Florida Network for Youth and Family Services
Compliance Monitoring Report for

Orange County Youth and Family Services

1800 East Michigan Avenue
Orlando, Florida 32806

April 3-4, 2024

Compliance Monitoring Services Provided by

FOREFRONT

EXECUTIVE SUMMARY

Forefront LLC conducted a Quality Improvement (QI) monitoring visit on behalf of the Florida Network of Youth and Family Services (FNYFS) for Orange County Youth and Family Services (OCYFS) for the FY 2023-2024 at its program office located at 1800 East Michigan Avenue, Orlando, 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. Orange County Youth and Family Services 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 Keith Carr, Consultant for Forefront LLC. Agency representatives from Orange County Youth and Family Services present for the entrance interview were: Barbara Williams, Division Manager; Shashonadalyn Upson, Senior Program Manager; Angela Patton, Program Manager; Vemari Rivera, Supervisor; Cayla Williams, Supervisor; Lyneisha Morrison, Program Manager; Felicia Brown, Senior Program Manager; Diana Mendez, Medical and Mental Health Administrator; Bevetta Sibblies Martin, Senior Fiscal Coordinator; Paulette Hinton, Senior On-Call; and Leslie Rivera, Registered Nurse. The last onsite QI visit was conducted on October 12-13, 2022.

In general, the Reviewer found that Orange County Youth and Family Services is in compliance with specific contract requirements. **The agency received an overall compliance rating of 100% for achieving full compliance with twelve out of fourteen compliance indicators** on the CINS/FINS Monitoring Tool. There were no corrective actions or recommendations as a result of the compliance 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 4-3-4-2023-2024

Agency Name: Orange County Youth and Family Services	**Monitor Name: Keith Carr, Lead Reviewer**
Contract Type : CINS/FINS	**Region/Office: 1800 East Michigan Avenue, Orlando, Florida 32806**
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.	☐	☐	☒	☐	☐	The agency meets the minimum of two staff members that have been trained to be certified as DJJ QI Peer Reviewers. The following certified peer reviewer staff includes Shashonadalyn Upson, Senior Program Manager and Angela Patton, Program Manager. Each of the aforementioned staff have participated on an onsite Quality Improvement Review during FY2023-2024.	
Additional Contracts a. Provider shall provide a listing of all current federal, state, or local government contracts, as well as other contracts entered into with for profit and not-for-profit organizations. Such a listing shall identify the awarding entity and contract start & end dates. **PTV**	☐	☐	☒	☐	☐	The agency has three Florida Department of Juvenile Justice (DJJ) contracts that include the Juvenile Assessment Center, Oaks Specialized Community Supervision Program (Oaks SCSP), and DJJ Respite. The agency has an additional contract with the Florida Department of Children and Families (DCF) that includes Great Oaks Village (GOV).	

2023-2024 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 4-3-4-2023-2024

Agency Name: Orange County Youth and Family Services	**Monitor Name: Keith Carr, Lead Reviewer**
Contract Type : CINS/FINS	**Region/Office: 1800 East Michigan Avenue, Orlando, Florida 32806**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): April 3-4, 2024**

Major Programmatic Requirements	**Explain Rating**					**Ratings Based Upon:** **I = Interview** **O = Observation** **D = Documentation** **PTV = Submitted Prior To Visit** **(List Who and What)**	**Notes** **Explain Unacceptable or Conditionally Acceptable:**
	Unacceptable	**Conditionally Unacceptable**	**Fully Met**	**Exceeded**	**Not Applicable**		
						All other contracts are funded by the FNYFS. At the time of this onsite program review, there are no contracts under corrective action.	
Limits of Coverage a. Provider shall provide and maintain during this contract, the following minimum kinds of insurance: Worker's Compensation and Employer's liability insurance as required by Chapter 440, F.S. with a minimum of $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**	☐	☐	☒	☐	☐	Documentation – Orange County, a political subdivision of the State of Florida, has an ongoing inter-local self-insurance program for workers' compensation, general liability, auto liability, and property. This program covers the employees, officials, and most of the constitutional officers of Orange County, Florida. Orange County is designated as a Qualified Self Insurer. The County self-insured property deductible is $2,500 with a $1,000,000 limit. The County also purchases commercial general liability insurance. The property program consists of several layers with several insurance carriers participating with a limit of	

2023-2024 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 4-3-4-2023-2024

Agency Name: Orange County Youth and Family Services	**Monitor Name: Keith Carr, Lead Reviewer**
Contract Type : CINS/FINS	**Region/Office: 1800 East Michigan Avenue, Orlando, Florida 32806**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): April 3-4, 2024**

Major Programmatic Requirements	**Explain Rating**					**Ratings Based Upon:** **I = Interview** **O = Observation** **D = Documentation** **PTV = Submitted Prior To Visit** **(List Who and What)**	**Notes** **Explain Unacceptable or Conditionally Acceptable:**
	Unacceptable	**Conditionally Unacceptable**	**Fully Met**	**Exceeded**	**Not Applicable**		
						$1,000,000,000. Policy effective date is 10/1/2023-10/1/2024. The County also elects to purchase excess liability coverage above and beyond the limits of the inter-local self-insurance program ($1,000,000). However, the limits of the self-insurance program and the purchasing of excess coverage should not be construed as a waiver of the County's sovereign immunity or the provisions of Section 768.28 of the Florida Statutes. The automotive insurance coverage is addressed through the County's Self-Insured Insurance coverage and exceeds all required automobile insurance limits. The Florida Network is listed as the certificate holder.	

2023-2024 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 4-3-4-2023-2024

Agency Name: Orange County Youth and Family Services	**Monitor Name: Keith Carr, Lead Reviewer**
Contract Type : CINS/FINS	**Region/Office: 1800 East Michigan Avenue, Orlando, Florida 32806**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): April 3-4, 2024**

Major Programmatic Requirements	**Explain Rating**					**Ratings Based Upon:** **I = Interview** **O = Observation** **D = Documentation** **PTV = Submitted Prior To Visit** **(List Who and What)**	**Notes** **Explain Unacceptable or Conditionally Acceptable:**
	Unacceptable	**Conditionally Unacceptable**	**Fully Met**	**Exceeded**	**Not Applicable**		
External/Outside Contract Compliance a. Provider has corrective action item(s) cited by an external funding source (Fiscal or Non-Fiscal). **ON SITE**	☐	☐	☐	☐	☒	I - During the Entrance Conference, the provider indicated that there are no outstanding corrective action item(s) cited by an external funding source.	
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**	☐	☐	☒	☐	☐	D – Fiscal Policies and Procedures are maintained in the agency's Procurement Procedures Manual that appears to be consistent with GAAP and provide for limited internal controls. The Accounting Policies and Procedures were last reviewed on September 14, 2022.	
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**	☐	☐	☒	☐	☐	D – General ledger (GL) for Department 062 (CINS/FINS) COMMUNITY AND FAMILY SERVICES FUND: 8005 CINS/FINS 14-22 for the period July 2023 through March 2024. The agency maintains a detailed general ledger with corresponding source documents.	

2023-2024 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 4-3-4-2023-2024

Agency Name: Orange County Youth and Family Services	**Monitor Name: Keith Carr, Lead Reviewer**
Contract Type : CINS/FINS	**Region/Office: 1800 East Michigan Avenue, Orlando, Florida 32806**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): April 3-4, 2024**

Major Programmatic Requirements	**Explain Rating**					**Ratings Based Upon:** **I = Interview** **O = Observation** **D = Documentation** **PTV = Submitted Prior To Visit** **(List Who and What)**	**Notes** **Explain Unacceptable or Conditionally Acceptable:**
	Unacceptable	**Conditionally Unacceptable**	**Fully Met**	**Exceeded**	**Not Applicable**		
						The general ledger is structured to track all funding sources and there is a separate GL for the CINS/FINS program and all additional FNYFS funded programs.	
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**	☐	☐	☒	☐	☐	I / D – The program is not allowed to access petty cash since supervisors and administrative assistants have credit cards to use for items that do not require a check request. The agency submitted documented evidence of the past six months, April 2022 – September 2022, of youth shelter petty cash reconciliation activity reports.	
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**	☐	☐	☒	☐	☐	I / D – Fiscal reconciliation transactions related to the CINS/FINS contract are handled by its Comptroller's office. Orange County monitors all fiscal transactions and expenditures related to children's program grants. Since the previous Compliance Monitoring review, the	

2023-2024 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 4-3-4-2023-2024

Agency Name: Orange County Youth and Family Services	**Monitor Name: Keith Carr, Lead Reviewer**
Contract Type : CINS/FINS	**Region/Office: 1800 East Michigan Avenue, Orlando, Florida 32806**
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:
						agency has not changed the practice of requiring all CINS/FINS related transactions to be processed by the OCYFS fiscal staff on a weekly basis. All expenditures and transactions processed are overseen by the agency's Medical and Mental Health Administrator.	
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**	☐	☐	☐	☐	☒	I – The agency has not purchased any items with FNYFS funds. Per the Division Program Manager, OCYFS does not have any inventory purchased with FNYFS funds.	
f. Agency submits payroll taxes and deposits (and retirement deposits as applicable), Employee IRS Form W-2 and Independent Contractors IRS Form 1099 forms prior to federal requirements. **ON SITE**	☐	☐	☒	☐	☐	D - The agency provided copies of Form 941 Employer's Quarterly Federal Tax Return for the 3rd (July, August and September) and the 4th (October, November and December) quarters of 2023. The tax payments are submitted and demonstrate that the agency submits payroll taxes to	

2023-2024 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 4-3-4-2023-2024

Agency Name: Orange County Youth and Family Services	**Monitor Name: Keith Carr, Lead Reviewer**
Contract Type : CINS/FINS	**Region/Office: 1800 East Michigan Avenue, Orlando, Florida 32806**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): April 3-4, 2024**

Major Programmatic Requirements	**Explain Rating**					**Ratings Based Upon:** **I = Interview** **O = Observation** **D = Documentation** **PTV = Submitted Prior To Visit** **(List Who and What)**	**Notes** **Explain Unacceptable or Conditionally Acceptable:**
	Unacceptable	**Conditionally Unacceptable**	**Fully Met**	**Exceeded**	**Not Applicable**		
						the appropriate authority as required. No balances due were reported on the 941s.	
g. Budget to actual reports prepared and reviewed by appropriate management. Variance from the budget are investigated and explained. **PTV/ON SITE**	☐	☐	☒	☐	☐	D - Agency provided budget-to-actual report for period 7/01/2023 – 2/01/2024 with budget, expenditures, and balance remaining for the period to date. The report tracks the expenditures for the FNYFS programs separately. The variances for both the residential and non-residential programs are reflected in the Net Income amounts.	
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**	☐	☐	☒	☐	☐	D – A copy of the annual financial audit conducted for year ending September 30, 2023 by Phil Diamond, CPA, LLP and dated, March 25, 2024. No Management Letter was required as there were no findings required to be reported in a separate management letter. A copy of the financial audit is on file with the Reviewer.	

2023-2024 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 4-3-4-2023-2024

Agency Name: Orange County Youth and Family Services	**Monitor Name: Keith Carr, Lead Reviewer**
Contract Type : CINS/FINS	**Region/Office: 1800 East Michigan Avenue, Orlando, Florida 32806**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): April 3-4, 2024**

Major Programmatic Requirements	**Explain Rating**					**Ratings Based Upon:** **I = Interview** **O = Observation** **D = Documentation** **PTV = Submitted Prior To Visit** **(List Who and What)**	**Notes** **Explain Unacceptable or Conditionally Acceptable:**
	Unacceptable	**Conditionally Unacceptable**	**Fully Met**	**Exceeded**	**Not Applicable**		
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**	☐	☐	☒	☐	☐	D – The agency Confidentiality Policy and Procedures are addressed in their HIPAA Privacy Rule Policies and Procedures and Information Technology Standards include: - Standards for In-House Servers and Server Operating Systems - Network Systems Requirements - Network Security - Wireless Local Area Network (LAN) (Ethernet) Security - Wireless Wide Area Network (WAN) Security - Externally-Hosted System Standards - Computing Center Standards All sensitive information is saved on the Universal drive and daily back-ups are made to keep data back-up current. The Program Manager reported no staff member is assigned a laptop.	

