Florida Network for Youth and Family Services
Compliance Monitoring Report for

Youth Crisis Center

3015 Parental Home Road
Jacksonville, FL 32216

May 15-16, 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 Youth Crisis Center (YCC) for the FY 2023-2024 at its program office located at 3015 Parental Home Road, Jacksonville, Florida 32216. 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. Youth Crisis Center 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 LaToya Robinson, LeAnn Gruentzel, Cyndy Freshour and Thresa Clove. Agency representatives from Youth Crisis Center present for the entrance interview were: Lisa Pitts, Stepheny Durham, and Logan Farrelly. The last onsite QI visit was conducted 02/23/2023.

In general, the Reviewer found that Youth Crisis Center is in compliance with specific contract requirements. **Youth Crisis Center received an overall compliance rating of 100% for achieving full compliance with 12 indicators** of the CINS/FINS Monitoring Tool. There were no corrective actions as a result of the monitoring visit.

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

2023-2024 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 05-15-16-2024

Agency Name: Youth Crisis Center	**Monitor Name: Andrea Haugabook, Lead Reviewer**
Contract Type: CINS/FINS	**Region/Office: 3015 Parental Home Road, Jacksonville, FL**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): May 15-16, 2024**

Major Programmatic Requirements	Explain Rating: Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable	Ratings Based Upon: I = Interview; O = Observation; D = Documentation; PTV = Submitted Prior To Visit (List Who and What)	Notes: Explain Unacceptable or Conditionally Acceptable:
I. Administrative and Fiscal							
DJJ (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 currently has two peer reviewers and has met the participation requirement of one on-site quality assurance review of a similar type of program in another judicial circuit during this current 12-month period of the contract.	
Additional Contracts a. Provider shall provide a listing of all current federal, state, or local government contracts, as well as other contracts entered into with for profit and not-for-profit organizations. Such a listing shall identify the awarding entity and contract start & end dates. **PTV**	☐	☐	☒	☐	☐	The following is the list of additional contracts provided by the agency: Public Service Grant, Touchstone; Public Service Grant, House of Hope (HOH); LGBTQ Fund, HOH Baptist, HOH; United Way ARP, St. Johns County Therapist; United Way ARPA; Family LINK KHA, Residential; Moran Foundation, Touchstone; United Way St. Johns County, Family Link & SNAP; KHA, Bright Beginnings; Everbank, HOH & Touchstone; Moran Foundation, HOH; KHA, Bright	

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	Unacceptable	**Conditionally Unacceptable**	**Fully Met**	**Exceeded**	**Not Applicable**		
						Beginnings; Rotary Club, Clubhouse; Community Foundation, Outpatient; Baptist Hospital, Residential Nurse; PSG, Touchstone; Basic Center, residential; KHA, Residential.	
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 has a current certificate of insurance from Arthur J. Gallagher Risk Management Services, LLC which shows the following coverages from 07/01/2023-07/1/2024 (except where indicated): Worker's Compensation and Employer's liability insurance as required by Chapter 440, F.S. with a limit of $500,000 per accident, $500,000 per person and $500,000 policy aggregate; Commercial General Liability, damage to rented property, personal and advance injury, each with a limit of $1,000,000, general aggregate and products liability with a limit of $300,000 each, and medical expense (any one person) $20,000. Automobile Liability Insurance, which	

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						includes a combined single limit of 1,000,000. Additional coverage includes professional liability and sexual abuse and molestation with a limit of $1,000,000 each claim and $3,000,000 aggregate. The Florida Network of Youth and Family Services is listed on the COI as a certificate holder.	
External/Outside Contract Compliance a. Provider has corrective action item(s) cited by an external funding source (Fiscal or Non-Fiscal). **ON SITE**	☐	☐	☐	☐	☒	The agency reports there are no corrective action items cited by 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 policies and procedure manuals that comply with GAPP 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**	☐	☐	☒	☐	☐	The agency maintains a general ledger and corresponding source documents. The general ledger is set up to track the activity of the grant separately for each revenue source.	

