Florida Network for Youth and Family Services
Compliance Monitoring Report for

Lutheran Services Florida Southwest (LSF SW) / Oasis

3615 Central Avenue, Suite 3
Fort Myers, FL 33901

April 3-4, 2024

Compliance Monitoring Services Provided by

EXECUTIVE SUMMARY

Forefront LLC conducted a Quality Improvement (QI) monitoring visit on behalf of the Florida Network of Youth and Family Services (FNYFS) for the Lutheran Services Florida Southwest (LSF SW) Oasis for the FY 2023-2024 at its program office located at 3615 Central Avenue, Suite 3, Fort Myers, Florida. Forefront LLC (Forefront) is an independent compliance monitoring firm that is contracted by the FNYFS to perform onsite program reviews to assess the agency's adherence to fiscal, programmatic and overall contract requirements. LSF SW Oasis is contracted with the Florida Network of Youth and Family Services (FNYFS) to provide direct services to Children/Families in Need of Services (CINS/FINS). The services to be provided are identified in Contract Section A - Descriptions and Specifications and Section B - Delivery and Performance, and are funded with General Revenue Funds effective from July 2023 through June 30, 2024.

The review was conducted by Marcia Tavares, Consultant for Forefront LLC and Peer Reviewers Vincelyn Barbier, Rondarrell George, Shelley Gress, and Mackenzie Tomasik. Agency representatives from LSF SW Oasis present for the entrance interview were Shelia Dixon, Executive Director; Nicole Lewis, Clinical Director; Samuel Laguerre, Residential Manager; Erick Scott, Shelter Supervisor; Emily Clinch, SNAP Coordinator; and Heidi Braeuer Smith, HR Liaison/Sr Administrative Assistant. The last onsite QI visit was conducted May 31, 2023.

In general, the Reviewer found that Lutheran Services Florida Southwest Oasis is in compliance with specific contract requirements. **LSF SW Oasis received an overall compliance rating of 100% for achieving full compliance with 13 indicators** of the CINS/FINS Monitoring Tool. There were no corrective actions or recommendations made as a result of the monitoring visit.

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

2023-2024 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 04-03-2023-2024

Agency Name: LSF SW - Oasis	**Monitor Name: Marcia Tavares, Lead Reviewer**
Contract Type : CINS/FINS	**Region/Office: 3615 Central Avenue, Suite 3, Fort Myer**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): April 3-4, 2024**

Major Programmatic Requirements	Explain Rating: Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable	Ratings Based Upon: I = Interview; O = Observation; D = Documentation; PTV = Submitted Prior To Visit; (List Who and What)	Notes: Explain Unacceptable or Conditionally Acceptable:
I. Administrative and Fiscal							
DJJ Quality Improvement Peer Reviewer a. Provider shall demonstrate that a minimum of two (2) staff members have been trained to be certified as DJJ QI Peer reviewers. Provider shall participate in a minimum of one (1) on-site quality assurance review of a similar type of program in another judicial circuit during each 12-month period of the contract, if requested.	☐	☐	☒	☐	☐	Documentation: The program currently has two staff members certified as DJJ QI Peer reviewers, Shelia Dixon and Samuel Laguerre. Both staff have participated in QI Reviews for the current fiscal year.	**No recommendation or Corrective Action.**
Additional Contracts a. Provider shall provide a listing of all current federal, state, or local government contracts, as well as other contracts entered into with for profit and not-for-profit organizations. Such a listing shall identify the awarding entity and contract start & end dates. **PTV**	☐	☐	☒	☐	☐	Documentation: A list of five additional contracts for FY 2023-2024 was provided by the provider. The list includes the funding sources and contract term dates. The program also maintains interagency agreements and Memorandums of Agreement (MOUs) with schools, substance abuse, mental health partners, and other treatment providers. All of the agreements reviewed had recent valid agreement dates.	**No recommendation or Corrective Action**
Limits of Coverage	☐	☐	☐	☒	☐	Documentation:	**No recommendation or Corrective Action**

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	Unacceptable	**Conditionally Unacceptable**	**Fully Met**	**Exceeded**	**Not Applicable**		
a. Provider shall provide and maintain during this contract, the following minimum kinds of insurance: Worker's Compensation and Employer's liability insurance as required by Chapter 440, F.S. with a minimum of $100,000 per accident, $100,000 per person and $500,000 policy aggregate. Commercial General Liability with a limit of $500,000 per occurrence, and $1,000,000 policy aggregate. Automobile Liability Insurance shall be required and shall provide bodily injury and property damage liability covering the operation of all vehicles used in conjunction with performance of this contract, with a minimum limit for bodily injury of $250,000 per person; with a minimum limit for bodily injury of $500,000 per accident; with a minimum limit for property damage of $100,000 per accident and with a minimum limit for medical payments or $5,000-$10,000 per person. Florida Network is listed as payee or co-payee. **PTV**						The provider's General Liability; Workers Compensation; and Automobile insurance policies all meet the required minimums per the Limits of Coverage and are in effect for the current FY 2023-2024. General Liability through Markel Global Insurance Company, for limits of coverage of $1,000,000 each $3,000,000 aggregate, and medical expense for $10,000, effective 6/01/2023 – 6/01/2024. Automobile insurance through Florida Insurance Trust for combined limits of liability/property damage for $1,000,000. Policy effective date 6/01/2023 – 6/01/2024. Workers Compensation through Accident Fund Insurance Company of America with limits of $1,000,000 each/aggregate, effective 6/01/2023 – 6/01/2024.	

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	Unacceptable	**Conditionally Unacceptable**	**Fully Met**	**Exceeded**	**Not Applicable**		
						Umbrella liability through Century Surety Company with limits of $1,000,000 each/aggregate, effective 6/01/2023 – 6/01/2024. Professional Liability/Abuse Molestation through Markel Global Insurance Company for $1,000,000 each and $3,000,000 aggregate, effective through 6/01/2023 – 6/01/2024. Florida Network is listed as certificate holder on the COL.	
External/Outside Contract Compliance a. Provider has corrective action item(s) cited by an external funding source (Fiscal or Non-Fiscal). **ON SITE**	☐	☐	☐	☐	☒	Interview: During the Entrance Conference, the provider indicated that there are no outstanding corrective action item(s) cited by any external funding source.	**No recommendation or Corrective Action**
Fiscal Practice a. Agency must have employee and fiscal policy/procedures manuals that are in compliance with GAAP and provide sound internal controls. Agency maintains fiscal files that are audit ready. **PTV**	☐	☐	☒	☐	☐	Documentation: Fiscal Policies and Procedures. Agency maintains a Finance Policies and Procedures Manual that is consistent with GAAP and provides for limited internal	**No recommendation or Corrective Action**

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						controls. Policies and procedures were last approved 11/13/14 by the Executive Vice President/Chief Financial Officer and Vice President of Finance. The procedures are updated as necessary with revised policies showing a revision/approval date.	
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: Expanded General Ledger for July 1, 2023 – January 2024. The agency maintains a detailed general ledger with corresponding source documents. A general ledger is structured to track all funding sources and there is a separate GL for the Lutheran Services Florida Oasis CINS/FINS program.	**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: Reviewed Petty Cash 4.32 Policy and Procedure included in the Fiscal Manual. Petty cash is maintained by the Residential Director (Shelter) and is stored in a secured cash box. Petty cash is reconciled at least monthly by	**No recommendation or Corrective Action**

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						the custodians, approved by management, and submitted to the corporate office for refunding as needed. Disbursements and invoices are approved by the program director/ designee.	
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 Ameris Bank operating account and the corresponding bank reconciliations for the period August 2023-January 2024. Bank reconciliations are processed by the finance department in the Tampa Corporate office. Successful bank reconciliations were conducted within 2 weeks of receipt of bank statements. All of the reconciliation worksheets were reviewed by a second party in addition to the preparer. Vendor payments are distributed through the corporate office in Tampa, Florida through check requisitions by the Broward office. Vendor files are	**No recommendation or Corrective Action**

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						maintained locally with copies of the invoices and check requisitions.	
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: The provider maintains an inventory for computer and periphery equipment purchased. No additional items were purchased with FN funds within the last year.	**No recommendation or Corrective Action**
f. Agency submits payroll taxes and deposits (and retirement deposits as applicable), Employee IRS Form W-2 and Independent Contractors IRS Form 1099 forms prior to federal requirements. **ON SITE**	☐	☐	☒	☐	☐	Documentation: ADP is contracted by LSF to process payroll. ADP is responsible for submitting information for W2s, Quarterly 941 reports, and payroll taxes. ADP Tax Ledger Deposit Details for the third and fourth quarters of 2023 were reviewed. These reports demonstrate submission of payroll taxes and deposits biweekly.	**No recommendation or Corrective Action**

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g. Budget to actual reports prepared and reviewed by appropriate management. Variance from the budget are investigated and explained. **PTV/ON SITE**	☐	☐	☒	☐	☐	Documentation: Budget to Actual report for July 1, 2023-January 31, 2024 for the CINS/FINS Program was reviewed. A net deficit was observed per the report. The provider has a monthly process for reviewing and explaining variances.	**No recommendation or Corrective Action**
h. A Single Audit is performed as part of the annual audit if expenses are greater than $750,000. The agency must submit a Corrective Action Plan for findings cited in the management letter and single audit. An annual financial audit was completed within 120 days after the previous fiscal year/calendar year and that a copy was provided to the Network unless and extension has been requested and approved in writing. Copy of Audit is submitted to the FNYFS by December 31st. **Can obtain from FNYFS**	☐	☐	☒	☐	☐	Documentation: The provider submitted a copy of the Financial audit conducted for the year ending June 30, 2023 and 2022 for the review. The audit was completed by RSM US, LLP and was dated March 29, 2024. Per the auditors, there was no management letter or deficiency control letter issued as there were no matters required to be reported in these letters.	**No recommendation or Corrective Action**

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i. Agency maintains confidentiality policy with written policies and procedures to ensure the security and privacy of all employee and client data. Personal information is not easily accessible. Agency maintains a backup system in case of accidental loss of financial information. Security procedures are in place to protect laptops. Obsolete documents are shredded and computer hard drives are wiped prior to discarding. **ON SITE**	☐	☐	☒	☐	☐	Documentation reviewed included policy and procedures regarding the following: data back-up contained in the Agency's Policy and Procedure Section 2.10, on Information Management; Section 1, 1.09 Confidentiality of Client Information; Section 12, 12.01 Access to Case Records; and 12.02 Case Record Keeping. Laptops are not furnished to case workers.	
j. Agency provided evidence that every direct care staff employee, as of October 1, 2023, is being paid at least $19.00 per hour. This also includes funding for additional staff as approved by the Department. **ON SITE**	☐	☐	☒	☐	☐	Documentation: A salary list of all staff was provided showing position title, pay rate, and scheduled hours. All direct care staff was observed to be paid at least $19 per hour.	

CONCLUSION

LSF SW Oasis has met the requirements for the CINS/FINS contract as a result of full compliance with 13 applicable indicators of the Administrative and Fiscal Contract Monitoring Tool. One of the fourteen indicators was not applicable because the program indicated there are no outstanding corrective action item(s) cited by any external funding source. Consequently, **the overall compliance rate for this contract monitoring visit is 100%.** There are no corrective actions cited or recommendations made as a result of the contract monitoring visit. Overall, the provider is performing satisfactorily in meeting the fiscal and administrative terms of its contract. In addition, the majority of indicators reviewed were carried out in a manner which meets the standard described in the report findings.

If required, the provider must submit a corrective action plan to address corrective actions cited in the corresponding section of this report. The provider's Corrective Action Plan should address the issues, corrective actions item cited, time frames and staff responsible. Responses to items cited for corrective actions are due to the Florida Network and the Florida Network Contract Manager within fourteen (14) working days of receipt of this report (See Florida Network Site for the Service Provider Corrective Action Form). The Florida Network Contract Manager will then review the response to the corrective action(s) to determine if the response adequately addresses the problem identified in the report within three (3) days. Upon approval the provider will then implement the approved measure to address the item(s) cited in the report. If the corrective action is successful in resolving the items cited in the report the contract monitor will notify the Provider in writing that the desired resolution has been achieved. Log on to the Florida Network (www.floridanetwork.org) website forms section and download the Service Provider Corrective Action Tracking Form.

Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Lutheran Services Florida/Southwest – Oasis
Residential Program

April 3-4, 2024

Compliance Monitoring Services Provided by

FOREFRONT

CINS/FINS Rating Profile

Standard 1: Management Accountability

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

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

Standard 2: Intervention and Case Management

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

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

Standard 3: Shelter Care & Special Populations

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

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

Standard 4: Mental Health/Health Services

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

Marcia Tavares - Lead Reviewer Consultant-Forefront LLC/Florida Network of Youth and Family Services
Rondarrell George – Regional Monitor, Department of Juvenile Justice
Vincelyn Barbier – Children's Home Society West Palm Beach
Shelley Gress – Youth and Family Alternatives
Mackenzie Tomasik – Family Resources

Methodology

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

Persons Interviewed

	Chief Executive Officer	X	Case Manager		Nurse – Full time
	Chief Financial Officer		Counselor Non-Licensed	X	Nurse – Part time
	Chief Operating Officer		Advocate		# Case Managers
X	Executive Director	X	Direct – Care Full time	2	# Program Supervisors
	Program Director		Direct – Part time		# Food Service Personnel
X	Program Manager		Direct – Care On-Call		# Healthcare Staff
	Program Coordinator		Intern		# Maintenance Personnel
X	Clinical Director		Volunteer	1	# Other (listed by title): Senior Administrative Assistant
	Counselor Licensed	X	Human Resources		

Documents Reviewed

	Accreditation Reports	X	Table of Organization		Visitation Logs
X	Affidavit of Good Moral Character	X	Fire Prevention Plan	X	Youth Handbook
X	CCC Reports	X	Grievance Process/Records	5	# Health Records
X	Logbooks		Key Control Log	5	# MH/SA Records
	Continuity of Operation Plan	X	Fire Drill Log	16	# Personnel /Volunteer Records
X	Contract Monitoring Reports	X	Medical and Mental Health Alerts	8	# Training Records
	Contract Scope of Services	X	Precautionary Observation Logs	13	# Youth Records (Closed)
X	Egress Plans	X	Program Schedules	10	# Youth Records (Open)
X	Fire Inspection Report	X	List of Supplemental Contracts		# Other: ___
	Exposure Control Plan	X	Vehicle Inspection Reports		

Observations During Review

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

Surveys

6	# of Youth	15	# of Direct Staff		# of Other		

Comments

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

Monitoring Purpose

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

Strengths and Innovative Approaches

Lutheran Services Florida Southwest (LSF SW), Inc. contracts with the Florida Network to operate the Child in Need of Services and Family in Need of Services (CINS/FINS) program in Fort Myers, Florida. CINS/FINS funding allows the agency to provide residential, community counseling, and case management services over five counties in Circuit 20; Collier, Hendry, Glades, Charlotte, and Lee. Oasis Youth Shelter is licensed to serve twenty-two (22) youth and the program's license was renewed by the Department of Children and Families (DCF) effective 2/1/2024, and is valid until 1/31/2025.. The agency also provides specialized services to youth who meet the criteria for Staff Secure shelter, Domestic Minor Sex Trafficking, and youth referred by the Juvenile Justice Court System for domestic violence, probation respite, and Family/Youth Respite Aftercare Services (FYRAC). The agency continues to be contracted to provide Intensive Case Management (ICM) and Stop Now And Plan (SNAP) services. During the current review period, the executive management structure for LSF-SW remained intact and stable. The agency is accredited by COA through February 2026.