2023-2024 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 4-3-4-2023-2024

Agency Name: Orange County Youth and Family Services	**Monitor Name: Keith Carr, Lead Reviewer**
Contract Type : CINS/FINS	**Region/Office: 1800 East Michigan Avenue, Orlando, Florida 32806**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): April 3-4, 2024**

	Explain Rating						
Major Programmatic Requirements	**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:**
j. Agency provided evidence that every direct care staff employee, as of October 1, 2023, is being paid at least $19.00 per hour. This also includes funding for additional staff as approved by the Department. **ON SITE**	☐	☐	☒	☐	☐	The agency provided documented evidence of each direct care staff member's hourly rate of pay as of October 1, 2023, being paid at least $19.00 per hour.	

CONCLUSION

Orange County Youth and Family Services has met the requirements for the CINS/FINS contract as a result of full compliance with 12 applicable indicators of the Administrative and Fiscal Contract Monitoring Tool. Consequently, the overall compliance rate for this contract monitoring for applicable compliance monitoring indicators on this visit is 100%. There are no corrective actions or recommendations made as a result of the contract monitoring. Overall, the provider is performing satisfactorily in meeting the fiscal and administrative terms of its contract. In addition, all of the indicators reviewed were carried out in a manner which meets the standard as described in the report findings.

SUMMARY OF RECOMMENDATIONS

No Recommendations or Corrective Actions.

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 Orange County Youth and Family Services - Orlando
CINS/FINS 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	Satisfactory
3.07 Video Surveillance System	Satisfactory

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

Standard 4: Mental Health/Health Services

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

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

Overall Rating Summary

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

Rating Definitions

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

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

Reviewers

Members

Keith Carr – Lead Reviewer Consultant-Forefront LLC/Florida Network of Youth and Family Services
Venus Highsmith – Area Director, Nehemiah Educational & Economic Development, Inc.
Kristi Walsh – Children's Home Society of FL, Program Supervisor
Diana Davila – Counselor, Lutheran Services Florida

Methodology

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

Persons Interviewed

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

Documents Reviewed

X	Accreditation Reports	X	Table of Organization		Visitation Logs
X	Affidavit of Good Moral Character	X	Fire Prevention Plan	X	Youth Handbook
X	CCC Reports	X	Grievance Process/Records	8	# Health Records
X	Logbooks	X	Key Control Log	8	# MH/SA Records
X	Continuity of Operation Plan	X	Fire Drill Log	8	# Personnel /Volunteer Records
	Contract Monitoring Reports	X	Medical and Mental Health Alerts	8	# Training Records
X	Contract Scope of Services	X	Precautionary Observation Logs	8	# Youth Records (Closed)
X	Egress Plans	X	Program Schedules	1	# Youth Records (Open)
X	Fire Inspection Report	X	List of Supplemental Contracts		# Other: ___
X	Exposure Control Plan	X	Vehicle Inspection Reports		

Observations During Review

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

Surveys

8 # of Youth	**8** # of Direct Staff	**18** # of Community Counseling Staff

Comments

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

Monitoring Purpose

The purpose of this monitoring is to provide an annual quality improvement program review. This 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

The agency holds current accreditations with the Council of Accreditation (COA). The next COA review is scheduled for February 2025. New CINS/FINS program initiatives include partnering with schools to provide Academic Group Counseling during the summer months for youth in summer school. The focus of this initiative will be on academic success, time management, learning style, study skills, and coping skills. The program also provides families with a $25 gas gift card, Lyft or Uber gift card as an incentive for coming to counseling sessions and/or SNAP groups.

The agency's current service delivery practice models include group sessions, virtual, office, or in-home service for the provision of Family Counseling services.

The agency utilizes paper files. All information is also entered electronically into Florida Network NetMIS system and DJJ JJIS.

The CINS program also includes outreach activities such as "meet the teacher events", community events, Town Hall meetings, Mayor's activities, parent engagement events, and resource fairs.

Populations served at this agency are youth ages six to seventeen who have behavior issues, anger issues, school related issues, truancy, mental health concerns, and runaway youth. The program also provides Family and Youth Respite Aftercare Services (FYRAC), however, they have not had one FYRAC case this year.

The following programmatic updates were provided by the agency:

The management team responsible for CINS/FINS services consist of a YFS Division Manager, Senior Program Manager, Youth Shelter Program Manager, Family Counseling/SNAP Program Manager, Quality Assurance Program Manager and a Registered Nurse. At the time of this program review, staff vacancies consist of one Children's Service Counselor, two SNAP Caseworkers, seven Youth Care Workers, one Residential Services Supervisor, one Residential Counseling Services Supervisor, one Senior Children Services Counselor, three Family Teacher Assistants and one Caseworker. The agency reported significant staff changes in the last several months, including one SNAP Caseworker who promoted to Community Service Worker for SNAP for Youth. One Sr. Children Services Counselor was promoted to Counseling Services Supervisor. One Caseworker (Family Counseling) supervising Court Supervision Counselors retired after over 20 years of service.

The agency reported that the physical plant and infrastructure improvements included (internal and external) renovations to the youth shelter. The County replaced all the carpet in all offices and file room, installed new cabinetry to ensure proper storage of records, and completed roofing repairs due to inclement weather. The washer and dryer were updated to ensure a smooth process for youth when practicing independent living skills. The agency's Department of Children and Families license was granted on December 20, 2023, and shall continue until the nineteenth day of December 2024. The facility is licensed for a capacity of 20 residents.

Narrative Summary

Orange County Youth and Family Services (OCYFS) is sub-contracted with the Florida Network of Youth and Family Services (Florida Network) to provide temporary residential and non-residential services to youth and families through the Children in Need of Services/Families in Need of Services (CINS/FINS) program. The agency is located at 1758 East Michigan Street, Orlando, Florida. OCYFS serves both male and female youth in Orange and Osceola counties between the ages of ten to seventeen years for residential services and six to seventeen for community counseling services who are locked out, runaway, ungovernable and/or truant, homeless, abused, neglected, or at-risk. The program is also contracted to provide services for Staff Secure Shelter and is a provider for youth referred through the Juvenile Justice Court System for domestic violence, probation respite, domestic minor sex trafficking, and Stop Now and Plan (SNAP). The agency's accreditation by the Council of Accreditation (COA) is effective through February 28, 2025.

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

Standard 1: There are seven indicators for Standard 1. Indicator 1.01 Background Screening of Employees/Volunteers was rated **Satisfactory with Exception**, Indicator 1.02 Provision of an Abuse Free Environment was rated **Satisfactory**, Indicator 1.03 Incident Reporting was rated **Satisfactory**, Indicator 1.04 Training Requirements was rated **Satisfactory with Exception**, Indicator 1.05 Analyzing and Reporting Information was rated **Satisfactory**, Indicator 1.06 Client Transportation was rated **Satisfactory with Exception**, 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 with Exception**, Indicator 2.02 Needs Assessment was rated **Satisfactory**, Indicator 2.03 Case/Service Plan was rated **Satisfactory**, Indicator 2.04 Case Management and Service Delivery was rated **Satisfactory**, Indicator 2.05 Counseling Services was rated **Satisfactory**, Indicator 2.06 Adjudication/Petition Process was rated **Satisfactory**, Indicator 2.07 Youth Records was rated **Satisfactory**, Indicator 2.08 Specialized Additional Program Services was rated **Satisfactory**, and Indicator 2.09 Stop Now and Plan (SNAP) was rated **Satisfactory**.

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

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

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: Orange County Youth & Family Services has a written policy and procedures that meets all of the requirements. Policy # 1.01 Background Screening was last reviewed/revised on 8/1/2023, and approved by the Residential Services Supervisor.	

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: 5
Total number of 5 Year Re-screen Employee Files: 5
Staff Position(s) Interviewed *(No Staff Names)* **: Program Manager**
Type of Documentation(s) Reviewed: Clearinghouse Log, Employee Roster
Describe any Observations: All background screenings are processed by Orange County and maintained in employee's personnel file maintained offsite.

All positions providing direct services to youth has successfully passed pre-employment suitability assessment on the initial attempt.	**Compliance**	The program requires score of Medium to pass the Suitability Assessment. Five new staff files reviewed and all five met requirements. There were zero volunteers and mentors.	
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**	No prospective applicants had evidence of this occurring during their assessment and evaluation process.	
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**	No employees had a break in service.	
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**	A total of five out of five new staff members had background screenings completed prior to their hire date.	

Five-year re-screening is completed every 5 years from the date of the last screening or prior to retained fingerprints expiration date.	**Compliance**	Regarding five year re-screens, five out of five were completed prior to their 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?	**Exception**	The Affidavit of Compliance with Good Moral Character was completed and included proof of receipt from Background Screening Unit.	The Affidavit of Good Moral Character was submitted late, on 2/15/2024, due to the notice of due date was sent to an old email address of a former employee. The residential program manager did not receive notice until 2/14/2024 and completed document on 2/15/2024.
Proof of E-Verify for all new employees obtained from the Department of Homeland Security	**Compliance**	Orange County maintains personnel files and provided proof of E-Verify documents for each new employees as required.	
1.02: Provision of an Abuse Free Environment			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 1.02		**YES** If NO, explain here: Orange County Youth & family Services has a written policy and procedures that meets all of the requirements. Policy # 1.02 Provision of an Abuse Free Environment was last reviewed on 8/1/2023. It was approved by the Residential Services Supervisor.	
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** **Type of Documentation(s) Reviewed: Abuse Signs, Abuse Report Log, Grievance Forms, Grievance Boxes** **Describe any Observations: Notices were placed in common areas and youth living quarters.**			
Agency has a code of conduct of policy and there is evidence that staff are aware of agency's code of conduct.	**Compliance**	Standards of Conduct was last reviewed on August 1, 2023. One staff survey indicates staff is aware. The program also has a Code of Conduct and a Behavior Management System.	
The agency has a process in place for reporting and documenting child abuse hotline calls.	**Compliance**	A review of agency documents over the last six months was conducted. There have been a total of 16 child abuse calls in the last six months. None of the abuse reports were against staff members. They were reported to be against parents, care givers, etc. per the Program Manager.	
Youth were informed of the Abuse and Contact Number	**Compliance**	Abuse Registry notices are posted in program common areas and dormitories. Youth surveys indicate that, upon entry, youth are provided with an orientation about the program, behavior management system and all major program rules. Seven of eight youth know the abuse hotline number is available for them to report abuse at the shelter. Zero out of eight youth stated they have been stopped or delayed in making the call to the abuse hotline.	
Grievance			

The program must have an accessible and responsive grievance process for youth to provide feedback and address complaints. Program director/ supervisor will have access to and manage grievances unless it is towards themselves.	**Compliance**	The program has an accessible and responsive grievance process. Youth are allowed to provide written feedback and address complaints. The Program Manager has access to the grievances and manages responding to all reported grievances.	
Shelter only: Grievances are maintained on file at minimum for 1 year.	**Compliance**	Grievance forms are maintained by the agency for a year.	
Shelter only: There are formal grievance procedures for youth, including grievance forms, and a locked box which are easily accessible to youth in a common area.	**Compliance**	Youth have access to blank forms on each youth shelter dormitory hallway. They place completed forms into a locked grievance box in the commons living area. Only the Program Manager has the key to the locked box, which she checks daily for completed 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.	**Compliance**	The Program Manager was interviewed and she stated that she checks the grievance box daily. The Program Manager demonstrated that her key opens the locked grievance boxes.	
Shelter only: All grievances are resolved within 72 hours and documented by program director/supervisor or escalated to higher leadership if grievance involves them directly.	**Compliance**	The Program Manager stated that she resolves grievances within 24 hours.	
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: Orange County Youth & Family Services has a written policy and procedures that meets all of the requirements. Policy # 1.03 Incident Reporting and Risk Management was last reviewed on 8/1/2023 and approved by the Residential Services Supervisor.	
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)* **: Admin. Staff** **Type of Documentation(s) Reviewed: Notices/Flyers, CCC Log, Incident Reports** **Describe any Observations: Program has organized system for reporting, documenting and maintaining Incident Reports to the CCC.**			
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 Manager or Supervisors report incidents to the CCC no later than two hours after any reportable incident occurred or within two hours of the program learning of the incident.	
The program completes follow-up communication tasks/special instructions as required by the CCC	**Compliance**	The Program Manager follows up on incident reports.	
Agency internal incidents are documented on incident reporting forms and all CCC reportable incidents were consistently reported to CCC as required.	**Compliance**	Incidents are reported on incident reporting forms. There was no evidence of incidents not being reported.	