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c. Petty cash ledger system is balanced and all cash disbursements are compliant with financial policies and allowable under the contract. (Disbursements/invoices are approved & monitored by management.) –**ON SITE**	☐	☐	☒	☐	☐	The director of residential services maintains the petty cash fund. It is reconciled monthly. The designated amount of the petty cash fund is $400. Staff make requests for petty cash and bring back a receipt for the funds used. Funds are typically used for outings, clothing, activities, and anything pertaining to the youth's needs in shelter. The petty cash is maintained in a locked cash box in the office of the director of residential services. The petty cash was reconciled on-site and all cash on hand ($102.58) and receipts on hand ($297.42) balanced out to the designated fund amount of $400.	
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**	☐	☐	☒	☐	☐	An interview with the CEO indicates that bank statements are pulled on the 1st of the month and reconciled by the Chief Development Officer. Every two weeks, the Chief Development Officer also uploads invoices to Klasfeld (3rd party bookkeeper). The bookkeeper then prepares a report for the CEO to	

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						approve for payment and payments are made by Klasfeld electronically or by printed checks.	
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 currently has no assets purchased with Florida Network funds.	
f. Agency submits payroll taxes and deposits (and retirement deposits as applicable), Employee IRS Form W-2 and Independent Contractors IRS Form 1099 forms prior to federal requirements. **ON SITE**	☐	☐	☒	☐	☐	The agency compiles the payroll information in-house and submits it to the 3rd party bookkeeper (Klasfeld) for verification and submission to ADP for processing bi-monthly. Payroll taxes, deposits, IRS forms and retirement deposits are all processed through ADP.	

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g. Budget to actual reports prepared and reviewed by appropriate management. Variance from the budget are investigated and explained. **PTV/ON SITE**	☐	☐	☒	☐	☐	An interview with the CEO indicated that budget reports are prepared by the Chief Development Director with 29 cost centers. The CEO reviews each of those cost centers monthly. The CEO reports all budget to actual reports and explains variances to the finance committee of the board.	
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 presented an audit report completed on November 10, 2023, by Neville Waino, CPA's. The report is a combined financial statement for the years ended June 30, 2023, and 2022. There is no management letter.	
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	☐	☐	☒	☐	☐	The agency has a confidentiality policy pertaining to confidentiality of medical information, outlined in the Employee Handbook last revised February 1, 2023. There is additional language in the 2023-2024 YCC Operations	

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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:**
documents are shredded and computer hard drives are wiped prior to discarding. **ON SITE**						Manual, included in 1.01 Program Description and Mission Statement, which discusses client confidentiality.	
j. Agency provided evidence that every direct care staff employee, as of October 1, 2023, is being paid at least $19.00 per hour. This also includes funding for additional staff as approved by the Department. **ON SITE**	☐	☐	☒	☐	☐	The agency provided a report of all direct care staff with titles, pay rate, hire date. All direct care staff are currently being paid at least $19.00 per hour.	

CONCLUSION

Youth Crisis Center has met the requirements for the CINS/FINS contract as a result of full compliance with --- applicable indicators of the Administrative and Fiscal Contract Monitoring Tool. Two of the fourteen indicators were not applicable because the agency has no assets purchases with the Florida Network funds and there are no corrective action items from external funding sources. Consequently, **the overall compliance rate for this contract monitoring visit is 100%.** There are no corrective actions cited but --- recommendation is made as a result of the contract monitoring visit. Overall, the provider is performing satisfactorily in meeting the fiscal and administrative terms of its contract. In addition, the majority of indicators reviewed were carried out in a manner which meets the standard described in the report findings.