The following programmatic updates were provided by the agency:

Staffing

During the current review period, the executive management structure and CINS/FINS operation for LSF-SW remains intact and stable under the leadership of Regional Director, Shelia Dixon LCSW. Heidrun Braeuer-Smith continues in her role as Senior Administrative Assistant. Samuel Laguerre has led the program's residential services since June 2019. Erick Scott is one of the program's longest tenured (11 years) direct care staff and has served in the role of Youth Care Specialist III (YCS III) for the past 4 years. Nicole Lewis, LMHC has been in the role of CINS/FINS program manager since June 2022. Ms. Lewis provides supervision and oversight of the ICM, residential, and community counseling programs. Additionally, Nicole facilitates the Case Staffing committee in parts of Circuit 20. Emily Mohammed Clonch is the SNAP Site Coordinator as of December 2023. Venus Chambergo remains as the ICM coordinator and has been in this role for the past 2 years.

Program Updates

LSF Oasis was selected by the Florida Network of Youth and Family Services to participate in their new Fatherhood Initiative program (FIP) and is excited to have been selected as it is one of five SNAP sites across the state to expand SNAP into this population. The provider hired a FIP Case Manager, full-time facilitator, and is in the process of hiring another FT facilitator which we will then be fully staffed. The program is actively doing outreach in efforts to bring awareness of the expansion and acquire referrals. The Community Counseling programs have been successful in providing summer group programming at a local Boys and Girls Club in Charlotte County for the past two summers. This has been a rewarding experience as the program has been able to provide prevention services to youth who otherwise may not have been referred to services traditionally. Last summer, the program was given the opportunity to provide psychoeducational group presentations to another Boys and Girls Club (BGC) in Fort Myers in a low socioeconomic, high-risk zip code area. This allowed the agency to develop positive relationships with both youth and staff at the BGC and build a rapport with this community which proved to be successful as they've asked the program return this summer. LSF Oasis mainly provides services via groups in the community, office based with satellite offices or community partners that provide space in the circuit, in school settings, in home, and virtual as needed if it in the best interest of the client. The program currently uses paper files in all CINS/FINS programs and utilize an electronic logbook in the shelter program.

The agency has partnered up with the Florida Network of Youth and Family Services to participate in a Youth Homelessness Demonstration Project funded through a three-year grant by the Federal Youth Services Bureau called The Shareet Cares Project. This project is named after its late SW Regional Director Shareet Pennino who passed away in November 2021. This demonstration project will be a collaborative effort among the CINS/FINS programs in the south Florida region including SWFL (5 county area), Broward, Palm Beach, and Miami-Dade and the local community providers in the form of a Multidisciplinary Task Force as well as a six-member Youth Advisory Board compromised of youth with lived experience.

Facility

LSF Oasis was awarded a CDBG grant in December of 2022 to renovate Oasis and its former community counseling building. With the increased costs of inflation and delays in construction time frames in our community after Hurricane Ian, the program was not able to renovate as much at Oasis; however, it was able to transform the former community counseling building into a teen drop-in center and resource center for its families and was renamed Shareet's Oasis. The exterior of the shelter was repainted and the HVAC system was replaced.

The agency's Development team in Central Services is planning fundraising events to raise funds for a new van, new furniture, kitchen renovations, and interior painting. The agency also applied for another CDBG grant and is awaiting notification of the award.

Funding

The agency has received funding through Federal Youth Services Bureau for the Shareet Cares Project and SNAP Expansion funding for the Fatherhood Initiative Program. In March 2024, a fundraiser call Friends of Foster Care raised $15,000 in funds to be used to purchase new lockers for the youth rooms at Oasis. The Development team is actively engaged in a CAPITAL CAMPAIGN aimed at "Building Hope" by utilizing funds gained to improve the program's facilities.

Governance and Community

In November 2023 LSF Oasis hosted an open house event to invite the community to tour the new Shareet's Oasis resource center as well as provided tours of Oasis shelter. It also hosted a Christmas toy drive resulting in gifts to approximately 150 families and the existing community counseling families. The agency has continued to develop an informal partnership with FK Your Diet who has supported it with food for the open house, annual holiday dinners for youth, and recently acquired a new stove for the shelter kitchen. Partnership with the local sheriff's office threat assessment team, who has become a major referral source for the SNAP program and recently connected the program to a local charter school, presented the opportunity to facilitate bullying presentations with the elementary students.

New collaborative agreements include PACE Center for Girls and Florida State University, College of Social Work. LSF has also partnered with a Lutheran Organization that serves the NW region of the US.

Narrative Summary

LSF Oasis is under the leadership of a management team, including a regional director, a shelter manager, a licensed clinical director, a quality assurance specialist, and a senior administrative assistant. The residential program is staffed by a youth care specialist supervisor, a part-time registered nurse, twelve YCS II, three YCS I, and a case manager. In addition to the clinical director, the clinical component includes six counselor I position, three counselor II, one counselor III, and a lead case manager. The program has not reported any major challenges, incidents, administrative review, or current external investigations. At the time of the QI review the census in the shelter was 15 youth. The program reported two CINS/FINS vacancies for one fulltime master's level community counseling staff and one fulltime youth care worker.

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

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

Standard 2: There are nine indicators for Standard 2. Indicator 2.01 Screening and Intake was rated **Satisfactory**, Indicator 2.02 Needs Assessment was rated **Satisfactory**, Indicator 2.03 Case/Service Plan was rated **Satisfactory with Exception**, Indicator 2.04 Case Management and Service Delivery was rated **Satisfactory**, 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**, Indicator 2.08 Specialized Additional Program Services was rated **Satisfactory with Exception**, and Indicator 2.09 Stop Now and Plan (SNAP) was rated **Satisfactory with Exception**.

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

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

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

Standard 3:
Indicator 3.06 - Limited
There were six 2-hour periods reviewed for nightly walks throughout the month of March. Across the board there were multiple walks not completed on camera, inconsistencies with the time the walk was documented and the time the walk was completed by the staff, and inconsistencies in viewed walks taking longer than documented in the log book. The shelter manager was advised to report the findings to CCC.

CINS/FINS QUALITY IMPROVEMENT TOOL

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

Standard One – Management Accountability

1.01: Background Screening of Employees, Contractors and Volunteers		**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 1.01	**YES**	
	If NO, explain here:	
	The provider has the required policy and procedures, 1.01- Background Screening of Employees, Interns, and Volunteers, that was revised 2/8/2024 by the Executive Director (ED).	

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: Nine new staff hired and six interns/volunteers.
Total number of 5 Year Re-screen Employee Files: One 5-year rescreened staff.
Type of Documentation(s) Reviewed: Staff roster, Department of Juvenile Justice Background Screening results, Predictive Index Suitability Screenings, E-Verify, Annual Affidavit of Compliance with Level 2 Screening Standards

All positions providing direct services to youth has successfully passed pre-employment suitability assessment on the initial attempt.	**Exception**	The agency uses the Predictive Index (PI) pre-employment assessment that was implemented July 2018. The tool was administered prior to the hiring of eight of nine new direct care staff hired during the review period. All eight staff who completed the assessment obtained passing scores (greater than five) on a scale of 1-10. The one staff who did not complete the assessment was hired prior to the agency developing and testing the PI for counseling staff.	One of nine staff hired did not complete the Predictive Index pre-employment assessment prior to hire 7/10/23
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**	All eight staff who completed the suitability assessment received passing scores.	
Agency has evidence for employees who have had a break in service for 18 months or more, and/or when the agency had a change or update in the suitability assessment tool used was different from the employee's original assessment, that a new suitability assessment and background screening was completed as required.	**No eligible items for review**	None of the new hires were prior employees with a break in service for greater than 18 months	

Background screening completed prior to hire/start date (or exemption obtained prior to working with youth if rated ineligible) for new hires, volunteers/interns, and contractors. *(Employees who have had a break in service and are in good standing may be reemployed with the same agency without background screening if the break is less than 90 days.)*	**Compliance**	Background screenings for all nine new hires and six interns/volunteers were initiated prior to hire/start dates with eligibility documented on the DJJ background screening results. There were no exemptions required.	
Five-year re-screening is completed every 5 years from the date of the last screening or prior to retained fingerprints expiration date.	**Compliance**	The program had one eligible five year re-screening since the last QI visit. The re-screening was completed prior to the employee's retained fingerprints expiration date.	
Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?	**Compliance**	The program emailed its Annual Affidavit of Compliance with Level 2 Screening Standards to the Background Screening Unit on January 9, 2024 prior to the January 31st deadline.	
Proof of E-Verify for all new employees obtained from the Department of Homeland Security	**Compliance**	Proof of employment authorization from the Department of Homeland Security was obtained through E-verify and maintained on file for all nine new hires.	
Additional Comments: **There are no additional comments for this indicator.**			
1.02: Provision of an Abuse Free Environment			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 1.02	**YES**		
	If NO, explain here:		
	The provider has the required policy and procedures, 1.02- Provision of an Abuse Free Environment, that was revised 2/5/2024 by the ED.		
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** **Type of Documentation(s) Reviewed: code of conduct, grievances, Share Point Incident Reports, logbook, resident handbook** **Describe any Observations: postings of abuse hotline number, grievance box, and grievance forms**			
Agency has a code of conduct of policy and there is evidence that staff are aware of agency's code of conduct.	**Compliance**	The agency has a code of conduct that prohibits the use of physical abuse, profanity, threats or intimidations. All new staff are required to signs the code of conduct form during the hire and/or orientation process.	

The agency has a process in place for reporting and documenting child abuse hotline calls.	**Compliance**	Postings of the Abuse Hotline Number was observed in each bedroom, the dayroom, and supervisor's office. The agency has a process in place for reporting and documenting abuse hotline calls. Once an abuse call is made, staff completes a Child Abuse and Neglect form that is maintained in the youth's file. The call is also documented on a reporting form that is maintained in the Incident Report binder as well as entered in the agency's SharePoint portal. A review of the SharePoint report showed eleven abuse hotline calls reported during the past six months. None of the eleven calls were institutional.	
Youth were informed of the Abuse and Contact Number	**Compliance**	Per the shelter manager, youth are informed of the abuse hotline during orientation. The abuse hotline information is included in the resident handbook that is reviewed with the youth and parent/guardian during orientation. Three residential youth records reviewed included an acknowledgement of receipt of the handbook.	
Grievance			
The program must have an accessible and responsive grievance process for youth to provide feedback and address complaints. Program director/ supervisor will have access to and manage grievances unless it is towards themselves.	**Compliance**	The grievance procedure is included in the resident handbook that is reviewed with the youth and parent/guardian during orientation. Grievance procedures are also posted on a board in each youth bedroom. Only the shelter manager and supervisor have access to the grievance box. Three youth records reviewed included an acknowledgement of receipt of the resident handbook.	
Shelter only: Grievances are maintained on file at minimum for 1 year.	**Compliance**	The shelter manager maintains records of grievances in a file for a minimum one year.	
Shelter only: There are formal grievance procedures for youth, including grievance forms, and a locked box which are easily accessible to youth in a common area.	**Compliance**	The agency has a grievance procedure in place that is reviewed with youth during intake. The grievance box was observed to be locked and is mounted on a wall in the day room along with grievance forms.	
Shelter only: There is evidence that grievance boxes are checked by management or a designated supervisor at least daily as evidenced in the program logbook.	**Exception**	Logbook documentation of grievance box checks was reviewed for twelve randomly selected weeks during the past six months. A total of 56 work days were reviewed during the following dates: October 2-13, November 13-22, December 18-29, January 8-19, February 12-23, and March 4-15. Grievance box checks were documented in the logbook for 31 of the 56 days reviewed.	Grievance box checks were not documented in the logbook for 25 of the 56 days reviewed between October 2023 - March 2024.
Shelter only: All grievances are resolved within 72 hours and documented by program director/supervisor or escalated to higher leadership if grievance involves them directly.	**Exception**	Eight grievances were reported by youth during the review period. Three of the eight grievances were addressed within 72 hours and were signed by the youth and shelter manager indicating an acceptable solution was reached.	Five of the eight grievances reported by youth were not resolved within the 72 hour timeframe (grievances were submitted on 10/11, 12/29, 2/16, 2/29, and 3/7)

1.03: Incident Reporting			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 1.03	**YES**		
	If NO, explain here:		
	The provider has the required policy and procedures, 1.03 - Incident Reporting, that was revised 12/15/2023 by the ED.		
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 **Type of Documentation(s) Reviewed: Agency internal incident reports, logbook** **Describe any Observations: CCC number posted in facility**			
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 34 reportable incidents within the last six months. A review of 10 incidents found each were reported to the Department's Central Communications Center (CCC) within two hours of the incident or when staff became aware of the incident. Each report was documented in the program electronic logbook.	
The program completes follow-up communication tasks/special instructions as required by the CCC	**Compliance**	All reviewed incidents were closed and applicable follow up tasks were completed as requested.	
Agency internal incidents are documented on incident reporting forms and all CCC reportable incidents were consistently reported to CCC as required.	**Compliance**	The shelter manager reported that staff fill out the CCC incident report electronically and submit it for review by the shelter manager/administration. Once the shelter manager reviews the information, the information is submitted to the corporate office.	
Incidents are documented in the program logs and on incident reporting forms	**Compliance**	A review was conducted of 10 randomly selected CCC incidents to determine if incidents are documented in the program log. Evidence supported all 10 CCC incidents were recorded in the program logbook.	
All incident reports are reviewed and signed by program supervisors/ directors	**Compliance**	The electronic system does not have a place to sign but has area for the manager to indicate review of the incident report. All 34 incidents were reviewed by the program manager. The reportable incidents were classified as follows: 4 – Mental Health, 7 – Medical, 11 - contraband, 6 - program disruption, and 6 - abscond.	

