care Specialist and Non-Residential Community Counselors. The shelter is open 24 hours per day across three staff work shifts. The YCS III oversees each shift. The youth shelter is a residential home which

has been converted into a temporary youth shelter. There are three bedrooms upstairs; one of the bedrooms sleeps four youth and the other two bedrooms sleep two youth each. The bedroom which sleeps four youth is primarily used for the boys' room and the other two bedrooms are primarily used for the girls. The youth shelter has a recently renewed DCF license on September 27, 2023, for 12 beds at Currie House and 8 beds at HOPE House.

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

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

Standard 2: There are nine indicators for Standard 2. Indicator 2.01 Screening and Intake was rated Limited, 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 with Exception, Indicator 2.05 Counseling Services was rated Satisfactory with Exception, Indicator 2.06 Adjudication/Petition Process was rated Satisfactory, Indicator 2.07 Youth Records was rated Satisfactory with Exception, Indicator 2.08 Specialized Additional Program Services was rated Satisfactory with Exception, and Indicator 2.09 Stop Now and Plan (SNAP) was rated Not Applicable.

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

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

Summary of Deficiencies resulting in Limited or Failed Rating:

Standard 2: Indicator 2.01 - Limited: None of the 10 files were able to show evidence that the screening for eligibility is logged into NetMIS within 72 hours of screening completion. Two community counseling files were unable to prove evidence of youth and parents receiving available service options and rights and responsibilities of the youth and parent. Two residential files were unable to show evidence of the parent/guardian receiving required information. Three residential files were unable to show evidence of the required information. Two of the community counseling files were unable to show evidence of the CINS information being given to the parents. One of the community counseling files did not show evidence of a suicide screening in the file. One community counsleing file did not show evidence of further assesment being completed by required staff. One residential file did not show evidence of further assesment being completed by required staff.

CINS/FINS QUALITY IMPROVEMENT TOOL

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

Standard One – Management Accountability

1.01: Background Screening of Employees, Contractors and Volunteers		**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 1.01	**YES** If NO, explain here: The agency has a policy titled 1.01 Background Screening of Employees and Volunteers, DCF FAC 65C, FDJJ-1800PC, FN YFS PPM 2020- 5.03, 5.04 that was reviewed by the Regional Director on November 1, 2023.	

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

Total number of New Hire Employee/Intern/Volunteer Files: 7
Total number of 5 Year Re-screen Employee Files: 0
Staff Position(s) Interviewed (No Staff Names): N/A
Type of Documentation(s) Reviewed: BUS-006, background screening, pre-assessment, E-Verify.
Describe any Observations: N/A

All positions providing direct services to youth has successfully passed pre-employment suitability assessment on the initial attempt.	**Exception**	Seven (7) staff member personnel files were reviewed for this indicator. Five (5) of the seven (7) completed pre-assessments prior to being hired by the provider. The remaining two (2) staff completed the pre-assessment, however were documented having been completed after hire date. The agency utilizes a suitability assessment tool with a scoring function for all positions providing direct services to youth. The provider cannot lower the passing rate of the assessment, but can elect to have the applicant retake the assessment. It must be taken and passed within five (5) business days of the initial attempt, not to exceed three (3) attempts within thirty (30) days.	The agency did not report a cause as to why one staff member completed the pre-assessment approximately five months after hire date. One staff person completed a pre-assessment two days after their hire date.
For any applicant that did not pass the initial suitability assessment, there was evidence that the applicant retook the assessment and passed within five (5) business days of the initial attempt, not exceeding three (3) attempts within thirty (30) days.	**No eligible items for review**	The agency reported they did not have any applicant prospects that did not pass the suitability assessment on the first attempt prior to being hired.	

Agency has evidence for employees who have had a break in service for 18 months or more, and/or when the agency had a change or update in the suitability assessment tool used was different from the employee's original assessment, that a new suitability assessment and background screening was completed as required.	**No eligible items for review**	The agency did not have any employees with a break in service for 18 months or more during this review period.	
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**	Seven (7) staff member files were reviewed and the background screening contained evidence each was completed prior to hire/start date and all were deemed 'eligible' on the screening form.	
Five-year re-screening is completed every 5 years from the date of the last screening or prior to retained fingerprints expiration date.	**No eligible items for review**	The agency did not have any employees which require a five-year screening or prior to retained fingerprints expiring during this review period.	
Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?	**Compliance**	The Annual Affidavit of Compliance with Good Moral Character Standards (Form IG/BSU-006) is completed by the program and sent to the DJJ Background Screening Unit by January 31st of each year. A review of this document indicated it was submitted to DJJ on or before January 31st of 2024. An email was provided to support transmission of screening form.	
Proof of E-Verify for all new employees obtained from the Department of Homeland Security	**Compliance**	Seven (7) staff reviewed had proof of completion of E-Verify; conducted a review of each staff record and found copy of E-Verify from Department of Homeland Security.	
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 policy number 1.02 titled Provision of an Abuse Free Environment that was reviewed/approved by the Regional Director on November 7, 2023.	

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

Staff Position(s) Interviewed *(No Staff Names)* **: Residential Supervisor.**
Type of Documentation(s) Reviewed: Grievance(s), Abuse hotline log, youth survey(s).
Describe any Observations: Location of grievance box was located in day room of the youth shelter.

Agency has a code of conduct of policy and there is evidence that staff are aware of agency's code of conduct.	**Compliance**	Program staff adheres to a code of conduct which prohibits the use of physical abuse, profanity, threats, or intimidation. Staff complete orientation/training on child abuse reporting and prevention. Additionally, any person who knows, or has reasonable cause to suspect a child is abused, abandoned, or neglected by parent, legal custodian, caregiver, or other person responsible for the child's welfare, reports such knowledge or suspicion to the Florida Abuse Hotline. There was evidence found in nine calls made over the review period where staff called the abuse registry.	
The agency has a process in place for reporting and documenting child abuse hotline calls.	**Compliance**	As applicable, the agency indicated total number of nine child abuse calls in the last six months.	
Youth were informed of the Abuse and Contact Number	**Compliance**	One youth reported having heard a Youth Care Worker use curse words when speaking with youth (one of seven youth interviewed). Seven of seven youth report they feel safe.	
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**	A review of 14 on-site grievances was conducted. All grievances were reviewed by the Manager or designated supervisor and all reported grievance issues were addressed as required.	
Shelter only: Grievances are maintained on file at minimum for 1 year.	**Compliance**	The agency maintains all grievances in a binder.	
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 is located in the common day room of the youth shelter.	
Shelter only: There is evidence that grievance boxes are checked by management or a designated supervisor at least daily as evidenced in the program logbook.	**Compliance**	A window was observed in the bottom of the box which allows for easy visibility of any documents in the lock box.	
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**	A review of 14 grievances over the last six months indicated there were no issues with being resolved with specified timeframe.	
1.03: Incident Reporting			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 1.03		**YES** If NO, explain here: Agency policy 1.03 Incident Reporting/Risk Management was reviewed/approved by the Regional Director on November 17, 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): N/A **Type of Documentation(s) Reviewed: central communication center (CCC) reports** **Describe any Observations: N/A**			
During the past 6 months, the program notified the Department's CCC (Central Communication Center) no later than two hours after any reportable incident occurred or within two hours of the program learning of the incident	**Compliance**	The program had a total of 15 Central Communications Center (CCC) reports during the annual compliance review period.	A review of the incident documents found a total of . one (CCC - 202306151: failure to report) out of 15 for the 6 month annual compliance review period.
The program completes follow-up communication tasks/special instructions as required by the CCC	**Compliance**	Whenever a reportable incident occurs, the program notifies the Department's CCC within two (2) hours of the incident, or within two (2) hours of becoming aware of the incident. The program completes follow-up communication tasks as required by the CCC in order to address specific cases.	
Agency internal incidents are documented on incident reporting forms and all CCC reportable incidents were consistently reported to CCC as required.	**Compliance**	The program had a total of 15 CCC reports during the annual compliance review period.	
Incidents are documented in the program logs and on incident reporting forms	**Compliance**	A review of logbook and internal program reports over the last six months indicate incidents are being documented accordingly.	
All incident reports are reviewed and signed by program supervisors/ directors	**Compliance**	The agency provided a total fifteen (15) CCC reports for this review period. All incidents have been reviewed by a designated supervisor.	
1.04: Training Requirements (*Staff receives training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions*)			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 1.04		**YES**	
		If NO, explain here:	
		Agency policy 1.04 Training Requirements was reviewed/approved by the Regional Director on November 7, 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: Four new employee training files.
Total number of Annual In-Service Staff Files: Four ongoing employee training files.
Total number of Non-Licensed Mental Health Clinical Shelter Staff Files: None.
Annual Training Plan Timeframe (*Program timeframe for annual trainings*)**: Calendar / Anniversary date.**
Staff Position(s) Interviewed *(No Staff Names)* **: Personnel staff.**
Type of Documentation(s) Reviewed: Employee training files.
Describe any Observations: See report.

First Year Direct Care Staff			
All direct care staff have completed new hire pre-service training requirements for safety and supervision as required.	**Exception**	A review of four pre-service and four in-service training records were reviewed. As most of the trainings were completed, there were a few exceptions observed. Only two trainings were missing completely by one of the four staff reviewed for in-services. Three of the four staff for pre-service had completed training requirements, however the trainings recorded were completed late. None of the trainings observed to be late or missing impacted the staff members ability to provide a safe and secure environment for the youth.	A review of the staff member files indicated that staff trainings were not completed within the required training period. The following training was noted as late for one staff person and included Information Security Awareness, CINS/FINS Core training, Florida Network Youth Suicide Prevention, Cultural Humility, Confidentiality, Fire Safety Equipment, Signs and Symptoms of Mental Health and Substance Abuse, and Adolescent Development. An additional staff member did not complete Civil Rights training within the required training period. A third staff member did not complete Civil Rights within the required training period. A fourth staff person did not complete Information Security Awareness and Sexual Harassment training topics.
All staff completed the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days from date of hire.	**Exception**	Two staff were observed as having completed the Civil Rights training. However, they completed the training late.	A total of two staff members did not complete this training course within the 30 day training period.
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**	Four staff were reviewed for pre-service training requirements. Each staff member's file had the minimum required training completed.	
All staff receives all mandatory training during the first 90 days of employment from date of hire.	**Exception**	A review of the training files were conducted. A total of ten courses were documented as having been completed late and past 90 days of hire. There was no reason noted by administration as to why any courses were found completed late.	Training topics documented as late include Information Security Awareness (1 staff) / Civil Rights (2 staff) / CINS/FINS Core training (1 staff) / FN youth suicide prevention (1 staff) / Cultural Humility (1 staff) / Confidentially (1 staff) / Fire Safety Equipment (1 staff) / Signs and Symptoms of MH&SA (1 staff) / Adolescent Development (1 staff).
Staff Required to Complete Data Entry for NIRVAN/A or access the Florida Department of Juvenile Justice Information System (JJIS)			

