Florida Network for Youth and Family Services
Compliance Monitoring Report for

Safe Children Coalition

2841 Sixth Street
Sarasota, FL 34237

April 24-25, 2024

Compliance Monitoring Services Provided by

EXECUTIVE SUMMARY

Forefront LLC conducted a Quality Improvement (QI) monitoring visit on behalf of the Florida Network of Youth and Family Services (FNYFS) for the Safe Children Coalition for the FY 2023-2024 at its program office located at 2841 Sixth Street Sarasota, Florida 34237. 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. Safe Children Coalition is contracted with the Florida Network of Youth and Family Services (FNYFS) to provide direct services to Children/Families in Need of Services (CINS/FINS). The services to be provided are identified in Contract Section A - Descriptions and Specifications and Section B - Delivery and Performance and are funded with General Revenue Funds effective from July 2023 through June 30, 2024.

The review was conducted by Andrea Haugabook, Consultant for Forefront LLC and Andy Coble, Crystal Blair-Gallon, Melissa Johnson, Shelia Dixon, and Michele Almond. Agency representatives from Safe Children Coalition present for the entrance interview were: Jill Steiner, Alan Abernathy, Tammy McNesby, Amy Loomis, Fern Ellenwood, Stacey Schaeffer, and Michelle Gaines. The last onsite QI visit was conducted February 22-23, 2023.

In general, the Reviewer found that the Safe Children Coalition is in compliance with specific contract requirements. **Safe Children Coalition received an overall compliance rating of 92% for achieving full compliance with 12 indicators** of the CINS/FINS Monitoring Tool. There was one corrective action as a result of the monitoring visit.

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

2023-2024 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 04-24-25-2024

Agency Name: Safe Children Coalition	**Monitor Name: Andrea Haugabook, Lead Reviewer**
Contract Type: CINS/FINS	**Region/Office: 2841 Sixth Street Sarasota, FL 34237**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): April 24-25, 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. Administrative and Fiscal							
DJJ (Department of Juvenile Justice) Quality Improvement Peer Reviewer a. Provider shall demonstrate that a minimum of two (2) staff members have been trained to be certified as DJJ QI Peer reviewers. Provider shall participate in a minimum of one (1) on-site quality assurance review of a similar type of program in another judicial circuit during each 12-month period of the contract, if requested.	☐	☐	☒	☐	☐	The agency has three certified peer reviewers.	
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**	☐	☐	☒	☐	☐	In addition to the Florida Network of Youth and Family Services, the agency receives funding from the following entities: Department of Children and Families (07/01/2019 - 06/30/2024), Sarasota County Government (10/01/2023 - 09/30/2024) and FEMA (04/01/2024 - 12/31/2024).	

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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**	☐	☐	☒	☐	☐	The agency provided a certificate of insurance from M.E. Wilson Company, LLC. Alliance of nonprofits for insurance is the insurer affording coverage. The following minimum kind of insurance is valid 07/01/2023-07/01/2024: Commercial General Liability with a limit of $1,000,000 per occurrence, and $3,000,000 policy aggregate, $500,000 damage to rented premises, $20,000 medical expenses, $1,000,000 personal & advance injury, and $1,000,000 products – comp/op aggregate is included. Automobile Liability with a $1,000,000 combined limit and $10,000 Personal Injury Protection. Umbrella Liability $6,000,000 per occurrence and $6,000,000 aggregate and Professional Liability $1,000,000 per occurrence and $3,000,000 aggregate. The Florida Network is listed as a certificate holder.	

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External/Outside Contract Compliance a. Provider has corrective action item(s) cited by an external funding source (Fiscal or Non-Fiscal). **ON SITE**	☐	☐	☐	☐	☒	Interview with the senior accountant indicated there are no corrective action plans with external funding sources.	
Fiscal Practice a. Agency must have employee and fiscal policy/procedures manuals that are in compliance with GAAP and provide sound internal controls. Agency maintains fiscal files that are audit ready. **PTV**	☐	☐	☒	☐	☐	The agency has employee and fiscal policy/procedures that comply with GAAP and provide sound internal controls. The agency maintains fiscal files that are audit ready.	
b. Agency maintains a general ledger and the corresponding source documents. A general ledger must be set up to track the activity of the grant separately (standard account numbers / separate funds for each revenue source, etc.). **PTV**	☐	☐	☒	☐	☐	A review of the agency's general ledger for the most recent six months shows that the ledger is set up to track the activities of the grant separately using standard account numbers and separates funds from different revenue sources.	
c. Petty cash ledger system is balanced, and all cash disbursements are compliant with financial policies and allowable under the contract. (Disbursements/invoices are approved & monitored by management.) –**ON SITE**	☒	☐	☐	☐	☐	An interview with the senior accountant indicated that the assistant director of children's programs is responsible for the petty cash. It was reported that the petty cash is audited quarterly, there are surprise audits and there is an annual audit. Petty cash is limited to $450 and is used for	**Corrective Action:** A petty cash ledger needs to be kept with a current balance and regularly reconciled to ensure accuracy. Review of one reconciliation (dated December 6, 2023) was performed in the past six months. The previous reconciliation was performed in June 2023.

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	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:**
						occasional food on weekends and outings. Requests to reimburse petty cash are submitted as needed, approximately every 30-60 days. Onsite review of the petty cash with the assistant director of children's programs revealed the petty cash was kept in a locked cash box inside a locked office. The cash box was opened and contained several receipts with petty cash request slips attached and an assortment of cash and coins. The assistant director of children's programs counted the cash and coins and totaled the receipts, totaling $384.84. The petty cash was out of balance (short $65.16). The assistant director of children's programs indicated that December 6, 2023, was the last time the petty cash was reconciled. That was the date of the last request to reimburse petty cash and the balance was brought up to $450 following that request.	

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d. Financial records and reports are current. Includes bank statements reconciled within 6 weeks of receipt. Vendor invoices past 6 months. Invoices are submitted on a monthly basis with supporting documentation. (Disbursements/invoices are approved & monitored by management). **ON SITE**	☐	☐	☒	☐	☐	A review of the most recent six months of bank statements was conducted. All bank statements had been reconciled. An interview with the senior accountant indicates the bank statements are reconciled within the first week following the end of the month for each statement. Reconciliations are completed by the accounts payable clerk and the fiscal accountant. The accounts payable clerk pays invoices weekly. Vendor invoices (under $500 are approved for payment by the assistant director of children's programs, $501 - $ 2500 are approved by the director of residential programs and over $2500 are approved by the vice president of out of home care) are paid weekly by the accounts payable clerk. The senior accountant reviews all vendor payment requests prior to payments being issued by the accounts payable clerk and CFO reviews all payments.	

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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**	☐	☐	☒	☐	☐	The agency maintains inventory in accordance with its written policy and FNYFS contractual requirements. The following inventory of property valued over $1,000 was observed on-site and had DJJ Property Inventory Number/Tags: (10) protege bunk beds, (2) protege single beds, (1) centerline dishwasher, (1) Manitowoc ice maker.	
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**	☐	☐	☒	☐	☐	All payroll is done in Paylocity. Payroll tax payments were reviewed in the general ledger and 941 quarterly reports for the most recent six months were reviewed.	
g. Budget to actual reports prepared and reviewed by appropriate management. Variance from the budget are investigated and explained. **PTV/ON SITE**	☐	☐	☒	☐	☐	Interview with the senior accountant indicates that budget reports are prepared by the senior accountant and reviewed by the chief financial officer before they are presented to the chief executive officer and board of directors for approval. The senior accountant conducts a monthly forecast and reviews the budget for variances. The monthly forecasts and variances are	

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Major Programmatic Requirements	Explain Rating: Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable	Ratings Based Upon: I = Interview; O = Observation; D = Documentation; PTV = Submitted Prior To Visit (List Who and What)	Notes: Explain Unacceptable or Conditionally Acceptable:
						reviewed and monitored by the chief financial officer and reported chief executive officer and board of directors.	
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**	☐	☐	☒	☐	☐	The agency provided an audit report and related financial statements which was completed on March 5, 2024, by Kerkering Barberio and Company, Certified Public Accountants. The audit was conducted in accordance with government auditing standards for the period ending June 30, 2023. There is no management letter associated with the audit report reviewed.	
i. Agency maintains confidentiality policy with written policies and procedures to ensure the security and privacy of all employee and client data. Personal information is not easily accessible. Agency maintains a backup system in case of accidental loss of financial information. Security procedures are in place to protect laptops. Obsolete documents are shredded and computer hard drives are wiped prior to discarding. **ON SITE**	☐	☐	☒	☐	☐	The agency maintains written policies and procedures as follows: HR-4.02 Confidentiality (last revised 12/01/2019), FM-265 Records Retention (last revised 03/02/2020), IT-220 File and Data Security (last revised 02/26/2024), IT-260 Data Breach (last revised 02/26/2024), and PM-710 Equipment and real property (last revised 04/2023). The various	

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						agency policies cover confidentiality, ensure the security and privacy of all employee and client data. Personal information is not easily accessible, and the agency maintains a backup system in case of accidental loss of financial information. The policy covers security procedures to protect laptops and other equipment.	
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**	☐	☐	☒	☐	☐	A review of the general ledger supports the evidence provided by the agency that each direct care staff is paid at least $19.00 per hour.	

CONCLUSION

Safe Children Coalition 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. One of the fourteen indicators were not applicable because, Safe Children Coalition does not have corrective action plans from outside funding sources. Consequently, **the overall compliance rate for this contract monitoring visit is 92%.** There was one corrective action cited as a result of this contract monitoring visit. Overall, the provider is performing satisfactorily in meeting the fiscal and administrative terms of its contract. In addition, the majority of indicators reviewed were carried out in a manner which meets the standard described in the report findings.

SUMMARY OF RECOMMENDATIONS

Corrective Action (1)
Maintain a petty cash ledger and perform regular reconciliations of the petty cash fund.

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 Safe Children Coalition - Sarasota
CINS/FINS Program

Date: April 24-25, 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)	Not Applicable

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

Standard 3: Shelter Care & Special Populations

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

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

Standard 4: Mental Health/Health Services

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

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

Overall Rating Summary

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

Rating Definitions

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

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

Reviewers

Members

Andrea Haugabook - Lead Reviewer Consultant-Forefront LLC/Florida Network of Youth and Family Services
Melissa Johnson – Regional Monitor, Department of Juvenile Justice
Andy Coble – Family Resources, Inc.
Michelle Almand – Youth and Family Alternatives, Inc.
Shelia Dixon – Lutheran Services Florida/ SW Oasis

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

Documents Reviewed

	Accreditation Reports	X	Table of Organization		Visitation Logs
X	Affidavit of Good Moral Character	X	Fire Prevention Plan	X	Youth Handbook
	CCC Reports	X	Grievance Process/Records		# Health Records
X	Logbooks		Key Control Log	5	# MH/SA Records
	Continuity of Operation Plan	X	Fire Drill Log	14	# Personnel /Volunteer Records
	Contract Monitoring Reports	X	Medical and Mental Health Alerts	8	# Training Records
	Contract Scope of Services	X	Precautionary Observation Logs	6	# Youth Records (Closed)
X	Egress Plans	X	Program Schedules	5	# Youth Records (Open)
X	Fire Inspection Report	X	List of Supplemental Contracts		# Other: ___
X	Exposure Control Plan	X	Vehicle Inspection Reports		

Observations During Review

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

Surveys

3	# of Youth	15	# of Direct Staff		# of Other		

Comments

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

Monitoring Purpose

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

Strengths and Innovative Approaches

The Safe Children Coalition, Inc. Is a not-for-profit community-based care provider of education, prevention, diversion, and child welfare services including adoption and foster care. The organization's youth shelter serves youth ages 10-17 who are runaway, truant, ungovernable, and lock-out. The shelter is open 24 hours a day, 7 days a week. The shelter is located at, 2841 6th Street, Sarasota, FL 34237. The agency is currently accredited by the Council on Accreditation and licensed as a child caring facility through the Florida Department of Children and Families. The agency operates a community counseling program offering free school-based counseling services through the Youth Prevention Services program. The agency has plans to build a new shelter and should be breaking ground soon.

The following programmatic updates were provided by the agency:

Staffing

In March 2023, Safe Children Coalition did some restructuring with the Executive Leadership Team, creating a Chief Operating Officer position and 4 Vice President positions: VP of Prevention and Diversion, VP of Out of Home Care, VP of Case Management, and VP of Programs. The previous VP of CBC Operations, retired in August 2023. The position was dissolved due to the restructuring previously mentioned.

In July 2023, the YPS Program Supervisor vacancy was filled. The YPS program was also moved under the direction of the Director of Community Prevention Services, in July 2023.

The YPS Program added an additional counselor position due to the high demands for more school-based counselors in Sarasota County. An additional YPS Counselor joined the team in October 2023.