1.04: Training Requirements (*Staff receives training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions*)		**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 1.04	**YES** If NO, explain here: The provider has the required policy and procedures, 1.04 - Training Requirement, that was revised 2/5/2024 by the ED.	

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

Total number of New Hire Staff Files: 4 first year staff training records
Total number of Annual In-Service Staff Files:4 annual in-service training records
Training Plan Timeframe (Program timeframe for annual trainings): staff's anniversary date
Staff Position(s) Interviewed (No Staff Names): program manager
Type of Documentation(s) Reviewed: Staff training records, annual training plan, DJJ SkillPro transcript, Florida Network Bridge transcript, training certificates, sign-in sheets

First Year Direct Care Staff			
All direct care staff have completed new hire pre-service training requirements for safety and supervision as required.	**Compliance**	Three of the four direct care staff members have completed the required new hire pre-service safety and supervision training. The fourth staff, hire date 1/29/2024, is still within the 90 days required and has time to complete pre-service training. Said staff has not worked independently with youth in the interim.	
All staff completed the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days from date of hire.	**Compliance**	All four direct care staff completed the Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days from date of hire.	
All direct care CINS/FINS staff (full time, part time, or on-call) demonstrated a minimum of 80 hours of training or more for the first full year of employment.	**Compliance**	Three of the four direct care staff members have completed the required 80 hours of training. The fourth staff, hire date 1/29/2024, is still within the 90 days required and has time to complete the required hours.	
All staff receives all mandatory training during the first 90 days of employment from date of hire.	**Compliance**	Reviewed documentation of SkillPro, approved annual training plan, and training required by the Florida Network confirmed three applicable staff completed all mandatory training during the first 90 days of employment from date of hire.	

Staff Required to Complete Data Entry for NIRVANA or access the Florida Department of Juvenile Justice Information System (JJIS)			
Any designated staff that is responsible for entering NIRVANA or ensuring accurate and complete data entry in the Florida Department of Juvenile Justice Information System (JJIS) have completed all of the required trainings.	**Compliance**	One applicable staff member responsible for entering NIRVANA completed the NIRVANA training as required.	
Staff Participating in Case Staffing & CINS Petitions (within first year of employment)			
Documentation of instructor led FL Statute 984 CINS Petition Training by a local DJJ Attorney. *Effective for staff hired after 7/1/23*	**No eligible items for review**	The provider did not have any eligible staff hired after 7/1/23 that participates in Case Staffing.	
Non-licensed Mental Health Clinical Shelter Staff (within first year of employment)			
Documentation of non-licensed mental health clinical staff person's training in Assessment of Suicide Risk form or written confirmation by a licensed mental health professional of training (includes date, signature and license number of the licensed mental health professional supervisor).	**No eligible items for review**	The program has not hired any new non-licensed mental health clinical shelter staff person during the review period.	
In-Service Direct Care Staff			
Direct care staff completes 24 hours of mandatory refresher Florida Network, SkillPro, and job-related training annually *(40 hours if the program has a DCF child caring license).*	**Compliance**	Four in-service direct care staff files were reviewed and each completed an excess of 40 hours of mandatory refresher Florida Network, SkillPro, and job-related training annually.	
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**	Reviewed documentation confirmed the agency has a training plan that includes all of the required training topics including the pre-service and in-service.	
The agency has a designated staff member responsible to manage all employee's individual training files and completes routine tracking and reviews of staff files to ensure compliance.	**Compliance**	The shelter and community counseling managers are responsible to manage all employees' individual training files and completes routine reviews and tracking of staff files to ensure compliance.	

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**	Each training record reviewed was maintained in a training file which included 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.	
Additional Comments: **There are no additional comments for this indicator.**			
1.05 - Analyzing and Reporting Information			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 1.05		**YES** If NO, explain here: The provider has the required policy and procedures, 1.05 - Analyzing and Reporting Information, that was revised 12/15/2023 by the ED. In addition, there is a comprehensive agency-wide Performance Quality Improvement (PQI) plan that includes detailed procedures to collect, review, and reports various sources of information to identify patterns and trends.	
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): Director of Compliance, Shelter Manager, Community Counseling Director **Type of Documentation(s) Reviewed: LSF PQI Plan 2023, staff meeting agendas/minutes, LSF Monthly CQI metrics, Peer Review Report**			
Case record review reports demonstrate reviews are conducted quarterly, at a minimum	**Compliance**	Shelter records are reviewed biweekly by the licensed community counseling manager. A form showing record review is maintained in the file. All closed records are reviewed again prior to storage. Community counseling staff conduct peer record reviews monthly and document each review on review checklists that are maintained in a binder. The results of the record reviews related to deficiencies observed are entered in the agency's Share Point portal. A total of 77 residential and 146 community counseling records were reviewed for the period October 2023-February 2024.	
The program conducts reviews of incidents, accidents, and grievances quarterly, at a minimum	**Compliance**	Data regarding the number of incidents/accidents and grievances is entered into the agency's PQI Monthly CQI Program Metrics Report. The spreadsheet captures a variety of data for all the programs statewide as well as regionally and monitors the numbers of incidents, accidents, and grievances. Incidents and accidents are tracked on the companion report monthly by level of severity. A review of monthly staff meeting agendas showed evidence of discussion of incidents/accidents and grievances during the review period.	

The program conducts an annual review of customer satisfaction data	**Compliance**	The programs collect customer satisfaction survey data monthly and enter the number completed each month by program into the CQI Program Metrics. There is communication and discussion of client satisfaction surveys during staff meetings.	
The program demonstrates a monthly review of the statewide End-of-Month ("EOM") report generated by the Florida Network Office. This includes monthly data, fiscal year to date data, benchmarks for residential and community counseling, screening data, report card measures, follow-up reporting measures.	**Compliance**	The provider has established program and contract outcomes and collects performance measures data monthly on the monthly CQI Program Metrics by program. Data collected includes EOM benchmarks and performance measures such as: client satisfaction; client functioning; staff turnover; incidents/accidents; grievances; care days; data entry; service completion and status at discharge; 30 and 60-day follow-up; and exits. PQI, outcomes, and NetMIS data is reviewed and discussed at monthly staff meetings and monthly management meetings and are documented in the meeting minutes.	
The program has a process in place to review and improve accuracy of data entry & collection	**Compliance**	The program managers are responsible for verifying timely submission and accuracy of program data that is captured in NetMIS. The managers communicate with the Florida Network to reconcile any discrepancies and maintain a communication systems to ensure contractual requirements are met, and to analyze data for trends and patterns.	
There is documentation that findings are regularly reviewed by management and communicated to staff and stakeholders.	**Compliance**	Findings are regularly reported on a monthly basis and documented in the agency's monthly CQI Program Metrics where reports can be generated and shared with staff at monthly staff meetings. Documentation supported findings are reviewed by management and communicated with staff during staff meetings. The agency's publishes an Annual Report to share program information with 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**	LSF's CQI team is responsible for data collection, data processing, analysis, and reporting of performance quality and improvement to the Executive Leadership Team and the LSF Board of Directors. Metrics that impact the agency are reviewed via LSF's cross-functional continuous quality improvement workgroups, committees, and departmental meetings. Per the agency's PQI, the Board of Directors/Executive Leadership reviews performance targets, including QI performance, on a quarterly basis.	
There is evidence that strengths and weaknesses are identified, improvements are implemented or modified, and staff are informed and involved throughout the process.	**Compliance**	The agency has an Associate Vice President Quality Assurance and Compliance who leads the development, implementation, documentation, evaluation, and promotion of continuous improvement practices and systems. LSF SW also has a compliance specialist who is responsible for oversight at the regional level. Processes are in place and established in the PQI plan to collect date and identify areas needing improvement. Should negative trends be observed, a corrective action will be implemented as a priority issue to be addressed and is monitored by the compliance staff as well as the program management team.	
Additional Comments: **There are no additional comments for this indicator.**			

1.06: Client Transportation			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 1.06		**YES**	
		If NO, explain here:	
		The provider has the required policy and procedures, 1.06 - Client Transportation, that was revised 12/15/2023 by the ED.	

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

Dates or Timeframe Reviewed: October 2023- March 2024
Staff Position(s) Interviewed (No Staff Names): Shelter Manager
Type of Documentation(s) Reviewed: Vehicle utilization transportation logs, approved driver's list with approved driver's licenses, insurance verification of approved drivers
Describe any Observations: Vehicle #205 and Vehicle #914

Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	**Compliance**	The agency's policy reviewed outlines the procedure for transportation. Reviewed documentation with informal interview with the shelter manager confirmed the program maintains an approved list of 11 agency staff to transport youth in agency vehicles.	
Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	**Compliance**	Verification of valid driver's licenses were submitted for all approved drivers. All approved drivers have current driver's licenses and are covered under the agency's insurance policy.	
Agency's Transportation policy prohibit transporting a client without maintaining at least one other passenger in the vehicle during the trip and include exceptions in the event that a 3rd party is NOT present in the vehicle while transporting	**Compliance**	The policy reviewed outlines the procedure for transportation. The basis of the policy is to avoid situations that put youth or staff in danger of real or perceived harm, or allegations of inappropriate conduct by either staff or youth. The best practice to prevent such situations is to have a 3rd party present in the vehicle while transporting a client. The 3rd party is a volunteer, intern, agency staff or other youth if approved.	
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**	Informal interview with the shelter manager reported 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 before approving a one to one transport.	
The 3rd party is an approved volunteer, intern, agency staff, or other youth	**Compliance**	The program's policy references the use of a third party which is an approved approved staff, other youth, volunteer, or intern; however, informal interview with the shelter manager confirms only staff or other youth were used as third parties. No volunteers or interns have assisted with any transport.	
The agency demonstrated evidence via logbook or other written verification that supervisor approval was obtained prior to all single youth transports.	**Compliance**	During the review period, a total of 145 single transports were identified from the review of transportation logs for one agency van used to transport youth. All single transports showed evidence of supervisor's approval prior to transport.	

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**	Reviewed documentation of the vehicle utilization tracking log revealed it has all the required information.	
Additional Comments: **There are no additional comments for this indicator.**			
1.07 - Outreach Services			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 1.07		**YES** If NO, explain here: The provider has the required policy and procedures, 1.07 - Outreach Services, that was revised 10/15/2023 by the ED.	
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): Executive Director, Shelter Manager **Type of Documentation(s) Reviewed: NetMIS Outreach Activity Report, Circuit Advisory Board 20 meeting minutes, memorandums of agreement**			
The program has a lead staff member designated to participate in local DJJ board, Circuit and Council meetings with evidence that includes minutes of the event or other verification of staff participation.	**Compliance**	Position title of lead staff reviewed: Outreach and Mentor Coordinator and Shelter Manager. Reviewed documentation confirmed 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 to two meetings held during the review period.	
The program maintains written agreements with other community partners which include services provided and a comprehensive referral process.	**Compliance**	Reviewed documentation confirmed the program maintains written agreements with other community partners which include services provided and a comprehensive referral process such as Barry University, BB&B, Collier County School district, Continuum of Care Lee County, and Salus Care.	
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**	Reviewed documentation with informal interview with the shelter manager confirmed the program maintains documentation of outreach activities and enters into NetMIS the title, date, duration (hours), zip code, location description, estimated number of people reached, modality, target audience and topic. A copy of the NetMIS outreach report was provided.	
The program has designated staff that conducts outreach which is defined in their job description.	**Compliance**	The provider has an Outreach and Mentor Coordinator whose main responsibility is community outreach. The shelter manager is designated as the backup for the outreach coordinator.	
Additional Comments: **There are no additional comments for this indicator.**			

2.01 - Screening and Intake			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 2.01		**YES** If NO, explain here: The provider has the required policy and procedures, 2.01 - Screening and Intake, that was last revised on 10/5/2023 by the ED.	
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: 3 open residential and 2 open community counseling youth records **Total number of Closed (Residential & Community) Files: 2 closed residential and 3 closed community counseling youth records** **Staff Position(s) Interviewed** *(No Staff Names)* **: Program Manager of Residential and Community Counseling** **Type of Documentation(s) Reviewed: client case files, policy and procedure**			
Shelter youth: Eligibility screening form is completed immediately for all shelter placement inquiries.	**Compliance**	All five residential case files reviewed demonstrated eligibility screening form was completed immediately for placement inquires.	
Community counseling: Eligibility screening form is completed within 3 business days of referral by a trained staff using the Florida Network screening form.	**Compliance**	All five community counseling case files reviewed demonstrated screening form was completed by a trained staff within three business days using the Florida Network screening form.	
There is evidence all referrals for service is screened for eligibility and is logged in NetMIS within 72 hours of screening completion.	**Not Applicable**	There is evidence of all referrals for service is screened for eligibility. However, there's no evidence that screenings are logged in NetMIS within 72 hours of screening completion. The Florida Network has waived this measure because of the inability to evaluate data entry and the provider does not capture that information separately.	
Youth and parents/guardians receive the following in writing: a. Available service options b. Rights and responsibilities of youth and parents/guardians	**Compliance**	All files reviewed confirmed the youth's receipt of available service options, and rights and responsibilities of youth and parents/guardians in writing by their signature.	