Any designated staff that is responsible for entering NIRVAN/A or ensuring accurate and complete data entry in the Florida Department of Juvenile Justice Information System (JJIS) have completed all of the required trainings.	**Not Applicable**	This requirement became effective July 2023 and there were no staff training files reviewed to whom this indicator applied.	
Staff Participating in Case Staffing & CINS Petitions (within first year of employment)			
Documentation of instructor led FL Statute 984 CINS Petition Training by a local DJJ Attorney. *Effective for staff hired after 7/1/23*	**Not Applicable**	This requirement became effective July 2023 and there were no staff training files reviewed to whom this indicator applied.	
Non-licensed Mental Health Clinical Shelter Staff (within first year of employment)			
Documentation of non-licensed mental health clinical staff person's training in Assessment of Suicide Risk form or written confirmation by a licensed mental health professional of training (includes date, signature and license number of the licensed mental health professional supervisor).	**Not Applicable**	There were no staff training files reviewed applicable to this indicator.	
In-Service Direct Care Staff			
Direct care staff completes 24 hours of mandatory refresher Florida Network, SkillPro, and job-related training annually *(40 hours if the program has a DCF child caring license).*	**Exception**	Four staff were reviewed for in-service training. Three staff members had evidence of completing a minimum of 24 annual training requirements. One staff was observed as missing two trainings (not completed) for training year 2023.	The agency had one staff member that did not have evidence of Information Security Awareness training and one staff member was missing Sexual Harassment training.
Required Training Documentation			
The agency has a training plan that includes all of the required training topics including the pre-service and in-service.	**Compliance**	Training plan is current and addressed all required trainings needed to complete pre-service and in-services training requirements.	
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**	One staff member on-site is the designated training liaison for the program.	
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**	A review of eight training records (four pre-service and four in-service) was conducted and contained evidence that the program has systems in place for tracking, documenting, and monitoring training expectations and requirements.	
1.05 - Analyzing and Reporting Information			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for		**YES** If NO, explain here:	

Indicator 1.05		Policy 1.05 Analyzing and Reporting Information was approved by the Regional Director on November 7, 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)* **: Regional Director and Residential Supervisor.** **Type of Documentation(s) Reviewed: Monthly operations and program services reports.** **Describe any Observations: See report.**			
Case record review reports demonstrate reviews are conducted quarterly, at a minimum	**Compliance**	A review of quarterly case record review reports was conducted. The agency reviews a total of ten peer reviewed records. The agency reviews case records monthly. These monthly reports were provided for the last six months.	
The program conducts reviews of incidents, accidents, and grievances quarterly, at a minimum	**Compliance**	The agency's Quality Improvement monthly spreadsheet companion report was reviewed. The document provides the "benchmark" to achieve with a "target" application and duration/output/outcome. In addition, the monthly review of this report enables the provider to identify effectiveness of intervention or areas for improvement. Once an issue is identified (area), the provider is able to set "goals" with action (steps) and reasonable timeframes and accountability for completion. The Lutheran Services Florida (LSF) Quality Improvement Plan 2023 is the document used to review their internal practices. Through these processes, LSF has made a commitment to move from collecting and analyzing Process Outcomes only, to the collecting and analyzing Transformational Outcomes to demonstrate impact. Email correspondence is reviewed to assist in identifying stakeholder and provider participation in conducting meetings (agenda), which address identified deficiencies along with root cause analysis process and input from attendees. The agency also has an internal corrective action plan (CAP) which identifies and demonstrates the provider proactive approach in handling "performance". The plan enables the shelter to address and meet (if not exceed) objectives by reaching measurable outcomes. The plan has those person(s) responsible and timeframes to be met. They meet weekly with agency quality assurance staff to review over any issues and discuss compliance of operations. Every Tuesday meetings held to address quality initiatives, which are then disseminated monthly to front line staff (meetings). Corporate has open dialogue with board of directors this is not conducted by staff on-site per program director.	

The program conducts an annual review of customer satisfaction data	**Compliance**	The agency reviews monthly reports focused on the agency's client satisfaction, incidents, accidents, and grievances. These reports are reviewed on a monthly basis during monthly meetings. Customer satisfaction data is also reported on annual agency reports.	
The program demonstrates a monthly review of the statewide End-of-Month ("EOM") report generated by the Florida Network Office. This includes monthly data, fiscal year to date data, benchmarks for residential and community counseling, screening data, report card measures, follow-up reporting measures.	**Compliance**	The agency receives FNYFS data extracts on numerous performance indicators. The agency reviews these measures with designated staff to ensure the agency meets minimum requirements. If performance is detected to be below the standard, the agency implements a corrective action or intervention plan to address the performance issue until the matter is corrected.	
The program has a process in place to review and improve accuracy of data entry & collection	**Compliance**	The agency reviews information in JJIS and NetMIS on a monthly basis to ensure accuracy of data entry, timeliness and completeness of data collected and entered. All identified differences or errors related to data are reconciled once identified by the Regional Director or other designated staff.	
There is documentation that findings are regularly reviewed by management and communicated to staff and stakeholders.	**Compliance**	The agency provided documentation of monthly meetings. The agency addresses identified program performance issues through meeting minutes. All findings are shared with key staff members and stakeholders.	
There is evidence the program demonstrates that program performance is routinely reviewed with the Board of Directors. All final reports that include a Limited or Failed score is submitted electronically or by mail to the providers Executive Committee on the Board of Directors.	**Compliance**	The agency has all reports submitted to leadership staff and governance boards. Regardless of the rating all Executive Committee members are provided with annual performance reports.	
There is evidence that strengths and weaknesses are identified, improvements are implemented or modified, and staff are informed and involved throughout the process.	**Compliance**	There is evidence that monthly residential and community counseling meeting minutes are routinely shared on a monthly basis. All major strengths and weaknesses are identified and interventions are planned and implemented to address specific issues. Staff are involved in all action plans and intervention efforts from the start of the process to its conclusion.	
1.06: Client Transportation			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 1.06		**YES** If NO, explain here: The agency has a policy -- 1.06 Client Transportation. The policy was reviewed and approved by the Regional Director on November 7, 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: Prior six months. **Staff Position(s) Interviewed** *(No Staff Names)* **: Residential Supervisor.** **Type of Documentation(s) Reviewed: Transportation, insurance, client personnel files.** **Describe any Observations: See report.**			
Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	**Compliance**	The program has two vans used for transporting youth. Both were found to have automobile insurance. Review of thirteen staff licensure reveals no issues with "list" and verification through Florida Highway Safety Motor Vehicles (FLHSMV).	
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 insurance which includes provisions for insurance coverage for all approved agency drivers with a valid State of Florida driver's license.	
Agency's Transportation policy prohibit transporting a client without maintaining at least one other passenger in the vehicle during the trip and include exceptions in the event that a 3rd party is NOT present in the vehicle while transporting	**Compliance**	The program has a transportation policy which addresses approved drivers. The basis for the policy is to avoid situations which might put youth or staff in danger of real or perceived harm, and/or allegations of inappropriate conduct. The noted best practice to prevent any situation from occurring is to have a third-party present in the vehicle for all transports. The policy addresses approved agency drivers, approved by administrative personnel. In addition, all drivers are documented as having a valid Florida driver's license and will be covered under the program's insurance policy. While conducting a transport, the driver will document the use of the vehicle, which would include name of driver, date and time, mileage, number of passengers, purpose of travel and location. Should a third party not be available, written policy addresses practices prior to transport.	
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**	In the event that a 3rd party cannot be obtained for transport, the agency's supervisor or managerial personnel does consider the client's history, evaluation and recent behavior. However, the agency's third party accommodations include an additional staff member, a volunteer, intern or an additional youth.	
The 3rd party is an approved volunteer, intern, agency staff, or other youth	**Compliance**	The agency has a policy and their current practice which includes designated third parties as staff members, youth, interns and volunteers.	
The agency demonstrated evidence via logbook or other written verification that supervisor approval was obtained prior to all single youth transports.	**Compliance**	The agency completed a total number of 23 documented supervisor approvals prior to transport. All transports were approved by the Supervisor prior to the single transport event.	
There is documentation of use of vehicle that notes name or initials of driver, date and time, mileage, number of passengers, purpose of travel and location.	**Compliance**	A review of transport logs documented requirements for each line in the transport log as needed. The current form captures the driver, date, time, mileage at start and ending mileage, number of passengers, purpose of trip, and destination.	
1.07 - Outreach Services			**Satisfactory**
		YES	

Provider has a written policy and procedure that meets the requirement for Indicator 1.07		If NO, explain here:	
		The agency has policy number 1.02 Provision of an Abuse Free Environment. This policy was reviewed and approved by the Regional Director on March 13, 2024.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Staff Position(s) Interviewed *(No Staff Names)* **: Residential Supervisor and designated Outreach staff.** **Type of Documentation(s) Reviewed: Outreach activities and event documentation.** **Describe any Observations: See report**			
The program has a lead staff member designated to participate in local DJJ board, Circuit and Council meetings with evidence that includes minutes of the event or other verification of staff participation.	**Compliance**	The program has designated local lead staff members in outreach positions to attend local DJJ board, Circuit and Council meetings.	
The program maintains written agreements with other community partners which include services provided and a comprehensive referral process.	**Compliance**	The program provides extensive on-going referral for services as deemed/assessed from intake process through end of stay. A review of written agreements was conducted onsite included National Runaway Switchboard, a number of law enforcement agencies, Okaloosa/Walton First Call for Help, Healthy Families Santa Rosa/Walton, COPE Center, Big Brothers/Big Sisters, and Children's Home Society, Bridgeway Center. In summary: LSF Hope House accepts referrals and provide services to abused, neglected, runaway, truant, and homeless youth and their families.	

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 review of ancillary documentation provided addressed requirements: 1. A review of outreach activities yielded the provider participates in a number of community (stakeholder) events. A variety of activities were documented for the duration of the annual compliance review period; Community network Baptist hospital, Santa Rosa County Minister's Association, Pensacola Yacht Club, Destin-FWB Beach Convention Center, Ellyson Industrial Park, and Legion Field (to name a few). 2. Advisory board meeting (agenda) reviewed. 3. Email correspondence to stakeholders and provider participants in outreach activities (notification). 4. Reviewed Community flyer incorporating community partnership(s). 5. A sample of six outreach type activities reviewed along with ancillary documentation provided (there was a total of 49 outreach activities documented during the annual compliance review period). 6. Program provides extensive on-going (when necessary) referral for services as deemed/assessed from intake through end of stay. Written agreements reviewed: ex: National Runaway Switchboard, a number of law enforcement agencies, Okaloosa/Walton First Call for Help, Healthy Families Santa Rosa/Walton, COPE Center, Big Brothers/Big Sisters, and Children's Home Society, Bridgeway Center. In summary: LSF will accept referrals and provide services to abused, neglected, runaway, truant, and homeless youth and their families.	
The program has designated staff that conducts outreach which is defined in their job description.	**Compliance**	The agency has dedicated staff members with outreach and local partnership duties assigned to conduct promoting the development and sustainment of partnerships throughout the community.	
2.01 - Screening and Intake			**Limited**
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 called 2.01 Screening and Intake. The policy was reviewed and approved by the Regional Director on November 23, 2023.	