The Community Prevention branch also added an Operations Manager position to provide support and program compliance monitoring for all our community preventions programs. This position was filled in December 2023 and the YPS Operations Coordinator position was dissolved.

In May 2023, a newly re-hired employee filled the position of Youth and Family Advocate.

In July 2023, a newly re-hired employee returned to the agency as the Residential Manager.

In September 2023, a current employee was promoted to Assistant Director of Residential Programs.

Program Updates

In July 2023, the YPS Program moved from a paper-file system to the electronic record-keeping system CaseWorthy.

In March 2023, the Youth Shelter moved to a temporary location while the new shelter facility is constructed. The address is 2841 6th Street, Sarasota, FL 34237.

Facility

The program recently added a concrete basketball pad for youth with funds from the Pinkerton Foundation for $6,986. There was an upgrade to the fire alarm system, which is now locally monitored, and installation of a new fence to secure the backyard and enhance its overall appearance.

Funding/ Finance

Our Annual Fundraising plan (July 1 – June 30) includes our End of Year Appeal and Giving Breakfast, and this year it also included the Giving Challenge. Our Annual Fundraising has resulted in $366,298 in contributions through February 2024.

The Youth Shelter Capital campaign was authorized by the SCC Board of Directors in November 2022. As of April 2024, the campaign has reached 71% of its goal.

Received $2,050 in miscellaneous contributions and $10,000 from the Cordero Foundation (not including Capital Campaign) in this fiscal year.

Governance/ Community

The agency recently added three new board members. There is one board member who moved out of state and is no longer on the board. The chairs/officers of the board remain the same.

Narrative Summary

Safe Children Coalition serves youth ages 10-17 in Circuit 12, DeSoto, Manatee and Sarasota counties. The program offers information and referral, shelter/ safe house, therapy, transitional housing and individual counseling. The program has undergone major organizational restructuring and is in the process of building a new shelter facility. The agency holds a COA accreditation through 2025 and is licensed for 12 beds through the Florida Department of Children and Families through May 1, 2024. There are no external corrective action plans nor major challenges reported by the agency.

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**,
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,**
Indicator 1.07 Outreach Services was rated **Satisfactory with Exception.**

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 with Exception**,
Indicator 2.03 Case/Service Plan was rated **Satisfactory with Exception**,
Indicator 2.04 Case Management and Service Delivery was rated **Satisfactory**,
Indicator 2.05 Counseling Services was rated **Satisfactory**,
Indicator 2.06 Adjudication/Petition Process was rated **Satisfactory**,
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 **Not Applicable**.

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

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

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

Standard 3: Indicator 3.06 was rated limited due to four, ten minute checks completed late. Two were documented in Note ACTIVE; however these checks were not completed at all, as confirmed by video review. Both the director of residential programs and assistant of residential programs were made aware of this information and reviewed the video for confirmation that the bed checks were documented and not completed. The CCC was contacted by director of residential programs and the report number is 0517.

CINS/FINS QUALITY IMPROVEMENT TOOL

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

Standard One – Management Accountability

1.01: Background Screening of Employees, Contractors and Volunteers		**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 1.01	**YES**	
	If NO, explain here:	
	The agency has a policy, 1.01 Background Screening, last reviewed 02/09/2024 by the CEO.	

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: Five
Total number of 5 Year Re-screen Employee Files: Nine
Staff Position(s) Interviewed (No Staff Names): Human Resources, Vice President of Prevention and Diversion Services, Operations Manager Community Prevention
Type of Documentation(s) Reviewed: Pre-employment suitability assessments, Department of Homeland Security E-Verify/ I-9 documentation, Agency for Healthcare Administration (AHCA)/ Department of Juvenile Justice (DJJ) background screening results
Describe any Observations:

All positions providing direct services to youth has successfully passed pre-employment suitability assessment on the initial attempt.	**Compliance**	Five of five new hire staff have evidence of successfully passing the pre-employment suitability assessment on the initial attempt.	
For any applicant that did not pass the initial suitability assessment, there was evidence that the applicant retook the assessment and passed within five (5) business days of the initial attempt, not exceeding three (3) attempts within thirty (30) days.	**No eligible items for review**	All new hire staff passed the suitability assessment on the initial attempt.	
Agency has evidence for employees who have had a break in service for 18 months or more, and/or when the agency had a change or update in the suitability assessment tool used was different from the employee's original assessment, that a new suitability assessment and background screening was completed as required.	**Compliance**	Two employees were previously employed with the agency and suitability assessment and background screening was completed as required.	
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**	Five of five new hire staff have completed background screening completed prior to 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**	Nine of nine employee files reviewed for five year rescreening contained screenings prior to the expiration of the retained fingerprints date or five years from the date of the last screening.	

Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?	**Compliance**	An annual affidavit of compliance with level two screening was signed on January 19, 2024 and emailed to DJJ's background screening unit. The affidavit had a stamp from DJJ indicating it was received on January 19, 2024.	
Proof of E-Verify for all new employees obtained from the Department of Homeland Security	**Compliance**	Proof of E-Verify was present in five of five new hire employee files.	
Additional Comments: **There are no additional comments for this indicator.**			
1.02: Provision of an Abuse Free Environment			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 1.02		**YES** If NO, explain here: The agency has a policy, 1.02, entitled Provision of an Abuse Free Environment approved by the CEO/President in February 2024.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Staff Position(s) Interviewed *(No Staff Names)* **: Director of Residential Services** **Type of Documentation(s) Reviewed: Employee training files, Youth intake/ orientation documentation, abuse hotline postings, policies, grievance logs** **Describe any Observations: Abuse Hotline Signs posted throughout, location of grievance box in shelter.**			
Agency has a code of conduct of policy and there is evidence that staff are aware of agency's code of conduct.	**Compliance**	Staff acknowledge the code of conduct upon hire.	
The agency has a process in place for reporting and documenting child abuse hotline calls.	**Compliance**	The agency has a process in place for reporting and documenting child abuse hotline calls. There were zero calls in last 6 months.	
Youth were informed of the Abuse and Contact Number	**Compliance**	Agency has the abuse hotline number posted throughout the facility. In addition, they provide the youth, upon intake, a handbook which contains this information.	
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**	Locked box is available in each living room area, with forms next to it. The director of residential services has access, responds to grievances, addresses complaints and provides feedback unless the grievance is towards themself; in that case it would be directed to higher leadership.	
<u>Shelter only:</u> Grievances are maintained on file at minimum for 1 year.	**Compliance**	Interview with the assistant director indicated that grievances are maintained on file for minimum of one year.	

Shelter only: There are formal grievance procedures for youth, including grievance forms, and a locked box which are easily accessible to youth in a common area.	**Compliance**	The agency has a formal grievance procedure for the youth. There is a locked box in the living room area, with forms next to it.	
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**	Verified the most recent past 30 days of Note ACTIVE entries showing that grievance box was checked daily.	
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**	Two grievances were received and processed in the past six months. Both were documented by the supervisor and were handled within the 72 hour requirement.	
1.03: Incident Reporting			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 1.03		**YES** If NO, explain here: The agency has a policy, 1.03 entitled Incident Reporting which was approved by the CEO/President in February 2024.	

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

Staff Position(s) Interviewed *(No Staff Names)* **: Director of Residential Services**
Type of Documentation(s) Reviewed: Incident reports, episodic reports related as incidents
Describe any Observations: Program used Episodic log up until 1/31/24 then changed to Narrative format to capture all follow-up information. Narratives do not include times but details needed are otherwise captured.

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**	Internal incident reports reviewed indicated they were reported to the CCC within two hours of the reportable incident. Unable to compare with CCC reports at the time of the review due to CCC system being unavailable.	
The program completes follow-up communication tasks/special instructions as required by the CCC	**Compliance**	The program has a current practice of creating a narrative of the incident, to include any follow-up for every incident.	
Agency internal incidents are documented on incident reporting forms and all CCC reportable incidents were consistently reported to CCC as required.	**Compliance**	Reviewed the forms for 15 internal incidents they are all documented on internal reporting forms which are compliant. Internal incidents reviewed indicate that they were reported to the CCC as required. Unable to compare with CCC reports at the time of the review due to CCC system being unavailable.	
Incidents are documented in the program logs and on incident reporting forms	**Compliance**	Verified all 15 incident reports were documented in Note ACTIVE.	
All incident reports are reviewed and signed by program supervisors/ directors	**Compliance**	The following incident reports were reviewed and signed by the program supervisors:1 Escape/Abscond, 4 Medical, 9 MH/SA, 1 Youth Behavior.	

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		**NO**	
		If NO, explain here: Provider Orientation does not include Agency Policies & Procedures	
		The agency has a training policy, 1.04, entitled Training Requirements, approved by the CEO/President February 2024.	

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

Total number of New Hire Staff Files: Six
Total number of Annual In-Service Staff Files: Two
Total number of Non-Licensed Mental Health Clinical Shelter Staff Files: Zero
Annual Training Plan Timeframe (*Program timeframe for annual trainings*)**: Anniversary date**
Staff Position(s) Interviewed *(No Staff Names)* **: Charles Harris, Amy Loomis**
Type of Documentation(s) Reviewed: Training file transcripts, certificates and training perpetual logs
Describe any Observations: Trainings are tracked very well. Only one exception with a Community Counseling file- one training exceeded 30 day deadline by one day.

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 of four residential staff files for pre-service requirements showed evidence of training for safety and supervision.	
All staff completed the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days from date of hire.	**Exception**	One of two community counseling and four residential staff files reviewed completed the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days from the date of hire.	One community counseling staff did not complete Civil Rights & Federal Funds within first 30 days of employment (done 1 day late).
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**	Two of two community counseling and four of four residential staff files reviewed, demonstrated a minimum of 80 hours of training in the first full year of employment.	
All staff receives all mandatory training during the first 90 days of employment from date of hire.	**Compliance**	Two of two community counseling and four of four residential staff files reviewed completed all mandatory training during the first 90 days of employment.	

Staff Required to Complete Data Entry for NIRVANA or access the Florida Department of Juvenile Justice Information System (JJIS)			
Any designated staff that is responsible for entering NIRVANA or ensuring accurate and complete data entry in the Florida Department of Juvenile Justice Information System (JJIS) have completed all of the required trainings.	**Compliance**	Reviewed two community counseling first year files. Both showed compliance with this area. No applicable shelter staff to review.	
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*	**Compliance**	Reviewed three community counseling files for this standard. Both files met this requirement. No shelter staff to review for this.	
Non-licensed Mental Health Clinical Shelter Staff (within first year of employment)			
Documentation of non-licensed mental health clinical staff person's training in Assessment of Suicide Risk form or written confirmation by a licensed mental health professional of training (includes date, signature and license number of the licensed mental health professional supervisor).	**No eligible items for review**	None of the staff files reviewed required Suicide Risk assessment training.	
In-Service Direct Care Staff			
Direct care staff completes 24 hours of mandatory refresher Florida Network, Skill Pro, and job-related training annually (40 hours if the program has a DCF child caring license).	**Compliance**	All direct care staff files reviewed completed 40 hours of mandatory refresher Florida Network, Skill Pro, and job-related training annually.	
Required Training Documentation			
The agency has a training plan that includes all of the required training topics including the pre-service and in-service.	**Compliance**	The agency has a training plan that includes all of the required training topics including the pre-service and in-service.	
The agency has a designated staff member responsible to manage all employee's individual training files and completes routine tracking and reviews of staff files to ensure compliance.	**Compliance**	The 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.	

The program maintains an individual training file or employee file AND a FLN Training Log (or similar document that includes all requirements) for each staff, which includes an annual employee training hours tracking form and related documentation, such as electronic record/transcript, training certificates, sign-in sheets, and agendas for each training attended.	**Compliance**	The program maintains an individual training file with a training log for each staff. The training log includes tracking of the employee training hours annually. Documentation of completed training was present in the training files.	
Additional Comments: **There are no additional comments for this indicator.**			
1.05 - Analyzing and Reporting Information			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 1.05		**YES** If NO, explain here: The agency has a policy, 1.05, entitled Analyzing and Reporting Information which was approved by the CEO/President February 2024.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Staff Position(s) Interviewed *(No Staff Names)* **: Director of Residential Services** **Type of Documentation(s) Reviewed: Board of Director meeting minutes, Staff Meeting Minutes, Agency-wide periodic report summaries** **Describe any Observations: Staff meetings discussed reporting data and PQI in indirect manner.**			
Case record review reports demonstrate reviews are conducted quarterly, at a minimum	**Compliance**	PQI procedures are in place. File reviews are done regularly and reported back in staff meetings, both in shelter and community counseling.	
The program conducts reviews of incidents, accidents, and grievances quarterly, at a minimum	**Compliance**	Evidence in minutes showed that incidents, accidents and grievances are reviewed periodically within the shelter.	
The program conducts an annual review of customer satisfaction data	**Compliance**	Evidence shows that this is discussed annually in meetings, for shelter staff.	
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**	Shelter minutes and Community Counseling minutes show that this data is discussed regularly.	
The program has a process in place to review and improve accuracy of data entry & collection	**Compliance**	The program has a process in place to review and improve accuracy of date entry and collection. Data is reviewed by multiple staff on a regular and consistent basis. End of month reports are verified. The program also has a third party entity which reviews data on a regular basis and provides comprehensive reports that are evaluated by management, leadership and the governing board.	
There is documentation that findings are regularly reviewed by management and communicated to staff and stakeholders.	**Compliance**	Board of director meetings show evidence that data is communicated. An agency-wide report is distributed to include information on the shelter as well as community counseling data.	
There is evidence the program demonstrates that program performance is routinely reviewed with the Board of Directors. All final reports that include a Limited or Failed score is submitted electronically or by mail to the providers Executive Committee on the Board of Directors.	**Compliance**	There was evidence that the last FN QI Review, done in February 2023, was reviewed with the Board of Directors, including the Corrective Action Plan submitted.	