SUMMARY OF RECOMMENDATIONS

Recommendation (1)
None

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

Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Youth Crisis Center - Jacksonville
CINS/FINS Program

Date: May 15-16, 2024

Compliance Monitoring Services Provided by

FOREFRONT

CINS/FINS Rating Profile

Standard 1: Management Accountability

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

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

Standard 2: Intervention and Case Management

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

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

Standard 3: Shelter Care & Special Populations

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

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

Standard 4: Mental Health/Health Services

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

Percent of Indicators rated Satisfactory: 80 %
Percent of Indicators rated Limited: 20 %
Percent of Indicators rated Failed: 0 %

Overall Rating Summary

Percent of indicators rated Satisfactory: 92.86 %
Percent of indicators rated Limited: 7.14 %
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
LeAnn Gruentzel – Regional Monitor, Department of Juvenile Justice
LaToya Robinson – CDS East
Cyndy Freshour – Lutheran Services Florida NW
Teresa Clove – Thaise Educational and Exposure Tours, Inc.

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

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

Documents Reviewed

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

Observations During Review

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

Surveys

- 8 # of Youth
- 9 # 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

Youth Crisis Center (YCC) celebrated its 50th anniversary. The agency met with legislators, did outreach to four Rotary Clubs, attended numerous health fairs, met with three county jail staff, met with the sheriff's office in all counties served, and met with the Superintendent and school staff at Duval County Public Schools. The agency also met with school board administrators in Clay and St. Johns counties and met with a judge in Baker County. The agency attends Circuit 7 Safety Council meetings, meets with family Support Services and Department of Children and Families to engage in new agreements for respite care for youth served. The agency attends local Department of Juvenile Justice (DJJ) Circuit Advisory Board Meetings.

YCC has fostered new partnerships with Family Support Services, Gift of Dance, Navy Federal and Amazon. The agency has a new mental health agreement with Flager CareConnect.

The following programmatic updates were provided by the agency:

STAFFING

The program reported the following changes to key staff positions: Logan Farrelly was promoted to Chief Clinical Officer and Pete Hicks was promoted to Chief Development Officer. Hannah Hampton was promoted to SNAP Manager. The following is a list of credentialed staff members: Kim Sirdevan, LCSW, Logan Farrelly, LCSW, Brandi Nash-Valasquez, LMHC, Casey Macias, MS, Lauren Hauser, MA, Jillian Jackson, MS, Kasie Johnson, Registered Marriage and Family Therapist Intern, Carl Keller, Provisional Clinical Social Worker License, Shanequa Thomas, Registered Mental Health Counselor Intern, Jazmyne Brunson, Registered Clinical Social Worker Intern, Isabella Copley, Registered Mental Health Counselor, Ashley Kogleman, Registered Clinical Social Worker Intern, Heather Kusmirek, MA, and Jackie Queen, BSW. The program has two PT Registered Nurses (one funded by a local hospital and one by CINS/ FINS.

There are currently 7 open full-time positions and one part-time position within the agency. The open positions consist of these various titles: Family Llink Therapist South St. Johns, Duval Outpatient Therapist, SNAP Specialist - Two Part-time (PT) St. Johns, SNAP Lead Duval, and four Youth Care Specialists. At the time of this QI on-site review, one potential candidate was in process for one of the vacant YCS positions and potential candidates were being interviewed for YCS, SNAP lead Duval and DANP Specialist (PT) St. Johns positions.

FACILITY

The following facility and building improvements were completed in the past year: A new roof on the outpatient building, replaced a water heater, replaced two air-conditioning units, developed a movie theater and arcade in the clubhouse, landscape improvements, lockers in the outpatient and residential lobbies for security purposes, replaced four security cameras in residential, renovated SNAP space with new flooring, painting, furniture and electronics.

Future facility updates include: camera system in outpatient, painting a historical timeline in outpatient behavioral health building, renovation to maintenance warehouse to become a recreational center, building tiny homes for maternity independent living program, building a space in St. Johns County for SNAP, laying of turf for an outdoor recreational space, replace remaining carpeted areas of residential with luxury vinyl plank, and painting residential hallways.

SNAP administration has moved from 100 Whetstone Plaza in St. Johns County, however groups are still held there. SNAP administration is now sharing an office with the Bailey Group at 1200 Plantation Island Drive S. Unit #210, St Augustine, FL 32080.