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

Total number of Open (Residential & Community) Files: 6
Total number of Closed (Residential & Community) Files: 4
Staff Position(s) Interviewed *(No Staff Names)* **: Residential Counselor, Community Counselors, Intensive Case Management Coordinator**
Type of Documentation(s) Reviewed: Case Files
Describe any Observations: See report.

Shelter youth: Eligibility screening form is completed immediately for all shelter placement inquiries.	**Compliance**	Five residential files were reviewed, two open and three closed. All files contained evidence of a completed eligibility screening form.	
Community counseling: Eligibility screening form is completed within 3 business days of referral by a trained staff using the Florida Network screening form.	**Compliance**	Five community counseling files were reviewed, four open and three closed. All screenings were completed immediately upon contact with the referral source. Eligibility was determined immediately upon referral.	
There is evidence all referrals for service is screened for eligibility and is logged in NetMIS within 72 hours of screening completion.	**Exception**	All 10 client files proved eligibility was determined immediately upon receiving a referral. Each had evidence of being documented in NetMIS.	None of the 10 files were able to show evidence that the screening for eligibility is logged into 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	**Exception**	Eight community counseling files were able to show evidence of youth and parents receiving available service options and rights and responsibilities of the youth and parent. Eight residential files were able to show evidence of the parent/guardian receiving required information.	Out of ten files reviewed, two community counseling files were unable to show evidence of youth and parents receiving available service options and rights and responsibilities of the youth and parent. Two residential files were unable to show evidence of the parent/guardian receiving required information.
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	**Exception**	Two residential files were able to show evidence of required information via the Voluntary Placement Agreement. Three of the community counseling files were able to show evidence via the CINS Brochure and packet of signed documents parents received.	Three residential files were unable to show evidence of the required information. Two of the community counseling files were unable to show evidence of the CINS information being given to the parents.
During intake, all youth were screened for suicidality and correctly assessed as required if needed.	**Exception**	Four of the community counseling files contained evidence of a suicide screening in file. Four community counseling files did contain evidence of further assessment being completed by required staff. Four residential files do show evidence of further assessment being completed by required staff.	One of the community counseling files did not show evidence of a suicide screening in file. One community counseling file did not show evidence of further assessment being completed by required staff. One residential file did not show evidence of further assessment being completed by required staff.
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 called 2.02 Network Inventory of Risk, Victories, and Needs Assessment. The policy was reviewed and approved by the Regional Director on March 14, 2024.	

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

Total number of Open (Residential & Community) Files: 6
Total number of Closed (Residential & Community) Files: 4
Staff Position(s) Interviewed *(No Staff Names)* **: Residential Counselor, Community Counselor, and Intensive Case Management Coordinator**
Type of Documentation(s) Reviewed: Case Files
Describe any Observations: See report.

Shelter Youth: NIRVAN/A is initiated within 72 hours of admission	**Compliance**	There is evidence of all five residential files being initiated before 72 hours.	
Non-Residential youth: NIRVAN/A is initiated at intake and completed within 2 to 3 face-to-face contacts after the initial intake OR updated, if most recent assessment is over 6 months old	**Compliance**	All community counseling files contained evidence of completing the NIRVAN/A at the initial intake.	
Supervisor signatures is documented for all completed NIRVAN/A assessments and/or the chronological note and/or interview guide that is located in the youths' file.	**Compliance**	There's evidence of the supervisor's signature documented on the needs assessment in all ten client files reviewed.	
(Shelter Only) NIRVAN/A 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**	There's evidence of the completion of the NIRVAN/A in three residential client files.	Two residential files were unable to show verification of when the NIRVAN/A was completed.
A NIRVAN/A Post-Assessment is completed at discharge for all youth who have a length of stay that is greater than 30 days.	**No eligible items for review**	At time of the Quality Improvement program review, none of the files in the sample met the post 30 residential stay requirement for review.	
A NIRVAN/A Re-Assessment is completed every 90 days excluding files for youth receiving SN/AP services.	**Compliance**	Four community counseling files were eligible and contained evidence of a completed NIRVAN/A Re-Assessment in each client file.	
All files include the interview guide and/or printed NIRVAN/A.	**Compliance**	All files reviewed contained evidence of an interview guide copy of NIRVAN/A.	

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 called 2.03 Case/Service Plan authorized by Regional Director and last approved November 7, 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: 6
Total number of Closed (Residential & Community) Files: 4
Staff Position(s) Interviewed *(No Staff Names)* **: Residential Counselor, Community Counselors, and Intensive Case Management Coordinator**
Type of Documentation(s) Reviewed: Case Files
Describe any Observations: See report.

approved form or through NETMIS and is based on information gathered during the initial screening, intake, and NIRVAN/A.	**Compliance**	All ten files reviewed met the standard requirements.	
Case/Service plan is developed within 7 working days of NIRVAN/A	**Compliance**	All ten client files reviewed met the seven day case plan development requirement.	
Case plan/service plan includes: **1. Individualized and prioritized need(s) and goal(s) identified by the NIRVAN/A** **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**	All ten files reviewed prioritized needs and goals identified by NIRVAN/A. Eight of the files reviewed contained service type, frequency, and location of service. All ten files reviewed contained person(s) responsible. Eight files contained the target date; three residential files did not show target date on the NetMIS page printout, though residential counselor showed reviewer on NetMIS the date was entered in the Service Plan. Reviewer and counselor attempted to print it with date on it, though it continued to print without the date. Two residential files had evidence of an actual completed date and two residential files were N/A. Three community counseling files had actual completion dates, and one was N/A. All ten files reviewed had signatures of youth and counselor. Nine of the files had signatures of the guardian. One of the residential guardian signatures was a Zoom call and contained a documented reason for it being necessary was listed. All ten files met Standard requirement.	One residential file and one community counseling file did not contain location of service. One community counseling file did not have a target date listed. One residential file and one community counseling file did not have actual completion dates listed. One residential file did not have evidence of guardian signature.
Case/service plans are reviewed for progress/revised by counselor and parent (if available) every 30 days for the first three months and every 6 months after	**Compliance**	All five community counseling files had reviews every 30 days. All residential files were N/A for 30 day reviews.	
2.04 - Case Management and Service Delivery			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 2.04		**YES** If NO, explain here: The agency has a policy called 2.04 Case Management and Service Delivery. The policy was reviewed and authorized by Regional Director on November 7, 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: 6 **Total number of Closed (Residential & Community) Files: 4** **Staff Position(s) Interviewed** *(No Staff Names)* **: Residential Counselor, Community Counselor, and ICM Coordinator** **Type of Documentation(s) Reviewed: Case Files** **Describe any Observations: See report.**			
Counselor/Case Manager is assigned	**Compliance**	All ten files reviewed contained evidence of the supervisor assigning a counselor as required.	

The Counselor/Case Manager completes the following as applicable: 1. Establishes referral needs and coordinates referrals to services based upon the on-going assessment of the youth's/family's problems and needs 2. Coordinates service plan implementation 3. Monitors youth's/family's progress in services 4. Provides support for families 5. Monitoring progress of court ordered youth in shelter 6. Makes referrals to the case staffing to address problems and needs of the youth/family 7. Accompanies youth and parent/guardian to court hearings and related appointments 8. Refers the youth/family for additional services when appropriate 9. Provides case monitoring and reviews court orders 10. Provides case termination notes 11. Provides follow-up after 30 days post discharge 12. Provides follow-up after 60 days post discharge	**Exception**	All community counseling files contained evidence of the youth being referred to services by the agency based on results of screening, intake and assessment. All community counseling files contained evidence which demonstrated the agency coordinating all necessary services in the implementation of the treatment plan. Each of the files reviewed contained evidence in the progress notes that the counselor/case manager monitors the youth's and family's progress services and support each receives throughout the entire period of service delivery. Of all the files reviewed no files were referred to the case staffing process. Of all the files reviewed within shelter and community counseling files, none were documented the client needed to be accompanied to court or applicable appointments. If deemed necessary referrals were made by the case manager/counselor to additional services.	One resident file indicated the youth was discharged on 10/7/2023. The 30-day follow up should have been due around 11/7/23 though completed 1/2-1/5/2024. The 60-day should have been due around 12/7/2023 though was documented as being completed on 1/2-1/5/2024.
The program maintains written agreements with other community partners that include services provided and a comprehensive referral process	**Exception**	Seven of the ten files reviewed required a service plan review and five of the seven included all required reviews.	Two files did not include one or multiple reviews and evidence was not noted elsewhere in the files.
2.05 - Counseling Services			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 2.05		**YES** If NO, explain here: The agency has a policy called 2.05 Counseling Services authorized by Regional Director and last reviewed on November 7, 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: 6
Total number of Closed (Residential & Community) Files: 4
Staff Position(s) Interviewed *(No Staff Names)* **: Residential Counselor, Community Counselor, and ICM Coordinator**
Type of Documentation(s) Reviewed: Case Files
Describe any Observations: See report.

Shelter Program			
Shelter programs provides individual and family counseling	**Compliance**	All five residential files reviewed contained evidence that individual and/or family counseling services were offered.	