Incidents are documented in the program logs and on incident reporting forms	**Compliance**	Review of several incident reports and the program log book reflect that the CCC reports were consistently documented in the program logs and on incident reporting forms.	
All incident reports are reviewed and signed by program supervisors/ directors	**Compliance**	There were 19 incident reports for the six month review period, as follows: Program Disruption (1), Escape (2), Medical (10), Mental Health/Substance Abuse (3) and Youth Behavior (3).	
1.04: Training Requirements (*Staff receives training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions*)			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 1.04		**YES** If NO, explain here: The agency policy number is 1.0/3.01, Section 5,3,1, Training Requirements. This policy content addresses all requirements for this indicator. The policy was reviewed and signed by the Program Manager on 8/1/2023.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of New Hire Staff Files: 4 **Total number of Annual In-Service Staff Files: 4** **Total number of Non-Licensed Mental Health Clinical Shelter Staff Files: 1** **Annual Training Plan Timeframe** (*Program timeframe for annual trainings*)**: July through June following FN Fiscal Year** **Staff Position(s) Interviewed** *(No Staff Names)* **: Program Manager** **Type of Documentation(s) Reviewed: Training files** **Describe any Observations: Files were organized with a log section and separate sections for certificates or supporting verification.**			
First Year Direct Care Staff			
All direct care staff have completed new hire pre-service training requirements for safety and supervision as required.	**Compliance**	Four first year training files were reviewed. All four had the pre-service training for safety and supervision as required.	
All staff completed the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days from date of hire.	**Exception**	Four first year training files were reviewed. Three staff member files did have evidence of completing the US Department of Justice Civil Rights and Federal Funds within 30 days from date of hire.	One staff of the four first year training files did not complete the US Department of Justice Civil Rights and Federal Funds 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 first year training files have already met or exceeded the required 80 hours of training. The remaining first year staff has over 45 hours within the first four months of employment.	

All staff receives all mandatory training during the first 90 days of employment from date of hire.	**Exception**	One of the four staff completed the required training within the first 90 days of employment.	Two staff members missed Adverse Childhood Experiences (ACE) training. One of those two staff members completed training outside the 90 day required timeframe- SkillPro Civil Rights and Federal Funds, Equal Employment Opportunity, Information Security Awareness and Trauma Responsive Practices. A third staff member completed ACE outside the required 90 days 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.	**No eligible items for review**	None of the eight training files reviewed entered NIRVANA or completed data entry in the Florida Department of Juvenile Justice Information System (JJIS).	
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 program has not yet had their instructor led CINS Petition Training scheduled. Training has been requested by the agency. This training is led and delivered by the local attorney.	
Non-licensed Mental Health Clinical Shelter Staff (within first year of employment)			
Documentation of non-licensed mental health clinical staff person's training in Assessment of Suicide Risk form or written confirmation by a licensed mental health professional of training (includes date, signature and license number of the licensed mental health professional supervisor).	**Compliance**	There was one staff training file that was trained in the Assessment of Suicide Risk by the licenses mental health professional with the proper documentation.	
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**	All direct care staff completed over the 40 hours of mandatory refresher FN, SkillPro and job related required training. One first year staff only four months into her training was just shy of the 40 hours with eight months remaining.	
Required Training Documentation			
The agency has a training plan that includes all of the required training topics including the pre-service and in-service.	**Compliance**	The agency does have a training plan that includes topics for pre-service and in-service training requirements.	
The agency has a designated staff member responsible to manage all employee's individual training files and completes routine tracking and reviews of staff files to ensure compliance.	**Compliance**	The agency has designated each program supervisor to be the staff member responsible for their program staff's individual training files. The Administrative Specialist also routinely tracks and reviews training completion for compliance. Each employee's training is monitored through the County training system and is reflected in employee performance reviews.	

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**	Training logs are utilized that list the required trainings by platform where trainings were completed with the total number of hours listed. Certificates, sign-in sheets and transcripts were included for review.	
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: Orange County Youth & Family Services has a written policy and procedures that meets all of the requirements. Policy # 1.05 Analyzing and Reporting Information was last reviewed on 8/1/2023 and approved by the Residential Services Supervisor.	
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** **Type of Documentation(s) Reviewed: agendas, minutes and sign in sheets; Monthly Operational Report; Quarterly Risk Management Review forms ; Program Satisfaction Reports** **Describe any Observations: Incidents are documented, discussed and followed up.**			
Case record review reports demonstrate reviews are conducted quarterly, at a minimum	**Compliance**	The Youth & Families Services (YFS) Division produces a Community & Family Services Department Quarterly Operational Report. The Senior Program Manager compiles the Youth and Family Services Monthly Operational Report and provides it to the YFS Division Manager.	
The program conducts reviews of incidents, accidents, and grievances quarterly, at a minimum	**Compliance**	The Program Director conducts reviews of incidents, accidents and grievances as required. Program Director provides a Monthly Manager's Report to the Senior Program Manager.	
The program conducts an annual review of customer satisfaction data	**Compliance**	Program satisfaction reports were 99% satisfactory for Calendar Year 2023. The information is reviewed by Program Director.	
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**	Program reviews NetMIS 3 data and EOM report on a monthly basis for accuracy and to review status of their performance related to each program requirement.	

The program has a process in place to review and improve accuracy of data entry & collection	**Compliance**	The agency routinely reviews NetMis information entered. There are designated staff members assessing the entry of data to ensure that it is entered on time and that it is accurate and date is completed.	
There is documentation that findings are regularly reviewed by management and communicated to staff and stakeholders.	**Compliance**	The agency has evidence that documents management and designate staff are reviewing NetMIS data extracts in staff meeting minutes.	
There is evidence the program demonstrates that program performance is routinely reviewed with the Board of Directors. All final reports that include a Limited or Failed score is submitted electronically or by mail to the providers Executive Committee on the Board of Directors.	**Compliance**	The program's annual reporting of program performance is documented and submitted to the Division Manager. The Division Manager is then required to submit to the Department leadership.	
There is evidence that strengths and weaknesses are identified, improvements are implemented or modified, and staff are informed and involved throughout the process.	**Compliance**	All program performance resulted are reported to all managers, supervisors and the Leadership team of this Division. This is documented in meeting minutes.	
1.06: Client Transportation			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 1.06		**YES** If NO, explain here: The agency policy number is 1.06, Client Transportation. This policy content addresses all requirements for this indicator. The policy was reviewed and signed by the Program Manager on 8/1/2023.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Dates or Timeframe Reviewed: Last six months. **Staff Position(s) Interviewed** *(No Staff Names)* **: Program Manager.** **Type of Documentation(s) Reviewed: Administrative, personnel and insurance documents.** **Describe any Observations: See report.**			
Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	**Compliance**	All youth shelter staff members have been approved by administration through confirming that staff have a valid drivers license. All staff are designated as transportation personnel assigned to drive clients(s) in agency or approved vehicles on an as needed basis.	
Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	**Compliance**	The agency provided proof of commercial automobile insurance covering staff members assigned to drive agency vehicles for youth shelter related duties. Human resources is responsible for notifying the insurance carrier and receives authorization for all assigned drivers. The agency completes a yearly verification of all regular full-time and part-time employees' motor vehicle history to ensure all staff performing transportation duties are doing so with a valid drivers license.	

Agency's Transportation policy prohibit transporting a client without maintaining at least one other passenger in the vehicle during the trip and include exceptions in the event that a 3rd party is NOT present in the vehicle while transporting	**Compliance**	The agency transportation policy requires all client transportation events include at least one other passenger not including the driver. The policy further states the agency also must evaluate the client's and employee's recent and past behavior prior to giving consideration to allowing the youth to be transported.	
In the event that a 3rd party cannot be obtained for transport, the agency's supervisor or managerial personnel consider the clients' history, evaluation, and recent behavior	**Compliance**	The agency reviews the client's history, current assessments, evaluations and recent behavior.	
The 3rd party is an approved volunteer, intern, agency staff, or other youth	**Compliance**	All third party transport events completed by the agency were conducted with an agency staff member or client.	
The agency demonstrated evidence via logbook or other written verification that supervisor approval was obtained prior to all single youth transports.	**Compliance**	A review of the last six months of transportation logs revealed a total of 56 single client transports which were approved prior to transport by the supervisor or designee.	
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.	**Exception**	The transportation logbook consisted of documented transportation events which included the name of the driver, date, mileage, purpose of travel and location.	Six out of 56 single transport events did not document return time on the Shelter Trip Plan Form as required. The returned time is reflected on the van check-out and check-in log.
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: Program has a written policy and procedures that meets all of the requirements. Policy # 1.07 Interagency Agreements and Outreach was last reviewed on 8/1/2023 and approved by the Residential Services Supervisor.	
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)* **: Administrative Specialist, Program Manager, Division Program Manager** **Type of Documentation(s) Reviewed: NetMIS 3 Outreach Report, Outreach Activity Binder** **Describe any Observations: Program engages in a lot of outreach.**			
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**	Program Manager attends DJJ Advisory Board Meetings. Attendance is documented via notes, pictures and minutes of the meetings.	
The program maintains written agreements with other community partners which include services provided and a comprehensive referral process.	**Compliance**	The Program has written agreements with: The School Board of Orange County, Covenant House Florida Inc. and The Mustard Seed of Central Florida Inc.	

The program will maintain documentation of outreach activities and enter into NetMIS the title, date, duration (hours), zip code, location description, estimated number of people reached, modality, target audience and topic.	**Compliance**	The Program documents outreach activities and requirements appropriately in NetMIS. In past months, the program documented 47 outreach activities.	
The program has designated staff that conducts outreach which is defined in their job description.	**Compliance**	Division Program Manager is the designated staff person who conducts outreach.	
2.01 - Screening and Intake			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 2.01		**YES** If NO, explain here: The agency has a policy 2.01 Screening and Intake. The policy was last reviewed and approved by the Program Manager on August 21st, 2023.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
For Standard 2.01, nine cases were reviewed. Five out of nine were from the community counseling program. One out of those five is currently opened while the other four are closed. Four cases were reviewed from the residential program.			
Shelter youth: Eligibility screening form is completed immediately for all shelter placement inquiries.	**Compliance**	Four residential files (two open and two closed) were reviewed and the screenings were completed immediately in all four files. Four out of five community counseling files (one open and four closed) reviewed were screened within the required timeframe.	□
Community counseling: Eligibility screening form is completed within 3 business days of referral by a trained staff using the Florida Network screening form.	**Exception**	Four out of five community counseling files had evidence of the screening form being completed within three business days of referral.	One of five community counseling cases' screening form was not completed within three business days.
There is evidence all referrals for service is screened for eligibility and is logged in NetMIS within 72 hours of screening completion.	**Compliance**	A total of nine client files were reviewed, four residential files and five community counseling files. There is evidence all referrals for service being screened for eligibility and entered in NetMIS within 72 hours of the screening being completed.	
Youth and parents/guardians receive the following in writing: a. Available service options b. Rights and responsibilities of youth and parents/guardians	**Compliance**	All nine client files reviewed had parent/guardians' and youth's acknowledgement of receipt of rights & responsibilities along with service options being provided.	
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 nine client files reviewed contained evidence of parents/guardians being provided a CINS/FINS parent brochure detailing CINS/FINS services. The agency's grievance procedures are included in the intake package provided to all youth and families during the intake process.	
During intake, all youth were screened for suicidality and correctly assessed as required if needed.	**Compliance**	All client files contained evidence of being screened for suicide risk. There is evidence of completed assessments in all four residential client files.	.
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 agency has a policy 2.02 Needs Assessment. The policy was last reviewed by the Program Manager on 8/21/2023.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
This sample included nine cases. Out of those nine cases, five are from the community counseling program and four from Residential Services. Out of nine only one is currently opened in the community counseling program. All files were reviewed and documentation regarding NIRVANA is present in all files, completed on time and signed by a counselor and supervisor.			
Shelter Youth: NIRVANA is initiated within 72 hours of admission	**Compliance**	Four closed residential client file records were reviewed. The Needs Assessment was initiated within 72 hours in all four residential client file records.	
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**	Five community counseling youth records were reviewed, one open and four closed. There was evidence of a Needs Assessment being completed within two to three face-to-face sessions in all five client file records.	
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**	There was evidence of NIRVANA being completed in all nine residential and community counseling client file records reviewed.	
(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**	There is evidence of the NIRVANA Self-Assessment being completed within 24 hours of youth being admitted into shelter. No barriers to completion of the NIRVANA were noted.	
A NIRVANA Post-Assessment is completed at discharge for all youth who have a length of stay that is greater than 30 days.	**Compliance**	The agency has evidence of the NIRVANA Post-Assessment being completed at discharge for four of the five applicable youth client files that have length of stay that is greater than 30 days.	
A NIRVANA Re-Assessment is completed every 90 days excluding files for youth receiving SNAP services.	**Compliance**	The NIRVANA Re-Assessment is completed every 90 days excluding files for youth receiving SNAP services.	
All files include the interview guide and/or printed NIRVANA.	**Compliance**	All files contained evidence of the interview guide and/or printed NIRVANA.	
2.03 - Case/Service Plan			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.03		**YES** If NO, explain here: The agency has a policy 2.03 Case/Service Plan. The policy was last reviewed by the Program Manager on 8/21/2023.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			