There is evidence that strengths and weaknesses are identified, improvements are implemented or modified, and staff are informed and involved throughout the process.	**Compliance**	Shelter minutes and Community Counseling minutes show that this data is discussed regularly.	
Additional Comments: **There are no additional comments for this indicator.**			
1.06: Client Transportation			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 1.06		**YES** If NO, explain here: The agency has a policy, 1.06, entitled Client Transportation approved by the CEO/President in February 2024.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Dates or Timeframe Reviewed: 10/1/23 - 4/15/24 **Staff Position(s) Interviewed (No Staff Names): Director of Residential Services** **Type of Documentation(s) Reviewed: Vehicle Logs, Note Active tablet entries** **Describe any Observations: Logs have written in information on the side (margin) to capture Single Transport calls and whether there was any issues.**			
Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	**Compliance**	A list of approved agency drivers was provided for review. All approved drivers operate the agency vehicles.	
Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	**Compliance**	Approved agency drivers all have valid Florida driver's license and are covered under company insurance policy.	
Agency's Transportation policy prohibit transporting a client without maintaining at least one other passenger in the vehicle during the trip and include exceptions in the event that a 3rd party is NOT present in the vehicle while transporting	**Compliance**	The policy meets this requirement. The agency's policy prohibits transporting a client without maintaining at least one other passenger in the vehicle during the trip and include exceptions in the event that a 3rd party is not present in the vehicle while transporting.	
In the event that a 3rd party cannot be obtained for transport, the agency's supervisor or managerial personnel consider the clients' history, evaluation, and recent behavior	**Compliance**	The agency's policy indicates that a 3rd party cannot be obtained for transport, the agency's supervisor or managerial personnel consider the client's history, evaluation and recent behavior.	
The 3rd party is an approved volunteer, intern, agency staff, or other youth	**Compliance**	The agency's policy indicates, the 3rd party is an approved volunteer, intern, agency staff, or other youth.	

The agency demonstrated evidence via logbook or other written verification that supervisor approval was obtained prior to all single youth transports.	**Compliance**	The agency maintains a manual transportation log which was reviewed from 11/01/2023-4/16/24. There were a total of 187 single transports recorded during that time frame. It is the program's practice to draft a transport schedule at night for the next day. Supervisor approvals are obtained in person or by phone prior to the single transports taking place and are recorded on the log and entered into Note Active. Evidence of supervisor approvals were observed in the program's vehicle log and in Note Active.	
There is documentation of use of vehicle that notes name or initials of driver, date and time, mileage, number of passengers, purpose of travel and location.	**Compliance**	The agency's vehicle log has most of the required data (i.e., name or initials of driver, date and time, mileage, number of passengers) captured. The agency log lists the destination as the purpose of the trip.	
Additional Comments: **There are no additional comments for this indicator.**			
1.07 - Outreach Services			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 1.07		**YES** If NO, explain here: The agency has a policy, 1.07, entitled Outreach Services which was approved by the CEO/President in December 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)* **: Director of Residential Services** **Type of Documentation(s) Reviewed: Outreach documentation, NetMis Report** **Describe any Observations: Good documentation captured for evidence**			
The program has a lead staff member designated to participate in local DJJ board, Circuit and Council meetings with evidence that includes minutes of the event or other verification of staff participation.	**Compliance**	The program's admin staff (Director of Residential Programs, Assistant Director, Residential Youth and Family Advocate) are designated to participate in local DJJ board, circuit and council meetings. Meeting minutes and documentation was reviewed to verify staff participation.	
The program maintains written agreements with other community partners which include services provided and a comprehensive referral process.	**Exception**	The program maintains written agreements with the following community partners: NAMI and Family Resources. Other referrals provided to parent/guardian but not to community resources due to HIPAA.	The program's written agreement with Circuit 12 School from 2020, contained all signatures and expired 2023. They are working currently working on obtaining all signatures on an agreement to go from 2023-2028.

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 maintains documentation of outreach activities. All the program's outreach activities were observed in NetMis. Each NetMis entry included the title, date, duration, zip code, location description, estimated number of people reached, modality, target audience and topic. NetMis does not capture length of time (hours) in current format, otherwise all required information is entered into NetMis.	
The program has designated staff that conducts outreach which is defined in their job description.	**Compliance**	The program has the following designated staff that conduct outreach as defined in the job descriptions: Director of Residential Programs, Assistant Residential Director, Residential Youth and Family Advocate, Operations Manager, Program Supervisor, Community Counselors and Community Counseling Director of Community Prevention Services.	
Additional Comments: **There are no additional comments for this indicator.**			
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 provider has a written policy for 2.01 Screening and Intake, last reviewed/approved/signed 2-24 by CEO/President.	
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: Residential & Community (3 open) **Total number of Closed (Residential & Community) Files: Residential &Community (2 closed)** **Staff Position(s) Interviewed** *(No Staff Names)* **: Operations Manager and Program Supervisor** **Type of Documentation(s) Reviewed: Electronic case files and paper files** **Describe any Observations: Electronic record is easy to navigate, paper files are organized with documentation required available in the files.**			
Shelter youth: Eligibility screening form is completed immediately for all shelter placement inquiries.	**Compliance**	There were (3) three open and (2) two closed Residential files reviewed. All files reviewed showed evidenced that eligibility screening is completed immediately for shelter placement.	
Community counseling: Eligibility screening form is completed within 3 business days of referral by a trained staff using the Florida Network screening form.	**Compliance**	There were (3) three open and (2) two closed Community files reviewed. All files reviewed showed evidenced that eligibility screening is completed within required time frames.	
There is evidence all referrals for service is screened for eligibility and is logged in NetMIS within 72 hours of screening completion.	**Compliance**	There were (3) three open and (2) two closed Residential and Community files reviewed were screened for eligibility and evidence fund that they are logged into NetMIS within 72 hours of completion which was reviewed in NetMIS.	
Youth and parents/guardians receive the following in writing: a. Available service options b. Rights and responsibilities of youth and parents/guardians	**Compliance**	All Community counseling and shelter files showed that youth/parents receive in Available service options and Rights and responsibility of both youth and parent/guardians via the intake forms observed in the electronic record and client files.	

The following is also available to the youth and parents/guardians: a. Possible actions occurring through involvement with CINS/FINS services (case staffing committee, CINS petition, CINS adjudication) b. Grievance procedures	**Exception**	All Community counseling files reviewed demonstrated that the following were available to youth and parents a. possible actions occurring through involvement with CINS/FINS services and grievance procedures. All shelter files with the exception of one (1) demonstrated this information was available.	Available service options and grievance procedures topics were found to be checked off on intake checklist. One file noted that, Mother checked 'no' to receiving CINS/FINS brochure on the voluntary placement agreement as it pertains to the possible actions involving CINS/FINS services.
During intake, all youth were screened for suicidality and correctly assessed as required if needed.	**Compliance**	All files reviewed for both Residential and Community were screened for suicidality with the 5 screening questions at intake and correctly assessed as required using the assessment of suicide risk for shelter and Columbia Rating scale for Community.	
Additional Comments: **There are no additional comments for this indicator.**			
2.02 - Needs Assessment			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 2.02		**YES** If NO, explain here: The program has a written policy 2.02 Network Inventory of Risks, Victories and Needs Assessment, reviewed/approved/signed by CEO/President 2-24	
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: Residential and Community (3 open) **Total number of Closed (Residential & Community) Files: Residential and Community (2 closed)** **Staff Position(s) Interviewed** *(No Staff Names)* **: Program Supervisor and Operations Manager** **Type of Documentation(s) Reviewed: Electronic client case record for community and paper client file for Residential** **Describe any Observations: Client documentation is organized and easy to find within the record keeping system.**			
Shelter Youth: NIRVANA is initiated within 72 hours of admission	**Compliance**	All shelter files reviewed do not necessarily have an initiated date, but were found to have NIRVANAs completed on the day of admission or prior to the 72 hour time required.	
Non-Residential youth: NIRVANA is initiated at intake and completed within 2 to 3 face-to-face contacts after the initial intake **OR** updated, if most recent assessment is over 6 months old	**Compliance**	All Community files reviewed showed that NIRVANAs were initiated at intake and completed within 2-3 face to face contacts. There were no files reviewed that were over 6 months old.	
Supervisor signatures is documented for all completed NIRVANA assessments and/or the chronological note and/or interview guide that is located in the youths' file.	**Compliance**	All files reviewed for both Residential and Community counseling demonstrated supervisor signatures were documented on all completed NIRVANA assessments.	
(Shelter Only) NIRVANA Self-Assessment (NSR) is completed within 24 hours of youth being admitted into shelter. If unable to complete, there must be documentation in NetMIS and the youth's file explaining the barriers to completion.	**Compliance**	All shelter files reviewed showed that NIRVANA Self-Assessment were completed within 24 hours. There were no instances found that NSRs were not completed within the 24 hour time frame.	

A NIRVANA Post-Assessment is completed at discharge for all youth who have a length of stay that is greater than 30 days.	**Exception**	All Community files showed that a post assessment was completed at discharge for all youth with a length of stay over 30 days.	Shelter files reviewed two (2) closed files with a length of stay greater than 30 days did not have a post NIRVANA; however a Re-Assessment was completed after the 30 days.
A NIRVANA Re-Assessment is completed every 90 days excluding files for youth receiving SNAP services.	**No eligible items for review**	There were no Community or Residential files reviewed that were open past 90 days. There were two (2) shelter files reviewed that had NIRVANA Re-Assessments completed as those cases were opened past 30 days.	
All files include the interview guide and/or printed NIRVANA.	**Compliance**	All files reviewed for both Residential and Community included the printed NIRVANA.	
Additional Comments: **There are no additional comments for this indicator.**			
2.03 - Case/Service Plan			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 2.03		**YES** If NO, explain here: The program has a written policy 2.03 Case/Service Plan, reviewed/approved/signed 2-24 by CEO/President.	
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: Residential and Community (3 Open) **Total number of Closed (Residential & Community) Files: Residential and Community (2 closed)** **Staff Position(s) Interviewed** *(No Staff Names)* **: Operations Manager and Program Supervisor** **Type of Documentation(s) Reviewed: Electronic client record and client paper files**			
The case/service plan is developed on a local provider-approved form or through NETMIS and is based on information gathered during the initial screening, intake, and NIRVANA.	**Compliance**	All files reviewed for both Residential and Community counseling utilize a case/service plan on a provider approved form. Community counseling program utilizes the NETMIS system. All case/service plans reviewed were developed based upon information gathered from the initial screening, intake, and NIRVANA.	
Case/Service plan is developed within 7 working days of NIRVANA	**Compliance**	All files reviewed for both Residential and Community had a case/service plan developed within 7 working days of a NIRVANA. Shelter files reviewed showed that the case/service plan was completed the day of intake with the exception of one which was developed 2 working days after intake.	

Case plan/service plan includes: 1. Individualized and prioritized need(s) and goal(s) identified by the NIRVANA 2. Service type, frequency, location 3. Person(s) responsible 4. Target date(s) for completion and actual completion date(s) 5. Signature of youth, parent/guardian, counselor, and supervisor 6. Date the plan was initiated	**Exception**	All Community counseling and shelter files were found to include all the components required for the case/service plan. 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- Two (2) community counseling plans were found with no parent signature; however there are documented efforts by the counselor to obtain the parents signature in the case record. Parents are made aware of case/service plan goal development at time of intake. 6. Date the plan was initiated	One (1) open shelter client file reviewed was found to be missing a supervisor signature on the case/service plan.
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**	Three (3) open Community files reviewed were found to not be due for a 30 day review. One (1) Community filed review was found to have the 30 days review completed on time with the youth and parent notified verbally. Two (2) closed shelter files reviewed were found to have 30 day reviews on time with youth participation. Shelter case/service plans are reviewed on a weekly basis which was observed in shelter client files.	
Additional Comments: **There are no additional comments for this indicator.**			
2.04 - Case Management and Service Delivery			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.04		**YES** If NO, explain here: The program has a written policy 2.04 Case Management and Service Delivery, reviewed/approved/signed 2-24 by CEO/President.	
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: Residential and Community (3 open) **Total number of Closed (Residential & Community) Files: Residential and Community (2 closed)** **Staff Position(s) Interviewed** *(No Staff Names)* **: Operations Manager and Program Supervisor** **Type of Documentation(s) Reviewed: Electronic case record and paper client files**			
Counselor/Case Manager is assigned	**Compliance**	All community counseling and shelter files were found to have a Counselor/Case Manager assigned.	