Group counseling sessions held a minimum of five days per week	**Compliance**	A review of the agency's group log for the last six months was conducted. Group sessions were completed five days per week as required.	
Groups are conducted by staff, youth, or guests and group counseling sessions consist of : 1. A clear leader or facilitator 2.Relevant topic - educational/informational or developmental 3. Opportunity for youth to participate 4. 30 minutes or longer	**Compliance**	The youth shelter has a group log that lists group topics each day. All group sessions include documented initials of the group leader and youth participants. All groups have a specified topic such as anger management, conflict resolution, and general mental health and substance abuse.	
Documentation of groups must include date and time, a list of participants, length of time, and topic.	**Compliance**	The groups log includes a form which captures the facilitator and youth who participated, and log states groups are 30 minutes in duration.	
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**	Of the five community counseling files reviewed, all provided community-based counseling services to provide family stabilization. Services in these files were primarily provided at local provider's office. There was one client and family that received virtual services provided via Zoom. The progress note did provide justification for services provided in this format. All other files indicate services were provided in the office, clients' homes, in schools, libraries, and in the community.	
Counseling Services			
There is evidence the program completes review of all case files for coordination between presenting problem(s), psychosocial assessment, case/service plan, case/service plan reviews, case management, and follow-up.	**Compliance**	A review of ten client files contained documented evidence of coordination of services areas including the presenting problems, intake, the needs assessment, service plan, service plan reviews, case management, and follow-up.	
Maintain individual case files on all youth and adhere to all laws regarding confidentiality.	**Compliance**	All ten client files reviewed were maintained in an individual file. All client files met the requirements for confidentiality.	
Case notes maintained for all counseling services provided and documents youth's progress.	**Compliance**	A review of all ten client files indicated evidence of adequate case notes documented in each client file.	
On-going internal process that ensures clinical reviews of case records and staff performance.	**Exception**	One residential file had a Peer Review sheet.	Community counseling files contained two documents that appeared to be a checklist for file review. The documents were not dated and the reviewer was unable to clearly determine an on-going internal process of reviews. Four of the residential files did not have evidence of a Peer Review being completed.

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.	**Compliance**	One residential file did have evidence of sessions with a parent via Zoom virtual meeting. There was written evidence of documentation as to why the Zoom sessions were necessary.	
2.06 - Adjudication/Petition Process			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.06		**YES** If NO, explain here: The agency has a policy called 2.06 Adjudication/Petition Process. The policy was last reviewed and approved by the Regional Director and last reviewed on November 7, 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: 6 **Total number of Closed (Residential & Community) Files: 4** **Staff Position(s) Interviewed** *(No Staff Names)* **: Residential Counselor, Community Counselor, and ICM Site Coordinator** **Type of Documentation(s) Reviewed: Case Files** **Describe any Observations: See report.**			
Must include: a. DJJ rep. or CINS/FINS provider b. Local school district representative	**Compliance**	In both staffings reviewed, a CINS/FINS rep and local school district rep were present.	
Other members may include: a. State Attorney's Office b. Others requested by youth/ family c. Substance abuse representative d. Law enforcement representative e. DCF representative f. Mental health representative	**Compliance**	Staffing committed system members included several partners including DJJ attorney, local mental health representative, DCF representative as needed and other local service providers requested by youth/family.	
The program has an established case staffing committee, and has regular communication with committee members	**Compliance**	The program has an existing staffing committee which meets on a routine basis.	
The program has an internal procedure for the case staffing process, including a schedule for committee meetings	**Compliance**	The agency has a membership roster that includes each staffing committee member. Members are notified when case staffing committee meetings are scheduled.	
The youth and family are provided a new or revised plan for services	**Compliance**	When applicable the agency develops a plan for services which is included in the case staffing committee recommendations form.	
Written report is provided to the parent/guardian within 7 days of the case staffing meeting, outlining recommendations and reasons behind the recommendations	**Compliance**	When applicable, a case staffing committee recommendations form is included in each client file. In addition, all parents are given the form prior to the close of the case staffing meeting. Parents can also receive the form via mail within 7 days.	

If applicable, the program works with the circuit court for judicial intervention for the youth/family	**Not Applicable**	A review of agency policy 2.06 indicates when applicable, the program does work with the circuit court for judicial intervention.	
Case Manager/Counselor completes a review summary prior to the court hearing	**No eligible items for review**	The agency had no items to review to assess this requirement.	
2.07 - Youth Records			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 2.07		**YES** If NO, explain here: The agency has a policy called 2.07 Youth Records. The policy was reviewed and approved by the Regional Director on November 7, 2023.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Staff Position(s) Interviewed *(No Staff Names)* **: Residential Counselor and Community Counselor** **Type of Documentation(s) Reviewed: Case Files** **Describe any Observations: The Shelter filing cabinet, the Residential Counselor office, the opaque traveling case, and case files.**			
All records are clearly marked 'confidential'.	**Compliance**	All files reviewed were clearly marked with a "Confidential" stamp.	
All records are kept in a secure room or locked in a file cabinet that is marked "confidential"	**Exception**	The shelter files are kept in a lock filing cabinet in the YCS locked office and the files are labeled confidential.	The Residential Counselor files are kept in a locked office. However, at the time of the onsite program review, the cabinet is not marked confidential.
When in transport, all records are locked in an opaque container marked "confidential"	**Compliance**	Files are transported in a black locked tote and the tote was marked confidential.	
All records are maintained in a neat and orderly manner so that staff can quickly and easily access information	**Compliance**	All files reviewed were maintained in a neat and orderly manner with a Table of Contents for each section.	
2.08 - Specialized Additional Program Services			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 2.08		**YES** If NO, explain here: The agency has a policy called 2.08 Specialized Additional Program Services. The policy was reviewed and approved by the Regional Director on November 7, 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: 0 **Total number of Closed Files: 0** **Staff Position(s) Interviewed (No Staff Names):** **Type of Documentation(s) Reviewed: Case Files** **Describe any Observations: N/A**			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? **(If no, select rating "No eligible items for review")**	**No eligible items for review**	The agency did not serve any staff secure youth in the last six months or since the last onsite program review. No youth met the criteria for review of this indicator.	
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 does have a staff secure policy that addresses the requirement of this indicator. No youth met the criteria for review of this indicator.	
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**	No youth met the criteria for review of this indicator.	
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**	No youth met the criteria for review of this indicator.	
Agency provides a written report for any court proceedings regarding the youth's progress	**No eligible items for review**	No youth met the criteria for review of this indicator.	
Domestic Minor Sex Trafficking (DMST)			
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.			
Total number of Open Files: 0 **Total number of Closed Files: 0** **Staff Position(s) Interviewed (No Staff Names):** **Type of Documentation(s) Reviewed:** **Describe any Observations: N/A**			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	**No eligible items for review**	No youth met the criteria for review of this indicator.	

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**	No youth met the criteria for review of this indicator.	
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**	No youth met the criteria for review of this indicator.	
Services provided to these youth specifically designated services designed to serve DMST youth	**No eligible items for review**	No youth met the criteria for review of this indicator.	
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**	No youth met the criteria for review of this indicator.	
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**	No youth met the criteria for review of this indicator.	
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**	No youth met the criteria for review of this indicator.	
All other services provided to DMST youth are consistent with all other general CINS/FINS program requirements	**No eligible items for review**	No youth met the criteria for review of this indicator.	
Domestic Violence			
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: 0 **Total number of Closed Files:1** **Staff Position(s) Interviewed** *(No Staff Names)* **: Residential Counselor** **Type of Documentation(s) Reviewed: Case File** **Describe any Observations: See report.**			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	**Yes**	Agency had one Domestic Violence (DV) case within the last six months. The case was a closed case.	
Youth admitted to DV Respite placement have evidence in the file of a pending DV charge	**Exception**	A review of the client file was conducted to determine if the respite place contained evidence in the file of a pending DV charge.	There was no evidence of a pending DV charge in the youth's file.
Data entry into NetMIS within (3) business days of intake and discharge	**Exception**	A review of the client file was conducted to determine if the respite place contained evidence in the file of the case being entered in to NetMIS within three business days of intake and discharge.	Youth exited the program 9/12/2024 though entered into NetMIS on 9/19/2024.

Youth length of stay in DV Respite placement does not exceed 21 days. If more than 21 days, documentation exists in youth file of transition to CINS/FINS or Probation Respite placement, if applicable.	**Compliance**	A review of the youth's client file indicates the residential stay in shelter was a total of nine days.	
Case plan in file reflects goals for aggression management, family coping skills, or other intervention designed to reduce propensity for violence in the home	**Compliance**	A review of the case plan indicated it included goals for aggression management and family coping skills.	
All other services provided to Domestic Violence Respite youth are consistent with all other general CINS/FINS program requirements	**Compliance**	A review of the file indicates all other services are consistent with the general array of CINS/FINS services and requirements associated with services provided to clients.	
Probation Respite			
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: 0 **Total number of Closed Files: 0** **Staff Position(s) Interviewed (No Staff Names):** **Type of Documentation(s) Reviewed:** **Describe any Observations: N/A**			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating “No eligible items for review”)	**No eligible items for review**	The agency does have a Probation Respite policy that addresses the requirement of this indicator. The agency did not serve any youth designated as Probation Respite in the last six months or since the last onsite program review.	
All probation respite referrals are submitted to the Florida Network.	**No eligible items for review**	No applicable youth met the criteria for review of this indicator.	
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**	No applicable youth met the criteria for review of this indicator.	
Data entry into NetMIS and JJIS within (3) business days of intake and discharge	**No eligible items for review**	No applicable youth met the criteria for review of this indicator.	
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**	No applicable youth met the criteria for review of this indicator.	
All case management and counseling needs have been considered and addressed	**No eligible items for review**	No applicable youth met the criteria for review of this indicator.	
All other services provided to Probation Respite youth are consistent with all other general CINS/FINS program requirements	**No eligible items for review**	No applicable youth met the criteria for review of this indicator.	
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: 1 **Total number of Closed Files:1** **Staff Position(s) Interviewed** *(No Staff Names)* **: ICM Coordinator** **Type of Documentation(s) Reviewed:** **Describe any Observations: See report.**			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	**Yes**	The agency has provided Intensive Case Management to two clients in the past six months.	
Youth receiving services were deemed chronically truant and/or runaway and require more intensive and lengthy services. The youth was determined to be eligible because they have gone through petition and/or case staffing and was in need of case management services.	**Compliance**	A review of both client files indicated youth are receiving services identified as a chronic status offender and was also determined eligible due to having gone through petition or case staffing and required case management services.	
Services for youth and family include: a. Two (2) direct contacts per month b. Two (2) collateral contacts per week c. Direct and collateral contacts not obtained must have documentation to support attempts made to obtain them. All reasonable attempts (at minimum of three) must be made to reach all contacts (direct and collateral) and documented in the case file and NetMIS.	**Compliance**	A review of the client files indicate both youth had two direct contacts per month and two had collateral contacts per week. In addition, both client files contained evidence of eight collateral contacts each month.	
Assessments include a. NIRVAN/A at intake b. NIRVAN/A Re-Assessment every 90 days c. Post NIRVAN/A at discharge as aligned with timeframe requirements	**Compliance**	A review of the client files indicate both youth had documented evidence of a NIRVAN/A assessment being completed at intake and a Re-Assessment every 90 days. In addition, both client files contained evidence of eight collateral contacts each month.	
Service/case plan demonstrates a strength-based, trauma-informed focus	**Compliance**	Both client cases contain evidence of case plans with demonstrated strength-based and trauma-informed focus skill building goals for each client.	
For any virtual services provided, there is written documentation in the youths' file as to why virtual contact is in the best interest of the youth and family	**Not Applicable**	None of the cases contained evidence that this service was provided via a virtual service delivery format.	
Family and Youth Respite Aftercare Services (FYRAC)			
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			

Total number of Open Files: 0
Total number of Closed Files: 0
Staff Position(s) Interviewed (No Staff Names):
Type of Documentation(s) Reviewed:
Describe any Observations: N/A

Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	**No eligible items for review**	The agency does have a Family Respite Aftercare Services (FYRAC) policy that addresses the requirement of this indicator. The agency did not serve any youth designated as FYRAC in the last six months or since the last onsite program review.	
Youth is referred by DJJ for a domestic violence arrest on a household member, and/or the youth is on probation regardless of adjudication status and at risk of violating.	**No eligible items for review**	No applicable youth met the criteria for review of this indicator.	
Agency has evidence that all FYRAC referrals have documented approval from the Florida Network office	**No eligible items for review**	No applicable youth met the criteria for review of this indicator.	
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**	No applicable youth met the criteria for review of this indicator.	
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**	No applicable youth met the criteria for review of this indicator.	
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**	No applicable youth met the criteria for review of this indicator.	