Out of this sample of nine cases all are presented with a detailed Case plan. Goals and objectives are based in the needs reflected on NIRVANA and screening. Dates for achievement are documented as well as when the goals and objectives were completed. Case plans are signed by client, counselor and supervisor. Reviews at 30 and 60 days were completed on time.			
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**	Four open residential files and five community counseling files were reviewed. All nine client files met the criteria with case plan development within the required case plan development timeframe.	
Case/Service plan is developed within 7 working days of NIRVANA	**Compliance**	Case/Service plan is developed within seven working days of NIRVANA.	
Case plan/service plan includes: 1. Individualized and prioritized need(s) and goal(s) identified by the NIRVANA 2. Service type, frequency, location 3. Person(s) responsible 4. Target date(s) for completion and actual completion date(s) 5. Signature of youth, parent/guardian, counselor, and supervisor 6. Date the plan was initiated	**Compliance**	There is evidence in each of nine client files reviewed that the service includes individualized and prioritized need(s) based on the screening, intake and assessment. Each client file includes goals based on the NIRVANA. Each of the client files has evidence of service type, frequency, location, person(s) responsible, target date(s) for completion and actual completion date(s). Goals for court-ordered youth are also listed respectively. Each client file includes evidence of signature of youth, parent/guardian, counselor, and supervisor. Each client file includes date the plan was initiated.	
Case/service plans are reviewed for progress/revised by counselor and parent (if available) every 30 days for the first three months and every 6 months after	**Compliance**	There is documented evidence that service plans are reviewed by counselor and parent daily/weekly for residential clients and every 30 days for the first three months and every six months after for community counseling clients.	
2.04 - Case Management and Service Delivery			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.04		**YES** If NO, explain here: The agency has Policy 2.04 Case Management and Service Delivery. The policy was last reviewed by the Program Manager on 8/21/2023.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
For this standard, the sample was reviewed for referral process and service delivery. The sample of five community counseling program case progress notes were organized and well described of services rendered. Every file has proof of referrals and recommendations for clients and family. From the four cases in the residential program reviewed, case notes are completed by clinical and floor staff. Floor staff are detailed and chronologically recorded. Clinical notes are detailed and reflect services rendered to each youth.			
Counselor/Case Manager is assigned	**Compliance**	There is evidence of a counselor being assigned in each of the nine client case records.	

The Counselor/Case Manager completes the following as applicable: 1. Establishes referral needs and coordinates referrals to services based upon the on-going assessment of the youth's/family's problems and needs 2. Coordinates service plan implementation 3. Monitors youth's/family's progress in services 4. Provides support for families 5. Monitoring progress of court ordered youth in shelter 6. Makes referrals to the case staffing to address problems and needs of the youth/family 7. Accompanies youth and parent/guardian to court hearings and related appointments 8. Refers the youth/family for additional services when appropriate 9. Provides case monitoring and reviews court orders 10. Provides case termination notes 11. Provides follow-up after 30 days post discharge 12. Provides follow-up after 60 days post discharge	**Compliance**	All nine client files reviewed during the program review included evidence of applicable case management services that were provided as needed. All referrals are based on information gathered during the screening, intake and assessment phases. The progress and status of referrals made is monitored. All follow-up activities are were applicable to the five closed files reviewed. All closed files indicate that the agency provides follow-ups for 30 (four residential and one non-residential) and 60 days (three closed residential) post their respective discharge date from the agency.	
The program maintains written agreements with other community partners that include services provided and a comprehensive referral process	**Compliance**	One client case has evidence of youth being referred to individual counseling and psychological evaluation. Youth was also recommended to seek substance abuse counseling through Court Liaison.	
2.05 - Counseling Services			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.05		**YES** If NO, explain here: The agency has a policy 2.05 Counseling Services. The policy was last reviewed by the Program Manager on 8/21/2023.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Shelter Program			
Shelter programs provides individual and family counseling	**Compliance**	A review of all four residential client files revealed the shelter program has documented evidence of providing individual and family counseling.	
Group counseling sessions held a minimum of five days per week	**Compliance**	A review of all four residential client files revealed the shelter program has documented evidence of conducting group counseling sessions held a minimum of five days per week.	
Groups are conducted by staff, youth, or guests and group counseling sessions consist of : 1. A clear leader or facilitator 2.Relevant topic - educational/informational or developmental 3. Opportunity for youth to participate 4. 30 minutes or longer	**Compliance**	The agency has evidence of all four residential files receiving group counseling at least five days per week. There was documentation of group sessions for the last six months. All group sessions included documentation of groups held with the date and times of groups; length of group for at least 30 minutes; youth engagement and list of youth participants; relevant topics; and the facilitator.	

Documentation of groups must include date and time, a list of participants, length of time, and topic.	**Compliance**	The agency has evidence of group documentation of group sessions performed. Evidence includes date and times of groups; length of group for at least 30 minutes; youth engagement and list of youth participants; relevant topics; and the name of the group facilitator.	
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**	Documentation of referrals to therapeutic community-based services by program counselors was observed in all five community counseling client files reviewed.	
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**	There is documented evidence of follow-up within the required time period of 30 days or less. There is proof of coordination of services being observed in all five applicable client files.	
Maintain individual case files on all youth and adhere to all laws regarding confidentiality.	**Compliance**	An individual youth client file is maintained for each of the youth records reviewed.	
Case notes maintained for all counseling services provided and documents youth's progress.	**Compliance**	There is documented evidence of progress notes maintained in all youth records reviewed.	
On-going internal process that ensures clinical reviews of case records and staff performance.	**Compliance**	There is documented evidence of supervisor and clinical director reviewing and signing off on assessments on a consistent basis. Additionally, the review of files to demonstrate ongoing internal process of overall review of clients files for accuracy, completeness and timeliness of services being delivered to youth and family.	
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**	If applicable, the agency has a process which requires written documentation provided in the youth's file for reasons why virtual sessions are in the best interest of the youth and family.	
2.06 - Adjudication/Petition Process			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.06		**YES** If NO, explain here: The agency has Policy 2.0 Adjudication/Petition Process Counseling Services. The policy was last reviewed by the Program Manager on 8/21/2023.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			

For this indicator, a sample of two cases were reviewed-- one from the Community Counseling Program and one from the Residential Program. In both cases, case staffing was conducted. Recommendation for adjudication is reflected, files have all documentation for petition of Adjudication and hearing, as well as reports for Court.			
Must include: a. DJJ rep. or CINS/FINS provider b. Local school district representative	**Compliance**	The agency provided two applicable client files. Both files indicate that a local school district representative and DJJ representative or CINS/FINS provider attended the case staffing.	
Other members may include: a. State Attorney's Office b. Others requested by youth/ family c. Substance abuse representative d. Law enforcement representative e. DCF representative f. Mental health representative	**Compliance**	Both applicable client files included a mental health representative and other person(s) requested by youth/family. The established committee members include representatives from the youth's school district, DJJ, and program staff.	
The program has an established case staffing committee, and has regular communication with committee members	**Compliance**	The established committee members include the required representatives and program staff. An email communication is sent to the committee in advance of scheduled meetings.	
The program has an internal procedure for the case staffing process, including a schedule for committee meetings	**Compliance**	The agency is engaged with case staffings which are held on the 3rd Friday of each month to maximize participation.	
The youth and family are provided a new or revised plan for services	**Compliance**	There is evidence of the youth and family being provided a new or revised plan for services as required.	
Written report is provided to the parent/guardian within 7 days of the case staffing meeting, outlining recommendations and reasons behind the recommendations	**Compliance**	The established committee members include representatives from the youth's school district, DJJ, and program staff. Email communication is sent to the committee in advance of scheduled meetings. Notification was sent via email to the committee and youth/family more than 5 days prior to the case staffing for each youth.	
If applicable, the program works with the circuit court for judicial intervention for the youth/family	**Compliance**	There is evidence that the case staffing was initiated by the counselor in both closed case staffing files reviewed.	
Case Manager/Counselor completes a review summary prior to the court hearing	**Compliance**	There is evidence counselor completes a review summary prior to the court hearing.	
2.07 - Youth Records			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.07		**YES** If NO, explain here: The agency has Policy 2.07 Youth Records. The policy was last reviewed and approved by the Program Manager on 8/21/2023.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
There was a tour of the confidential room for the Community Counseling Program files and the Residential Program files and were observed all files were locked and marked confidential. There is a black, opaque container marked confidential utilized to transport files.			
All records are clearly marked 'confidential'.	**Compliance**	A review of the nine client files shows all records are stamped and marked confidential.	

All records are kept in a secure room or locked in a file cabinet that is marked “confidential”	**Compliance**	The agency has a confidential room located in the Community Counseling building where files are locked and marked confidential. Files are stamped confidential. The confidential room assigned to SNAP Program files is also locked and confidential.	
When in transport, all records are locked in an opaque container marked “confidential”	**Compliance**	All client files are required to be transported inside a black, opaque container marked confidential.	
All records are maintained in a neat and orderly manner so that staff can quickly and easily access information	**Compliance**	All files are organized per the agency's file format. Each file reviewed in the sample as organized in a uniform format and all areas in the file are marked and easy to locate the required information.	
2.08 - Specialized Additional Program Services			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.08		**YES** If NO, explain here: The agency has Policy 2.08 Specialized Additional Program Services. The policy was last reviewed by the Program Manager on 8/21/2023.	
Staff Secure			
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: None. **Total number of Closed Files: None.** **Staff Position(s) Interviewed (No Staff Names): None.** **Type of Documentation(s) Reviewed: None.** **Describe any Observations: None.**			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? **(If no, select rating “No eligible items for review”)**	**No eligible items for review**	The provider has not served any youth designated as meeting the criteria for staff secure since the last QI review.	
Staff Secure policy and procedure outlines the following: a. In-depth orientation on admission b. Assessment and service planning c. Enhanced supervision and security with emphasis on control and appropriate level of physical intervention d. Parental involvement e. Collaborative aftercare	**Compliance**	The agency has a detailed Staff Secure policy which addresses all the requirements of this indicator.	
Program only accept youth that meet legal requirements of F.S. 984 for being formally court ordered in to Staff Secure Services	**No eligible items for review**	At the time of this program review, the agency has not served any youth which meet the criteria to provide this specific category of residential services.	