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**	The Counselor/Case Manager completes the following as applicable in all community counseling and shelter case files reviewed: 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. Referrals to the youth/family for additional services when appropriate 9. Case monitoring and reviews court orders 10. Case termination notes 11. Follow-up after 30 days post discharge 12. Follow-up after 60 days post discharge	
The program maintains written agreements with other community partners that include services provided and a comprehensive referral process	**Compliance**	The following written agreements with community partners were reviewed: NAMI, Family Resources, Circuit 12 School (2020 all signatures, expired 2023); current agreement in progress to go from 2023-2028. Other referrals provided to parent/guardian but not to community resources due to HIPAA. Referrals are also made internally from shelter program to youth prevention services for community counseling.	
Additional Comments: **There are no additional comments for this indicator.**			
2.05 - Counseling Services			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.05		**YES** If NO, explain here: The program has a written policy 2.05 Counseling Services, reviewed/approved/signed 2-24 by CEO/President.	
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: Residential and Community (3 open) **Total number of Closed (Residential & Community) Files: Residential and Community (2 open)** **Staff Position(s) Interviewed** *(No Staff Names)* **: Operations Manager and Program Supervisor** **Type of Documentation(s) Reviewed: Electronic client filed and paper client file**			
Shelter Program			
Shelter programs provides individual and family counseling	**Compliance**	All shelter files reviewed were found that the program provides individual and family counseling.	
Group counseling sessions held a minimum of five days per week	**Compliance**	All shelter files reviewed were found that the program provides group counseling.	

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**	All shelter files were shown to have the requirements outlined in policy for groups. Groups are conducted by staff, youth or guests and consist of: a clear leader, a topic, and are 30 minutes or longer. All youth are given an opportunity of participate in groups.	
Documentation of groups must include date and time, a list of participants, length of time, and topic.	**Compliance**	Documentation of groups was reviewed. The shelter utilizes a form that lists participants, activity/topic, a date and time, and the length of time. There is also a group counseling note that is available for each youth and documents their individualized participation in group.	
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**	Based upon review of community counseling records the program provides therapeutic community based services as required by the policy. The counseling services are provided mostly in the school setting and no virtual session were found to be conducted during this review period with the 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**	Based upon review of community counseling records and the shelter files reviewed the program completes review of all case files for coordination between presenting problem(s), psychosocial assessment, case/service plan and reviews, case management, and follow up.	
Maintain individual case files on all youth and adhere to all laws regarding confidentiality.	**Compliance**	Community counseling records are kept electronically and accessed through a secure lap top which adhere to confidentiality. Shelter files are marked confidential and program adheres to confidentiality requirements.	
Case notes maintained for all counseling services provided and documents youth's progress.	**Compliance**	All shelter files and community counseling files reviewed were found that the program maintains case notes for all counseling services and documents youth progress.	
On-going internal process that ensures clinical reviews of case records and staff performance.	**Compliance**	Review of shelter and community counseling files found that there is an ongoing internal process that ensures clinical reviews of case records and staff performance. Community counseling supervisor meets with community counselors regularly for supervision which is documented in the client electronic record. The shelter program conducts weekly reviews of client progress, which includes at a minimum, the counselor, supervisor, and shelter staff.	
When an intake is conducted through virtual means, consent is confirmed by the counselor, documented in the file, and reviewed with the supervisor during supervision/case review. There is written documentation provided in the youths file for reasons why virtual sessions are in the best interest of the youth and family.	**No eligible items for review**	There were no files reviewed that were found to have virtual means.	
Additional Comments: **There are no additional comments for this indicator.**			

2.06 - Adjudication/Petition Process			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 2.06		**YES** If NO, explain here: The program has a written policy 2.06 Adjudication/Petition Process, reviewed/approved/signed 2-24 by CEO/President.	
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: One(1) open Community File **Total number of Closed (Residential & Community) Files: Two (2) Closed Community files** **Staff Position(s) Interviewed** *(No Staff Names)* **: Operations Manager and Program Supervisor** **Describe any Observations: Electronic client record**			
Must include: a. DJJ rep. or CINS/FINS provider b. Local school district representative	**Compliance**	The program has an established committee that includes the CINS/FINS provider as the DJJ representative and a local school district representative.	
Other members may include: a. State Attorney's Office b. Others requested by youth/ family c. Substance abuse representative d. Law enforcement representative e. DCF representative f. Mental health representative	**Compliance**	The program has an established committee that includes the local Mental Health agency and others requested by the family.	
The program has an established case staffing committee, and has regular communication with committee members	**Compliance**	Review of the process and interview with program managers found that the program has an established case staffing committee with regularly communication. Meetings are prescheduled on a monthly basis and communicated in advance to the committee.	
The program has an internal procedure for the case staffing process, including a schedule for committee meetings	**Compliance**	Review of the process and interview with program managers found that the program has an established case staffing committee with regularly communication. Meetings are prescheduled on a monthly basis and communicated in advance to the committee.	
The youth and family are provided a new or revised plan for services	**Compliance**	The agency has a plan in which the family receives a new/revised plan via mail the following day from case staffing being held. The counselor also follows up with the family via phone call.	
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 agency has a plan in which the family receives a new/revised plan via mail the following day from case staffing being held. The counselor also follows up with the family via phone call.	
If applicable, the program works with the circuit court for judicial intervention for the youth/family	**No eligible items for review**	Judicial intervention was not warranted in the three youth files reviewed.	
Case Manager/Counselor completes a review summary prior to the court hearing	**No eligible items for review**	No court hearings were attended in the three youth files reviewed.	
Additional Comments: **There are no additional comments for this indicator.**			
2.07 - Youth Records			**Satisfactory**

Provider has a written policy and procedure that meets the requirement for Indicator 2.07		**YES** If NO, explain here: The program has a written policy 2.07 Youth Records, reviewed/approved/signed 2-24 by CEO/President.	
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)* **: Operations Manager, Program Supervisor, Director of Residential Services** **Type of Documentation(s) Reviewed: Residential files, staff office** **Describe any Observations: Observed the shelter office that stores files and the transport boxes.**			
All records are clearly marked 'confidential'.	**Compliance**	Shelter files are marked confidential and placed in a file cabinet marked confidential. Community counseling files are on an electronic medical record that is accessed on a secured computer/laptop.	
All records are kept in a secure room or locked in a file cabinet that is marked "confidential"	**Compliance**	Observed shelter files are stored in a locked file cabinet, and stored in an office that remains locked. The file cabinet is marked confidential.	
When in transport, all records are locked in an opaque container marked "confidential"	**Compliance**	While in transport, shelter files are locked in a carrying case that is locked and accessible with a combination.	
All records are maintained in a neat and orderly manner so that staff can quickly and easily access information	**Compliance**	All records reviewed were maintained in a neat, orderly manner and information is easily accessed.	
Additional Comments: **There are no additional comments for this indicator.**			
2.08 - Specialized Additional Program Services			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.08		**YES** If NO, explain here: The agency has a written policy 2.08 Specialized Program Services, reviewed/approved/signed 2-24 by CEO/President.	
Staff Secure			
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: Zero **Total number of Closed Files: Zero** **Staff Position(s) Interviewed** *(No Staff Names)* **: Operations Manager and Program Supervisor**			
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 program has not had any staff secure cases in the past six months or back to the date of the last 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 policies and procedures that address staff secure cases in the following manner: 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	
Program only accept youth that meet legal requirements of F.S. 984 for being formally court ordered in to Staff Secure Services	**No eligible items for review**	The program has not had any staff secure cases in the past six months or back to the date of the last review.	
Staff Assigned: a. One staff secure bed and assigned staff supervision to one staff secure youth at any given time b. Program assign specific staff during each shift to monitor location/ movement of staff secure youth c. Agency clearly documents the specific staff person assigned to the staff secure youth in the logbook or any other means on each shift	**No eligible items for review**	The program has not had any staff secure cases in the past six months or back to the date of the last review.	
Agency provides a written report for any court proceedings regarding the youth's progress	**No eligible items for review**	The program has not had any staff secure cases in the past six months or back to the date of the last review.	
Domestic Minor Sex Trafficking (DMST)			
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: Zero **Total number of Closed Files: Zero** **Staff Position(s) Interviewed** *(No Staff Names)* **: Operations Manager and Program Supervisor**			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	**No eligible items for review**	The agency had no domestic minor sex trafficking cases in the past six months or back to the date of the last review.	
Agency has evidence that the FNYFS was contacted for approval prior to admission for all Domestic Minor Sex Trafficking (DMST) placements.	**No eligible items for review**	The agency had no domestic minor sex trafficking cases in the past six months or back to the date of the last review.	
There is evidence the youth was entered into NetMIS as a Special Populations youth at admission and a Human Trafficking Screening Tool (HTST) was completed.	**No eligible items for review**	The agency had no domestic minor sex trafficking cases in the past six months or back to the date of the last review.	
Services provided to these youth specifically designated services designed to serve DMST youth	**No eligible items for review**	The agency had no domestic minor sex trafficking cases in the past six months or back to the date of the last review.	
Did the placement of DMST youth require additional supervision for the safety of the youth or the program? If so, did the agency provide the appropriate level of supervision and safety measures?	**No eligible items for review**	The agency had no domestic minor sex trafficking cases in the past six months or back to the date of the last review.	
Length of Stay: a. Youth in program do not have length of stay in DMST placement that exceeds seven (7) days b. Agency has approval for stays and support beyond seven (7) days for DMST placements that are obtained on a case-by-case basis? (If applicable.)	**No eligible items for review**	The agency had no domestic minor sex trafficking cases in the past six months or back to the date of the last review.	

Agency has evidence that staff assigned to DMST youth under this provision are to enhance the regular services available through direct engagement in positive activities designed to encourage the youth to remain in shelter	**No eligible items for review**	The agency had no domestic minor sex trafficking cases in the past six months or back to the date of the last review.	
All other services provided to DMST youth are consistent with all other general CINS/FINS program requirements	**No eligible items for review**	The agency had no domestic minor sex trafficking cases in the past six months or back to the date of the last review.	
Domestic Violence			
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: No DV respite youth this reporting period **Total number of Closed Files: Residential files (2 closed)** **Staff Position(s) Interviewed** *(No Staff Names)* **: Operations Manager and Director of Residential Programs** **Type of Documentation(s) Reviewed: Shelter client paper files** **Describe any Observations: Observation of NetMIS data entry dates entered**			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	**Yes**	The agency has provided services to DV clients in the last 6 months.	
Youth admitted to DV Respite placement have evidence in the file of a pending DV charge	**Compliance**	Shelter files reviewed, found that DV pending charges are documented on the intake forms.	
Data entry into NetMIS within (3) business days of intake and discharge	**Compliance**	NetMIS review of the intake/discharge was observed and found to be within the (3) business days as required.	
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**	The program documents the transfer of DV Respite to CINS/FINS services in the shelter file.	
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**	The two (2) shelter files reviewed were found to have case/service plan to reflect goals for aggression management, family coping skills, or other interventions to reduce propensity of violence in the home. The client files reviewed were also found to have family engagement and participation in counseling services during the youth's shelter stay.	
All other services provided to Domestic Violence Respite youth are consistent with all other general CINS/FINS program requirements	**Compliance**	The shelter files reviewed documented that all services provided to DV respite youth are consistent with all other general CINS/FINS program requirements.	
Probation Respite			
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: Zero **Total number of Closed Files: Zero** **Staff Position(s) Interviewed** *(No Staff Names)* **: Operations Manager and Program Supervisor**			

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

Intensive Case Management (ICM)

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

N/A

Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	**Not Applicable**	The agency is not contracted to provide intensive case management.	
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.	**Not Applicable**	The agency is not contracted to provide intensive case management.	
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.	**Not Applicable**	The agency is not contracted to provide intensive case management.	
Assessments include a. NIRVANA at intake b. NIRVANA Re-Assessment every 90 days c. Post NIRVANA at discharge as aligned with timeframe requirements	**Not Applicable**	The agency is not contracted to provide intensive case management.	
Service/case plan demonstrates a strength-based, trauma-informed focus	**Not Applicable**	The agency is not contracted to provide intensive case management.	
For any virtual services provided, there is written documentation in the youths' file as to why virtual contact is in the best interest of the youth and family	**Not Applicable**	The agency is not contracted to provide intensive case management.	