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**	No applicable youth met the criteria for review of this indicator.	
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**	No applicable youth met the criteria for review of this indicator.	
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**	No applicable youth met the criteria for review of this indicator.	
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**	No applicable youth met the criteria for review of this indicator.	
All data entry in NetMIS is completed within 3 business days as required.	**No eligible items for review**	No applicable youth met the criteria for review of this indicator.	
2.09- Stop Now and Plan (SN/AP)			**Not Applicable**
Provider has a written policy and procedure that meets the requirement for Indicator 2.09		**YES** If NO, explain here: The agency has a policy 2.09 Stop Now and Plan (SN/AP) and was last reviewed and approved by the Regional Director on 11/7/23.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: 0 **Total number of Closed Files: 0** **Staff Position(s) Interviewed (No Staff Names):** **Type of Documentation(s) Reviewed:** **Describe any Observations: N/A**			
SN/AP Clinical Groups Under 12			
Youth are screened to determine eligibility of services.	**Not Applicable**	The agency does not conduct SN/AP services at this program location.	
The NIRVAN/A was completed at initial intake, or within two sessions.	**Not Applicable**	The agency does not conduct SN/AP services at this program location.	
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 agency does not conduct SN/AP services at this program location.	

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 agency does not conduct SN/AP services at this program location.	
SN/AP Clinical Groups Under 12 - Discharge			
There is evidence of the completed SN/AP Discharge Report located within the file for any discharged youth.	Not Applicable	The agency does not conduct SN/AP services at this program location.	
There is evidence of the completed SN/AP Discharge Report located within the file for any discharged youth.	Not Applicable	The agency does not conduct SN/AP services at this program location.	
There is evidence of the SN/AP Boys/SN/AP Girls Child Group Evaluation Form located in the file.	Not Applicable	The agency does not conduct SN/AP services at this program location.	
There is evidence of the SN/AP Boys/SN/AP Girls Parent Group Evaluation Form located in the file.	Not Applicable	The agency does not conduct SN/AP services at this program location.	
SN/AP Clinical Groups for Youth 12-17			
Youth are screened to determine eligibility of services.	Not Applicable	The agency does not conduct SN/AP services at this program location.	
The Consent to Treatment and Participation in Research Form is completed and located within the file.	Not Applicable	The agency does not conduct SN/AP services at this program location.	
The NIRVAN/A was completed at initial intake, or within two sessions.	Not Applicable	The agency does not conduct SN/AP services at this program location.	
There is evidence of the completed 'How I Think Questionnaire' (HIT) form located within the file or evidence of at least three (3) documented attempts in the youths' file to obtain this information.	Not Applicable	The agency does not conduct SN/AP services at this program location.	
There is evidence of the completed Social Skills Improvement System (SSIS) Student form located within the file or evidence of at least three (3) documented attempts in the youths' file to obtain this information.	Not Applicable	The agency does not conduct SN/AP services at this program location.	
There is evidence of the completed Social Skills Improvement System (SSIS) Teacher/Adult form located within the file or evidence of at least three (3) documented attempts in the youths' file to obtain this information.	Not Applicable	The agency does not conduct SN/AP services at this program location.	
SN/AP 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 SN/AP Facilitator signatures. (This must include a total of 13 attendance sheets for a full cycle)	Not Applicable	The agency does not conduct SN/AP services at this program location.	
The program maintained evidence of a completed "Class Goal" Document for the class reviewed.	Not Applicable	The agency does not conduct SN/AP services at this program location.	

The program maintained evidence of both pre AND post Measure of Classroom Environment (MoCE) completed documents for the class reviewed.	**Not Applicable**	The agency does not conduct SN/AP services at this program location.	
The program maintained evidence of completed pre and post evaluation documents for the class reviewed.	**Not Applicable**	The agency does not conduct SN/AP services at this program location.	
There is evidence of the fidelity adherence checklist maintained in the file for each class reviewed.	**Not Applicable**	The agency does not conduct SN/AP services at this program location.	
3.01 - Shelter Environment			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 3.01		**YES** If NO, explain here: The agency has a policy called 3.01 Shelter Environment. The policy was last reviewed and approved by the Regional Director on March 13, 2024.	

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

Staff Position(s) Interviewed *(No Staff Names)* **: Shelter Manager, Maintenance Coordinator, Youth Care Worker III**
Type of Documentation(s) Reviewed: Posting throughout the facility, in particular the Day Room, Kitchen and Dining Areas, MSDS sheets, Chemical inventory
Describe any Observations: There are two bathrooms upstairs for client use in the sleeping quarters. These include 3 sinks, 2 showers and 2 toilets.

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.	**Exception**	There was a full tour and inspection of the youth shelter. Overall, furnishings appeared to be in good repair. There was no visible evidence of insect infestation at the time of the review. There were two bathrooms upstairs in the sleeping quarters for the youth to use. The bathrooms included a shower and toilet in each bathroom. There are two sinks in one bathroom and one sink in the other. There was evidence (washcloths, makeup powder) of recent use though there was no foul odor, mildew, etc. noted in the bathrooms. Bathrooms were were in working order during the introductory tour and throughout the entire program review. The facility was observed to be secured and no obvious graffiti was noted. Staff granted reviewers access to requested areas with assigned keys. The Shelter Manager explained that Youth Care Staff on duty check out and use keys upon reporting for each shift. Supervisors and counselors have "permanent" keys issued to them. The outdoor grill was covered, as was the dumpster. Egress plans were seen posted throughout the facility in areas accessible to visitors and youth living areas. Other important information such as program rules, grievance forms and procedures, DJJ and Abuse Reporting Hotlines were posted prominently in the day room, as well as several other areas within the facility.	During tour of the exterior grounds, minor debris including plastic water bottle, candy / cracker wrappers, frisbee were observed. A few cigarette butts were noted in the trash / ashtray receptacle on the front porch area that is accessible to the public. The youth do not frequent this area unsupervised. It was noted the staff members which typically oversee the maintenance at this facility has recently been off duty for a few weeks due to a medical issue. There was an exception noted with a few drills missing, as well as one supervisory logbook review gap. A leak was found behind the washing machine which appeared to have been ongoing for a while based on the condition of the woodwork.

Facility Inspection: a. All agency and staff vehicles are locked. b. Agency vehicles are equipped with major safety equipment including first aid kit, (all items in the first aid kit are current and do not have expired items; all expired items should be replaced regularly), fire extinguisher, flashlight, glass breaker and, seat belt cutter.	**Exception**	The agency uses two Chrysler Pacifica vans for transporting clients. Both were found to be secured when not in use. Upon inspection, both were observed to have the required first aid kit, fire extinguisher, flashlight, glass breaker and seatbelt cutter. Proof of registration and proof of insurance were observed in the vehicles as well.	One employee's vehicle was found to be unlocked with the driver's window down. The employee was outside within sight of the vehicle and the youth were not present.
Facility Inspection: All chemicals are listed, approved for use, inventoried weekly and perpetually, stored securely and Material Safety Data Sheets (MSDS) are maintained on each item (minimum 1 time per week or per agency policy). A perpetual inventory will be the primary means of maintaining a current and real-time inventory. The weekly inventory will be conducted weekly at a minimum to ensure that a perpetual inventory is being maintained consistently and accurately. If more than one location is used to store chemicals, there is an inventory wherever chemicals are stored that is current and well maintained unless previously approved by the Network.	**Exception**	The perpetual chemical inventory is maintained with the utilization of chemical usage logs. One log is located in the kitchen and one in the laundry room where chemicals are stored. The Shelter Manager or designee conducts an inventory and check for supplies that need to be replenished on a weekly basis. The most recent kitchen inventory was conducted on 3/19/24 (one day prior to the onsite program review) and the last laundry room inventory on 3/19/24. Chemicals used in the shelter are stored in padlocked cabinets in laundry room and in kitchen below sink. The Material Safety Data Sheets (MSDS) binder overfilled with papers (some old and not on inventory) and falling apart.	There were several MSDS sheets initially missing from the labeled binder for chemicals that were observed on the inventory sheets. The MSDS sheets were printed and added to the binder when brought to the attention of the Shelter Manager (corrected while reviewers on site).
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**	There is an older model washer and dryer located in the designated laundry area. At the time of the this onsite program review, both appliances were functional. There was minimal lint inside the dryer vent as there were clothes recently dried and in the dryer. The agency had a current DCF license displayed that indicated a capacity of eight youth and valid 9/28/23 through 9/27/24. The bedrooms have an ample number of beds to accommodate each youth. The beds were made with appropriate linens and there were extra sheets and blankets in a designated closet in the upstairs hallway/ landing area. There is a locking file cabinet with drawers for youth to store personal belongings in addition to a Sentry Safe to store more valuable items such as personal items.	