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**	At the time of this program review, the agency has not served any youth which meet the criteria to provide this specific category of residential services.	
Agency provides a written report for any court proceedings regarding the youth's progress	**No eligible items for review**	At the time of this program review, the agency has not served any youth which meet the criteria to provide this specific category of residential services.	
Domestic Minor Sex Trafficking (DMST)			
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: None. **Total number of Closed Files: None.** **Staff Position(s) Interviewed** *(No Staff Names)* **: None.** **Type of Documentation(s) Reviewed: None.** **Describe any Observations: None.**			
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**	At the time of this program review, the agency has not served any youth which meet the criteria to provide this specific category of residential services.	
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**	At the time of this program review, the agency has not served any youth which meet the criteria to provide this specific category of residential services.	
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**	At the time of this program review, the agency has not served any youth which meet the criteria to provide this specific category of residential services.	
Services provided to these youth specifically designated services designed to serve DMST youth	**No eligible items for review**	At the time of this program review, the agency has not served any youth which meet the criteria to provide this specific category of residential services.	
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**	At the time of this program review, the agency has not served any youth which meet the criteria to provide this specific category of residential services.	
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**	At the time of this program review, the agency has not served any youth which meet the criteria to provide this specific category of residential services.	

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**	At the time of this program review, the agency has not served any youth which meet the criteria to provide this specific category of residential services.	
All other services provided to DMST youth are consistent with all other general CINS/FINS program requirements	**No eligible items for review**	At the time of this program review, the agency has not served any youth which meet the criteria to provide this specific category of residential services.	
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.*			
For this standard, four cases were reviewed. All four have evidence in the file of a pending DV charge. Data entry completed in time.			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	**Yes**	A total of four residential client files (two open and two closed) were reviewed to assess the agency's adherence to this Domestic Violence (DV) indicator.	
Youth admitted to DV Respite placement have evidence in the file of a pending DV charge	**Compliance**	All four client files reviewed have documented evidence of the youth being admitted to Domestic Violence Respite placement and have a pending DV charge in their respective client file.	
Data entry into NetMIS within (3) business days of intake and discharge	**Compliance**	All four client files reviewed have documented evidence of the youth's client information being entered into NetMIS within three business days of intake date and discharge date.	
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**	All four client files reviewed have documented evidence of the youth's length of stay in DV Respite placement not exceeding 21 days.	
Case plan in file reflects goals for aggression management, family coping skills, or other intervention designed to reduce propensity for violence in the home	**Compliance**	All four client files reviewed have documented evidence of the case plan incorporating interventions to address the key causes which resulted in the DV incident. The goals outlined in the respective plans involve addressing the intiation of outburst of anger and escalating behaviors. Each of the plans are specifically designed to include coping techniques for the youth and family to utilize in order to reduce the chances of a reoccurrence.	
All other services provided to Domestic Violence Respite youth are consistent with all other general CINS/FINS program requirements	**Compliance**	A review of the files found evidence in each case that all other collateral service the youth received is consistent with all other CINS/FINS service delivery practices.	
Probation Respite			
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			

Total number of Open Files: None. **Total number of Closed Files: None.** **Staff Position(s) Interviewed (No Staff Names): None.** **Type of Documentation(s) Reviewed: None.** **Describe any Observations: None.**			
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**	At the time of this program review, the agency has not served any youth which meet the criteria for this specific category of residential services.	
All probation respite referrals are submitted to the Florida Network.	**No eligible items for review**	At the time of this program review, the agency has not served any youth which meet the criteria for this specific category of residential services.	
All Probation Respite Referral come from DJJ Probation and there is evidence that the youth is on Probation regardless of adjudication status.	**No eligible items for review**	At the time of this program review, the agency has not served any youth which meet the criteria for this specific category of residential services.	
Data entry into NetMIS and JJIS within (3) business days of intake and discharge	**No eligible items for review**	At the time of this program review, the agency has not served any youth which meet the criteria for this specific category of residential services.	
Length of stay is no more than fourteen (14) to thirty (30) days. Any placement beyond thirty (30) days contains evidence in the file that the JPO was contacted in writing to request the need of an extension no later than the 25th day the youth was admitted into the program.	**No eligible items for review**	At the time of this program review, the agency has not served any youth which meet the criteria for this specific category of residential services.	
All case management and counseling needs have been considered and addressed	**No eligible items for review**	At the time of this program review, the agency has not served any youth which meet the criteria for this specific category of residential services.	
All other services provided to Probation Respite youth are consistent with all other general CINS/FINS program requirements	**No eligible items for review**	At the time of this program review, the agency has not served any youth which meet the criteria for this specific category of residential services.	
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: None. **Total number of Closed Files: None.** **Staff Position(s) Interviewed (No Staff Names): None.** **Type of Documentation(s) Reviewed: None.** **Describe any Observations: None.**			
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**	At the time of this program review, the agency has not served any youth which meet the criteria for this specific category of residential services.	

Youth receiving services were deemed chronically truant and/or runaway and require more intensive and lengthy services. The youth was determined to be eligible because they have gone through petition and/or case staffing and was in need of case management services.	**No eligible items for review**	At the time of this program review, the agency has not served any youth which meet the criteria for this specific category of residential services.	
Services for youth and family include: a. Two (2) direct contacts per month b. Two (2) collateral contacts per week c. Direct and collateral contacts not obtained must have documentation to support attempts made to obtain them. All reasonable attempts (at minimum of three) must be made to reach all contacts (direct and collateral) and documented in the case file and NetMIS.	**No eligible items for review**	At the time of this program review, the agency has not served any youth which meet the criteria for this specific category of residential services.	
Assessments include a. NIRVANA at intake b. NIRVANA Re-Assessment every 90 days c. Post NIRVANA at discharge as aligned with timeframe requirements	**No eligible items for review**	At the time of this program review, the agency has not served any youth which meet the criteria for this specific category of residential services.	
Service/case plan demonstrates a strength-based, trauma-informed focus	**No eligible items for review**	At the time of this program review, the agency has not served any youth which meet the criteria for this specific category of residential services.	
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**	At the time of this program review, the agency has not served any youth which meet the criteria for this specific category of residential services.	
Family and Youth Respite Aftercare Services (FYRAC)			
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: None. **Total number of Closed Files: None.** **Staff Position(s) Interviewed (No Staff Names): None.** **Type of Documentation(s) Reviewed: None.** **Describe any Observations: None.**			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	**Not Applicable**	At the time of this program review, the agency does not have a contract to provide this specific category of residential services.	
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.	**Not Applicable**	At the time of this program review, the agency does not have a contract to provide this specific category of residential services.	
Agency has evidence that all FYRAC referrals have documented approval from the Florida Network office	**Not Applicable**	At the time of this program review, the agency does not have a contract to provide this specific category of residential services.	

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.	**Not Applicable**	At the time of this program review, the agency does not have a contract to provide this specific category of residential services.	
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.	**Not Applicable**	At the time of this program review, the agency does not have a contract to provide this specific category of residential services.	
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.	**Not Applicable**	At the time of this program review, the agency does not have a contract to provide this specific category of residential services.	
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	**Not Applicable**	At the time of this program review, the agency does not have a contract to provide this specific category of residential services.	
There is evidence of completed 30 and/or 60 day follow-ups and is documented in NetMIS following case discharge.	**Not Applicable**	At the time of this program review, the agency does not have a contract to provide this specific category of residential services.	
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	**Not Applicable**	At the time of this program review, the agency does not have a contract to provide this specific category of residential services.	
Any service that is offered virtually, is documented in the youth's file why it was in the youth and families best interest.	**Not Applicable**	At the time of this program review, the agency does not have a contract to provide this specific category of residential services.	

All data entry in NetMIS is completed within 3 business days as required.	Not Applicable	At the time of this program review, the agency does not have a contract to provide this specific category of residential services.	
2.09- Stop Now and Plan (SNAP)			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.09		**YES** If NO, explain here: The agency has Policy 2.08 Stop Now and Plan. The policy was last reviewed by the Program Manager on 8/21/2023.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
For indicator, five cases were reviewed. One out of five was SNAP Clinical-Under 12 Youth. One out of five was SNAP Clinical Youth File and three from SNAP in Schools. All five file cases are well organized and documented. Data entry was completed on time.			
SNAP Clinical Groups Under 12			
Youth are screened to determine eligibility of services.	Compliance	All youth files have evidence of youth being screened to determine the eligibility of SNAP services.	
The NIRVANA was completed at initial intake, or within two sessions.	Compliance	All youth files have evidence of these cases having all NIRVANA assessment related documents being completed on intake or no more than two to three counseling sessions.	
There is evidence of the completed Child Behavior Checklist (CBCL) by the caregiver (pre and post) and is located within the file.	Compliance	All files reviewed contain documented evidence of the completed Child Behavior Checklist (CBCL) by the caregiver (pre and post) and is located in the client file.	
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	All files reviewed contain documented evidence of the Teacher Report Form (TRF) completed by the teacher (pre and post) and is located in the client file.	
There is evidence of the completed TOPSE is completed by the caregiver (pre and post) and is located within the file.	Compliance	All files reviewed contained documented evidence of having evidence of the TOPSE being completed by the caregiver (pre and post) and is located in the client file.	
SNAP Clinical Groups Under 12 - Discharge			
There is evidence of the completed SNAP Discharge Report located within the file for any discharged youth.	Compliance	All files reviewed contained documented evidence of the completed SNAP Discharge Report located within the file for any discharged youth.	
There is evidence of the SNAP Boys/SNAP Girls Child Group Evaluation Form located in the file.	Compliance	All files reviewed contained documented evidence of the SNAP Boys/SNAP Girls Child Group Evaluation Form located in the file.	
There is evidence of the SNAP Boys/SNAP Girls Parent Group Evaluation Form located in the file.	Compliance	All files reviewed contained documented evidence of the SNAP Boys/SNAP Girls Parent Group Evaluation Form located in the file.	
SNAP Clinical Groups for Youth 12-17			
Youth are screened to determine eligibility of services.	Compliance	All youth files have evidence of youth being screened to determine the eligibility of SNAP services.	
The Consent to Treatment and Participation in Research Form is completed and located within the file.	Compliance	All files reviewed contained documented evidence of consent to Treatment and Participation in Research Form in each client file.	

The NIRVANA was completed at initial intake, or within two sessions.	**Compliance**	All files reviewed contained documented evidence of the NIRVANA being completed at initial intake or within two sessions.	
There is evidence of the completed 'How I Think Questionnaire' (HIT) form located within the file or evidence of at least three (3) documented attempts in the youths' file to obtain this information.	**Compliance**	All files reviewed contained documented 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.	
There is evidence of the completed Social Skills Improvement System (SSIS) Student form located within the file or evidence of at least three (3) documented attempts in the youths' file to obtain this information.	**Compliance**	All files reviewed contained documented 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.	
There is evidence of the completed Social Skills Improvement System (SSIS) Teacher/Adult form located within the file or evidence of at least three (3) documented attempts in the youths' file to obtain this information.	**Compliance**	All files reviewed contained documented 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.	
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**	All files reviewed contained documented evidence of the program demonstrating all of the required weekly attendance sheets that included youth names and/or identifying numbers completed with the teacher and trained SNAP Facilitator signatures.	
The program maintained evidence of a completed "Class Goal" Document for the class reviewed.	**Compliance**	All files reviewed have evidence of the file with the agency maintaining evidence of a completed "Class Goal" Document for the class reviewed.	
The program maintained evidence of both pre AND post Measure of Classroom Environment (MoCE) completed documents for the class reviewed.	**Compliance**	The agency maintains evidence of both pre and post Measure of Classroom Environment (MoCE) completed documents for the class reviewed for each client file.	
The program maintained evidence of completed pre and post evaluation documents for the class reviewed.	**Compliance**	The agency maintains evidence of completed pre and post evaluation documents for the class reviewed.	
There is evidence of the fidelity adherence checklist maintained in the file for each class reviewed.	**Compliance**	The agency maintains evidence of the fidelity adherence checklist being maintained in the client file for each class reviewed.	
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: Policy 3.01, including sections 3,5,1 were last reviewed on 8/1/2023 by the Program Manager.	
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, Direct Care Worker** **Type of Documentation(s) Reviewed: Egress Plans, Inspections, drills, training certificates, log books** **Describe any Observations: Signage and postings located in common areas.**			
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**	Facility and furnishings are in good repair and free of insect infestation. The bathrooms and shower areas are free of foul odors, leaks, dust and mildew and in good working order. There was no graffiti on walls, doors or windows. Lighting is adequate for performing necessary tasks. There are detailed maps and egress plans of the facility posted in both the female and male dorm room hallway and the common area room. There are also large encased bulletin boards in all three areas with client rules, abuse hotline information and DJJ Incident reporting number. This information is also posted in the staff control room. Grievance forms are located in the hallways of both female and male dorms for easy access and the grievance box is located in the common room, just outside the control room. Interior areas did not appear to contain contraband and is free from hazardous unauthorized metal/foreign objects.	
Facility Inspection: a. All agency and staff vehicles are locked. b. Agency vehicles are equipped with major safety equipment including first aid kit, (all items in the first aid kit are current and do not have expired items; all expired items should be replaced regularly), fire extinguisher, flashlight, glass breaker and, seat belt cutter.	**Compliance**	All agency and staff vehicles were locked upon inspection. The agency has three 2020 Toyota Sienna Vans that are equipped with all of the required safety equipment. Each has a first aid kit with an expiration date of 2025, fire extinguishers last inspected February 2024, flashlights, and a glass punch and seatbelt cutter. Vans are maintained by the County and are in excellent shape.	