The following is also available to the youth and parents/guardians: a. Possible actions occurring through involvement with CINS/FINS services (case staffing committee, CINS petition, CINS adjudication) b. Grievance procedures	**Compliance**	All files reviewed confirmed possible actions occurring through involvement with CINS/FINS services and grievance procedures are provided and acknowledged by obtaining signature from client and parent/guardian	
During intake, all youth were screened for suicidality and correctly assessed as required if needed.	**Compliance**	All files reviewed demonstrated all ten youth were screened for suicidality. Four of the ten youth were identified as suicide risk and were assessed by a licensed clinician.	
Additional Comments: **There are no additional comments for this indicator.**			
2.02 - Needs Assessment			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.02		**YES** If NO, explain here: The provider has the required policy and procedures, 2.02 titled Network Inventory of Risk, Victories and NIRVANA, that was last revised on 2/5/2024 by the ED.	
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: 3 open residential and 2 open community counseling youth records **Total number of Closed (Residential & Community) Files: 2 closed residential and 3 closed community counseling youth records** **Staff Position(s) Interviewed (No Staff Names): Program Manager of Residential and Community Counseling** **Type of Documentation(s) Reviewed: client case files, policy and procedure**			
Shelter Youth: NIRVANA is initiated within 72 hours of admission	**Compliance**	The Nirvana Assessments for all five residential youth records reviewed were all completed within 72 hours of admission and was placed in the case file.	
Non-Residential youth: NIRVANA is initiated at intake and completed within 2 to 3 face-to-face contacts after the initial intake **OR** updated, if most recent assessment is over 6 months old	**Compliance**	All community counseling records reviewed noted Nirvana assessments were completed within service days of initiation or two to three days after face to face contact.	
Supervisor signatures is documented for all completed NIRVANA assessments and/or the chronological note and/or interview guide that is located in the youths' file.	**Compliance**	All 10 records had the supervisor's signatures signed on all completed NIRVANA assessments.	
(Shelter Only) NIRVANA Self-Assessment (NSR) is completed within 24 hours of youth being admitted into shelter. If unable to complete, there must be documentation in NetMIS and the youth's file explaining the barriers to completion.	**Compliance**	The five residential records reviewed included NIRVANA Self-Assessment (NSR) that were completed within 24 hours of youth being admitted into shelter.	

A NIRVANA Post-Assessment is completed at discharge for all youth who have a length of stay that is greater than 30 days.	**Compliance**	None of the five residential youth were in shelter care for 30 days and therefore did not require a NIRVANA post-assessment; however, three of the five community counseling records were applicable. A NIRVANA post-assessment was completed in all three records.	
A NIRVANA Re-Assessment is completed every 90 days excluding files for youth receiving SNAP services.	**Compliance**	One applicable community counseling record contained a NIRVANA re-assessment as required.	
All files include the interview guide and/or printed NIRVANA.	**Compliance**	All ten youth records included a printed NIRVANA assessment.	
Additional Comments: **There are no additional comments for this indicator.**			
2.03 - Case/Service Plan			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 2.03		**YES** If NO, explain here: The provider has the required policy and procedures, 2.03 - Case/Service Plans, that was last revised on 10/5/23 by the ED.	
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: 3 open residential and 2 open community counseling youth records **Total number of Closed (Residential & Community) Files: 2 closed residential and 3 closed community counseling youth records** **Staff Position(s) Interviewed (No Staff Names): Program Manager of Residential and Community Counseling** **Type of Documentation(s) Reviewed: client case files, policy and procedure**			
The case/service plan is developed on a local provider-approved form or through NETMIS and is based on information gathered during the initial screening, intake, and NIRVANA.	**Compliance**	All ten case/service plans reviewed were documented on a local provider-approved form and are based on information gathered during the initial screening, intake, and NIRVANA	
Case/Service plan is developed within 7 working days of NIRVANA	**Compliance**	All ten case/service plans reviewed were developed within 7 working days of completion of the NIRVANA.	
Case plan/service plan includes: 1. Individualized and prioritized need(s) and goal(s) identified by the NIRVANA 2. Service type, frequency, location 3. Person(s) responsible 4. Target date(s) for completion and actual completion date(s) 5. Signature of youth, parent/guardian, counselor, and supervisor 6. Date the plan was initiated	**Exception**	All ten case/service plans reviewed contained individualized and prioritized need(s) and goal(s) identified by the NIRVANA and date plan was initiated; service type, frequency, location; person(s) responsible for completing goals; and target date(s) for completion of goals. All ten case plans reviewed included actual goal completion dates. Signatures of youth, parent/ guardian, counselor, and supervisor were observed on nine of the ten case plans.	One of the case plans did not have the youth and parent/guardian's signature. Verbal consent was provided by youth and parent/guardian, however, no note in the file reflected verbal consent was given.

Case/service plans are reviewed for progress/revised by counselor and parent (if available) every 30 days for the first three months and every 6 months after	**Compliance**	Six applicable records reviewed demonstrated timely reviews for progress every 30 days by the counselor during the required timeframes.	
Additional Comments: **There are no additional comments for this indicator.**			
2.04 - Case Management and Service Delivery			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.04		**YES** If NO, explain here: The provider has the required policy and procedures, 2.04 - Case Management and Service Delivery, that was last revised on 10/5/23 by the ED.	
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: 3 open residential and 2 open community counseling youth records **Total number of Closed (Residential & Community) Files: 2 closed residential and 3 closed community counseling youth records** **Staff Position(s) Interviewed (No Staff Names): Program Manager of Residential and Community Counseling** **Type of Documentation(s) Reviewed: client case files, policy and procedure**			
Counselor/Case Manager is assigned	**Compliance**	Each of the ten files demonstrated a counselor/case manager was assigned to work with the youth/family from case assignment to termination.	
The Counselor/Case Manager completes the following as applicable: 1. Establishes referral needs and coordinates referrals to services based upon the on-going assessment of the youth's/family's problems and needs 2. Coordinates service plan implementation 3. Monitors youth's/family's progress in services 4. Provides support for families 5. Monitoring progress of court ordered youth in shelter 6. Makes referrals to the case staffing to address problems and needs of the youth/family 7. Accompanies youth and parent/guardian to court hearings and related appointments 8. Refers the youth/family for additional services when appropriate 9. Provides case monitoring and reviews court orders 10. Provides case termination notes 11. Provides follow-up after 30 days post discharge 12. Provides follow-up after 60 days post discharge	**Compliance**	As applicable, all10 records were observed to demonstrate identification of referral needs, coordination of service plans, provision of various types of support, referrals for needed services, and provision of case management and overall support and follow up. Two of the ten records reviewed were court ordered or referred to the case staffing committee but did not require judicial/adjudication services. Case termination notes were completed for five applicable closed cases. Thirty-day follow ups were conducted for four applicable closed cases as well as two applicable 60-day follow up.	
The program maintains written agreements with other community partners that include services provided and a comprehensive referral process	**Compliance**	The program maintains written agreements with other community partners which include services provided and a comprehensive referral process such as Barry University, BB&B, Collier County School district, Continuum of Care Lee County, and Salus Care.	
Additional Comments: **There are no additional comments for this indicator.**			

2.05 - Counseling Services			Satisfactory with Exception
Provider has a written policy and procedure that meets the requirement for Indicator 2.05		**YES**	
		If NO, explain here:	
		The provider has the required policy and procedures, 2.05 - Counseling Services, that was last revised on 9/26/23 by the ED.	

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: 3 open residential and 2 open community counseling youth records
Total number of Closed (Residential & Community) Files: 2 closed residential and 3 closed community counseling youth records
Staff Position(s) Interviewed (No Staff Names): Program Manager of Residential and Community Counseling
Type of Documentation(s) Reviewed: client case files, policy and procedure

Shelter Program			
Shelter programs provides individual and family counseling	**Compliance**	Residential youth received individual and family counseling as evident by the counseling notes in the five residential youth records.	
Group counseling sessions held a minimum of five days per week	**Compliance**	The program's group sign in sheets for the 6-month review period were reviewed. It was evident from the documents presented the program is conducting groups five days per week consistently.	
Groups are conducted by staff, youth, or guests and group counseling sessions consist of : 1. A clear leader or facilitator 2.Relevant topic - educational/informational or developmental 3. Opportunity for youth to participate 4. 30 minutes or longer	**Compliance**	Group documentation reviewed included: a clear leader or facilitator, relevant topic - educational/informational or developmental, opportunity for youth to participate, and duration of 30 minutes or longer.	
Documentation of groups must include date and time, a list of participants, length of time, and topic.	**Compliance**	The group sign-in sheets reviewed included the date and time of the group, names of all participating youth, length of time, and topic discussed.	
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**	Counseling services that address the needs identified during the assessment process were established in all applicable records reviewed in accordance with the youth's case/service plan. All five applicable community counseling files reviewed showed youth received counseling services as evident with attached case notes	

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**	All of the files reviewed reflected coordination between presenting problem(s), psychosocial assessment, case/service plans, case/service plan reviews, case management, and follow-up when applicable. The Program Director meets with staff monthly to discuss case concerns and progress.	
Maintain individual case files on all youth and adhere to all laws regarding confidentiality.	**Compliance**	All ten youth records were maintained in individual case files with adherence to all laws regarding confidentiality.	
Case notes maintained for all counseling services provided and documents youth's progress.	**Compliance**	Case notes were maintained in all ten files indicating the youth's progress as well as case notes for all services provided.	
On-going internal process that ensures clinical reviews of case records and staff performance.	**Compliance**	The program has an internal process that ensures clinical reviews of case records and staff performance. The Program Manager meets monthly with staff to review all open cases and prior to closing each case.	
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**	Nine of the ten intakes conducted were done face-to-face.	One youth's intake was completed on 11/19/23 and sessions were provided on 12/27/2023, 1/9/2024, 1/23/2024, 2/8/2024 virtually: however, no note indicating why virtual was in the best interest for client and family was documented in the file.
Additional Comments: **There are no additional comments for this indicator.**			

2.06 - Adjudication/Petition Process		**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.06	**YES**	
	If NO, explain here:	
	The provider has the required policy and procedures, 2.06 Adjudication/Petition Process, that was last revised on 10/5/2023 by the ED.	

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

Total number of Open (Residential & Community) Files: 2 open youth records
Total number of Closed (Residential & Community) Files: 1 closed youth record
Staff Position(s) Interviewed *(No Staff Names)* **: Program Managers of Residential and Community Counseling**

Must include: a. DJJ rep. or CINS/FINS provider b. Local school district representative	**Compliance**	Three records reviewed demonstrated the provider has a case staffing committee that consists of a DJJ Representative, the CINS/FINS provider, and a school district representative.	

Other members may include: a. State Attorney's Office b. Others requested by youth/ family c. Substance abuse representative d. Law enforcement representative e. DCF representative f. Mental health representative	**Compliance**	Other members present at two of the three case staffings included law enforcement and a mental health representative.	
The program has an established case staffing committee, and has regular communication with committee members	**Compliance**	The agency has established a case staffing committee in the event the youth/family is not in agreement with services or treatment; the youth/family will not participate in the services selected; or the program receives a written request from a parent/guardian or any other member of the committee. Email communication is sent to committee members when a request for case staffing is made.	
The program has an internal procedure for the case staffing process, including a schedule for committee meetings	**Compliance**	The case staffing meetings occur monthly and additional meetings may be held if, requested, including emergency case staffing. Members of the committee are notified via email when a case staffing is scheduled to be convened.	
The youth and family are provided a new or revised plan for services	**Compliance**	Evidence supported the youth and family for the three records reviewed were provided a new or revised plan for services as a result of the case staffing.	
Written report is provided to the parent/guardian within 7 days of the case staffing meeting, outlining recommendations and reasons behind the recommendations	**Compliance**	A review of the three case staffing records revealed a report was provided immediately after the case staffing to the youth/family outlining the recommendations of the committee.	
If applicable, the program works with the circuit court for judicial intervention for the youth/family	**No eligible items for review**	None of the three records reviewed required court/judicial intervention.	
Case Manager/Counselor completes a review summary prior to the court hearing	**No eligible items for review**	None of the three records reviewed required court/judicial intervention.	
Additional Comments: **There are no additional comments for this indicator.**			
2.07 - Youth Records			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.07		**YES** If NO, explain here: The provider has the required policy and procedures, 2.07- Youth Records, that was last revised on 10/5/2023 by the ED.	
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)* **: Program Manager of Residential and Community Counseling** **Type of Documentation(s) Reviewed: ten youth records** **Describe any Observations: File storage room and container that is used to transport files offsite**			

All records are clearly marked 'confidential'.	**Compliance**	All ten case records reviewed were marked confidential.	
All records are kept in a secure room or locked in a file cabinet that is marked "confidential"	**Compliance**	All records were kept in a secure locked room in a locked file cabinet marked confidential as observed during onsite tour.	
When in transport, all records are locked in an opaque container marked "confidential"	**Compliance**	Staff provided evidence showing they have locked opaque containers marked "confidential" to use for the transportation of records.	
All records are maintained in a neat and orderly manner so that staff can quickly and easily access information	**Compliance**	All files were observed to be clearly divided into sections which were consistent in their organization among residential and community counseling files. Each client case record includes: chronological sheet and youth demographic data, program information, correspondence, service/treatment plans, needs information, case management information and other materials relevant to the case.	
Additional Comments: **There are no additional comments for this indicator.**			
2.08 - Specialized Additional Program Services			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 2.08		**YES**	
		If NO, explain here:	
		The provider has the required policy and procedures, 2.08 - Special Populations, that was last revised on 10/5/2023 by the ED.	
Staff Secure			
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Staff Position(s) Interviewed (No Staff Names): Shelter Manager			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? **(If no, select rating "No eligible items for review")**	**No eligible items for review**	The agency has not served any youth who met the criteria for staff secure in the last 6 months or since the last onsite QI review.	
Staff Secure policy and procedure outlines the following: a. In-depth orientation on admission b. Assessment and service planning c. Enhanced supervision and security with emphasis on control and appropriate level of physical intervention d. Parental involvement e. Collaborative aftercare	**Compliance**	A review of the current staff secure policy and procedures indicate protocols are in place to provide the following as required: In-depth orientation on admission; assessment and service planning; enhanced supervision and security with emphasis on control and appropriate level of physical intervention; parental involvement; and collaborative aftercare.	
Program only accept youth that meet legal requirements of F.S. 984 for being formally court ordered in to Staff Secure Services	**No eligible items for review**	The agency has not served any youth who met the criteria for staff secure in the last 6 months or since the last onsite QI review.	