Fire and Safety Health Hazards: a. Annual facility fire inspection was conducted, and the facility is in compliance with local fire marshal and fire safety code within jurisdiction. b. Agency completes a minimum of 1 fire drill on each shift monthly (within 2 minutes or less). c. Completes 1 mock emergency drill per shift per quarter. d. All annual fire safety equipment inspections are valid and up to date (extinguishers, sprinklers, alarm system and kitchen overhead hood, including fire extinguishers in all vehicles).	**Exception**	The facility was found to be in compliance with local fire safety guidelines. There was a current fire inspection from the local fire official, as well as separated documentation of inspections of extinguishers (including those in vehicles) (3/19/24) and the fire Alarm and Emergency Communication system (5/23/23). The agency has a practice of conducting required fire and mock emergency drills per requirement.	Exceptions were noted in the consistency of completed drills. In particular there was only one fire drill noted for the month of October, and two for November and December. The pattern improved in January and February with one drill completed on each shift each month. There were two emergency drills recorded in September and none noted for October - December.
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 Group Care Inspection Report was most recently completed on 7/12/23. It was rated " Satisfactory" with notes of previous violations corrected from the prior inspection. For the current inspection, the freezer seal required replacement, the upstairs A/C vent was loose and the tile at the base of the shower entrance needed repair. These issues were not observed at the time of the QI review. The kitchen was inspected at the time of the Group Care Inspection on 7/12/23. The menu was posted in the kitchen and in the living area. The menus were signed by a licensed dietician and the dieticians credentials were posted alongside the menus. There were two clean and neatly organized refrigerators and a large upright freezer in the kitchen /dining area. All appliances were clean and organized. The temperature readings in the refrigerators were 40 degrees and 38 degrees Fahrenheit and the freezer temperature was eight degrees Fahrenheit. The leftover food was observed stored in the refrigerator. One item was in plastic containers with fitted lids. A container of peaches and a container of pork were covered with plastic wrap and foil, respectively. All were dated appropriately and were within two days of date recorded. Dry goods were neatly stored in appropriate containers in the kitchen cabinets or on the countertop (labeled / organized). The microwave and countertops appeared clean.	
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 schedule of activities were posted in the day room and the kitchen. There is a separate "weekday" schedule and a "weekend and holiday" schedule included in the resident handbook as well. There are structured times and activities to include personal hygiene, educational time, job skills, character building, recreation, free time, independent living skills, library skills etc. Reading/homework time and physical activity time are designated daily. The Shelter Manager indicated that in addition to the designated reading time, youth may also choose to read during "quiet time". The day room of the program was arranged to provide tabletop workspace for games or homework, as well as couches and chairs. There was audio and television equipment observed and the Karaoke machine was reported to be one of the recent favored leisure activities. There were several sets of bookshelves that contained a large number of books and games for client use. The schedule includes a Bible Study on Tuesday night which staff reported is voluntary. During the time of the QI review, the youth were on Spring Break from school and participated in a field trip to the Florida Caverns State Park one day and Dave and Busters on the following outing activity.	
3.02 - Program Orientation			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 3.02		**YES** If NO, explain here: The agency has a policy 3.02, Program Orientation. The policy was reviewed and approved by the Regional Director on November 7, 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: 3
Total number of Closed Files: 4
Staff Position(s) Interviewed *(No Staff Names)* **: Shelter Manager, YCS III**
Type of Documentation(s) Reviewed: Three open and three closed files, resident handbook, Client Intake Checklist Forms, results of youth surveys
Describe any Observations: See report.

Youth received a comprehensive orientation and handbook provided within 24 hours	**Compliance**	The program's policy mirrors the indicator exactly. During the intake process, each youth is given a thorough orientation by staff that includes a wide range of information. The youth is given a client / resident handbook that also contains the information. There are individual forms in the client files that the youth signs acknowledging various topics (Youth Contract, Grievance Process, Safety Contract). Each file contains a "Client Intake Checklist" that lists the steps and topics covered. The staff conducting the youth's intake initials beside each listed item to indicate that it was covered and the youth signs the form upon completion.	
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	**Exception**	All (seven) youth surveyed answered that when they entered the program, they were given an orientation about the program, the behavior management system, and the major rules they were expected to follow. Six of the seven indicated they had been instructed on what to do in case of a fire. Six of the seven offered commentary on the orientation experience. No major concerns were noted. One youth, by self and staff report was very emotional / nervous during intake and staff dealt first with her crisis before pursuing completion of the orientation.	One of the seven indicated they had not been instructed on what to do in case of a fire.
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	**Exception**	All files contained the "Client Intake Checklist" that itemizes elements of the intake and indicated that youth received a client handbook.	In one of the seven files reviewed, the youth had not signed the Client Intake Checklist.
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 agency has a policy called 3.03 "Youth Room Assignment". The policy was reviewed and approved by the Regional Director on March 13, 2024.	

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

Total number of Open Files: 3
Total number of Closed Files: 3
Staff Position(s) Interviewed *(No Staff Names)* **: Program Manager, Residential Counselor**
Type of Documentation(s) Reviewed: Residential Intake forms in client files; Client Intake Checklists, logbook
Describe any Observations: See report

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 system is in place to assess each youth and make room assignments considering the elements indicated in the indicator. During the intake process information is gathered about the youth's age, physical and mental health needs / conditions, suicide risk, collateral contacts, history of aggression, presenting demeanor, etc. The staff member discusses the information and any concerns with the Residential Counselor. A youth's room assignment may be changed upon further assessment.	There is a designated space to notate the room assignment for a youth on the Residential Intake Form. Room assignment is also listed on the separate Client Intake Checklist. In six of seven files reviewed, the specific room/bed assignment was not recorded on the Residential Intake Form though five of those six had signed and staff initialed completion of room assignment on the Client Intake Checklist.
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	**Exception**	The program has a designated room for youth who are on sight and sound. Policy and procedure outline process of alerts. See 4.04.	Three of six residential files reviewed appeared to lack the designation on the client file. Two of those were closed files and it is unknown if it was on the file at the time.
3.04 - Log Books			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 3.04		**YES** If NO, explain here: The agency has a policy called 3.04 " Logbooks (Electronic). The policy was reviewed and approved by the Regional Director on March 13, 2024.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Dates or Timeframe Reviewed: October 2023 - through time of review **Staff Position(s) Interviewed** *(No Staff Names)* **: Shelter Manager** **Type of Documentation(s) Reviewed: Sample logbook entries** **Describe any Observations: The program utilizes the NoteActive Electronic Notebook. The Shelter Manager provided evidence of sample documentation both directly from the tablet used to record entries as well as printouts taken from the electronic record.**			
Log book entries that could impact the security and safety of the youth and/or program are highlighted	**Compliance**	Entries were viewed wherein potential safety and security issues were noted. In addition to emergency drills, such things as agitated youth behavior, a precaution about a heightened awareness of an individual who called the program, and the location/return of program keys by a staff member were highlighted. Entries were observed to be highlighted in either pink or yellow based on the type/importance level of the entry.	
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**	Because the electronic logbook is used, entries are uniformly and neatly " type written " in the log. Entries consistently contained the date and time, the youth involved, a brief statement (and/or a standard symbol representing the event or information). Each entry is signed and dated by the person making the entry.	

Recording errors are struck through with a single line. The staff person must initial and date the correction. The use of whiteout and erasures is prohibited.	**Compliance**	Errors are struck through with a single line electronically and signed and dated by the person making the correction. Use of white out and erasures is not applicable as the logbook is electronic.	
The program director or designee reviews the facility logbook(s) every week and makes a note chronologically in the logbook indicating the dates reviewed and if any correction, recommendations and follow-up are required and sign/date the entry	**Compliance**	The Shelter Manager reviews logbook weekly in conjunction with camera reviews. Documentation of review was observed during demonstration with Shelter Manager. Additionally, the YCS III (lead/supervisory role) reviews the past two shifts as do the Youth Care Staff.	
All staff review the logbook of the previous two shifts and makes an entry signed and dated into the logbook indicating the dates reviewed	**Exception**	Staff are consistently recording review of the logbook in free form notes in the logbook.	The specific dates staff are stating they have reviewed are not always explicitly noted. Staff review of logbooks is implied by the terminology of "past two shifts" being reviewed.
At the beginning of their shift, oncoming supervisor and shelter counselor reviews the logbook of all shifts since their last log entry and makes a signed and dated entry and into log book indicating the dates reviewed.	**Compliance**	Review of logbook was routinely noted by oncoming supervisor and counselor.	
Logbook entries include: a. Supervision and resident counts b. Visitation and home visits	**Compliance**	Census notations, client whereabouts, visitations, phone calls, activities/outings etc. are routinely noted in the logbook.	
3.05 - Behavior Management Strategies			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 3.05		**YES** If NO, explain here: The agency has a policy called 3.05 Behavior Management Strategies. The policy has not been signed at the time of initial review. The Regional Director signed the policy on 3/21/24 when brought to attention by the review team.	
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)* **:** **Type of Documentation(s) Reviewed: Policies and Procedures** **Describe any Observations: The Policy for this indicator addressed all the elements of the indicator, plus additional to the program. The policy had not been signed at the time of initial review. However, the Regional Director signed during the review once brought to management's attention.**			
The program has a detailed written description of the BMS and it is explained during program orientation	**Compliance**	The Behavior "Motivation" / Management System is explained during intake orientation and the youth sign the orientation checklist which acknowledges they received the explanation.	
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 has a behavior management system in place that adheres to the guidelines in the indicator. The behavior management system is designed to foster accountability for one's behavior and compliance with the program's rules and expectations. More specifically, the program recently implemented it's "Journey to Success (JTS) component of the overall behavior management system. JTS is a points system whereby youth attain points for completing tasks and adhering to expectations. The system relies on affirming and validating youth for positive behaviors and maintaining compliance with program rules and routines rather than being consequence based, per se. Points are accumulated and tallied to assign a level each week based on the percentage of points attained. The levels are identified as "Discovery", "Achieve/Believe", "Ownership", and "Empowerment". Incentive options are based on the level of the youth. Each day youth may draw from a "treat box" and other incentives may include such things as special outings, etc. Room restriction is only used when it is considered to be the most appropriate intervention and is used to allow youth time away from the interaction of the group to regain control of his or her behavior.	
Program's use of the BMS			
All staff are trained in the theory and practice of administering BMS rewards and consequences	**Compliance**	Training begins during the first week of employment through observation and review of policies and procedures. More specific training is provided by certified trainers and at monthly in-service training sessions. The Shelter Manager has been through the full training and is/will be the certified trainer for the program staff.	
There is a protocol for providing feedback and evaluation of staff regarding their use of BMS rewards and consequences	**Compliance**	The YCS III (and Shelter Manager) provides feedback to staff regarding their use of rewards and consequences with youth. During their annual performance evaluation, youth care staff are evaluated on their appropriate use of the Behavior Management System.	
Supervisors are trained to monitor the use of rewards and consequences by their staff	**Compliance**	A review of the agency's training files indicates supervisors are trained on all aspects of the staff execution and performance related to the behavior management system. Supervisors are required to monitor and redirect and re-training if deemed necessary for staff to effectively delivery the behavior management system.	
3.06 - Staffing and Youth Supervision			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for		**YES** If NO, explain here:	