Family and Youth Respite Aftercare Services (FYRAC)			
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: Zero **Total number of Closed Files: Zero** **Staff Position(s) Interviewed** *(No Staff Names)* **: Operations Manager and Program Supervisor**			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	**No eligible items for review**	The agency has no FYRAC cases in the past six months or back to the date of the last review.	
Youth is referred by DJJ for a domestic violence arrest on a household member, and/or the youth is on probation regardless of adjudication status and at risk of violating.	**No eligible items for review**	The agency has no FYRAC cases in the past six months or back to the date of the last review.	
Agency has evidence that all FYRAC referrals have documented approval from the Florida Network office	**No eligible items for review**	The agency has no FYRAC cases in the past six months or back to the date of the last review.	
Intake and initial assessment sessions meets the following criteria: a. Services shall be documented through the signature of the youth and his/her parent/guardian as well as orientation to the program which is kept in the youths file. b. The initial assessment shall be face-to-face, in person or through virtual means, to include a gathering of all family history and demographic information, as well as the development of the service plan. c. For youth on probation, a copy of the youths Community Assessment Tool (CAT) to assist with development of the family service plan.	**No eligible items for review**	The agency has no FYRAC cases in the past six months or back to the date of the last review.	
Life Management Sessions meets the following criteria: a. Sessions are face-to-face, sixty (60) minutes in length and focus on strengthening the family unit b. Services are highly supportive, individualized, and flexible and require a "whole family" approach to dealing with the problems affecting the youth and family.	**No eligible items for review**	The agency has no FYRAC cases in the past six months or back to the date of the last review.	
Individual Sessions: a. The program conducted sessions with the youth and family to focus on work to engage the parties and identify strengths and needs of each member that help to improve family functioning. b. Issues to be covered through each session include but are not limited to: Identifying emotional triggers; body cues; healthy coping strategies through individual, group and family counseling; understanding the cycle of violence and the physical and emotional symptoms of anger; developing safety plans; and educating families on the legal process and rights.	**No eligible items for review**	The agency has no FYRAC cases in the past six months or back to the date of the last review.	

Group Sessions: a. Focus on the same issues as individual/family sessions with application to youth pulling on similar experiences with other group members with the overall goal of strengthening relationships and prevention of domestic violence. b. Shall be no more than eight (8) youth at one (1) time and shall be for a minimum of sixty (60) minutes per session	**No eligible items for review**	The agency has no FYRAC cases in the past six months or back to the date of the last review.	
There is evidence of completed 30 and/or 60 day follow-ups and is documented in NetMIS following case discharge.	**No eligible items for review**	The agency has no FYRAC cases in the past six months or back to the date of the last review.	
Youth and family participate in services for thirteen (13) sessions or ninety (90) consecutive days of services, or there is evidence in the youth's file that an extension is granted by DJJ circuit Probation staff	**No eligible items for review**	The agency has no FYRAC cases in the past six months or back to the date of the last review.	
Any service that is offered virtually, is documented in the youth's file why it was in the youth and families best interest.	**No eligible items for review**	The agency has no FYRAC cases in the past six months or back to the date of the last review.	
All data entry in NetMIS is completed within 3 business days as required.	**No eligible items for review**	The agency has no FYRAC cases in the past six months or back to the date of the last review.	

Additional Comments: **There are no additional comments for this indicator.**			
2.09- Stop Now and Plan (SNAP)			**Not Applicable**
Provider has a written policy and procedure that meets the requirement for Indicator 2.09		**N/A** If NO, explain here: N/A	
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*			
N/A			
SNAP Clinical Groups Under 12			
Youth are screened to determine eligibility of services.	**Not Applicable**	The agency is not contracted to provide SNAP services.	
The NIRVANA was completed at initial intake, or within two sessions.	**Not Applicable**	The agency is not contracted to provide SNAP services.	
There is evidence of the completed Child Behavior Checklist (CBCL) by the caregiver (pre and post) and is located within the file.	**Not Applicable**	The agency is not contracted to provide SNAP services.	
There is evidence of the completed Teacher Report Form (TRF) is completed by the teacher (pre and post) and is located within the file.	**Not Applicable**	The agency is not contracted to provide SNAP services.	
There is evidence of the completed TOPSE is completed by the caregiver (pre and post) and is located within the file.	**Not Applicable**	The agency is not contracted to provide SNAP services.	
SNAP Clinical Groups Under 12 - Discharge			
There is evidence of the completed SNAP Discharge Report located within the file for any discharged youth.	**Not Applicable**	The agency is not contracted to provide SNAP services.	
There is evidence of the SNAP Boys/SNAP Girls Child Group Evaluation Form located in the file.	**Not Applicable**	The agency is not contracted to provide SNAP services.	
There is evidence of the SNAP Boys/SNAP Girls Parent Group Evaluation Form located in the file.	**Not Applicable**	The agency is not contracted to provide SNAP services.	
SNAP Clinical Groups for Youth 12-17			
Youth are screened to determine eligibility of services.	**Not Applicable**	The agency is not contracted to provide SNAP services.	
The Consent to Treatment and Participation in Research Form is completed and located within the file.	**Not Applicable**	The agency is not contracted to provide SNAP services.	
The NIRVANA was completed at initial intake, or within two sessions.	**Not Applicable**	The agency is not contracted to provide SNAP services.	
There is evidence of the completed 'How I Think Questionnaire' (HIT) form located within the file or evidence of at least three (3) documented attempts in the youths' file to obtain this information.	**Not Applicable**	The agency is not contracted to provide SNAP services.	
There is evidence of the completed Social Skills Improvement System (SSIS) Student form located within the file or evidence of at least three (3) documented attempts in the youths' file to obtain this information.	**Not Applicable**	The agency is not contracted to provide SNAP services.	
There is evidence of the completed Social Skills Improvement System (SSIS) Teacher/Adult form located within the file or evidence of at least three (3) documented attempts in the youths' file to obtain this information.	**Not Applicable**	The agency is not contracted to provide SNAP services.	
SNAP for Schools & Communities			
The program demonstrated all of the required weekly attendance sheets that included youth names and/or identifying numbers completed with the teacher and trained SNAP Facilitator signatures. (*This must include a total of 13 attendance sheets for a full cycle*)	**Not Applicable**	The agency is not contracted to provide SNAP services.	
The program maintained evidence of a completed "Class Goal" Document for the class reviewed.	**Not Applicable**	The agency is not contracted to provide SNAP services.	

The program maintained evidence of both pre AND post Measure of Classroom Environment (MoCE) completed documents for the class reviewed.	**Not Applicable**	The agency is not contracted to provide SNAP services.	
The program maintained evidence of completed pre and post evaluation documents for the class reviewed.	**Not Applicable**	The agency is not contracted to provide SNAP services.	
There is evidence of the fidelity adherence checklist maintained in the file for each class reviewed.	**Not Applicable**	The agency is not contracted to provide SNAP services.	
Additional Comments: **There are no additional comments for this indicator.**			
3.01 - Shelter Environment			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 3.01		**YES**	
		If NO, explain here:	
		The agency has a policy and procedure titled shelter environment. Policy number 3.01 was last reviewed February 9, 2024 by the CEO.	

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

Staff Position(s) Interviewed (No Staff Names): director of residential programs and assistant director of residential programs
Type of Documentation(s) Reviewed: Egress plans, DCF Child Care License, Chemical binder, SDS, Annual fire inspection report, fire drills, emergency drills, safety equipment inspections, Department of health inspection , Residential inspection report, temperature log, daily activity schedule,
Describe any Observations: Tour of the shelter to include furnishings and exterior grounds. We observed the staff vehicles. Doors inside of the shelter were secured. We observed grievance box and all required postings. Chemicals were located in the kitchen closet and chemical closet. Observed the laundry room to include the washers and dryers. Observation made of the food storage area. Observation made of staff and youth interaction.

Facility Inspection: a. Furnishings are in good repair. b. The program is free of insect infestation. c. Bathrooms and shower areas are clean and functional, free of foul odors, leaks, dust, and mildew and in good working order. d. There is no graffiti on walls, doors, or windows. e. Lighting is adequate for tasks performed there. f. Exterior areas are free of debris; grounds are free of hazards. g. Dumpster and garbage can(s) are covered. h. All doors are secure, in and out access is limited to staff members and key control is in compliance. i. Detailed map and egress plans of the facility, general client rules, grievance forms, abuse hotline information, DJJ Incident Reporting Number and other related notices are posted. j. Interior areas (bedrooms, bathrooms, common areas) do not contain contraband and are free from hazardous unauthorized metal/foreign objects.	**Exception**	Observations made during the tour supported furnishings were in good repair. The seats on the outside porch appeared to be a little worn by weather. Observations made during the tour supported the program was free of insect infestation. There are a total of seven bathrooms located in the shelter. There are a total of four youth bedrooms. Three of the youth bedrooms had bathrooms attached to the bedroom. One bedroom used a bathroom located in the hallway. There is a bathroom located in the intake area. The remaining bathrooms are designated throughout the shelter as staff bathrooms. Review team member confirmed the bathrooms had hot running water. All bathrooms were clean and functional and free of foul odors and mildew. Observations made during the tour supported there was no evidence of graffiti and the shelter was well maintained and very clean. Observations made during the tour supported each area in the shelter including youth bedrooms and staff offices had appropriate lighting. The day room has a window and small track lighting on the vaulted ceiling. The assistant director of residential programs indicated the limited lighting in the evening assists the youth in getting ready to sleep. When youth are sleeping the hall light and staff office light is kept on so the staff have a visual of the youth in their rooms and there is adequate lighting to view staff on camera conducting the ten-minute checks. Observations made during the tour supported the exterior areas are free from debris. The shelter has a large back yard that was well maintained with no debris. The garbage can used in the kitchen is an industrial trash bin on wheels. It does not have a cover. Trash is removed from the program and placed in large trash bins provided by the county. The outside trash bins are covered. The shelter director reported trash is collected once a week. Throughout the review all doors were locked and secured. List location of all items: Observations confirmed egress plans are posted throughout the shelter. Client expectations are posted in the day room. Grievance forms were located in the day room next to the grievance box. The grievance box is a clear, locked box. The Florida Abuse Hotline telephone numbers and directions on how to call the Florida Abuse Hotline was posted on every bedroom door. The program activity schedule was posted in the day room. The DJJ Incident Reporting number is posted in the staff office. There was no contraband found in any of the shelter bedrooms, bathrooms and common areas.	Bathroom in Room three had a cabinet door found to be unattached to the cabinet. Program staff were made aware of the issue. On the second morning of the review the cabinet was fixed and the repair was verified by the review team. The garbage can used in the kitchen does not have a cover.
Facility Inspection: a. All agency and staff vehicles are locked. b. Agency vehicles are equipped with major safety equipment including first aid kit, (all items in the first aid kit are current and do not have expired items; all expired items should be replaced regularly), fire extinguisher, flashlight, glass breaker and, seat belt cutter.	**Compliance**	The program uses three vans to transport youth; a 2014 Kia Sorento, a 2022 Honda Odyssey, and a 2020 Toyota Sienna. During the review staff and agency vehicles were found to be locked and secure. All three vehicles were equipped with a first aid kit, fire extinguisher, flashlight, a window punch, and a seat belt cutter. All items in the first aid kit were current non-expired items. Documentation supported the safety equipment was checked on a weekly basis throughout the review period.	

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**	Kitchen Chemical Count: (1) Great Value Oven Cleaner, (2) Pro Easy Off Oven Cleaner (1) Dawn Dishwashing Soap. Chemical Closet Count: (1) Comet with Bleach (1) Comet with Bleach (1) Fabuloso. The past six months of completed weekly chemical inventories were reviewed and they were completed as required. There was an inventory for the chemicals maintained in the kitchen and a second inventory for the chemicals maintained in the hallway by the intake room. Both areas had a Safety Data Sheet (SDS) binder that contained the SDS sheets for the chemicals in that specific location. Both areas where chemicals are stored had a Safety Data Sheet (SDS) binder that contained the SDS sheets for the chemicals in that specific location. No chemicals were missing SDS.	
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**	Two washers and two dryers are currently working. Observations found the machines to be clean and the lint collectors were empty. The general area where the washers and dryers are maintained was neat and well organized. The shelter has a current DCF license issued on June 1, 2023 and expires May 31, 2024. (Picture uploaded). The DCF License is posted in the intake area of the shelter. Observations made during the tour supported each bedroom contains bunkbeds. The occupied beds were made and each had sheets, a comforter, and a pillow. Each mattress has a protective vinal covering on them. Linens are maintained in the laundry room. Towels and washcloths are provided to youth at shower time and are placed in a hamper located in the bathrooms once the youth are finished showering, Towels and washcloths are washed during third shift. Bed linens are washed weekly during the deep cleaning completed on Saturday. Observations made during the tour supported there were lockers located in each bedroom. Each bedroom contained enough lockers so each youth in the assigned bedroom could have their own locker. All lockers were observed to be locked.	
Additional Facility Inspection Narrative (if applicable)	The bathroom in Room Three had a pencil and sharpie pen found in the vanity above the sink. These items are considered unallowed items in the bedroom. Program staff were made aware of the issue and indicated they would address this oversight with staff.		