Staff Assigned: a. One staff secure bed and assigned staff supervision to one staff secure youth at any given time b. Program assign specific staff during each shift to monitor location/ movement of staff secure youth c. Agency clearly documents the specific staff person assigned to the staff secure youth in the logbook or any other means on each shift	**No eligible items for review**	The agency has not served any youth who met the criteria for staff secure in the last 6 months or since the last onsite QI review.	
Agency provides a written report for any court proceedings regarding the youth's progress	**No eligible items for review**	The agency has not served any youth who met the criteria for staff secure in the last 6 months or since the last onsite QI review.	
Domestic Minor Sex Trafficking (DMST)			
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Staff Position(s) Interviewed (No Staff Names): Shelter Manager			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	**No eligible items for review**	The agency has not served any youth who met the criteria for Domestic Minor Sex Trafficking (DMST) in the last 6 months or since the last onsite QI review.	
Agency has evidence that the FNYFS was contacted for approval prior to admission for all Domestic Minor Sex Trafficking (DMST) placements.	**No eligible items for review**		
There is evidence the youth was entered into NetMIS as a Special Populations youth at admission and a Human Trafficking Screening Tool (HTST) was completed.	**No eligible items for review**		
Services provided to these youth specifically designated services designed to serve DMST youth	**No eligible items for review**		
Did the placement of DMST youth require additional supervision for the safety of the youth or the program? If so, did the agency provide the appropriate level of supervision and safety measures?	**No eligible items for review**		
Length of Stay: a. Youth in program do not have length of stay in DMST placement that exceeds seven (7) days b. Agency has approval for stays and support beyond seven (7) days for DMST placements that are obtained on a case-by-case basis? (If applicable.)	**No eligible items for review**		

Agency has evidence that staff assigned to DMST youth under this provision are to enhance the regular services available through direct engagement in positive activities designed to encourage the youth to remain in shelter	**No eligible items for review**		
All other services provided to DMST youth are consistent with all other general CINS/FINS program requirements	**No eligible items for review**		
Domestic Violence			
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: 0 **Total number of Closed Files: 3** **Staff Position(s) Interviewed** *(No Staff Names)* **: Counselor** **Type of Documentation(s) Reviewed: Three charts for youth were reviewed to include all documentation supporting DV in their charts and other CINS/FINS needs. NetMIS was reviewed to ensure that all data was entered within the 3 business days.**			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	**Yes**	Three youth charts were reviewed. All three youth charts were closed. None of the present youth on site were DV youth.	
Youth admitted to DV Respite placement have evidence in the file of a pending DV charge	**Compliance**	Three youth charts all had indications that the placement was being sought out due to need for DV respite pending charges.	
Data entry into NetMIS within (3) business days of intake and discharge	**Compliance**	All three youth charts reviewed demonstrated data entry was entered into NetMIS timely.	
Youth length of stay in DV Respite placement does not exceed 21 days. If more than 21 days, documentation exists in youth file of transition to CINS/FINS or Probation Respite placement, if applicable.	**Compliance**	Two of three youth were at shelter for DV respite under 21 days. One of three youth was there longer than 21 days, but there was an indication in the chart showing the file transition to CINS/FINS.	
Case plan in file reflects goals for aggression management, family coping skills, or other intervention designed to reduce propensity for violence in the home	**Compliance**	Three of three youth charts and service plans reviewed indicated goals that focused on the following areas: plans for managing emotions, family coping skills, and/or other interventions to reduce the propensity for violence in the homes.	
All other services provided to Domestic Violence Respite youth are consistent with all other general CINS/FINS program requirements	**Compliance**	Services documented in the three youth charts reviewed were found to be consistent with other general CINS/FINS program requirements.	
Probation Respite			
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			

Total number of Closed Files: 1
Staff Position(s) Interviewed *(No Staff Names)* **: Counselor**
Type of Documentation(s) Reviewed: Youth chart and agency policy and procedures
Describe any Observations: Observations were also made in NetMIS to evaluate timely data entry of youth information.

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**	One eligible closed youth record was reviewed.	
All probation respite referrals are submitted to the Florida Network.	**Compliance**	One of one youth referrals was viewed to be submitted to the Florida Network.	
All Probation Respite Referral come from DJJ Probation and there is evidence that the youth is on Probation regardless of adjudication status.	**Compliance**	One youth chart was reviewed and was found to have documentation supporting that the referral was provided from the youth's probation officer.	
Data entry into NetMIS and JJIS within (3) business days of intake and discharge	**Compliance**	The NetMIS portal verified that all documentation was entered timely. JJIS was unable to be reviewed due to the system being down.	
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.	**Compliance**	The length of stay for youth record reviewed was within the appropriate timeline and did not exceed 30 days.	
All case management and counseling needs have been considered and addressed	**Compliance**	Documentation in case notes and service plan indicate the efforts to review case management and counseling needs. The youth was not at the shelter for an extended period of time to address all other needs.	
All other services provided to Probation Respite youth are consistent with all other general CINS/FINS program requirements	**Compliance**	All other services provided to the youth were consistent with general CINS/FINS Program requirements.	

Intensive Case Management (ICM)

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

Total number of Open Files: 2
Total number of Closed Files: 1
Type of Documentation(s) Reviewed: Three case files were reviewed. Within the charts, case notes, service plans and NIRVANAs were reviewed.
Describe any Observations: Three of three youth charts appeared well organized and easy to navigate. Findings of missing items were noted below.

Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	**Yes**	Three of three cases were reviewed that were ICM cases.	

Youth receiving services were deemed chronically truant and/or runaway and require more intensive and lengthy services. The youth was determined to be eligible because they have gone through petition and/or case staffing and was in need of case management services.	**Compliance**	All three youth were referred due to truancy.	
Services for youth and family include: a. Two (2) direct contacts per month b. Two (2) collateral contacts per week c. Direct and collateral contacts not obtained must have documentation to support attempts made to obtain them. All reasonable attempts (at minimum of three) must be made to reach all contacts (direct and collateral) and documented in the case file and NetMIS.	**Exception**	One of three youth chart showed on going efforts to reach the youth and their family for engagement in services. All three youth records showed two direct contacts per month with family and youth.	Two of three youth records reviewed did not have two collateral contacts every week. For one youth, during the weeks of 12/24/23 - 12/30/24, 12/31/23 - 1/6/24 and 1/7/23-1/13/24 there were no collateral contacts. A second youth record reviewed during the weeks of 11/12/23 - 11/18/23, 11/19/23 - 11/25/23 and 2/4/24 - 2/10/24 also did not document two collateral contacts during those weeks.
Assessments include a. NIRVANA at intake b. NIRVANA Re-Assessment every 90 days c. Post NIRVANA at discharge as aligned with timeframe requirements	**Exception**	Three of three youth charts reviewed had NIRVANAs completed at intake. One of one discharged youth chart reviewed had a post discharge NIRVANA completed.	Two of two youth charts that required a NIRVANA completed at 90 day re-assessment, did not have them completed timely.
Service/case plan demonstrates a strength-based, trauma-informed focus	**Compliance**	All three cases demonstrated having a strength-based, trauma-informed focus.	
For any virtual services provided, there is written documentation in the youths' file as to why virtual contact is in the best interest of the youth and family	**No eligible items for review**	Virtual services were not indicated or provided to the youth charts reviewed.	
Family and Youth Respite Aftercare Services (FYRAC)			
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Staff Position(s) Interviewed (No Staff Names): Clinical Director			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	**No eligible items for review**	The agency has not served any youth who met the criteria for Family and Youth Respite Aftercare Services (FYRAC) in the last 6 months or since the last onsite QI review.	
Youth is referred by DJJ for a domestic violence arrest on a household member, and/or the youth is on probation regardless of adjudication status and at risk of violating.	**No eligible items for review**		

Agency has evidence that all FYRAC referrals have documented approval from the Florida Network office	**No eligible items for review**		
Intake and initial assessment sessions meets the following criteria: a. Services shall be documented through the signature of the youth and his/her parent/guardian as well as orientation to the program which is kept in the youths file. b. The initial assessment shall be face-to-face, in person or through virtual means, to include a gathering of all family history and demographic information, as well as the development of the service plan. c. For youth on probation, a copy of the youths Community Assessment Tool (CAT) to assist with development of the family service plan.	**No eligible items for review**		
Life Management Sessions meets the following criteria: a. Sessions are face-to-face, sixty (60) minutes in length and focus on strengthening the family unit b. Services are highly supportive, individualized, and flexible and require a “whole family” approach to dealing with the problems affecting the youth and family.	**No eligible items for review**		
Individual Sessions: a. The program conducted sessions with the youth and family to focus on work to engage the parties and identify strengths and needs of each member that help to improve family functioning. b. Issues to be covered through each session include but are not limited to: Identifying emotional triggers; body cues; healthy coping strategies through individual, group and family counseling; understanding the cycle of violence and the physical and emotional symptoms of anger; developing safety plans; and educating families on the legal process and rights.	**No eligible items for review**		
Group Sessions: a. Focus on the same issues as individual/family sessions with application to youth pulling on similar experiences with other group members with the overall goal of strengthening relationships and prevention of domestic violence. b. Shall be no more than eight (8) youth at one (1) time and shall be for a minimum of sixty (60) minutes per session	**No eligible items for review**		
There is evidence of completed 30 and/or 60 day follow-ups and is documented in NetMIS following case discharge.	**No eligible items for review**		

Youth and family participate in services for thirteen (13) sessions or ninety (90) consecutive days of services, or there is evidence in the youth's file that an extension is granted by DJJ circuit Probation staff	**No eligible items for review**		
Any service that is offered virtually, is documented in the youth's file why it was in the youth and families best interest.	**No eligible items for review**		
All data entry in NetMIS is completed within 3 business days as required.	**No eligible items for review**		
Additional Comments: **There are no additional comments for this indicator.**			
2.09- Stop Now and Plan (SNAP)			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 2.09		**YES** If NO, explain here: The provider has the required policy and procedures, 2.09 - Stop Now and Plan (SNAP), that was revised 2/1/2024 by the ED.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: 1 open SNAP under 12 youth record **Total number of Closed Files: 2 closed SNAP under 12 youth records** **Staff Position(s) Interviewed** *(No Staff Names)* **: SNAP Coordinator** **Type of Documentation(s) Reviewed: youth records**			
SNAP Clinical Groups Under 12			
Youth are screened to determine eligibility of services.	**Compliance**	All three youth were screened using NetMIS and Brief SNAP screening forms to determine eligibility.	
The NIRVANA was completed at initial intake, or within two sessions.	**Compliance**	Each youth record contained a printed NIRVANA assessment that was completed at intake.	
There is evidence of the completed Child Behavior Checklist (CBCL) by the caregiver (pre and post) and is located within the file.	**Exception**	Two of the three youth records included evidence of CBCLs completed by the parent/guardian at intake and two applicable closed record included the post-CBCL.	Pre-Child Behavior Checklist was not completed at intake for one of three youth. Intake (9/29/23) was in person but CBCL was not completed by parent until later (10/23/23).
There is evidence of the completed Teacher Report Form (TRF) is completed by the teacher (pre and post) and is located within the file.	**Compliance**	Pre-TRFs were completed by the teachers for all three youth and post-TRFs were completed for two applicable closed records.	
There is evidence of the completed TOPSE is completed by the caregiver (pre and post) and is located within the file.	**Compliance**	TOPSE assessments were completed by the parent/guardian for all three youth at intake and were completed for two applicable closed records at discharge.	
SNAP Clinical Groups Under 12 - Discharge			

There is evidence of the completed SNAP Discharge Report located within the file for any discharged youth.	**Compliance**	Evidence of SNAP Discharge Report was located in two applicable closed records.	
There is evidence of the SNAP Boys/SNAP Girls Child Group Evaluation Form located in the file.	**Compliance**	Evidence of SNAP Boys/SNAP Girls Child Group Evaluation Form was located in two applicable closed records.	
There is evidence of the SNAP Boys/SNAP Girls Parent Group Evaluation Form located in the file.	**Compliance**	Evidence of SNAP Boys/SNAP Girls Parent Group Evaluation Form was located in two applicable closed records.	
SNAP Clinical Groups for Youth 12-17			
Youth are screened to determine eligibility of services.	**Not Applicable**	LSF Southwest does not provide SNAP groups for youth 12-17	
The Consent to Treatment and Participation in Research Form is completed and located within the file.	**Not Applicable**		
The NIRVANA was completed at initial intake, or within two sessions.	**Not Applicable**		
There is evidence of the completed 'How I Think Questionnaire' (HIT) form located within the file or evidence of at least three (3) documented attempts in the youths' file to obtain this information.	**Not Applicable**		
There is evidence of the completed Social Skills Improvement System (SSIS) Student form located within the file or evidence of at least three (3) documented attempts in the youths' file to obtain this information.	**Not Applicable**		
There is evidence of the completed Social Skills Improvement System (SSIS) Teacher/Adult form located within the file or evidence of at least three (3) documented attempts in the youths' file to obtain this information.	**Not Applicable**		
SNAP for Schools & Communities			
The program demonstrated all of the required weekly attendance sheets that included youth names and/or identifying numbers completed with the teacher and trained SNAP Facilitator signatures. (*This must include a total of 13 attendance sheets for a full cycle*)	**Compliance**	A total of 13 attendance sheets for a full cycle demonstrated evidence of the required attendance for all youth participating in a group in schools. A second group in progress showed nine completed weekly sessions.	
The program maintained evidence of a completed "Class Goal" Document for the class reviewed.	**Compliance**	Each of the two groups maintained evidence of a completed Class Goal document.	
The program maintained evidence of both pre AND post Measure of Classroom Environment (MoCE) completed documents for the class reviewed.	**Compliance**	Evidence of pre and post MoCE were located in each of the two groups reviewed.	
The program maintained evidence of completed pre and post evaluation documents for the class reviewed.	**Compliance**	Evidence of pre and post evaluations were located in each of the two groups reviewed.	
There is evidence of the fidelity adherence checklist maintained in the file for each class reviewed.	**Compliance**	Evidence of the fidelity adherence checklist was located in both groups reviewed.	