Facility Inspection: All chemicals are listed, approved for use, inventoried weekly and perpetually, stored securely and Material Safety Data Sheets (MSDS) are maintained on each item (minimum 1 time per week or per agency policy). A perpetual inventory will be the primary means of maintaining a current and real-time inventory. The weekly inventory will be conducted weekly at a minimum to ensure that a perpetual inventory is being maintained consistently and accurately. If more than one location is used to store chemicals, there is an inventory wherever chemicals are stored that is current and well maintained unless previously approved by the Network.	**Compliance**	The facility uses a select list of chemicals that are stored in the common room in a locked cabinet. The program maintains a binder that has a MSDS for each of these chemicals which are inventoried weekly and perpetually after each use. The perpetual inventory is then cross referenced with the weekly inventory to check for accuracy.	
Facility Inspection: Washer/dryer are operational & general area/lint collectors are clean. Agency has a current DCF Child Care License which is displayed in the facility. Each youth has own individual bed with clean covered mattress, pillow, sufficient linens and blanket. Youth have a safe, lockable place to keep personal belongings, if requested.	**Compliance**	The facility inspection revealed an operational washer and dryer, lint free with the area around them to be clean. All bedding is clean and contains all necessary sleeping items. The agency provides ample space for personal belongings that are secure.	
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**	Date of current Fire inspection by the County was conducted on October 24, 2023 and there were no violations documented. Fire safety equipment inspection(s): March 5, 2024. All annual fire safety equipment inspections are valid and up to date. This includes the extinguishers, sprinklers, alarm system (3/12/24) and kitchen overhead (3/5/2024). There is evidence of fire drills being conducted on First Shift: 10/9/23, 11/29/23, 12/14/23, 1/30/24, 2/8/24, 3/29/24. Second Shift: 10/13/23, 11/25/23, 12/10/23, 1/28/24, 2/18/24, 3/4/24. Third Shift: 10/13/23, 11/25/23, 12/30/23, 1/30/24, 2/9/24, 3/29/24. There is evidence of the agency conducting Mock Emergency drills on 1st Shift:12/12/23 second quarter, no drill third quarter 2nd Shift: 12/12/23 second quarter, 2/8/24 third quarter, 3/4/24 third quarter. As applicable, 3rd Shift: 12/15/23 second quarter, 1/16/24 third quarter. □ □	There was no evidence of a drill conducted during the first shift in the third quarter.

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**	There is evidence of the most recent inspection date and any comments being conducted on 10/24/2023. No violations noted at the time of the inspection.	
Youth Engagement			
a. Youth are engaged in meaningful, structured activities (e.g., education, recreation, counseling services, life and social skill training) seven days a week during awake hours. Idle time is minimal. b. At least one hour of physical activity is provided daily. c. Youth are provided the opportunity to participate in a variety of faith-based activities. Non-punitive structured activities are offered to youth who do not choose to participate in faith-based activities. d. Daily programming includes opportunities for youth to complete homework and access a variety of age appropriate, program approved books for reading. Youth are allowed quiet time to read. e. Daily programming schedule is publicly posted and accessible to both staff and youth.	**Compliance**	Youth have a structured schedule for Monday through Friday and a different schedule for the weekend. Schedule includes school, recreation, counseling, groups (including life skills) and outings if planned. There is a volleyball court, basket ball court and swing set that the youth enjoy on the campus. Faith-based activities are to be participated in with the parent/guardian. There are no faith-based activities on the County shelter campus. Youth can request to engage in and/or participate in faith-based activities. Time is provided after daily group for reading. Most homework is completed at the school on site. Daily program schedule is posted in the common room and on the walls in both the boys and girls dorms.	
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 agency has written policies and procedures that address the program Orientation process that was reviewed and approved by the Program Manager on 8/1/2023.	

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

Total number of Open Files: 3
Total number of Closed Files: 3
Staff Position(s) Interviewed *(No Staff Names)* **: Residential Supervisor.**
Type of Documentation(s) Reviewed: Client files.
Describe any Observations: See report.

Youth received a comprehensive orientation and handbook provided within 24 hours	**Compliance**	A total of six client files were reviewed, three open and three closed residential client files. All six files indicated the youth received an orientation and a handbook within 24 hours of intake.	
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**	There is evidence of all six client files indicating each have been provided information on all requirements of the orientation process. Each youth record includes an orientation checklist that consists of all items required to be completed during orientation.	
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**	There is evidence of documentation that the orientation checklist completed during intake is maintained in each youth record reviewed. The checklist is signed by the youth and staff member working with the youth to deliver the orientation.	
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 shelter has two written policies and procedures in place that include Initial Classification of Youth and Room Assignments, both of which were reviewed and approved by the Program Manager on 8/1/2023.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: 3 **Total number of Closed Files: 3** **Staff Position(s) Interviewed (No Staff Names): Residential Supervisor.** **Type of Documentation(s) Reviewed: Client files.** **Describe any Observations: See report.**			
A process is in place that includes an initial classification of the youths, to include:			

a. Review of available information about the youth's history, status and exposure to trauma b. Initial collateral contacts, c. Initial interactions with and observations or the youth d. Separation of younger youth from older youth, e. Separation of violent youth from non-violent youth f. Identification of youth susceptible to victimization g. Presence of medical, mental or physical disabilities h. Suicide risk i. Sexual aggression and predatory behavior j. Acute health symptoms requiring quarantine or isolation	**Compliance**	A review of six client files were reviewed. Three are open and three are closed. All of the requirements of the indicator were verified across all six files as observed on the CINS/FINS Intake form completed for each youth.	
An alert is immediately entered into the program's alert system when a youth is admitted with special needs and risks such as risk of suicide, mental health, substance abuse, physical health or security risk factors	**Compliance**	All six client files were reviewed. All client files have designated alerts. Of the six client files, three were observed to include the youth with alerts in all required areas.	
3.04 - Log Books			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 3.04		**YES** If NO, explain here: The agency has a Logbook Policy. The policy is documented as being reviewed and approved by the Program Manager on 5/16/2023.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Dates or Timeframe Reviewed: November 2023 to April 2024 **Staff Position(s) Interviewed** *(No Staff Names)* **: Program Manager** **Type of Documentation(s) Reviewed: Logbooks** **Describe any Observations: Detailed entries meeting documentation requirements.**			
Log book entries that could impact the security and safety of the youth and/or program are highlighted	**Compliance**	The program has a system in place for communicating safety and security issues in the logbook by highlighting according to issue such as pink for medical and green for AWOL/runaway youth. Also, highlighted are important notifications and supervisory reviews.	
All entries are brief, legibly written in ink and include: • Date and time of the incident, event or activity • Names of youth and staff involved • Brief statement providing pertinent information • Name and signature of person making the entry	**Compliance**	All entries have date/time, names of youth and staff involved, brief statement of pertinent information and signature of the person making the entry.	
Recording errors are struck through with a single line. The staff person must initial and date the correction. The use of whiteout and erasures is prohibited.	**Compliance**	Errors are addressed with a strike through with a single line and initialed by staff with the date. No whiteout was found in logbooks and all entries were made in ink with no erasures.	

The program director or designee reviews the facility logbook(s) every week and makes a note chronologically in the logbook indicating the dates reviewed and if any correction, recommendations and follow-up are required and sign/date the entry	**Compliance**	Different logbooks were reviewed and it confirmed that both the Shelter Manager and the Sr. Children's Services Counselor conducted routine logbook reviews and made an entry of the logbook review, dated and indicated the dates reviewed.	
All staff review the logbook of the previous two shifts and makes an entry signed and dated into the logbook indicating the dates reviewed	**Compliance**	Direct care staff members consistently document their review of the logbook at the beginning of each shift for the previous two shifts and sign and date 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.	**Compliance**	The Program Manager notes review of the time period as evidenced by date/signature. The Program Manager noted findings, comments of findings or trends (such as a reminder to put a heading on the top page).	
Logbook entries include: a. Supervision and resident counts b. Visitation and home visits	**Compliance**	Activity of youth including escorted or coming/going from the facility are documented in the logbook. Location and counts of the youth in the facility are on a different log kept in the control room. Visitation and home visits are clearly documented along with the intakes and discharges.	
3.05 - Behavior Management Strategies			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 3.05		**YES** If NO, explain here: The agency has a policy entitled 3.05 Behavior Management Strategies and a policy titled Crisis and Behavioral Intervention. Both policies were last reviewed on and approved by the Shelter Program Manager on 3/12/2023.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Staff Position(s) Interviewed *(No Staff Names)* **: Program Manager and Residential Supervisor.** **Type of Documentation(s) Reviewed: Client files.** **Describe any Observations: See report.**			
The program has a detailed written description of the BMS and it is explained during program orientation	**Compliance**	The agency has a Behavior Management System (BMS) and is detailed in the client handbook and the handbook is provided during orientation.	
Behavior Management Strategies must include:			

a. BMS is designed to teach youth new behaviors and help youth understand the natural consequences for their actions b. Behavioral interventions are applied immediately, with certainty, and reflect the severity of the behavior c. BMS uses a wide variety of awards/incentives to encourage participation and completion of the program d. Appropriate consequences and sanctions are used by the program and consequences for behavior are logical and designed to promote skill-building for the youth e. Counseling, verbal intervention and de-escalation techniques are used prior to physical intervention (Only techniques approved by the Florida Network and DJJ are used if physical intervention is required) f. Only staff discipline youth. Group discipline is not imposed g. Room restriction is not used as part of the system or for youth who are physically and/or emotionally out of control h. Youth should never be denied basic rights such as meals, clothing, sleep, services, exercise, or correspondence privileges	**Compliance**	The agency utilizes a Behavioral Management System (BMS) strategy that is based upon assessment of the youth's behavior, decision-making, interaction with others and cooperating with others. The BMS includes positive reinforcement and logical consequences. All of the client files reviewed include evidence that youth are provided orientation and information on the BMS during orientation/intake process. The agency provides the youth BMS handbook which informs the youth of the process and all the guidelines of the BMS system. The program is able to offer a broad array of incentives for the youth and uses appropriate interventions to teach the youth new behaviors and to help youth to understand natural consequences and positive decision-making.	
Program's use of the BMS			
All staff are trained in the theory and practice of administering BMS rewards and consequences	**Compliance**	The agency provided proof of delivering training on the BMS. The agency delivers training during orientation. Training files for four new hires were reviewed and are evident in each file. The agency utilizes a process to review each employee and support them in effective execution of the BMS.	
There is a protocol for providing feedback and evaluation of staff regarding their use of BMS rewards and consequences	**Compliance**	The agency reviews each staff member's application of the BMS. The supervisor conduct staff meetings which the use of the BMS is included and the effective execution of the behavior management system, as well as positive and negative consequences for youth.	
Supervisors are trained to monitor the use of rewards and consequences by their staff	**Compliance**	The agency requires both the Shelter Program Manager and Supervisor to monitor the direct care staff's use of the BMS. Both of these positions have received BMS training and monitoring of its use of rewards and consequences and coaching staff to use the BMS as designed.	
3.06 - Staffing and Youth Supervision			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 3.06		**YES** If NO, explain here: The agency has multiple policies titled Safety, Health, and Welfare of Clients; Work Schedule and OT; and Staff Coverage and Ratios. These policies were reviewed and approved by the Program Manager on 8/1/2023.	

Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Dates or Timeframe Reviewed: Last six months. **Staff Position(s) Interviewed** *(No Staff Names)* **: Residential Supervisor.** **Type of Documentation(s) Reviewed: Staff schedule.** **Describe any Observations: See report.**			
The program maintains minimum staffing ratios as required by Florida Administrative Code and contract. • 1 staff to 6 youth during awake hours and community activities • 1 staff to 12 youth during the sleep period	**Compliance**	A review of staff member schedules was conducted over the past six months. A review of the current youth census was conducted. A review of randomly selected days of camera views were also conducted to assess the agency's adherence to the requirements of this indicator. All schedules, census and camera views indicated the agency met minimum staff ratio requirements across all work shifts as required.	
All shifts must always provide a minimum of two direct care staff present that have met the minimum training requirements	**Compliance**	A review of the current staff practice was conducted via the assessment of schedules, video and staff training files. The presence of a minimum of two staff being present as required was supported by staff schedules and video surveillance. All staff on duty have evidence of received required trainings.	
Program staff included in staff-to-youth ratio includes only staff that are background screened and properly trained youth care workers, supervision staff, and treatment staff	**Compliance**	All staff listed on the program roster maintain eligible background screenings. Additionally, all staff on the program roster have received training as required. As it relates to new hires, specific training is conducted for these new staff members during onboarding prior to working with youth.	
The staff schedule is provided to staff or posted in a place visible to staff	**Compliance**	The staff member schedule is accessible in the staff office.	
There is a holdover or overtime rotation roster which includes the telephone numbers of staff who may be accessed when additional coverage is needed	**Compliance**	The staff member schedule is accessible in the staff office with contact information.	
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**	Staff conducted youth checks at least every 15 minutes on most occasions. Room check times were documented in real time as evidenced by the "Accountability Log". There is a male dorm side and female dorm side with four bedrooms each with the ability to house 10 female and 10 male youth. Three of the bedrooms in each dorm have two beds with one having four beds. Date of camera views are 3/29/24 Boy's Hall 12am-2:30am. 3/11/24 Girls Hall 10pm-1am. 2/24/2024Boy's Hall 3am-6am. Counts on two days are accurate.	There are missing bed checks on one of the three randomly selected nights, while youth were in their sleeping rooms. These missed checks were not documented as being conducted. One night of bed checks are beyond the 15 minute checks for the night of 2/24/2024. Specifically, 3:21am -3:54am missing counts at 3:35 and 3:50am. These missed checks were not documented as being conducted.
3.07 - Video Surveillance System			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 3.07		**YES** If NO, explain here: The agency has Policy 3.07 Safety, Health and Welfare of Clients. The policy was last reviewed by the Program Manager on 8/1/2023.	

Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Dates or Timeframe Reviewed: Last 30 days. **Staff Position(s) Interviewed** *(No Staff Names)* **: Residential Supervisor.** **Type of Documentation(s) Reviewed: Video camera footage.** **Describe any Observations: See report.**			
Surveillance System			
The agency, at a minimum, shall demonstrate: a. A written notice that is conspicuously posted on the premises for the purpose of security b. System can capture and retain video photographic images which must be stored for a minimum of 30 days c. System can record date, time, and location; maintain resolution that enables facial recognition d. Back-up capabilities consist of cameras' ability to operate during a power outage e. Have cameras placed in interior (e.g. intake office, counseling office, cafeteria, day room) and exterior (e.g. entrance/exit, recreation area, parking lot) general locations of the shelter where youth and staff congregate and where visitors enter and exit; to include locations where youth searches are conducted. Cameras are never placed in bathrooms or sleeping quarters. f. All cameras are visible	**Compliance**	The agency has cameras in common areas that are visible. No cameras are placed in private or sleeping areas. The video system is capable of operating during an outage. The agency has a back-up generator in place in the event of a power outage for the entire youth shelter. The shelter has a video surveillance system which operates 24 hours a day, 7 days a week. The video system can capture and retain video photographic images for a minimum 30 days. During the shelter tour it was observed that there are visible postings in general areas which notes that video surveillance is operating on campus for the purpose of security. Cameras were observed in the interior, exterior and general locations of the shelter where youth and staff congregate as well as where visitors enter and exit. The camera system can record the date, time, and location and maintain a resolution that enables facial recognition.	
A list of designated personnel who can access the video surveillance system is maintained (includes off-site capability per personnel)?	**Compliance**	The shelter has a list of designated supervisors and managers authorized to access the video camera surveillance system.	
Supervisory review of video is conducted a minimum of once every 14 days and timeframes reviewed are noted in the logbook.	**Compliance**	The agency's Program Manager documents all reviews of the video camera sessions completed. The Program Manager documents the date, time frame reviewed and any findings. The Program Manager also provides detailed items to be followed up on by Supervisors and Leads.	
The reviews assess the activities of the facility and include a review of random sample of overnight shifts	**Compliance**	The agency's management and supervisory staff conduct reviews on a two week cycle. All review periods and specific days on the overnight and day shifts are randomly selected.	
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 process for third party reviews of video recordings after a request from quality improvement visits or when an investigation is pursued after an allegation of an incident.	
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**	At the time of this onsite program review, all video camera views are working and fully operational. The agency reports no repair orders have been issued.	
4.01 - Healthcare Admission Screening			**Satisfactory with Exception**
		YES	

Provider has a written policy and procedure that meets the requirement for Indicator 4.01		If NO, explain here: The agency has Policy 4.01/Healthcare. This policy was last reviewed and approved by the Program Manager on 8/1/2023.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files:			
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	**Exception**	Four closed residential files and four open files were reviewed to assess the agency's adherence to the requirements of this indicator. There is documented evidence in each client file which indicates all areas associated with screening for past and current acute health and medical issues were administered to each client as required. Some files have evidence of health screening forms being reviewed by the supervisor or manager as required.	Three of the eight files did not have evidence of health screenings being reviewed by the Registered Nurse.
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**	Of the files reviewed, no youth had an existing medical issue which required a follow up referral to ensure proper medical care.	
When needed, the parent is involved with the coordination and scheduling of follow-up medical appointments	**No eligible items for review**	Parental/guardian follow-up for medical appointments was not applicable for all eight client file records reviewed.	
All medical referrals are documented on a daily log.	**No eligible items for review**	None of the records reviewed required a medical referral.	
The program has a thorough referral process and a mechanism for necessary follow-up medical care as required and/or needed	**Compliance**	The agency has a protocol and process for ensuring proper medical care is provided as required. All medical and health needs are identified and tracked to ensure to appropriate methods of supervision are applied and all follow-up needs are met.	
4.02 - Suicide Prevention			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 4.02		**YES** If NO, explain here: The agency has a Policy 4.02/Suicide Prevention. This policy was last reviewed and approved by the Program Manager on 8/1/2023.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			

Total number of Open (Residential & Community) Files: 3 Residential. **Total number of Closed (Residential & Community) Files: 1 Residential and 2 Community Counseling.** **Staff Position(s) Interviewed** *(No Staff Names)* **: Residential Supervisor.** **Type of Documentation(s) Reviewed: Client files.** **Describe any Observations: See report.**			
Suicide Risk Screening and Approval (*Residential and Community Counseling*)			
Suicide risk screening occurred during the initial intake and screening process. Suicide screening results reviewed and signed by the supervisor and documented in the youth's case file.	**Compliance**	A total of six client file records were reviewed. All six files have evidence of the youth receiving a suicide risk screening during the initial intake and screening process and the results were reviewed and signed by the supervisor and documented in the respective client record.	
The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	**Compliance**	The agency's suicide risk process and protocols have been previously approved by the FNYFS. The agency has not changed their review process since the last onsite program review.	
Supervision of Youth with Suicide Risk *(Shelter Only)*			
Youth are placed on the appropriate level of supervision based on the results of the suicide risk assessment.	**Compliance**	All four residential clients were placed on the appropriate level of supervision based on the results of the suicide risk assessment. In all four clients, there was evidence clients remained on constant or one-on-one sight and sound supervision until each were assessed and reviewed by the licensed clinician.	
Staff person assigned to monitor youth maintained one-to-one supervision or constant supervision and documented his/her observations of the youth's behavior at 30 minute or less intervals	**Compliance**	The agency utilizes a client close watch observation sheet that documents all obeservations conducted at 30 and 15 minuted intervals. All six client files have evidence of documenting observation checks at the designated intervals. All workshifts have documentation of the supervisor verifying the checks conducted on their respective shift.	
Documentation includes the time of day, behavioral observations, any warning signs observed, and the observers' initials and was maintained in either an observation log or in the shelter daily log.	**Compliance**	All four youth placed on sight and sound close watch supervision had observation logs reflecting staff efforts to document the status of the youths' behavior, activities, etc. at least once every fifteen minutes across all work shifts.	
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**	The youth placed on observation did not have their supervision status changed unless directed to do so by the licensed clinician. All changes in status are documented in real-time in the agency logbook.	
There was evidence that documentation was reviewed by supervisory staff each shift. If program uses an observation log, completed logs are maintained in the youth's file.	**Compliance**	All close watch supervision observations are documented in the agency program logbook and all observation sheets are reviewed by the supervisor on shift or Program Manager.	
Youth with Suicide Risk *(Community Counseling Only)*			
Youth identified for suicide risk during intake was immediately assessed by a licensed professional or non-licensed professional (under the direct supervision of a licensed mental health professional) and the parents and supervisor were both notified of the results.	**Compliance**	A total of two clients were screened positive for suicide risk. Both clients were referred to local mental health receiving facilities to receive follow-up assistance. In each case, a parent/guardian was present and notified of the results.	

During the intake, if the appropriate staff is unavailable, youth identified for suicide risk was immediately referred by the provider and the parent/guardian is notified of the suicide risk findings disclosed and advised that an Assessment of Suicide Risk should be completed ASAP by a licensed professional.	**No eligible items for review**	Both clients were screened and parent/guardian were notified and immediately referred to a local mental health agency.	
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**	Parents/guardians were provided information right away on locating resources to assist them on a safety plan. All clients were provided guidance on implementing a safety plan and on additional signs and recognizing additional risks on how to assist their child.	
If the parent/guardian cannot be contacted, all efforts to contact them are documented in the case file.	**Compliance**	Both clients were screened and parents/guardians were notified.	
When the screening was completed during school hours on school property, the appropriate school authorities were notified.	**Not Applicable**	Both clients were seen at the office location and not at their respective school.	
4.03 - Medications			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 4.03		**YES** If NO, explain here: The agency has Policy Medication: Ordering and Distribution, Storage, Access, Inventory and Disposal. The policy was last reviewed and approved by the Program Manager on 8/1/2023.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: 2 **Total number of Closed Files: 3** **Staff Position(s) Interviewed** *(No Staff Names)* **: Residential Supervisor.** **Type of Documentation(s) Reviewed:** **Describe any Observations: See report.**			
The agency has a Registered Nurse (RN) and/or a Licensed Practical Nurse (LPN) that is being supervised by RN and all of their credentials have been verified.	**Compliance**	Agency has a Registered Nurse (RN) that oversees the entire medication distribution process. The agency filled the part-time RN vacancy on 9/18/2023. The RN holds a part-time schedule for Monday evening, Wednesday and Friday morning. All credentials are verified by personnel department and license onsite.	