Fire and Safety Health Hazards: a. Annual facility fire inspection was conducted, and the facility is in compliance with local fire marshal and fire safety code within jurisdiction. b. Agency completes a minimum of 1 fire drill on each shift monthly (within 2 minutes or less). c. Completes 1 mock emergency drill per shift per quarter. d. All annual fire safety equipment inspections are valid and up to date (extinguishers, sprinklers, alarm system and kitchen overhead hood, including fire extinguishers in all vehicles).	**Compliance**	Original Fire Inspection was completed by the Sarasota County Fire Department on February 16, 2024. There were two items that required a re-inspection; Marking of Fire Alarm Circuit and Fire Alarm Breaker Lock. The reinspection was completed by the Sarasota County Fire Department on February 28, 2024 and both items were cleared during the reinspection. 1st Shift: 10/15/23, 11/12/23, 12/10/23, 1/1/24, 2/4/24, 3/3/24, 2nd Shift: 10/29/23, 11/11/23, 12/20/23, 1/19/24, 2/16/24, 3/21/24, As applicable 3rd Shift: 10/7/23, 11/26/23, 12/5/23, 1/27/24, 2/20/24, 3/26/24, All drills were conducted within two minutes or less. 1st Shift: 10/1/23, 11/1/23, 12/3/23, 1/2/24, 2/1/24, 3/5/24; 2nd Shift: 10/4/23, 11/13/23, 12/14/23, 1/24/24, 2/15/24, 3/28/24; and 3rd Shift: 10/2/23, 11/27/23, 12/23/23, 1/26/24, 2/26/24, 3/19/24, On 12/12/23 Wenzel electrical services completed the annual fire alarm inspection and all equipment is valid and up to date. On 3/15/24 Wenzel electrical services completed the second quarter alarm monitoring and all equipment is up to date. On 1/11/24 Tim's Fire and safety completed the inspections of all the fire extinguishers to include the fire extinguishers in the three vans. Observations made during the review supported all fire extinguishers were easily accessible and not locked away. The shelter does not have a sprinkler system but does have smoke detectors located in various areas throughout the building. The smoke detectors are wired to immediately notify the fire department if one sounds.	
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**	State of Florida Department of Health County Health Department Group Care Inspection Report was completed on 04/03/2024 with satisfactory results. State of Florida Department of Health County Health Department Food Service Report was completed on 03/11/2024 with satisfactory results. The shelter has a large freezer located in the dining area. The kitchen area has a regular sized refrigerator and freezer. There is a third refrigerator located in the hallway leading from intake area into the living area. Observation of the freezers, refrigerators, and dry pantry found the food was well organized and the areas were clean. None of the food was found to be past the expiration date. The shelter maintains a daily log which captures the Fahrenheit measurements of all the freezers, refrigerators, and dry pantry. Refrigerators/freezers observed to be clean and maintained in operable condition.	
Additional Fire and Safety Health Hazards Narrative (if applicable)			

Youth Engagement			
a. Youth are engaged in meaningful, structured activities (e.g., education, recreation, counseling services, life and social skill training) seven days a week during awake hours. Idle time is minimal. b. At least one hour of physical activity is provided daily. c. Youth are provided the opportunity to participate in a variety of faith-based activities. Non-punitive structured activities are offered to youth who do not choose to participate in faith-based activities. d. Daily programming includes opportunities for youth to complete homework and access a variety of age appropriate, program approved books for reading. Youth are allowed quiet time to read. e. Daily programming schedule is publicly posted and accessible to both staff and youth.	**Compliance**	During the review youth were observed engaged in homework activities when they returned to the shelter after school. The daily activity includes large muscle activity to occur once the youth returns from school and after snack time. The schedule indicates the youth has up to two hours of large muscle activity daily. The shelter has a policy and procedure that includes providing youth the opportunity to participate in faith-based activities of choice. The daily activity schedule includes time on Sunday to participate in religious activity. The daily programming schedule includes scheduled time for hygiene, education, meals, recreation and leisure time, snack time, homework time, chores, groups and house meetings, scheduled wake-up and lights out times. The daily programming schedule is posted in the dayroom.	
Additional Comments: **There are no additional comments for this indicator.**			

3.02 - Program Orientation		Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 3.02	**YES** If NO, explain here: The agency has a policy and procedure titled program orientation. Policy number 3.02 was last reviewed February 9, 2024 by the CEO.	

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: Six
Total number of Closed Files: Three
Staff Position(s) Interviewed *(No Staff Names)* **: Director of Residential Programs / Assistant of Residential Programs**
Type of Documentation(s) Reviewed: Youth open and closed records
Describe any Observations: N/A

Youth received a comprehensive orientation and handbook provided within 24 hours	**Compliance**	A review of six closed and three open youth records had documentation to support orientation to the program and a youth handbook was provided to each you within twenty-four hours of admission.	
Orientation includes the following: a. Youth is given a list of contraband items b. Disciplinary action is explained c. Dress code explained d. Review of access to medical and mental health services e. Procedures for visitation, mail and telephone f. Grievance procedure g. Disaster preparedness instructions h. Physical layout of the facility if. Sleeping room assignment and introductions j. Suicide prevention- alerting staff of feelings or awareness of others having suicidal thoughts	**Compliance**	A review of six closed and three open youth records had documentation to support each youth received a comprehensive orientation addressing all required topics.	

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**	Each completed orientation document included orientation topics and dates of presentation, as well as signatures of the youth and staff involved is maintained in the individual youth record.	
Additional Comments: **There are no additional comments for this indicator.**			
3.03 - Youth Room Assignment			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 3.03		**YES** If NO, explain here: The agency has a policy and procedure titled youth room assignment. Policy number 3.03 was last reviewed February 9, 2024 by the CEO.	
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: Six **Total number of Closed Files: Three** **Staff Position(s) Interviewed** *(No Staff Names)* **: Director of Residential Programs / Assistant of Residential Programs** **Type of Documentation(s) Reviewed: Youth open and closed records** **Describe any Observations: N/A**			
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**	Six closed and three open youth records were reviewed. Documentation supported the screening and intake process which includes a review of youth history status and exposure to trauma; Identification of youth susceptible to victimization; presence of medical, mental, or physical disabilities; suicide risk; sexually aggressive and predatory behavior; acute health symptoms requiring quarantine or isolation. All documentation was considered when making youth room assignments.	
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 three open records had special needs identified. A review of the internal alert board confirm all alerts were shared with staff.	
Additional Comments: **There are no additional comments for this indicator.**			
3.04 - Log Books			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 3.04		**YES** If NO, explain here: The agency has a policy and procedure titled log books. Policy number 3.04 was last reviewed February 9, 2024 by the CEO.	
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: 10/20/23, 11/18/23, 01/03/24, 02/05/24, 03/10/24
Staff Position(s) Interviewed (No Staff Names): Director of Residential Programs / Assistant of Residential Programs
Type of Documentation(s) Reviewed: Note ACTIVE
Describe any Observations: N/A

Log book entries that could impact the security and safety of the youth and/or program are highlighted	**Compliance**	A total of five random days and shifts during the review period were reviewed in Note Active. None of the dates and shifts reviewed had any safety and security issues that needed to be highlighted in the Note Active system.	
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**	A total of five random days and shifts during the review period were reviewed in Note Active. All entries included dates and times of activities, names of youth and staff involved, statements providing pertinent information, names to include signatures of persons making the entry. A total of five random days and shifts during the review period were reviewed in Note Active. All entries included dates and times of activities, names of youth and staff involved, statements providing pertinent information, names to include signatures of persons 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**	A total of five random days and shifts during the review period were reviewed in Note Active. On 11/18 there was a late entry documented with the staff member's initial following the entry. No additional errors noted in Note Active.	
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**	A total of five random days and shifts during the review period were reviewed in Note Active. Documentation on all reviewed dates and shifts supported the Program Director or designee reviewed the facility logbook in Note Active at a minimum of every week. Documentation to include corrections, recommendations and follow-ups were documented as needed.	
All staff review the logbook of the previous two shifts and makes an entry signed and dated into the logbook indicating the dates reviewed	**Compliance**	A total of five random days and shifts during the review period were reviewed in Note Active. All direct care staff reviewed the logbook in Note Active at the beginning of each shift for the previous two shifts. Dates reviewed were 10/20/23, 11/18/23, 1/3/24, 2/5/24 , 3/10/24. Dates and staff signature were present following the Note Active 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**	A total of five random days and shifts during the review period were reviewed in Note Active. At the beginning of each shift the oncoming supervisor and shelter counselor reviewed, signed and dated the logbooks in Note Active of all shifts since their last log entry indicating the dates reviewed.	
Logbook entries include: a. Supervision and resident counts b. Visitation and home visits	**Compliance**	A total of five random days and shifts during the review period were reviewed in Note Active. Supervision and resident counts were documented on each shift daily. No visitation or home visits were conducted on the dates the reviewed dates in Note Active.	

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

3.05 - Behavior Management Strategies		**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 3.05	**YES**	
	If NO, explain here:	
	The agency has a policy and procedure titled behavior management system. Policy number 3.05 was last reviewed February 9, 2024 by the CEO.	

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

Staff Position(s) Interviewed *(No Staff Names)* **: Director of Residential Programs / Assistant of Residential Programs** **Type of Documentation(s) Reviewed: Youth Handbook, Staff training records, completed point cards** **Describe any Observations: N/A**			
The program has a detailed written description of the BMS and it is explained during program orientation	**Compliance**	The youth handbook includes a detailed description of the behavior level system and orientation documentation includes an explanation of the level system.	
Behavior Management Strategies must include:			
a. BMS is designed to teach youth new behaviors and help youth understand the natural consequences for their actions b. Behavioral interventions are applied immediately, with certainty, and reflect the severity of the behavior c. BMS uses a wide variety of awards/incentives to encourage participation and completion of the program d. Appropriate consequences and sanctions are used by the program and consequences for behavior are logical and designed to promote skill-building for the youth e. Counseling, verbal intervention and de-escalation techniques are used prior to physical intervention (Only techniques approved by the Florida Network and DJJ are used if physical intervention is required) f. Only staff discipline youth. Group discipline is not imposed g. Room restriction is not used as part of the system or for youth who are physically and/or emotionally out of control h. Youth should never be denied basic rights such as meals, clothing, sleep, services, exercise, or correspondence privileges	**Compliance**	There are some behaviors that will prevent a youth from being able to earn daily points. These behaviors are addressed in the youth handbook along with the consequences that may get assigned as a result of these behaviors. There is also a list of cardinal rules that are illegal and result in the program being required to call law enforcement. The program holds a behavior management meeting, also referred to as the house meeting or hot seat meeting, every Monday and Thursday. During this meeting, youth are given the opportunity to address behaviors and discuss earning the privilege to move up in levels. During an informal interview with the director of residential programs, he indicated all behavior and consequences are addressed in real time. Staff redirect youth and give them the opportunity to correct the behavior. If the behavior continues, the youth will be informed the youth has not been able to earn points due to non-compliance with behavior expectations. The youth review and sign point sheets nightly. In addition to the privileges that can be earned on each level, youth have the opportunity to earn additional points and participate in various outings. The youth handbook addresses the protection of the youth rights. In addition to the privileges that can be earned on each level, youth have the opportunity to earn additional points and participate in various outings. The program holds a behavior management meeting, also referred to as the house meeting or hot seat meeting, every Monday and Thursday. During this meeting, youth are given the opportunity to address behaviors and discuss earning the privilege to move up in levels. The BMS provides constructive discipline that encourages youth to meet behavior expectations. Staff redirect youth and give them the opportunity to correct the behavior. If the behavior continues, the youth will be informed the youth has not been able to earn points due to non-compliance with behavior expectations. The youth review and sign point sheets nightly. The policy states only staff are only able to discipline youth and group discipline is not imposed. The policy also indicate room restriction is not used. The policy addresses the basic right of the youth and indicates disciplinary measures do not deny the youth any rights.	
Program's use of the BMS			
All staff are trained in the theory and practice of administering BMS rewards and consequences	**Compliance**	Five training files for residential staff supported they were trained in the theory and practice of administering BMS rewards and consequences.	
There is a protocol for providing feedback and evaluation of staff regarding their use of BMS rewards and consequences	**Compliance**	During an informal interview with the director of residential programs, he indicated management would provide redirection to staff individually as needed. If the issue becomes a collective systematic issue, management will address the issue in a staff meeting. There have been occasions where staff have talked to management to report when other staff don't use the BMS correctly. The youth also talk to management when they have questions about how the staff are using the BMS. Management will sit down and address the situation before it becomes a grievance.	
Supervisors are trained to monitor the use of rewards and consequences by their staff	**Compliance**	Two supervisor training records were reviewed and it was confirmed they were trained to monitor the use of rewards and consequences by their staff.	
Additional Comments: **There are no additional comments for this indicator.**			