Additional Comments: **There are no additional comments for this indicator.**			
3.01 - Shelter Environment			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 3.01	**YES**		
	If NO, explain here:		
	The provider has the required policy and procedures, 3.01- Shelter Environment, that was revised 10/5/2023 by the ED.		
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, Shelter Supervisor,** **Type of Documentation(s) Reviewed: Weekly and perpetual chemical inventory, MSDS, Fire Drills, Emergency Drills, County Fire Inspection, Fire equipment inspection, Department of Health Inspections, activity and program schedule.** **Describe any Observations: Tour of facility, postings, inspection of agency vehicle, chemical storage**			
Facility Inspection: a. Furnishings are in good repair. b. The program is free of insect infestation. c. Bathrooms and shower areas are clean and functional, free of foul odors, leaks, dust, and mildew and in good working order. d. There is no graffiti on walls, doors, or windows. e. Lighting is adequate for tasks performed there. f. Exterior areas are free of debris; grounds are free of hazards. g. Dumpster and garbage can(s) are covered. h. All doors are secure, in and out access is limited to staff members and key control is in compliance. i. Detailed map and egress plans of the facility, general client rules, grievance forms, abuse hotline information, DJJ Incident Reporting Number and other related notices are posted. j. Interior areas (bedrooms, bathrooms, common areas) do not contain contraband and are free from hazardous unauthorized metal/foreign objects.	**Compliance**	All furniture is in good working order, and there is no visible signs of an insect infestation. The bathrooms were tidy and clean. There are two bathrooms located in the facility, a female and male bathroom. Both bathrooms have three toilet stalls, and two showers. Both have a wheelchair accessible shower. There was no noted graffiti throughout the building and all areas, common areas and private spaces, had adequate and functioning lighting. The exterior grounds are well kept, although due to a recent hurricane are more barren in the back than normal. Staff have been working on re-planting in the back for a more homey feel. There is some garbage around the garbage can, however the staff worked on cleaning up right away. There were no hazards noted inside and out of the property. The garbage cans and dumpster are appropriate for the facility, and the dumpster is located in a fenced in area. The internal areas do not have any noted hazards, and it was free of any debris, screws/nails. There were no broken furniture pieces and the blinds did not have a chord to operate. The shower curtains are held in place by plastic rings. The main doors throughout the building are locked and only accessible by staff with keys. There are detailed maps and egress plans throughout the common areas of the facility, located in the hallways and day room for the youth. The DJJ reporting number, abuse hotline, grievance information and behavior management information are located in each youth's bedroom.	

Facility Inspection: **a. All agency and staff vehicles are locked.** **b. Agency vehicles are equipped with major safety equipment including first aid kit, (all items in the first aid kit are current and do not have expired items; all expired items should be replaced regularly), fire extinguisher, flashlight, glass breaker and, seat belt cutter.**	**Compliance**	The agency has two vehicles currently. They have a 2018 Ford Transit 350 van, that is in good condition. The van included a valid first aid kit, a valid fire extinguisher, a flashlight, a glass breaker and seatbelt cutter combo. The first aid kit and fire extinguisher are checked monthly by the supervisors. Due to a recent accident, the company's second vehicle is no longer in operation. They have been renting a 2024 Chrysler Pacifica in the meantime. The facility moved over their valid first aid kid, valid fire extinguisher, flashlight, and glass breaker and seat belt cutter combo into the rental vehicle in case of emergencies. The company also has a non-working decommissioned van that is located in the parking lot. The van is non-operational, however was found unlocked during the audit. Due to the van being non-working this is not an exception but an observation.	
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**	All chemicals used by the facility are kept in a double locked room - inside the medication room that youth are not allowed to access and inside a locked storage unit. There are matching MSDS sheets for the chemicals, and the organization keeps inventory daily instead of weekly. There is only one storage location for chemicals to prevent multiple locations, and the MSDS sheets, weekly inventory and perpetual counts are all kept in the medication room with the chemicals. The perpetual inventory is being kept for Lysol Spray and Clorox wipes, which shows every removal and return and time a chemical is removed. The organization recently updated their sheet to include the time the items are being removed and returned to the chemical closet as of 2/9/2024. No other chemicals are being documented on a perpetual log; however, after speaking with the program manager, most chemicals are not removed from the room itself when used such as the floor cleaner which is poured into the mop bucket in the same room without being removed.	Perpetual inventory is not maintained of certain chemicals such as toilet bowl cleaner, Windex or other commonly used items not being used around the youth.
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 are two washers and two dryers located in the laundry room of the facility. Both sets of units are fully functioning and no lint was noted in the lint collectors. Each bed in the facility was neatly made and had their own pillow, linen set and sheets, and extra clean sets are kept in the laundry room. Each youth has access to a storage locker in the day room that locks, to protect their valuables and store items that are not allowed in their bedrooms for safe keeping.	
Additional Facility Inspection Narrative (if applicable)			

Fire and Safety Health Hazards: a. Annual facility fire inspection was conducted, and the facility is in compliance with local fire marshal and fire safety code within jurisdiction. b. Agency completes a minimum of 1 fire drill on each shift monthly (within 2 minutes or less). c. Completes 1 mock emergency drill per shift per quarter. d. All annual fire safety equipment inspections are valid and up to date (extinguishers, sprinklers, alarm system and kitchen overhead hood, including fire extinguishers in all vehicles).	**Exception**	The facility had its recent fire inspection completed on 3/25/2024. There were a few deficiencies noted on the fire inspection, and the facility was given until 4/10/2024 to repair. The facility was in the process of completing the repairs while the auditors were on site, and will provide the auditing team with the updated inspection once completed by the fire marshal. The deficiencies on the report included two inoperable exit signs, an inoperable backflow valve, two missing electrical outlet covers, an electrical panel missing blank fuses, and a surge protection being plugged into another surge protector instead being plugged directly into the wall. Fire drills were reviewed between the months of October 2023-March of 2024. Each month had a fire drill completed and was documented to take two minutes or less to complete on the first and second shift. The mock drills for the facility were reviewed between October 2023 and March 2024. The facility completed 4 mock drills per month per shift, putting them well above the standard. The annual fire alarm report was completed on 6/13/2023, and one sprinkler valve was noted to be malfunctioning. There is documentation showing the shelter followed up on 6/14/2023 and again on 8/6/2023. The facility recently replaced their five fire extinguishers during their inspection on 5/19/2023. Their sprinkler inspection was completed on 12/6/2023 after needing sprinklers replaced from their 6/13/2023 inspection. The overhead hood inspection was completed in 3/29/2024, and is completed quarterly. The organization was able to provide invoices for the last three quarters. Both of the vehicles have valid fire extinguishers.	There were two fire drills that did not meet the required guidelines. The third shift was missing a fire drill in March 2024, and the drill in January took three minutes to complete instead of the required two minutes or less.
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 organization has a satisfactory group care inspection report from the department of health, which also covers the food service inspection as well. The current menus are posted in the kitchen, and are valid until August 2024. All cold and frozen food is stored properly in clean and functioning appliances. The shelter is currently down a refrigerator due to a compressor going bad, and was able to provide documentation showing that a work order was completed. All other appliances are in working order and well maintained.	
Additional Fire and Safety Health Hazards Narrative (if applicable)			

Youth Engagement			
a. Youth are engaged in meaningful, structured activities (e.g., education, recreation, counseling services, life and social skill training) seven days a week during awake hours. Idle time is minimal. b. At least one hour of physical activity is provided daily. c. Youth are provided the opportunity to participate in a variety of faith-based activities. Non-punitive structured activities are offered to youth who do not choose to participate in faith-based activities. d. Daily programming includes opportunities for youth to complete homework and access a variety of age appropriate, program approved books for reading. Youth are allowed quiet time to read. e. Daily programming schedule is publicly posted and accessible to both staff and youth.	**Compliance**	The youth daily schedule as well as the monthly schedule cycles through educational, fun and optional religious activities for the youth to participate in. The youth are required to complete some kind of educational activity during study hall, which can be homework, reading, or educational worksheets. The daily schedule is posted in multiple common areas at the facility.	
Additional Comments: **There are no additional comments for this indicator.**			

3.02 - Program Orientation		Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 3.02	**YES**	
	If NO, explain here:	
	The provider has the required policy and procedures, 3.02 - Program Orientation, that was revised 10/5/2023 by the ED.	

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

Total number of Open Files: 1 open residential youth record
Total number of Closed Files: 3 closed residential youth records
Staff Position(s) Interviewed *(No Staff Names)* **: Shelter Manager, Shelter Supervisor**
Type of Documentation(s) Reviewed: Youth Files, Residential Youth Handbook

Youth received a comprehensive orientation and handbook provided within 24 hours	**Compliance**	All four youth records reviewed had signed documentation by the youth and the parent on the same day as intake stating they received the orientation handbook.	

Orientation includes the following: a. Youth is given a list of contraband items b. Disciplinary action is explained c. Dress code explained d. Review of access to medical and mental health services e. Procedures for visitation, mail and telephone f. Grievance procedure g. Disaster preparedness instructions h. Physical layout of the facility i. Sleeping room assignment and introductions j. Suicide prevention- alerting staff of feelings or awareness of others having suicidal thoughts	**Compliance**	The orientation handbook each youth receives includes a list of contraband, the behavior management system, dress code, access to services and rights, visitation, mail and telephone procedures, grievance procedures, disaster plans, layout of the facility, sleeping assignment and suicide prevention plans. It is not documented if the daily activity schedule is discussed with the youth neither on the intake forms or orientation manual or any other documentation; however, per an interview with the shelter manager, it is something they discuss at length with the youth the first two days at the shelter due to there being a school hold placed on the youth.	
Documentation of each component of orientation, including orientation topics and dates of presentation, as well as signatures of the youth and staff involved is maintained in the individual youth record	**Compliance**	An orientation checklist is included in all reviewed files, which is signed by the youth, staff and parents.	
Additional Comments: **There are no additional comments for this indicator.**			
3.03 - Youth Room Assignment			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 3.03		**YES**	
		If NO, explain here:	
		The provider has the required policy and procedures, 3.03 - Youth Room Assignment, that was revised 10/5/2023 by the ED.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: 1 open residential youth record **Total number of Closed Files: 3 closed residential youth records** **Staff Position(s) Interviewed** *(No Staff Names)* **: Program manager** **Type of Documentation(s) Reviewed: Youth orientation handbook, policy, alert board, intake observation, daily youth notes, logbook**			
A process is in place that includes an initial classification of the youths, to include:			

a. Review of available information about the youth's history, status and exposure to trauma b. Initial collateral contacts, c. Initial interactions with and observations or the youth d. Separation of younger youth from older youth, e. Separation of violent youth from non-violent youth f. Identification of youth susceptible to victimization g. Presence of medical, mental or physical disabilities h. Suicide risk i. Sexual aggression and predatory behavior j. Acute health symptoms requiring quarantine or isolation	**Compliance**	The facility attempts to gather as much information from family members, DJJ history, etc. about the youths behavior, aggressiveness, physical and sexual history, and takes detailed notes of the youth's behavior upon arrival and as the youth gets comfortable at the facility. The facility has rooms designated based on age, and staff will move youth around if needed based on behaviors or history. During intake the staff assigns the rooms based on availability and age, and if issues arise they notify the shelter supervisor or manager for room change recommendations.	
An alert is immediately entered into the program's alert system when a youth is admitted with special needs and risks such as risk of suicide, mental health, substance abuse, physical health or security risk factors	**Compliance**	The facility creates an alert for the youth's behavior on an alert form that is part of their paper file, as well as updating the alert board that is located in the staff office. The alert information is documented in the log book upon intake as well, and is highlighted orange for intake.	
Additional Comments: **There are no additional comments for this indicator.**			
3.04 - Log Books			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 3.04		**YES** If NO, explain here: The provider has the required policy and procedures, 3.04 Log Books, that was revised 10/5/2023 by the ED.	
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: Two weeks at random for each month were reviewed between the months of October 2023 and March 2024. **Staff Position(s) Interviewed** *(No Staff Names)* **: Shelter manager, shelter supervisor** **Type of Documentation(s) Reviewed: logbook**			
Log book entries that could impact the security and safety of the youth and/or program are highlighted	**Compliance**	The shelter uses the following colors to document the following types of entries in their logbook: yellow for head count, purple for staff entering and exiting the shift, orange for intakes, green for youth behavior issues, and red for runaway instances. The entries are documented clearly and succinctly.	
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**	Due to the log book being electronic, each entry is documented by the user's account. The user account is the first initial and last name of the employee. The entries clearly document the time of the incident, any corrections, and who is involved in each incident.	
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**	Due to the log book being electronic, each voided entry is crossed out with a single line, and a new drop down section below the original entry is created with the corrected information.	

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	**Exception**	Two weeks at random for each month were reviewed between the months of October 2023 and March 2024. The only weeks that did not have a program director's note were during the Thanksgiving holiday and Christmas holiday period. The program director leaves detailed notes on what was documented well and what needs to be worked on.	The dates being reviewed are not included on the supervisor's entries in the logbook.
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**	Two weeks at random for each month were reviewed between the months of October 2023 and March 2024. The staff document their review of the log book every shift when they log in for the day, and the entries are highlighted purple.	The staff are not including the dates of the previous shifts they are reviewing in their entry.
At the beginning of their shift, oncoming supervisor and shelter counselor reviews the logbook of all shifts since their last log entry and makes a signed and dated entry and into log book indicating the dates reviewed.	**Exception**	Two weeks at random for each month were reviewed between the months of October 2023 and March 2024. It should be noted that November and December were holiday months and would explain why supervisory review of the logbooks were not as frequent during time off. Approximately 50% of the log book entries for the supervisor do not include the dates that are being reviewed. The counselors are documenting the log book reviews including the dates they are reviewing, however their reviews of the logbook are sporadic, with some two week periods having 9 checks over 10 days, and some having 5 checks over 10 days.	The staff are not documenting the specific dates they are reviewing upon starting their shift. The counselors and supervisors are not documenting reviewing the log book at the start of each shift. The counselors when they review do include the dates, the supervisors do not.
Logbook entries include: a. Supervision and resident counts b. Visitation and home visits	**Compliance**	The staff complete multiple headcounts throughout the shift and highlight yellow, document any youth movement and provide updates on what the youth are doing throughout the shift, and document when youth leave for a home visit, and return, as well as document any shelter visitors.	
Additional Comments: **There are no additional comments for this indicator.**			
3.05 - Behavior Management Strategies			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 3.05	**YES**		
	If NO, explain here:		
	The provider has the required policy and procedures, 3.05 - Behavior Management Strategies, that was revised 3/1/2024 by the ED.		