The agency has evidence of the following for all non-nursing shelter staff designated to assist with the self-administration of medication: a. Documentation of in-person self-administration of medication distribution training provided by a Registered Nurse b. Evidence demonstrating their competency to assist with self-administration of medication distribution c. Maintenance of their annual medication training re-certification	**Compliance**	The agency has a RN and a Medication Administration Approved Personnel list of 10 designated staff members assigned to assist with the self-administration of medication. The agency requires that the RN delivery and oversee all training and re-training of non-licensed staff members. The RN requires a designated level of proficiency in order to be authorized to give medication to clients. The RN also conducts intermittent reviews of practice of each staff member and conducts all training and re-certifications.	
The agency held at least quarterly staff meetings conducted by RN and/or Shelter Manager to review and assess: a. strategies implemented to reduce medication errors shelter wide b. analyze factors that contributed to medication errors c. allow staff the opportunity to practice and role-play solutions	**Compliance**	The agency conducts monthly and quarterly staff meetings conducted by the RN and/or Shelter Manager to review and assess the status of medication distribution. There was evidence of the most recent meeting which discussed medication practice on the 4th Tuesday of the month. The most recent meeting minutes discussed no distractions in March 2024. The agency has internal practices to address review and practice and all errors in the distribution of medication. The agency has a training model which supports the ability for staff members to practice and role-play prior to distribution medication to clients.	
The agency has strategies implemented to ensure medications are provided within the 2-hour time frame.	**Compliance**	The agency maintains a protocol of one hour prior and no more than one hour after the prescribed medication distribution time to ensure that the staff members are aware of the two hour time.	
All non-licensed staff members are clearly identified and designated on the staff schedule and shift change report/shift responsibility form for assisting with the self-administration of medications on each shift	**Compliance**	All staff qualified to distribute medications are listed on the staff schedule as the party responsible for distributing medication across each work shift.	
The agency has clear methods of communicating which youth are on medications with the times and dosage easily discernable by all staff on each shift.	**Compliance**	The agency utilizes a system that includes a binder with all clients required to receive prescribed medications. The binder includes medication forms specific to each child and their respective medication distribution instructions including type, dosage, time regimen.	
The delivery process of medications is consistent with the FNYFS Medication Management and Distribution Policy and the agency has an internal quality assurance process to include the following: a. to ensure appropriate medication management and distribution methods b. to track medication errors c. to identify systemic issues and implement mitigation strategies, as appropriate.	**Compliance**	The agency's process is consistent with the FNYFS medication distribution process. The controls involve the agency utilizing a quality control process for proper distribution, tracking errors, and identify issues with non-licensed staff assisting with the delivery of medication to clients. The RN, management and supervisors develop the interventions and corrective actions to address below standard performance issues.	
Admission/Intake of Youth □			

a. Upon admission, the youth and parent/guardian (if available) were interviewed by the Registered Nurse (when on-site) about the youth's current medications as part of the Medical and Mental Health Assessment screening process and/or an interview was conducted by the RN within three (3) business days if the RN was not on the premise at admission. **If the agency does not have a RN, there was a medication review conducted by a certified Leadership position.* b. Upon intake/admission, there is evidence that the on-shift certified supervisor of higher level staff did review all medication forms by the next business day.	**Compliance**	The agency has a RN and Medication Administration Approved Personnel list of 10 designated staff members assigned to assist with the self-administration of medication. The RN interviews parent(s)/guardian(s), and when the RN is not on duty, staff member gather information during the health screening process regarding the status of each youth and their respective medications that each are currently being prescribed. If the RN is off duty, the RN or other supervisory/managerial staff interviews the client within 72 hours regarding medication status and all requirements. Across the five files, there is evidence that each has been reviewed by the RN or other supervisor.	
Medication Storage			
a. All medications are stored in a Pyxis ES Medication Cabinet that is inaccessible to youth (when unaccompanied by authorized staff) b. Pyxis machine is stored in accordance with guidelines in FS 499.0121 and policy section in Medication Management c. Oral medications are stored separately from injectable epi-pen and topical medications d. Medications requiring refrigeration are stored in a secure refrigerator that is used only for this purpose, at temperature range 2-8 degrees C or 36-46 degrees F. (If the refrigerator is not secure, the room is secure and inaccessible to youth.) e. Narcotics and controlled medications are stored in the Pyxis ES Station f. Pyxis keys with the following labels are accessible to staff in the event they need to access medications if there is a Pyxis malfunction: a TOP COVER b BACK PANEL- LEFT TALL CABINET LOCK- LEFT, c BACK PANEL- RIGHT TALL CABINET LOCK- RIGHT	**Compliance**	The agency secures prescription medications and all over-the-counter medications in separate locked, cubed compartments in the cabinet. The medication cabinet is housed in the direct care staff office. The program has a locked medication refrigerator. At the time of this onsite program review, the refrigerator was empty and only used for medications requiring cold storage and is set between 36-40 degrees. The medication cabinet can maintain the current count, medication type and inventory. All keys to the medication cabinet are housed in the direct care staff office.	
Medication Distribution			

a. Agency maintains a minimum of 2 site-specific System Managers for the Pyxis ES Station b. Only designated staff delineated in User Permissions have access to secured medications, with limited access to controlled substances (narcotics) c. A Medication Distribution Log shall be used for distribution of medication by non-licensed and licensed staff d. Agency verifies medication using one of three methods listed in the FNYFS Policies & Procedures Manual e. When nurse is on duty, medication processes are ALWAYS conducted by the nurse or when the nurse is not onsite, then the designated staff who has been trained by a licensed Registered Nurse provides the medication. f. Agency does not accept youth currently prescribed injectable medications, except for epi-pens h. Non-licensed staff have received training in the use of epinephrine auto-injectors provided by a registered nurse	**Compliance**	The agency has a RN and a Medication Administration Approved Personnel list. This list consist of the RN and 10 designated staff members assigned to assist with the self-administration of medication. Only the staff members on the aforementioned list can have access to all prescribed medication. When on-site, the RN conducts medication administration duties. When the RN is not on-site, non-licensed certified staff dispense medication. The agency utilizes a medication distribution log to document the process when giving medication. The agency uses one of the three medication verification processes. The agency does not accept youth in need of a prescribed injectable medication, unless it is an epi-pen. All non-licensed staff members do receive training in the use of epi-pens. This traing is provided by the RN.	
The medication distribution log documentation includes: a. the time of medication administration b. evidence of youth initials that the dosage was given□ c. evidence of staff initials that the dosage was given□	**Compliance**	The current medication distribution log includes date, time and person assisting in the delivery of medication to each client assigned prescribed medication during their shelter stay.	
There is evidence that staff provide youth with medications within one hour of the scheduled time of delivery as ordered by the medication. Documentation is provided for instances this does not occur within the required timeframe.	**Compliance**	A review of five client files onsite found evidence that all youth received their medications on time and within one hour of the scheduled time of delivery as ordered by the medication. No youth received medications beyond the medication distribution time.	
During the review period, there were no instances where youth missed their medication due to failure to open the pyxis machine.	**Compliance**	At the time of this onsite program review, all residents with prescribed medications received over the last six months did not have a missed medication distribution session due to failure to open the medication cabinet.	
If applicable: Any staff member deemed responsible for a medication error, there was evidence that the staff member received refresher training from an RN and demonstrated competency prior to being assigned future medication administration responsibilities. There is evidence that any staff member deemed responsible for 3 errors within a 1-year time frame, had their certification suspended and was not recertified until the completion of the full **in-person** medication administration training, demonstrating competency and re-certification from an RN.	**Compliance**	During the month of January 2024, the program had a total of two errors, when previously only one error occurred within six months between July 2023 and December 2023. When an mediation error occurs an incident is filed. The RN investigates and reviews incident. The RN provided re-training and observed practice for the intended correction regarding the aforementioned errors. The RN designated the date when the staff member resumed duties of assisting in the delivery of medication.	
Medication Inventory			

a. For controlled substances, a perpetual inventory with running balances is maintained as well as a shift-to shift count verified by a witness and documented b. Over-the-counter medications that are accessed regularly and inventoried weekly c. Syringes and sharps (needles, scissors, etc.) are secured, and counted and documented weekly	**Compliance**	The agency conducts daily and weekly checks of prescribed medications. The agency conducts shift-to-shift counts on all controlled medications. This is documented in the medication cabinet as required. A review of documentation indicated the nurse conducts a minimum weekly inventory of the over-the counter medications. The agency had evidence of all sharp counts being conducted over the review period. All sharps are secured as required.	
There are monthly reviews of the Pyxis reports to monitor medication management practice.	**Exception**	At the time of this onsite program review, there was no evidence of Pyxis report being produced on a monthly basis.	The agency is not conducting monthly reviews of the agency's ongoing medication management practice via the Pyxis knowledge portal.
Medication discrepancies are cleared after each shift.	**Compliance**	The agency requires staff members to clear all medication discrepancies on a daily basis. At the time of this program review, there were no discrepancies.	
4.04 - Medical/Mental Health Alert Process			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 4.04		**YES** If NO, explain here: The agency has Policy 4.04 Alert Procedures. The policy was last reviewed and approved by the Program Manager on 8/1/2023.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: 4 **Total number of Closed Files: 4** **Staff Position(s) Interviewed** *(No Staff Names)* **: Residential Supervisor.** **Type of Documentation(s) Reviewed: Client Files.** **Describe any Observations: See report.**			
Youth with a medical, mental health, or food allergy was appropriately placed on the program's alert system	**Compliance**	A review of eight residential client files was conducted to determine the agency's adherence to the requirements of this indicator. All eight client files had evidence of screening for medical, mental health or food allergies. When an applicable alert was identified, the alert is properly marked in each client's file.	
Alert system includes precautions concerning prescribed medications, medical/mental health conditions	**Exception**	The agency's general alert system includes alerts for medications and medical/mental health conditions. The current system alerts are correctly placed on six of the eight client files.	One client on medication included both a Yellow code for Mental Health and a Red code for Medical. There were no medical concerns but file was marked with Red code. Another file included a Yellow code for Mental Health and no Red Code for Medication.
Staff are provided sufficient training, information and instructions to recognize/respond to the need for emergency care for medical/mental health problems	**Compliance**	All eight staff training records reviewed provided documentation of training in MHSA, CPR and First Aid and other emergency related trainings.	

A medical and mental health alert system is in place that ensures information concerning a youth's medical condition, allergies, common side effects of prescribed medications, foods and medications that are contraindicated, or other pertinent mental health treatment information, is communicated to all staff	**Compliance**	The agency utilizes a dot identification system to inform all staff members of a youth which has been identified with a medical or health condition which requires staff to be informed of the youth's status. Yellow is used for Mental Health. Blue is used for Substance Abuse. Red is used for Medical. Counselors assign Orange on an as needed basis. The agency also uses colored magnets placed near the youth's name on the Alert Board in the Direct Care staff office/box. The RN's reviews all health and medical screening. This review is documented with a signature of the Health Screen form.	
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 agency has Policy 4.05 Medical and Dental Procedures (Episodic/Emergency Care). The policy was reviewed and approved by the Program Manager on 8/1/2023.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: 1 **Total number of Closed Files: 5** **Staff Position(s) Interviewed** *(No Staff Names)* **: Residential Supervisor.** **Type of Documentation(s) Reviewed: Client files.** **Describe any Observations: See the report.**			
Off Site Emergency Care			
a. If off-site emergency medical or dental care was provided, an incident report was submitted for the medical or dental care b. Upon youth return, there is a verification receipt of medical clearance via discharge instructions with follow-up is present in file c. Youth's parent/guardian was notified d. A daily log is maintained for emergency care provided	**Compliance**	A total of five closed and one open records were reviewed. All six youth required off-site emergency medical care and an incident report was submitted for each. In all the cases, the parent/guardian transported the client from the youth shelter and transported them to the emergency room and returned them to the youth shelter. All six records included medical discharge instructions and follow-up care for the youth to return to the shelter. All six incidents were documented in the agency's episodic log and program logbook.	
All staff are trained on emergency medical procedures	**Compliance**	A review of staff training files indicate that all staff are trained in injury, emergency and universal precautions procedures. Specifically, the agency also conducts epi-Pen, CPR, first aid training and on the use of defibrillators.	
The program has a Knife-for-life and wire cutters accessible to staff in a secure location(s)	**Compliance**	The agency has multiple first aid kits and knife-for-life which are kept in a cabinet in the staff office and in all transportation vehicles.	