3.06 - Staffing and Youth Supervision			Limited
Provider has a written policy and procedure that meets the requirement for Indicator 3.06		**YES** If NO, explain here: The agency has a policy and procedure titled staffing and youth supervision. Policy number 3.06 was last reviewed February 9, 2024 by the CEO.	
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: 10/20/23, 11/18/23, 01/03/24, 02/05/24, 03/10/24 **Staff Position(s) Interviewed (No Staff Names): Director of Residential Programs / Assistant of Residential Programs** **Type of Documentation(s) Reviewed: Note ACTIVE, Six months of staff schedule** **Describe any Observations: Video Observation / Staff to youth ratio**			
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 weekly schedules from October 2023 through the second week of April 2024 and a review of documentation in Note Active supported the program maintained the minimum staffing ratios as required by Florida Administrative Code and the contract.	
All shifts must always provide a minimum of two direct care staff present that have met the minimum training requirements	**Compliance**	A review of weekly schedules from October 2023 through the second week of April 2024 supported each shift met the staff to youth ratio. The scheduled week begins on Monday and ends on Sunday. The weekly schedule designates the management staff on duty for that day, the three shifts and which staff is assigned to complete youth transports, medication distribution, and what staff is preparing the meals. The weekly schedules also designates what staff are assigned to provide supervision to the female youth and male youth. Shifts run from 7:30 AM to 3:30 PM, 3:30 PM to 11:30 PM, and 11:30 PM to 7:30 AM.	
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**	Reviewed team members and confirmed staff background screenings and training for staff were completed as required.	
The staff schedule is provided to staff or posted in a place visible to staff	**Compliance**	Observation of the staff schedule showed evidence that is posted in a place visible to staff. The staff schedule is also provided to staff.	
There is a holdover or overtime rotation roster which includes the telephone numbers of staff who may be accessed when additional coverage is needed	**Compliance**	During an informal interview with the director of residential programs, he indicated the program has a compliment of full-time staff, PRN staff, and an on-call manager every week that can be called in to work a shift at any time. The director of residential programs uses a list of staff when coverage is needed to be called in to work a shift.	
Staff observe youth at least every 15 minutes while they are in their sleeping room, either during the sleep period or at other times, such as during illness or room restriction	**Exception**	A review of four hour increments on five random dates indicate that 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. Seventy-six of eighty bed checks observed on the following dates: 10/20/2023, 11/18/2023, 01/03/2024, 02/05/2024, and 03/10/2024, were completed timely and in compliance with the 15 minute room check requirement.	Four, ten minute checks were completed late. Two were documented in Note ACTIVE; however these checks were not completed at all, as confirmed by video review. Both the director of residential programs and assistant of residential programs were made aware of this information and reviewed the video for confirmation that the bed checks were documented and not completed. The CCC was contacted by director of residential programs and the report number is 0517.
Additional Comments: **There are no additional comments for this indicator.**			

3.07 - Video Surveillance System			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 3.07	**YES** If NO, explain here:	The agency has a policy and procedure titled video surveillance system. Policy number 3.07 was last reviewed February 9, 2024 by the CEO.	

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: 03/27/24 1:00am through 5:00am, 03/30/24 2:58am through 6:55am, 04/03/24 9:00 pm through 12:01am, 04/15/24 8:50pm through 12:00am, 4/23/24 from 1:00 AM through 4:00 AM
Staff Position(s) Interviewed *(No Staff Names)* **: Assistant director of residential programs**
Type of Documentation(s) Reviewed: Supervisory review of video
Describe any Observations: N/A

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 shelter has a generator that is used to operate the camera system during a power outage. During an informal interview with the director of residential programs, he indicated video is recorded and maintained for thirty-days. During an informal interview with the director of residential programs, he indicated the video system records the date, time, and location. Recently the shelter had the camera system upgraded so two servers are now used to maintain recordings. This upgrade has greatly improved the quality of the video picture which includes clear facial recognition. The shelter has a generator that is used to operate the camera system during a power outage. During an informal interview with the assistant director of residential programs, he indicated there are a total of fifteen cameras located throughout the shelter. The cameras are posted around the exterior of the shelter and in general locations inside the shelter where staff and youth congregate and includes where visitors enter and exit. Policy 3.07 includes a list of where each camera is physically located. There is a camera located in the intake area where youth searches are conducted. Observations made during the tour supported all cameras are visible.	
A list of designated personnel who can access the video surveillance system is maintained (includes off-site capability per personnel)?	**Compliance**	The policy indicates the designated personnel who can access the video surveillance system include the director of residential programs, the assistant director of residential programs and the youth and family advocate manager. All three administrative staff have the capability to access video surveillance from they work phones.	
Supervisory review of video is conducted a minimum of once every 14 days and timeframes reviewed are noted in the logbook.	**Compliance**	A review of the completed video surveillance review documents supported supervisory reviews of video being conducted on a weekly basis. There was indication of the video system being upgraded in December 2023, however, supervisory reviews were conducted within the 14 day timeframe. The completed documentation consisted of the review date, the cameras reviewed, staff involved, issues noted as a result of the review, and action taken. The signature of the manager completing the video review and the director is also included on the document. Documentation the week of 3/2/24 supported an issue was observed with missed bed check and management addressed the issue with staff through a verbal warning. The assistant director of residential programs indicated he is responsible for completing the video review.	

The reviews assess the activities of the facility and include a review of random sample of overnight shifts	**Compliance**	Documentation confirmed the reviews included activities of the facility and include a review of random sample of overnight shifts.	
Grant the requesting of video recordings to yield a result within 24-72 hours from program quality improvement visits and when an investigation is pursued after an allegation of an incident	**Compliance**	During an informal interview with the director of residential programs, he indicated the process for third party review of video recordings includes contacting the program's IT department. Staff from the IT department will come to the shelter and download the requested video. The copy of the video is then uploaded into a SharePoint folder where the third party can have access to the recording.	
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**	During an informal interview with the director of residential programs, he indicated there were no issues during review period where camera system malfunctioned.	
Additional Comments: **There are no additional comments for this indicator.**			
4.01 - Healthcare Admission Screening			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 4.01		**YES** If NO, explain here: The agency has a policy and procedure titled healthcare admission screening. Policy number 4.01 was last reviewed February 9, 2024 by the CEO.	
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: Three **Total number of Closed Files: Eight** **Staff Position(s) Interviewed** *(No Staff Names)* **: Program Director** **Type of Documentation(s) Reviewed: Files** **Describe any Observations:**			
Preliminary Healthcare Screening			
Screening includes : a. Current medications b. Existing (acute and chronic) medical conditions c. Allergies d. Recent injuries or illnesses e. Presence of pain or other physical distress f. Observation for evidence of illness, injury, physical distress, difficulty moving, etc. g. Observation for presence of scars, tattoos, or other skin markings h. Acute health symptoms requiring quarantine or isolation	**Compliance**	Healthcare screening is completed in several places in the file: Residential Intake Form which includes the healthcare admission information, Nurse Review of Healthcare Admission Screening, Medical Questionnaire, and the Medical and Mental Health Alert Form. The healthcare admission information which is gathered in the Residential Intake form meets the requirements of the standard and captures all the required elements.	
Referral and Follow-Up			
Youth with chronic medical conditions have a referral to ensure medical care (e.g. diabetes, pregnancy, seizure disorder, cardiac disorders, asthma, tuberculosis, hemophilia, head injuries, etc.)	**Compliance**	The agency utilizes a Nurse Review of the Healthcare Admission Form, which documents any known chronic health conditions that were noted on the Residential Intake Form. Of the eleven files reviewed, two files were noted as having asthma and in both cases. The form noted further information provided about the guardian's attempt to get medical care and the status of the youth's condition; in which it shows the follow up is being addressed by the guardian.	

When needed, the parent is involved with the coordination and scheduling of follow-up medical appointments	**Compliance**	Of the eleven files reviewed, two files indicated a medical follow up. Both files had notations on the document titled Nurse Review of the Healthcare Admission Form regarding the follow-up and engaging the guardian or the program's current efforts to get the youth the medical care needed.	
All medical referrals are documented on a daily log.	**Compliance**	The agency maintains case notes on any medical referrals needed. One file reviewed, noted repeated attempts to have the guardian provide medical attention for the youth.	
The program has a thorough referral process and a mechanism for necessary follow-up medical care as required and/or needed	**Compliance**	As noted earlier, the document titled, Nurse Review of the Healthcare Admission Form, notes any follow up needed and actions taken.	
Additional Comments: **There are no additional comments for this indicator.**			
4.02 - Suicide Prevention			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 4.02		**YES** If NO, explain here: The agency has a policy and procedure titled suicide prevention. Policy number 4.02 was last reviewed February 9, 2024 by the CEO.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open (Residential & Community) Files: Two **Total number of Closed (Residential & Community) Files: Three** **Staff Position(s) Interviewed** *(No Staff Names)* **: Program Director for residential and program supervisor for community counseling** **Type of Documentation(s) Reviewed: Files, alert board, policy** **Describe any Observations:**			
Suicide Risk Screening and Approval (*Residential and Community Counseling*)			
Suicide risk screening occurred during the initial intake and screening process. Suicide screening results reviewed and signed by the supervisor and documented in the youth's case file.	**Compliance**	The program utilizes the Residential Intake Form per policy to assess suicide risk upon intake. If a youth answers affirmatively to any of the first five questions the agency places the youth on sight and sound until an ASR can be completed and then reviewed with a licensed professional. A total of five files were reviewed, four shelter and one community counseling, all which indicated suicide risk at the intake. Of the five, two were open and three were closed. All five files demonstrated that an ASR was initiated the same day as the intake and all five were reviewed by a licensed professional on the same day as well.	
The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	**Compliance**	The program utilizes an ASR that has been approved by the network and the licensed staff utilizes the Columbia assessment tool in addition.	
Supervision of Youth with Suicide Risk *(Shelter Only)*			
Youth are placed on the appropriate level of supervision based on the results of the suicide risk assessment.	**Compliance**	A total of five files were reviewed that indicated suicide risk upon entry into the programs. Of the four residential files, all four were placed on sight and sound immediately after screening for suicide risk. For the one community file reviewed, the counselor started the ASR and reviewed it with a licensed professional during the intake process.	
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**	Four residential files were reviewed that indicated suicide risk after initial intake. All four were properly placed on sight and sound and all four files contained documentation noting the 30 minute checks until the client was removed from sight and sound by the licensed professional.	

Documentation includes the time of day, behavioral observations, any warning signs observed, and the observers' initials and was maintained in either an observation log or in the shelter daily log.	**Exception**	The program utilizes a sight and sound sheet separate from the daily communication log that contains the required elements of observation. Of the four files reviewed, all four were filled out correctly.	One file, appears to have some times on the log that were pre-filled as the youth was removed from watch prior to the additional times indicated, but additional times were still noted and then crossed out.
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**	A total of five files were reviewed that indicated risk for suicide. Of the five, all five files followed proper procedure and the youth was not put at a reduced supervision level until it had been reviewed by a licensed professional.	
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**	Of the five files reviewed for suicide risk, all five showed supervisory review of pertinent documentation and the observation log was always signed off on by the licensed professional.	
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**	One file from community counseling was reviewed that had indicated a suicide risk, the ASR was conducted with the counselor in person and the licensed staff by phone.	
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**	There were no files in the sample reviewed that showed evidence of the appropriate staff not being available when a youth identified for suicide risk. The program has procedures in place to immediately refer the youth and notify the parent/ guardian of the suicide risk findings disclosed and advised that an Assessment of Suicide Risk should be completed ASAP by a licensed professional.	
Information on resources available in the community for further assessment was provided to the parent/guardian and is documented in the youth's file and signed by the parent/guardian OR a written follow-up notification was sent by certified mail if the parent/guardian was not present during the screening and was notified by telephone.	**Compliance**	The file reviewed was an ASR conducted at a school intake so the notes reflected the involvement of the school "gatekeeper" and discussions with the mother who ended up transporting the youth for further assessment to a Baker Act facility.	
If the parent/guardian cannot be contacted, all efforts to contact them are documented in the case file.	**Compliance**	The file reviewed showed evidence in the notes of the mother being contacted about the ASR and a discussion about resources and options. The mother transported the youth to a Baker Act facility.	