Provider has a written policy and procedure that meets the requirement for Indicator 3.06		The agency has a policy called 3.06 Staffing and Youth Supervision. The policy was reviewed and approved by the Regional Director on March 13, 2024.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Dates or Timeframe Reviewed: Current and intermittent past few months **Staff Position(s) Interviewed** *(No Staff Names)* **: Shelter Manager** **Type of Documentation(s) Reviewed: Log book entries and staff schedule posted in Youth Care Staff Office** **Describe any Observations: During review of video surveillance coverage, the reviewer and Shelter Manager observed that when conducting bed checks, staff at times do not appear to fully view the youth when they conduct the check by scanning the sensor of the room with the electronic tablet to record completion.**			
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**	The program maintains a staff schedule for two people on each shift which in alignment with the Florida Administrative code requirements.	
All shifts must always provide a minimum of two direct care staff present that have met the minimum training requirements	**Compliance**	Two staff members are scheduled for each shift and only staff who have completed minimum prerequisite training are placed on schedule.	
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 scheduled to work as part of the staff to youth ratio have been background screened.	
The staff schedule is provided to staff or posted in a place visible to staff	**Compliance**	Staff schedule is posted in the Youth Care Staff office.	
There is a holdover or overtime rotation roster which includes the telephone numbers of staff who may be accessed when additional coverage is needed	**Compliance**	Youth Care Staff phone numbers are posted/available to other staff. If a YCS is unavailable or delayed for a scheduled shift, they are responsible for contacting another staff person to arrange for coverage. If they are unable to obtain coverage from a peer, they contact the supervisor / Shelter Manager who will arrange for / provide coverage to maintain the required staffing level. It was noted during the review that due to staffing shortages, members of the shelter and administrative management team have assisted in covering shifts in the shelter, including the overnight shift.	
Staff observe youth at least every 15 minutes while they are in their sleeping room, either during the sleep period or at other times, such as during illness or room restriction	**Compliance**	The program's practice is to conduct bed checks every 10 minutes when they are in their room during sleeping hours or at other times, such as illness. Bed checks observed by the reviewer indicate the bed checks times are more frequent than required.	
3.07 - Video Surveillance System			**Satisfactory**
		YES	

Provider has a written policy and procedure that meets the requirement for Indicator 3.07	If NO, explain here: The agency has a policy called 3.07 Video Surveillance System. The policy was reviewed and approved by the Regional Director on March 13, 2024.	

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

Dates or Timeframe Reviewed: Random sample.
Staff Position(s) Interviewed *(No Staff Names)* **: Shelter Manager**
Type of Documentation(s) Reviewed: Sample of video surveillance footage
Describe any Observations: Observation of camera placement while walking around facility, live view of surveillance during review

Surveillance System			
The agency, at a minimum, shall demonstrate: a. A written notice that is conspicuously posted on the premises for the purpose of security b. System can capture and retain video photographic images which must be stored for a minimum of 30 days c. System can record date, time, and location; maintain resolution that enables facial recognition d. Back-up capabilities consist of cameras' ability to operate during a power outage e. Have cameras placed in interior (e.g. intake office, counseling office, cafeteria, day room) and exterior (e.g. entrance/exit, recreation area, parking lot) general locations of the shelter where youth and staff congregate and where visitors enter and exit; to include locations where youth searches are conducted. Cameras are never placed in bathrooms or sleeping quarters. f. All cameras are visible	**Compliance**	The program has an operational video surveillance system that records from 16 cameras. The cameras were observed placed overhead in reception area, the front hallway (near entrance), the conference room, the YCS office (x2) where searches are conducted, the dining area, the kitchen, the day room (x3), the top of the stairs/landing area of second floor, and the stairwell leading upstairs inside the facility. There were no cameras in the bathrooms or bedrooms. Outside cameras were seen in the backyard (three covering differing space/angles) and on the front porch/entry area. Notice of video surveillance was clearly posted in the entrance of the building as well as throughout. The system can retain video for 30 days as evidenced by review of recorded activity from 2/19/24 (30 days prior to QI site visit). The date and time were recorded and staff was able to recognize the youth who were recorded outside during recreation time. The Shelter Manager and Maintenance Coordinator explained that the system has a battery back up power supply to enable the cameras to operate 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**	At time of the QI review, only the Shelter Manager and the Regional Director had access to video surveillance.	
Supervisory review of video is conducted a minimum of once every 14 days and timeframes reviewed are noted in the logbook.	**Compliance**	The Shelter Manager routinely reviews and documents review of video footage. Shelter Manager explained that she does this approximately weekly and even more frequently if there is an incident that warrants it.	

The reviews assess the activities of the facility and include a review of random sample of overnight shifts	**Compliance**	Recorded video of bed checks was viewed for one overnight shift each week for the six weeks prior to the review and various nights of the week (week of February 19th - March 19th, 2024). All bed checks were found to be within and actually superseded the 15 minute interval timeline. Bed checks are conducted using an electronic sensor/monitoring that synchs automatically with the NoteActive logbook so that checks are dated and time stamped. The documented times were congruent with the times observed on the video.	
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 Shelter Manager explained the process for providing video to the OIG office, for example, when requested. She demonstrated the ability to save both still photos and video footage by downloading and then sending as requested.	
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	**No eligible items for review**	There were no reported instances of camera malfunction within the past six to nine months of review. The Shelter Manager articulated the process of contacting the surveillance equipment company to obtain repair in the event of such a problem.	
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 called 4.0 Healthcare Screening Admission. This policy was reviewed and approved by the Regional Director on November 7, 2023.	

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

Total number of Open Files: 2
Total number of Closed Files: 4
Staff Position(s) Interviewed (No Staff Names): Residential Supervisor and Residential Counselor
Type of Documentation(s) Reviewed: Client Files
Describe any Observations: See report.

Preliminary Healthcare Screening

Screening includes : a. Current medications b. Existing (acute and chronic) medical conditions c. Allergies d. Recent injuries or illnesses e. Presence of pain or other physical distress f. Observation for evidence of illness, injury, physical distress, difficulty moving, etc. g. Observation for presence of scars, tattoos, or other skin markings h. Acute health symptoms requiring quarantine or isolation	**Compliance**	A total of four files were reviewed for screening to determine the agency's adherence to the requirements of this indicator. All four client files had the healthcare screening completed on the day of admission. All four files were screened for past and current acute and chronic health and medical conditions at the time of intake. None of the youth were applicable for recent injuries, illnesses, diabetes, pregnancy, cardiac disorder, asthma, tuberculosis, hemophilia, or head injuries. The program does not keep a daily medical log for referrals. If the youth needs medical attention that is out of the program's scope, the parents are contacted to take youth to hospital. The program has procedures to include a through referral process and a mechanism for necessary follow-up medical care for youth admitted with chronic medical conditions.	
Referral and Follow-Up			
Youth with chronic medical conditions have a referral to ensure medical care (e.g. diabetes, pregnancy, seizure disorder, cardiac disorders, asthma, tuberculosis, hemophilia, head injuries, etc.)	**Compliance**	A review of current practice regarding youth with medical conditions revealed the agency's current practice involves the parent being contacted when a youth is having medical issues. The parents are still primarily responsible for youth's medical attention and meeting all medical needs while in the program.	
When needed, the parent is involved with the coordination and scheduling of follow-up medical appointments	**Compliance**	A review of the agency's practice indicates all parents are engaged in the coordination and scheduling of referral of all follow-up medical appointments.	
All medical referrals are documented on a daily log.	**Compliance**	All medical and health related referrals are documented in the agency's logbook system.	
The program has a thorough referral process and a mechanism for necessary follow-up medical care as required and/or needed	**Compliance**	The current process requires that the parent facilitate all medical follow-up care for the youth including all referrals for medical and health needs. Parents are primary contact to ensure all of the aforementioned needs are met.	
4.02 - Suicide Prevention			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 4.02		**YES** If NO, explain here: The agency has a policy 4.02 Suicide Prevention. This policy was reviewed and approved by the Regional Director on November 7, 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: 5
Total number of Closed (Residential & Community) Files: 0
Staff Position(s) Interviewed *(No Staff Names)* **: Regional Director and Licensed Clinician.**
Type of Documentation(s) Reviewed: Residential files screened positive for elevated supervision.
Describe any Observations: See report.

Suicide Risk Screening and Approval (Residential and community counseling)			
Suicide risk screening occurred during the initial intake and screening process. Suicide screening results reviewed and signed by the supervisor and documented in the youth's case file.	**Compliance**	A total of five residential client files were reviewed for screening to determine the agency's adherence to the requirements of this indicator. All five contained evidence of a suicide screening completed during the initial intake process and results were signed by the supervisor and documented in youth case file.	
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 of Youth and Family Services. The agency's current suicide risk assessment process has not been changed since the last onsite program review.	
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**	A total of five client files were reviewed. All five client files were properly screened for risk and were placed on the appropriate level of supervision based on the results of the suicide risk assessment.	
Staff person assigned to monitor youth maintained one-to-one supervision or constant supervision and documented his/her observations of the youth's behavior at 30 minute or less intervals	**Compliance**	A total of five client files were reviewed. All five client files contained observation sheets documenting 30 minute or less observations on the status of each youth. Three were applicable for sight-and-sound supervision.	
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**	All client assessments are inclusive of the client's behavioral observations. All five client assessments are completed by the agency's Licensed Clinician. Documentation in each client file includes date and time of observation, staff member's initials and was maintained in an observation log book.	
Supervision level was not changed/reduced until a licensed professional or a non-licensed mental health professional under the supervision of a licensed professional completed a further assessment OR Baker Act by local law enforcement	**Compliance**	All five client files were applicable for sight-and-sound supervision. All five clients were placed on sight-and-sound supervision until assessed by a Residential Counselor. The Residential Counselor at this site is a licensed professional. However, all five files were assessed for suicide risk by the licensed professional within 24 hours or within the applicable timeframe per policy as required.	
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**	All five files contained evidence of the Suicide risk assessment, observation logs, and youth's file are reviewed and contained a supervisor's signature.	
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**	None of the files reviewed met this criteria for the sample size reviewed.	

During the intake, if the appropriate staff is unavailable, youth identified for suicide risk was immediately referred by the provider and the parent/guardian is notified of the suicide risk findings disclosed and advised that an Assessment of Suicide Risk should be completed ASAP by a licensed professional	**No eligible items for review**	None of the files reviewed met this criteria for the sample size reviewed.	
Information on resources available in the community for further assessment was provided to the parent/guardian and is documented in the youth's file and signed by the parent/guardian OR a written follow-up notification was sent by certified mail if the parent/guardian was not present during the screening and was notified by telephone.	**No eligible items for review**	None of the files reviewed met this criteria for the sample size reviewed.	
If the parent/guardian cannot be contacted, all efforts to contact them are documented in the case file.	**No eligible items for review**	None of the files reviewed met this criteria for the sample size reviewed.	
When the screening was completed during school hours on school property, the appropriate school authorities were notified.	**No eligible items for review**	None of the files reviewed met this criteria for the sample size reviewed.	
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. This policy was reviewed and approved by the Regional Director on November 7, 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: 4 **Total number of Closed Files: 2** **Staff Position(s) Interviewed** *(No Staff Names)* **: Residential staff and Registered Nurse.** **Type of Documentation(s) Reviewed: Client medication documents** **Describe any Observations: See report.**			
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 agency has access to a Registered Nurse (RN). The program employs the part-time RN, whose certification has an expiration date of April 2025.	