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, shelter supervisor**
Type of Documentation(s) Reviewed: youth orientation manual, point system used for documenting youth for the week, point board, and behavior management system, training records

The program has a detailed written description of the BMS and it is explained during program orientation	**Compliance**	The youth and parents sign off on receiving a copy of the Resident Orientation Handbook, which has in detail what is expected of the behavior management policy. There are also posted documents hung in each youth room's for any questions they might have on the behavior management system.	
Behavior Management Strategies must include:			
a. BMS is designed to teach youth new behaviors and help youth understand the natural consequences for their actions b. Behavioral interventions are applied immediately, with certainty, and reflect the severity of the behavior c. BMS uses a wide variety of awards/incentives to encourage participation and completion of the program d. Appropriate consequences and sanctions are used by the program and consequences for behavior are logical and designed to promote skill-building for the youth e. Counseling, verbal intervention and de-escalation techniques are used prior to physical intervention (Only techniques approved by the Florida Network and DJJ are used if physical intervention is required) f. Only staff discipline youth. Group discipline is not imposed g. Room restriction is not used as part of the system or for youth who are physically and/or emotionally out of control h. Youth should never be denied basic rights such as meals, clothing, sleep, services, exercise, or correspondence privileges	**Compliance**	The system focuses on rewarding good behavior and having conversations around poor behavior. The benefits the youth receive are based on the level they earn based on their good behavior. The system states that if there are any behavioral issues that do not meet their severity level of the youth not receiving points, the staff follow the MAB de-escalation techniques and document in the logbook. The supervisors also have conversations with the youth or address issues in house meeting about the non-severe behaviors. The system is set up to give points for positive actions. The youth do no loose points. At the end of the week the percentage of points is calculated and the level they land on determine their level for the week. Based on the percentages of points received by the youth, they are placed in one of three levels. The three levels have different privileges associated with it - encouraging the youth to behave a certain way to get the benefits they are looking for. During the interview with the shelter supervisor, (BMS) procedure that is in place was described. It was confirmed that staff does explain the (BMS) during program orientation. In addition, staff document the behavioral notes daily. All consequences appear fair in respect to the behavior management plan. The system does not allow for group discipline or room restriction and does not deny the youth of basic rights.	
Program's use of the BMS			
All staff are trained in the theory and practice of administering BMS rewards and consequences	**Compliance**	Part of the new hire onboarding training includes a training for the Behavior Management System. All four new hire staff training records reviewed supported new staff receive this training.	
There is a protocol for providing feedback and evaluation of staff regarding their use of BMS rewards and consequences	**Compliance**	The youth and staff address any issues either one on one with the supervisor of the shelter, or can address issues as a whole during their house meetings held with the youth.	
Supervisors are trained to monitor the use of rewards and consequences by their staff	**Compliance**	The current supervisors were involved in the creation of the BMS system used, and are also responsible for training the staff on the behavior management system.	
Additional Comments: **There are no additional comments for this indicator.**			
3.06 - Staffing and Youth Supervision			**Limited**
Provider has a written policy and procedure that meets the requirement for Indicator 3.06		**YES** If NO, explain here: The provider has the required policy and procedures, 3.06 - Staffing and Youth Supervision, that was revised 10/5/2023 by the ED.	

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: Bed checks dates and times: March 6th between 2 am and 4 am; March 9th between 4 am and 6 am; March 15th between 1 am and 3 am; March 24th Between 3 am and 5 am; March 28th between 12 am and 2 am. **Staff Position(s) Interviewed (No Staff Names): Shelter Director and shelter supervisor.** **Type of Documentation(s) Reviewed: Staff schedule, electronic log book. Observation: Posting of staff schedule**			
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 schedule shows the program maintains a minimum of three staff per day and a minimum of two staff per night as seen on all staff schedules reviewed between October 8th 2023 and April 6th, 2024. All changes to the schedule due to PTO and other circumstances are noted on the schedule to show the attempt at maintaining ratio.	
All shifts must always provide a minimum of two direct care staff present that have met the minimum training requirements	**Compliance**	The schedule shows the program maintains a minimum of three staff during the daytime and a minimum of two staff per night.	
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 new staff hired were background screened and property trained youth care workers. A review of eligible re-screened staff indicate continued eligible screening results for the applicable staff.	
The staff schedule is provided to staff or posted in a place visible to staff	**Compliance**	This document is located in the locked utility closet of the staff office, which is where the computer for clocking in and out and the video camera's are located.	
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**	Holdover roster is located in the locked utility closet of the staff office, which is where the computer for clocking in and out and the video camera's are located.	

Staff observe youth at least every 15 minutes while they are in their sleeping room, either during the sleep period or at other times, such as during illness or room restriction	**Exception**	On the night of March 6th, there were 20 youth in house. It should be expected that most rooms have at least one youth in their room, as only 4 youth were awake and in the day room for the first few walks. There were 4 walks not seen on camera that night that were documented as being completed in the log book. The time of the documented walks as well as the viewed walks also do not match, as some walks have a 2- or 4-minute delay. Due to the changing time delays, it cannot be a camera date malfunction for this night. On the night of March 9th, there were 8 youth in house, as the remainder of the population was on home visits. The walks completed between the documented walks at 4:08 am and 5:14 am were completed appropriately, however there appears to be a 3-minute delay on the time on the camera and the time documented in the log book as it is consistent across all walks completed that day. The 5:30 documented walk only shows the first 3 rooms walk completed at 5:33 am, the last 3 rooms are not seen as being checked. The 5:39 am walk shows a 4-minute delay between the first 3 rooms and the last 3 rooms being checked, however the room documentation in the log book does not match. On the night of March 15th, there were 20 youth in house. All except 4 of the youth were in bed for the first part of the review, the remainder of the youth returned to bed at 2:22 am. For the 1:03 documented walk and the 1:14 documented walk the staff only reviewed the three rooms closest to them. All other walks were completed appropriately. There is a consistent 1 minute difference between documentation of the walks and the time the walks are completed, however some of the walks are done prior to documentation, and some are completed after documentation, resulting in the issue not being related to the time on the camera. On the night of March 24th, there were 5 youth in house. All rooms were checked by the staff completing the walks. All walks were documented and completed appropriately. There was a 1 minute delay between the documented time and the actual time of the walk, it is believed to be a issue with the time saved on the camera. On the night of March 28th, there were 18 youth in house. There were 6 walks that were documented in the log book however were not seen on the camera footage. On the walks completed, there were varying discrepancies between the documented times of the walks and the actual times completed, varying between 2 minutes and 7 minutes.	There were six 2-hour periods reviewed for nightly walks throughout the month of March. Across the board there were multiple walks not completed on camera, inconsistencies with the time the walk was documented and the time the walk was completed by the staff, and inconsistencies in viewed walks taking longer than documented in the log book. The shelter manager was advised to report the findings to CCC.
3.07 - Video Surveillance System			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 3.07		**YES** If NO, explain here: The provider has the required policy and procedures, 3.07 - Video Surveillance System, that was revised 10/5/2023 by the ED.	

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: April, 2023 through October, 2023.
Staff Position(s) Interviewed (No Staff Names): Shelter Director
Type of Documentation(s) Reviewed: Video Surveillance
Describe any Observations: Posting of video notice

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**	There is a large red and white sign located next to the front door for all visitors/clients to see that clearly document that the site is under 24 hour surveillance. The video footage is stored for the past 30 days, however to be able to meet 30 days worth of storage, the camera's are motion activated only. The date, time and location are included in the top right corner of the video footage. It should be noted that the time has to be manually adjusted by the program manager after a power surge or outage, resulting in the dates and times not matching exactly. The cameras are connected to the main building power source, which has a back up generator that automatically kicks in a few seconds after power is lost. There is a total of 26 cameras, 10 external and 16 internal. There are no cameras in private areas including bedrooms and bathrooms. The external cameras cover the main entrance and the parking lot. Youth searches are conducted inside the first lobby past the main lobby, which is in camera view.	
A list of designated personnel who can access the video surveillance system is maintained (includes off-site capability per personnel)?	**Compliance**	There is a list of personnel that can access the camera footage located in the staff office (which is the room the camera's are in). Those included on the list are the Regional Director, Shelter Manager and Shelter Supervisor.	
Supervisory review of video is conducted a minimum of once every 14 days and timeframes reviewed are noted in the logbook.	**Exception**	All cameras are directed in locations that allow observation of activities in the facility for 24 hours a day, seven days a week. The video reviews conducted by shelter director and supervisor included random samples of overnight shifts and other times of youth movement to adequately assess activities of the facility.	There was one missing supervisor's camera review between January 7th to 20th.
The reviews assess the activities of the facility and include a review of random sample of overnight shifts	**Compliance**	All cameras are directed in locations that allow observation of activities in the facility for 24 hours a day, seven days a week. The video reviews conducted by shelter director and supervisor included random samples of overnight shifts and other times of youth movement to adequately assess activities of the facility.	
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 has a policy in place that grants the requesting party video recordings within twenty-four to seventy-two hours from the time of the request. However, in practice, there appears to be a delay in providing the requested video footage within the required timeframe.	

Camera service order/requests will be made within 24 hours of discovery of camera malfunctioning or being inoperable. All efforts made to obtain repairs are documented and maintained	**Compliance**	There have been no documented outages in the last 6 months, however the program has a process in place in the instance the cameras do go out. The program manager or program supervisor would notify their chain of command, submit a CCC report and contact their vendor as soon as the issue is noticed. They would aim to get the vendor on site as soon as possible and try to get the situation resolved and update all before listed parties as changes happen.	
Additional Comments: **There are no additional comments for this indicator.**			
4.01 - Healthcare Admission Screening			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 4.01		**YES** If NO, explain here: The provider has the required policy and procedures, 4.01 - Healthcare Admission Screening, that was revised 12/8/2023 by the ED.	
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 residential youth records **Total number of Closed Files: 2 residential youth records** **Staff Position(s) Interviewed** *(No Staff Names)***: Shelter Manager and Shelter Supervisor** **Type of Documentation(s) Reviewed: youth records**			
Preliminary Healthcare Screening			
Screening includes : a. Current medications b. Existing (acute and chronic) medical conditions c. Allergies d. Recent injuries or illnesses e. Presence of pain or other physical distress f. Observation for evidence of illness, injury, physical distress, difficulty moving, etc. g. Observation for presence of scars, tattoos, or other skin markings h. Acute health symptoms requiring quarantine or isolation	**Compliance**	The policy reviewed indicates the need for a screening to be completed at time of intake with all youth and outlines all items to be included as present in the standard. Five of five youth charts were reviewed. All five youth charts indicated that the screening included the needed items. All screenings were complete. One of five youth chart did have some discrepancies on the form indicating 'no' for the response on several questions, however there were answers written in which would indicate a 'yes' was a more appropriate response. Three of the five youth were identified as being on medications. Two of the five youth had notations in their records regarding scars that were present on the youth at time of intake.	
Referral and Follow-Up			
Youth with chronic medical conditions have a referral to ensure medical care (e.g. diabetes, pregnancy, seizure disorder, cardiac disorders, asthma, tuberculosis, hemophilia, head injuries, etc.)	**No eligible items for review**	Five of five youth charts were reviewed. None of the charts indicated having a chronic medical condition that required follow up care.	

When needed, the parent is involved with the coordination and scheduling of follow-up medical appointments	**No eligible items for review**	The policy reviewed outlines in the procedure the process for including parents in in the coordination and scheduling of follow-up medical appointments. The shelter manager and shelter supervisor confirmed this by outlining current practice of how they would address any medical conditions presented by the youth.	
All medical referrals are documented on a daily log.	**Compliance**	The policy reviewed indicates that all medical referrals, follow up or care is documented in the log book and client case file.	
The program has a thorough referral process and a mechanism for necessary follow-up medical care as required and/or needed	**Compliance**	The shelter manager shared the process for follow-up medical care that included contacting the family members for feedback on any medical needs of the youth. The process also involves, if needed, assisting the youth in getting to the medical follow up appointments and ensuring the family is present.	
Additional Comments: **There are no additional comments for this indicator.**			
4.02 - Suicide Prevention			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 4.02		**YES** If NO, explain here: The provider has the required policy and procedures, 4.02 -Suicide Assessment, that was revised 12/8/2023 by the ED.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open (Residential & Community) Files: 1 residential youth record **Total number of Closed (Residential & Community) Files: 2 closed residential and 2 closed community counseling youth records** **Staff Position(s) Interviewed** *(No Staff Names)* **: Clinical Program Manager** **Type of Documentation(s) Reviewed: Intake Screening Forms, Suicide Assessment Forms, Observation Logs, Email Communication from Network to Clinical Program Manager**			
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**	The policy for the agency outlines all appropriate guidelines as indicated in the standard. Five of five youth charts reviewed all demonstrated that the suicide risk screening was completed at time of intake and all questions were asked and documented.	
The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	**Compliance**	The current suicide risk assessment is the most recently approved Florida Network suicide risk assessment and was present in all charts reviewed.	
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**	Within the agency policy and procedure, there is a guideline that breaks down the specific level the youth should be placed on and the type of supervision that is appropriate to that level. Three of three youth residential charts were reviewed and all three youth were placed on the appropriate level of supervision following their suicide risk assessments.	