When the screening was completed during school hours on school property, the appropriate school authorities were notified.	**Compliance**	The schools utilize a "gatekeeper" who is notified during all suicide risk assessments and acts as a liaison for the school system. The notes reflected that the "gatekeeper" was notified of the ASR.	
Additional Comments: **There are no additional comments for this indicator.**			
4.03 - Medications			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 4.03		**YES** If NO, explain here: The agency has a policy and procedure titled medications. Policy number 4.03 was last reviewed February 9, 2024 by the CEO.	
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: Three **Total number of Closed Files: One** **Staff Position(s) Interviewed** *(No Staff Names)* **: Program Supervisor and Direct Care Staff** **Type of Documentation(s) Reviewed: Staff training, Medication Distribution logs, Staff Schedules**			
The agency has a Registered Nurse (RN) and/or a Licensed Practical Nurse (LPN) that is being supervised by RN and all of their credentials have been verified.	**No eligible items for review**	The agency does not currently have a nurse on staff. At the time of the review, agency practice was good.	
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**	There are thirteen (13) staff who are designated to distribute medications. All thirteen (13) had current certificates from a RN on their training which was conducted in January of 2024.	
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**	Meetings were held in November and March, both of which showed documentation on the agenda of reviewing medication process and practice with a particular focus in March on the process for controlled medications and the clearing of discrepancies every shift. The agency has not had any medication errors during this review period.	
The agency has strategies implemented to ensure medications are provided within the 2-hour time frame.	**Compliance**	In review of the program process and interview with the program supervisor, staff utilize alarms for all medication times either on their phones or ones provided by the agency.	
All non-licensed staff members are clearly identified and designated on the staff schedule and shift change report/shift responsibility form for assisting with the self-administration of medications on each shift	**Compliance**	The monthly schedule delineates staff responsible for medication that specific shift with an "M" next to their name.	
The agency has clear methods of communicating which youth are on medications with the times and dosage easily discernable by all staff on each shift.	**Compliance**	The agency utilizes a census board in the staff office which notes specific medications each youth is on if applicable. In addition, the medication book where current MDL's are kept are specific to each individual medication.	

The delivery process of medications is consistent with the FNYFS Medication Management and Distribution Policy and the agency has an internal quality assurance process to include the following: a. to ensure appropriate medication management and distribution methods b. to track medication errors c. to identify systemic issues and implement mitigation strategies, as appropriate.	**Compliance**	A med pass was observed for a youth at 12pm and staff were in compliance with all related procedures for delivering medications. The agency has a PQI committee in which the Program Supervisor participates and who meet on a quarterly basis. The program has not had any medication errors in this review period but this committee is where any process and medication issues would be analyzed on a macro level. The program then utilizes staff meeting to disseminate any changes or reminders needed on the medication process.	
Admission/Intake of Youth			
a. Upon admission, the youth and parent/guardian (if available) were interviewed by the Registered Nurse (when on-site) about the youth's current medications as part of the Medical and Mental Health Assessment screening process and/or an interview was conducted by the RN within three (3) business days if the RN was not on the premise at admission. **If the agency does not have a RN, there was a medication review conducted by a certified Leadership position.* b. Upon intake/admission, there is evidence that the on-shift certified supervisor of higher level staff did review all medication forms by the next business day.	**Compliance**	The program does not currently have a registered nurse. The program utilizes a form labeled Nurse Review of the Healthcare Admission Screening. The youth and parent/guardian (if available) are interviewed upon intake/ admission, about the youth's current medications as a part of the Medical and Mental Health Assessment screening process and the Nurse Review form is currently being reviewed within the next business day, by one of the program supervisors who is in a certified leadership position.	
Medication Storage			
a. All medications are stored in a Pyxis ES Medication Cabinet that is inaccessible to youth (when unaccompanied by authorized staff) b. Pyxis machine is stored in accordance with guidelines in FS 499.0121 and policy section in Medication Management c. Oral medications are stored separately from injectable epi-pen and topical medications d. Medications requiring refrigeration are stored in a secure refrigerator that is used only for this purpose, at temperature range 2-8 degrees C or 36-46 degrees F. (If the refrigerator is not secure, the room is secure and inaccessible to youth.) e. Narcotics and controlled medications are stored in the Pyxis ES Station f. Pyxis keys with the following labels are accessible to staff in the event they need to access medications if there is a Pyxis malfunction: a TOP COVER b BACK PANEL- LEFT TALL CABINET LOCK- LEFT, c BACK PANEL- RIGHT TALL CABINET LOCK- RIGHT	**Compliance**	The agency stores all medications in the Pyxis as required that is kept behind a locked sliding glass door in the staff office. The program did not have any topical or epi-pen medications at the time of the review but their policy and practice is to store these in a separate location of the Pyxis. The program keeps a medication refrigerator in the same room which is also locked and was checked and noted to be in compliance with the correct temperature range. At the time of the review the program did not have any medications that were in need of refrigeration. During the review the program was noted to have two controlled medications which were stored properly in the Pyxis. The keys to the Pyxis are kept in the supervisor's office and the supervisor will come to the program to access the keys or if another higher level staff is on site will assist the staff in accessing the keys.	
Medication Distribution			

a. Agency maintains a minimum of 2 site-specific System Managers for the Pyxis ES Station b. Only designated staff delineated in User Permissions have access to secured medications, with limited access to controlled substances (narcotics) c. A Medication Distribution Log shall be used for distribution of medication by non-licensed and licensed staff d. Agency verifies medication using one of three methods listed in the FNYFS Policies & Procedures Manual e. When nurse is on duty, medication processes are ALWAYS conducted by the nurse or when the nurse is not onsite, then the designated staff who has been trained by a licensed Registered Nurse provides the medication. f. Agency does not accept youth currently prescribed injectable medications, except for epi-pens h. Non-licensed staff have received training in the use of epinephrine auto-injectors provided by a registered nurse	**Compliance**	The program has two current superusers who are both supervisors. A list of trained staff are maintained in a binder and this matches the staff who have access to the Pyxis. All youth who were on medication at the time of the review had a current MDL. The program policy denotes that they use one of the three methods for verification, however, the review noted the method being used consistently was verification by staff with the pharmacy. The verification is documented on a form labeled Medication Transfer and denotes the medication, dosage, pharmacy, date, and time of verification. The agency does not currently have a nurse and their policy notes that they do not accept youth with injectable medications.	
The medication distribution log documentation includes: a. the time of medication administration b. evidence of youth initials that the dosage was given c. evidence of staff initials that the dosage was given	**Compliance**	The program's MDL's all showed time of distribution along with initials of both staff and youth.	
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**	All MDL's reviewed showed compliance with the required timeframe for medication distribution. The agency has not had any medication errors in the review period and has given all medications within the required timeframe.	
During the review period, there were no instances where youth missed their medication due to failure to open the pyxis machine.	**No eligible items for review**	There were no medication errors in this review period. There were no instances where youth missed their medication due to failure to open the pyxis machine.	
<u>If applicable:</u> Any staff member deemed responsible for a medication error, there was evidence that the staff member received refresher training from an RN and demonstrated competency prior to being assigned future medication administration responsibilities. There is evidence that any staff member deemed responsible for 3 errors within a 1-year time frame, had their certification suspended and was not recertified until the completion of the full **in-person** medication administration training, demonstrating competency and re-certification from an RN.	**No eligible items for review**	There were no medication errors in this review period.	
Medication Inventory			

a. For controlled substances, a perpetual inventory with running balances is maintained as well as a shift-to shift count verified by a witness and documented b. Over-the-counter medications that are accessed regularly and inventoried weekly c. Syringes and sharps (needles, scissors, etc.) are secured, and counted and documented weekly	**Exception**	At the time of the review, the program had two controlled medication which showed evidence on the MDL's of a shift by shift count in addition to the running balance which is maintained on all MDL's. All of the counts show evidence of a witness. The agency maintains a sharps log in which they count any razors dispersed to the youth, knives in the kitchen, scissors in the program, tweezers, and nail clippers. All items are counted daily and each item had a daily count during the review period.	During the review, the agency maintained two (2) OTC's, acetaminophen and children's acetaminophen. There was a weekly log being kept through the end of 2023 but upon interviewing the program supervisor, the manual count was stopped in favor of using the Pyxis count. There was no evidence of a weekly inventory other than if any OTC's were removed through a perpetual count. When looking at the acetaminophen, the count in Pyxis stated 152, however, the actual count when done by the program supervisor was 106. The program supervisor noted that staff also utilizes the OTC's but that they are supposed to reduce the count in Pyxis every time they access it.
There are monthly reviews of the Pyxis reports to monitor medication management practice.	**Compliance**	The program supervisor reviews the Pyxis a minimum of weekly to look at discrepancy reports which are printed out.	
Medication discrepancies are cleared after each shift.	**Compliance**	The agency provided evidence of shift to shift clearances of discrepancies and staff meeting notes showed the discussions of this requirement.	
Additional Comments: **There are no additional comments for this indicator.**			
4.04 - Medical/Mental Health Alert Process			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 4.04		**YES** If NO, explain here: The agency has a policy and procedure titled medical/ mental health alert process. Policy number 4.04 was last reviewed February 9, 2024 by the CEO.	
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: Three **Total number of Closed Files: Eight** **Staff Position(s) Interviewed** *(No Staff Names)* **: Program Director** **Type of Documentation(s) Reviewed: Files/Census Board**			
Youth with a medical, mental health, or food allergy was appropriately placed on the program's alert system	**Compliance**	Alerts are noted in the youth file, on the spine of the youth file, and on the census board for youth currently in shelter. A total of eleven files were reviewed, eight closed and three open. Ten of the eleven files (closed and open) showed evidence of alerts being used on the residential intake form in the file. No alerts were indicated for one closed youth file, therefore it was not applicable. All three open files reviewed had alerts noted in all three places.	
Alert system includes precautions concerning prescribed medications, medical/mental health conditions	**Compliance**	The alert system uses color codes which are notated on the second page of the Residential Intake Form. There are specific alerts for medications and medical/mental health conditions. Specifically, the program uses a blue dot for medical issues, a red dot for medications, a red check for mental health, and a red "C" for controlled medications.	

Staff are provided sufficient training, information and instructions to recognize/respond to the need for emergency care for medical/mental health problems	**Compliance**	Within the initial orientation the staff are trained in the medical/mental health alert process and it is documented on the Employee Orientation Form. Four staff training files were reviewed, all four showed evidence of the required training on the alert system.	
A medical and mental health alert system is in place that ensures information concerning a youth's medical condition, allergies, common side effects of prescribed medications, foods and medications that are contraindicated, or other pertinent mental health treatment information, is communicated to all staff	**Compliance**	The program notes any alerts on the Residential Intake Form and the file spine utilizing a color coding system. Dots corresponding to the specific alert are placed on the second page above the classification system and specific notes are written when appropriate. In addition, the program utilizes a census board for open youth where the alerts are indicated and viewable in the staff office. A total of eleven files were reviewed, eight closed and three open. Ten of the eleven files contained indicated alerts and all were notated correctly. One file did not require alerts to be indicated.	
Additional Comments: **There are no additional comments for this indicator.**			
4.05 - Episodic/Emergency Care			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 4.05		**YES** If NO, explain here: The agency has a policy and procedure titled episodic/ emergency care. Policy number 4.05 was last reviewed February 9, 2024 by the CEO.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: Zero **Total number of Closed Files: Nine** **Staff Position(s) Interviewed** *(No Staff Names)* **: Program Director** **Type of Documentation(s) Reviewed: Episodic Log and Incident Reports, Training Files** **Describe any Observations:**			
Off Site Emergency Care			
a. If off-site emergency medical or dental care was provided, an incident report was submitted for the medical or dental care b. Upon youth return, there is a verification receipt of medical clearance via discharge instructions with follow-up is present in file c. Youth's parent/guardian was notified d. A daily log is maintained for emergency care provided	**Compliance**	The program maintains a binder labeled "Episodic Emergency Care Log for Off-Site Emergencies". There is a log sheet through January 2024, in the binder noting each entry. The program director noted discontinuing the log sheet and starting individual write ups on each incident which was evidenced in the book. There were nine total entries in this review period that required outside medical care, six were baker acts. In all incidents the parent/guardian was notified along with the CCC when appropriate. There were two instances where youth were taken to be seen for outside medical care and both youth had verification of receipt of medical clearance, via discharge documentation, was attached to each incident report.	
All staff are trained on emergency medical procedures	**Compliance**	A total of four staff training files were reviewed and all four showed evidence of training on emergency procedures which is documented on the employee orientation checklist.	
The program has a Knife-for-life and wire cutters accessible to staff in a secure location(s)	**Compliance**	The program maintains the Knife-for-life and wire cutters in an accessible case in the staff office which is kept separate from the youth common area.	
Additional Comments: **There are no additional comments for this indicator.**			