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 RN demonstrated proper distribution practice and no exceptions were noted. The RN conducts all initial and follow-up medication distribution practice training for all staff members.	
The agency held at least quarterly staff meetings conducted by RN and/or Shelter Manager to review and assess: a. strategies implemented to reduce medication errors shelter wide b. analyze factors that contributed to medication errors c. allow staff the opportunity to practice and role-play solutions	**Compliance**	The agency provided proof of conducting a minimum of quarterly meetings and in some instances monthly meetings. These meetings involve input from the RN and discuss a comprehensive array of medication practice techniques and effective general medication distribution protocols.	
The agency has strategies implemented to ensure medications are provided within the 2-hour time frame.	**Compliance**	The agency has standard operating procedures that require medication to be distributed with the two hour time frame. The agency ensures medication is given no more than one hour prior to the prescribed time or not to exceed one hour after the prescribed medication distribution time.	
All non-licensed staff members are clearly identified and designated on the staff schedule and shift change report/shift responsibility form for assisting with the self-administration of medications on each shift	**Compliance**	The agency has a process which identifies the staff person primarily responsible for distributing medication during the work shift. The agency also maintains a list of staff members that have been trained and approved by the RN to assist in the delivery of medications to youth shelter residents.	
The agency has clear methods of communicating which youth are on medications with the times and dosage easily discernable by all staff on each shift.	**Compliance**	The agency has a process to clearly identify the youth on prescribed or controlled medication, dosage amount, time specified for receiving medication and staff responsible for assisting in the delivery of medication per each work shift.	
The delivery process of medications is consistent with the FNYFS Medication Management and Distribution Policy and the agency has an internal quality assurance process to include the following: a. to ensure appropriate medication management and distribution methods b. to track medication errors c. to identify systemic issues and implement mitigation strategies, as appropriate.	**Compliance**	The agency's RN is primarily responsible for internal review of all of the agency's medication distribution practice by each staff member. The RN primarily and certain designated staff members review medication errors. The RN tracks all errors and specifically assesses each error and develops all corrective actions and mitigation strategies and measures to address the identified issues.	
Admission/Intake of Youth			

a. Upon admission, the youth and parent/guardian (if available) were interviewed by the Registered Nurse (when on-site) about the youth's current medications as part of the Medical and Mental Health Assessment screening process and/or an interview was conducted by the RN within three (3) business days if the RN was not on the premise at admission. **If the agency does not have a RN, there was a medication review conducted by a certified Leadership position.* b. Upon intake/admission, there is evidence that the on-shift certified supervisor of higher level staff did review all medication forms by the next business day.	**Compliance**	When the RN is onsite, the RN is primarily responsible for conducting all initial interview and screenings questions related to the status of the youth as it related to health, medical and applicable medication(s). At the time of this onsite program review, the RN has demonstrated evidence of fulfilling the duties of screening and review client records related to medical, health and applicable medication(s).	
Medication Storage			
a. All medications are stored in a Pyxis ES Medication Cabinet that is inaccessible to youth (when unaccompanied by authorized staff) b. Pyxis machine is stored in accordance with guidelines in FS 499.0121 and policy section in Medication Management c. Oral medications are stored separately from injectable epi-pen and topical medications d. Medications requiring refrigeration are stored in a secure refrigerator that is used only for this purpose, at temperature range 2-8 degrees C or 36-46 degrees F. (If the refrigerator is not secure, the room is secure and inaccessible to youth.) e. Narcotics and controlled medications are stored in the Pyxis ES Station f. Pyxis keys with the following labels are accessible to staff in the event they need to access medications if there is a Pyxis malfunction: a TOP COVER b BACK PANEL- LEFT TALL CABINET LOCK- LEFT, c BACK PANEL- RIGHT TALL CABINET LOCK- RIGHT	**Compliance**	The program utilizes the Pyxis Med-station cabinet system. The medication cabinet is locked at all times when the staff are not in the process of assisting with the delivery of medication. The cabinet can only be accessed with pass code and biometric fingerprint scan. The program stores controlled and over the counter separately within the medication cabinet. There are currently no injectables or topical medications at the program. The reviewer observed the medication distribution process.	
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 RN and two site-specific system managers for the Pyxis station. Only designated staff members with user permissions have access to secured medications. An interview with the RN revealed staff members are all trained to assist in the delivery of medication to residents. The Residential Supervisor or designated Lead staff assign which staff member on shift is responsible for assisting in the delivery of medication. The RN distributes medication when on site. Medication is given by the program twice a day 7:00AM and 7:00PM. At the time of this onsite program review, the onsite observation of medication pass was conducted and no issues were noted. The RN was observed administering the medications. Verification was done so by the RN by verifying the youth's name, date of birth, correct medication, and dosage. Both the youth and nurse were observed signing the Medication Distribution Log (MDR). No refusals of medication by the youth were observed. An interview with the RN revealed the program does not currently accept youth with prescribed injectable medications, except for epi-pens. Further, the RN revealed epi-pen training is provided to all staff upon employment and every four months after. The nurse stated a certificate of completion is placed in the personnel files.	
The medication distribution log documentation includes: a. the time of medication administration b. evidence of youth initials that the dosage was given□ c. evidence of staff initials that the dosage was given□	**Compliance**	The medication distribution log (MDR) was observed being used during med pass. The time of medication administration, the youth initials, and staff initials was observed being captured and documented during the medication pass by the reviewer.	
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 reviewer observed the youth being given medication within one hour of scheduled time of delivery as order by the medication. This information is documented in the medications binder located in the metal cabinet adjacent to the medication cabinet in the youth care office area. All medication is provided as required.	
During the review period, there were no instances where youth missed their medication due to failure to open the pyxis machine.	**Compliance**	A review of the medical distribution log revealed there were no instances where youth missed their medication due to failure to open the medication cabinet.	
If applicable: Any staff member deemed responsible for a medication error, there was evidence that the staff member received refresher training from an RN and demonstrated competency prior to being assigned future medication administration responsibilities. There is evidence that any staff member deemed responsible for 3 errors within a 1-year time frame, had their certification suspended and was not recertified until the completion of the full **in-person** medication administration training, demonstrating competency and re-certification from an RN.	**No eligible items for review**	No staff members met this requirement at the time of this program review.	

Medication Inventory			
a. For controlled substances, a perpetual inventory with running balances is maintained as well as a shift-to shift count verified by a witness and documented b. Over-the-counter medications that are accessed regularly and inventoried weekly c. Syringes and sharps (needles, scissors, etc.) are secured, and counted and documented weekly	**Compliance**	The agency has an internal inventory process for controlled substances and sharps. Controlled medications are inventoried shift-to-shift. All over-the-counter medications are inventoried using the medication cabinet. Sharps are also inventoried weekly. An inventory of sharps was completed during the annual compliance review and no issues were noted.	
There are monthly reviews of the Pyxis reports to monitor medication management practice.	**Exception**	An interview with the RN revealed that monthly reviews of the agency's medication distribution activity reports are not routinely conducted to monitor medication management practice.	Monthly reviews of medication distribution activities are not being conducted on a routine basis to monitor medication management practice.
Medication discrepancies are cleared after each shift.	**Compliance**	An interview with the RN indicated medication discrepancies are cleared after each work shift. When a discrepancy occurs, the agency's practice is to utilize two people conducting counts to clear all discrepancies.	
4.04 - Medical/Mental Health Alert Process			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 4.04		**YES** If NO, explain here: The policy number is 4.04 Medical/Mental Health Alert Process. This policy was reviewed and approved by the Regional Director on November 7, 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: 5 **Total number of Closed Files: 0** **Staff Position(s) Interviewed** *(No Staff Names)* **: Regional Director and Residential staff members.** **Type of Documentation(s) Reviewed: Residential client files.** **Describe any Observations: See report.**			
Youth with a medical, mental health, or food allergy was appropriately placed on the program's alert system	**Compliance**	Five files were reviewed to assess the agency's adherence to the requirements of this indicator. Five of the five files were applicable for medical or mental health condition or food allergy. All five youth were appropriately screened and the documentation of them being on medication is in place. When applicable food allergies are documented on an alert board in the kitchen. All allergies are documented in the Shift Pass Down Log and on the youth's file. Any applicable alerts with medication allergies are documented in medication cabinet.	One of the five youth were appropriately placed on the program's alert system. Youth's condition was screened as required and documented in the file. The Green Dot is missing to indicate youth are on medication.
Alert system includes precautions concerning prescribed medications, medical/mental health conditions	**Compliance**	An interview with the Regional Director and Residential Counselor indicated the alert system includes precautions concerning 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**	An interview with the Regional Director indicated staff members are provided training, information and instructions to recognize and respond to the need for emergency care for medical and 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 review of the general alert system was conducted onsite during the program review. The agency has a medical and mental health alert system in place to ensure information gathered during screening, intake and assessment 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 staff. A binder with all the information was observed during the annual compliance review period.	
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. This policy was reviewed and approved by the Regional Director on November 7, 2023.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: 0 **Total number of Closed Files: 5** **Staff Position(s) Interviewed (No Staff Names): Residential Supervisor.** **Type of Documentation(s) Reviewed: Residential client files.** **Describe any Observations: See report.**			
Off Site Emergency Care			
a. If off-site emergency medical or dental care was provided, an incident report was submitted for the medical or dental care b. Upon youth return, there is a verification receipt of medical clearance via discharge instructions with follow-up is present in file c. Youth's parent/guardian was notified d. A daily log is maintained for emergency care provided	**Exception**	Six closed files were reviewed to assess the agency's adherence to the requirements of this indicator. Upon return there is verification receipt of medical clearance via discharge instructions are documented in five of the six client files. The parent/guardian was notified in all six incidents as required. All medical incidents are documented in the electronic logbook.	One of the six client files does not have documented evidence of follow-up medical clearance information with instructions following discharge after the medical/health incident.
All staff are trained on emergency medical procedures	**Compliance**	A review of staff member training files indicated all staff are trained on first aid, CPR, universal precautions and other safety and general medical emergency response training topics.	

The program has a Knife-for-life and wire cutters accessible to staff in a secure location(s)	**Compliance**	The knife for life and wire cutters are securely locked and located in the youth care specialist office. The first aid kit locations are in the counseling youth care office area, kitchen, and both transport vehicles.	