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	**Exception**	Three of three youth residential records produced observation logs presented with a number system that allowed staff to choose the number most appropriate to what the youth were doing at that moment of observation.	Three of three youth residential charts were reviewed. All three residential youth were placed on sight and sound. Three of three residential youth participated in an outing while on sight and sound but there is no documentation of the checks being completed every thirty minutes. The logs are filled out by shelter staff indicating that the youth are on an outing with other shelter staff.
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.	**Exception**	The sight and sound observation logs utilized by the agency reflect that staff should be filling out the identified descriptors in this portion of the policy. All youth files observed appeared to have the appropriate sight and sound observation logs present.	One of three youth residential charts indicated that there was an indication of 15 minutes checked for the youth; however, there are no observations documented of the youth.
Supervision level was not changed/reduced until a licensed professional or a non-licensed mental health professional under the supervision of a licensed professional completed a further assessment OR Baker Act by local law enforcement	**Compliance**	Two of two residential file indicated an appropriate level change that was completed by a master's level clinician and signed off by a licensed professional. One of one residential file indicated that a level change has not been completed for the youth at this time due to continuous presenting risk.	
There was evidence that documentation was reviewed by supervisory staff each shift. If program uses an observation log, completed logs are maintained in the youth's file.	**Compliance**	Three of three youth residential records indicate that the documentation is reviewed each shift by the supervisor as evidenced by their signature located at the bottom of the page. All youth residential charts reviewed had the appropriate observation logs maintained in the file.	
Youth with Suicide Risk *(Community Counseling Only)*			
Youth identified for suicide risk during intake was immediately assessed by a licensed professional or non-licensed professional (under the direct supervision of a licensed mental health professional) and the parents and supervisor were both notified of the results.	**No eligible items for review**	There were no applicable community counseling youth screened as a suicide risk and immediately assessed by a licensed professional.	
During the intake, if the appropriate staff is unavailable, youth identified for suicide risk was immediately referred by the provider and the parent/guardian is notified of the suicide risk findings disclosed and advised that an Assessment of Suicide Risk should be completed ASAP by a licensed professional.	**Compliance**	Two of two community counseling youth records were reviewed and identified for suicide risk. Both youth and guardian participated in the discussion with staff to complete a safety plan. Parent/guardian was notified of the findings and were advised that a suicide risk assessment should be completed by a licensed professional.	
Information on resources available in the community for further assessment was provided to the parent/guardian and is documented in the youth's file and signed by the parent/guardian OR a written follow-up notification was sent by certified mail if the parent/guardian was not present during the screening and was notified by telephone.	**Compliance**	Two of two community counseling files were reviewed and it was observed that appropriate referrals were provided to the family for further assessment. The parent/guardian signed off on this documentation.	

If the parent/guardian cannot be contacted, all efforts to contact them are documented in the case file.	**No eligible items for review**	Of the charts reviewed, parent/guardian was able to be contacted.	
When the screening was completed during school hours on school property, the appropriate school authorities were notified.	**No eligible items for review**	Both records reviewed indicate the screening occurred in the home.	
Additional Comments: **There are no additional comments for this indicator.**			
4.03 - Medications			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 4.03		**YES** If NO, explain here: The provider has the required policy and procedures, 4.03 -Medications, that was revised 12/8/2023 by the ED.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: 1 open residential youth record **Total number of Closed Files: 2 closed residential youth record** **Staff Position(s) Interviewed** *(No Staff Names)* **: The Nurse, Shelter Manager,** **Type of Documentation(s) Reviewed: MARS log, list of staff authorized to assist in distribution of medications, staff training logs** **Observation: Pyxis Medication Station, medication room**			
The agency has a Registered Nurse (RN) and/or a Licensed Practical Nurse (LPN) that is being supervised by RN and all of their credentials have been verified.	**Compliance**	The agency has one registered nurse who is licensed through the State of Florida, verified through the Florida Department of Health website. The nurse's license expiration date is 07/2024.	
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**	Five staff training folders were reviewed for annual medication training and certification/recertification was marked off on their training logs for Medication Distribution. The last medication refresher training course was provided to staff on 10/25/2023 by the Nurse. This was documented in the staff meeting minutes with a sign in sheet for all staff members present to sign. This list was cross referenced with the current list of staff authorized to assist with medications and all of the names appeared on both lists. The training was provided but did not include a test in competency.	
The agency held at least quarterly staff meetings conducted by RN and/or Shelter Manager to review and assess: a. strategies implemented to reduce medication errors shelter wide b. analyze factors that contributed to medication errors c. allow staff the opportunity to practice and role-play solutions	**Compliance**	Monthly staff meetings are held where the topic of medications is included the agenda meeting minutes. The date(s) of quarterly meetings held are: 3/27/2024, 2/21/2024, 11/22/2023, 10/25/2023 and 9/27/2023. It should be noted that the nurse returned to staff in February of 2024. In the months documented prior to February of 2024, the medication training was held by the Shelter Manager. In a conversation with the nurse, it was identified that moving forward she plans to be present for all staff meetings where she will discuss medications.	

The agency has strategies implemented to ensure medications are provided within the 2-hour time frame.	**Compliance**	Medications are distributed between the times of 5:00 - 6:00 a.m. and 7:00 - 9:00 p.m. The shelter supervisor reported they set alarms on the shelter iPhone if needed for a medication pass time that is outside of their normal distribution times.	
All non-licensed staff members are clearly identified and designated on the staff schedule and shift change report/shift responsibility form for assisting with the self-administration of medications on each shift	**Compliance**	In the medication room and available for staff in the youth care office, there is a list of approved medication staff. The schedule was also reviewed and indicates, with an asterisk, who is responsible for medication passes during each shift. Of the six months reviewed, all identified medication pass staff were on the approved list.	
The agency has clear methods of communicating which youth are on medications with the times and dosage easily discernable by all staff on each shift.	**Compliance**	Reviewer observed the youth care office that has a board listing youth in the shelter and indications next to the youth if they were prescribed medications. Within the current MARs log book (two of two youth), there were clear indicators for each youth currently prescribed medications, the dosage and when the youth was required to take it. There are also indicators of prescribed medications on the alert pages in each youth chart.	
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 medication delivery process was found to be consistent with the FNYFS medication management and distribution policy. The program's registered nurse reviews all medical documentation each day she works at the program. There is a an internal quality assurance process in place that identifies medication issues, and discussion of medication management and errors during CINS/FINS meetings.	
Admission/Intake of Youth			
a. Upon admission, the youth and parent/guardian (if available) were interviewed by the Registered Nurse (when on-site) about the youth's current medications as part of the Medical and Mental Health Assessment screening process and/or an interview was conducted by the RN within three (3) business days if the RN was not on the premise at admission. **If the agency does not have a RN, there was a medication review conducted by a certified Leadership position.* b. Upon intake/admission, there is evidence that the on-shift certified supervisor of higher level staff did review all medication forms by the next business day.	**Exception**	Three youth medication records were reviewed. At the time of admission, medical information was either documented by a staff member or the registered nurse. Documentation supported the registered nurse reviewed all medical information recorded by staff no more then three days after the youth's admission.	Three of three youth residential records indicated that there is not a supervisor signature by the next business day following their intake.
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 Pyxis machine is located behind two locked doors. The only individuals that have access to these keys to access this room are the shelter manager, shelter supervisor, nurse and shelter staff. The machine is stored in accordance with guidelines in FS499.0121 and policy section in Mediation Management. Through observation, the Reviewer was able to see that oral medications are stored separately from injectable epi-pen and topical medications. Within the locked room, there was also a refrigeration system that could store medications. In the fridge there was a temperature gauge that read 41 degrees. A bag of keys was also located behind the Pyxis machine that had all appropriate keys to make it accessible to staff if the machine were to malfunction.	
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**	A list of staff who are authorized to access medication was provided. On that list, it indicates which users are identified as system managers. The agency has three (3) current staff members that are considered managers for the Pyxis system: the nurse, shelter supervisor, and shelter manager. The nurse is present in the shelter on Tuesdays (9:00 - 7:00 p.m.) and Fridays (7:00 - 5:00 p.m.). When present, the nurse indicated that she will provide medications. The program manager indicated they do not accept youth who are prescribed injectables, as supported by agency policy. Seven of seven training files were reviewed that showed all staff have received an EpiPen training provided by Bridge.	
The medication distribution log documentation includes: a. the time of medication administration b. evidence of youth initials that the dosage was given c. evidence of staff initials that the dosage was given	**Compliance**	A review of the Medication Distribution Log confirmed each log contained the time the medication is distributed, and initials of the youth and staff to indicate the dosage was given.	

There is evidence that staff provide youth with medications within one hour of the scheduled time of delivery as ordered by the medication. Documentation is provided for instances this does not occur within the required timeframe.	**Compliance**	Documentation on the Medication Distribution Log supported the medications were provided to the two youth, whose records were reviewed, within one hour of the scheduled time of delivery.	
During the review period, there were no instances where youth missed their medication due to failure to open the pyxis machine.	**Compliance**	The nurse reported that there was not an instance in which a youth missed a medication due to failure to open the pyxis machine. The nurse was able to show where the keys are to access the machine. No CCC incidents were found to be reported for similar incidents.	
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**	Upon review of their incident reports and conversation with the shelter manager, it was confirmed that there were no medication errors.	
Medication Inventory			
a. For controlled substances, a perpetual inventory with running balances is maintained as well as a shift-to shift count verified by a witness and documented b. Over-the-counter medications that are accessed regularly and inventoried weekly c. Syringes and sharps (needles, scissors, etc.) are secured, and counted and documented weekly	**Exception**	As reviewed in the MARS for current residents prescribed medications, one of one open youth was reviewed. The MARS indicates a perpetual count that is completed by staff on each shift to document the running balances of the medication. For this youth, there is also a form that indicates when an over the counter medication is provided to the youth. Nurse does the OTC count medications	No inventory was produced for over the counter medications.
There are monthly reviews of the Pyxis reports to monitor medication management practice.	**Exception**	Medication errors and practices are reviewed at staff meetings on a monthly basis. The program reported there were no discrepancies in the past six months and provided evidence of a report that supported no discrepancies occurred.	Monthly reports were not provided to support a review of the Pyxis to monitor the medication management practice.
Medication discrepancies are cleared after each shift.	**Compliance**	The shelter supervisor indicated there have been no medication discrepancies during the last six months. At the time of the review, there was a report that was pulled that indicated there were no discrepancies noted for any medications during that period.	
Additional Comments: **There are no additional comments for this indicator.**			

4.04 - Medical/Mental Health Alert Process			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 4.04		**YES** If NO, explain here: The provider has the required policy and procedures, 4.04 - Medical and Mental Health Alert Process, that was revised 12/8/2023 by the ED.	
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: 2** **Staff Position(s) Interviewed** *(No Staff Names)* **: Shelter Manager** **Type of Documentation(s) Reviewed: Residential Charts, Staff Training Log, Agency Policy and Procedure** **Describe any Observations: Census Board**			
Youth with a medical, mental health, or food allergy was appropriately placed on the program's alert system	**Compliance**	Five of five residential charts reviewed had the appropriate notification sheet in the front of the charts, as well as colored dots to indicate which alert is appropriate for the youth. Of the five youth, four youth were in need of appropriate alerts in their files and all alerts were indicated in the chart.	
Alert system includes precautions concerning prescribed medications, medical/mental health conditions	**Compliance**	The alert system that is present in the youth charts, in the youth care office, and documented in the log book all appropriately identify any concerns regarding medications, medical/mental health conditions.	
Staff are provided sufficient training, information and instructions to recognize/respond to the need for emergency care for medical/mental health problems	**Compliance**	A review of the staff training log indicates that all staff onboarded are receiving various trainings that would provide staff with sufficient training, information and instruction to recognize/respond to the need for emergency care for medical/mental health problems. Some of these types are trainings include: Suicide Awareness and Prevention, Mental Health & Substance Abuse, CPR/First Aid, Trauma Responsive Practices, EpiPen Safety and Trauma Informed Care.	
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**	There is an alert board present in the youth care office that indicates all appropriate precautions for youth. The shelter manager also indicated that the logbook reflects this as well. Three of three intakes were observed documented in the log book during October of 2023 and March of 2024 where precautions are notated next to the youth's names. These same alerts are also found in four of five youth charts had the alerts notated in the chart. One of five youth charts were not in need of any alerts	
Additional Comments: **There are no additional comments for this indicator.**			

4.05 - Episodic/Emergency Care			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 4.05		**YES** If NO, explain here: The provider has the required policy and procedures, 4.05 - Episodic/Emergency Care, that was revised 12/8/2023 by the ED.	
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: 2 closed residential youth records** **Staff Position(s) Interviewed** *(No Staff Names)* **: Shelter Manager, Shelter Supervisor** **Type of Documentation(s) Reviewed: Episodic Log Book, Incident Reports, Log Book and Agency Policy and Procedure, Training Files** **Describe any Observations: Observations were made of the knife-for-life and wire cutters in all of the documented locations.**			
Off Site Emergency Care			
a. If off-site emergency medical or dental care was provided, an incident report was submitted for the medical or dental care b. Upon youth return, there is a verification receipt of medical clearance via discharge instructions with follow-up is present in file c. Youth's parent/guardian was notified d. A daily log is maintained for emergency care provided	**Compliance**	Twp episodes were reviewed where youth were required to obtain off-site medical or dental care. Incident reports were verified for both youth. For both youth, the parent/guardian was notified and there was documentation in the log book of the event. For one of the two youth, appropriate discharge documentation was received and receipt of medical clearance with follow up in the file. The other youth was discharged home following their medical incident.	
All staff are trained on emergency medical procedures	**Compliance**	Seven of seven training files reviewed for staff indicated that they had received training on how to handle medical procedures/incidents. The training that the staff received that was appropriate is: CPR/First Aid, EpiPen safety and Disaster Preparedness Training and Universal Precautions.	
The program has a Knife-for-life and wire cutters accessible to staff in a secure location(s)	**Compliance**	There are four locations within the shelter that have a knife-for-life and wire cutters available for staff use. All of the four locations were observed to be locked. The four locations of the items are: youth care office, supervisors office, laundry room and file room.	
Additional Comments: **There are no additional comments for this indicator.**			