FUNDING/ FINANCE

The program received American Rescue Plan Act (ARPA) funding in St. Johns County to support the CINS/FINS Community Counseling program, as well as, funding from United Way/ Care Connect. The Community Counseling program also received funding from Clay County School Board and other new funding not related to CINS/FINS. Various fundraising activities include; a poker tournament, the agency's 50th anniversary celebration and YCC was the beneficiary of proceeds from the annual Hayden Hurst Family Foundation Golf Tournament. There is currently a capital campaign to support the conversion of a warehouse to a recreational center, install a turf field, build tiny homes on campus for maternity independent living program (contingent on State funding).

GOVERNANCE

The agency reports that members have changed on and off the board. There are no outstanding corrective action items from external funding sources and no major challenges reported.

Narrative Summary

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

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

Standard 2: There are nine indicators for Standard 2.
Indicator 2.01 Screening and Intake was rated **Satisfactory**,
Indicator 2.02 Needs Assessment was rated **Satisfactory**,
Indicator 2.03 Case/Service Plan was rated **Satisfactory**,
Indicator 2.04 Case Management and Service Delivery was rated **Satisfactory**,
Indicator 2.05 Counseling Services was rated **Satisfactory with Exception**,
Indicator 2.06 Adjudication/Petition Process was rated **Satisfactory**,
Indicator 2.07 Youth Records was rated **Satisfactory**,
Indicator 2.08 Specialized Additional Program Services was rated **Satisfactory**, and
Indicator 2.09 Stop Now and Plan (SNAP) was rated **Satisfactory with Exception**.

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

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 **Limited**,
Indicator 4.03 Medications was rated **Satisfactory**,
Indicator 4.04 Medical/Mental Health Alert Process was rated **Satisfactory**, and
Indicator 4.05 Episodic/Emergency Care was rated **Satisfactory with Exception.**

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

Standard 3: Indicator 3.06 - Limited

A review of fifteen-minute checks in a period of six months found an overall total of ten missed checks, late checks, and three logged falsification checks. The program notified the Central Communication Center of the falsification of bed checks.

Standard 4: Indicator 4.02 - Limited

Three of the five suicide risk assessments reviewed, were not completed according to the Florida Network QI standard which states the suicide risk assessment is to be completed within twenty-four hours after the completion of screening.

One record did not contain documentation of the entire period that the youth was placed on precautionary observation (PO) as required.

CINS/FINS QUALITY IMPROVEMENT TOOL

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

Standard One – Management Accountability

1.01: Background Screening of Employees, Contractors and Volunteers		**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 1.01	**YES**	
	If NO, explain here:	
	The agency has a policy 7.01 Background screening of employees and volunteers, last reviewed 02/20/2024 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: Thirty-eight
Total number of 5 Year Re-screen Employee Files: Seven
Staff Position(s) Interviewed (No Staff Names): HR Director, CEO
Type of Documentation(s) Reviewed: Suitability Assessments, E-Verify Documentation, Background Screening Results
Describe any Observations: 28 of 38 new hires completed suitability assessments on the date of hire. two new-hires completed suitability assessments prior to the date of hire and seven completed suitability assessments completed after the date of hire.

All positions providing direct services to youth has successfully passed pre-employment suitability assessment on the initial attempt.	**Exception**	Thirty of thirty-eight new hires, providing direct services to youth, successfully passed the pre-employment suitability assessments on their initial attempt. Two new-hires completed the pre-employment suitability assessment prior to the date of hire. Twenty-eight of thirty-eight new hires completed the pre-employment suitability assessment on the same day of hire. Interview with the HR Director indicated that new hires are given an offer of employment with a date to come into the administration office to complete various HR documents and tasks, including the pre-employment suitability assessment.	Eight of thirty-eight new hires did not successfully pass the pre-employment suitability assessment on the initial attempt prior to date of hire. Seven of thirty-eight new hires completed the pre-employment suitability assessment after the date of hire. Three pre-employment suitability assessments reviewed were observed to be sent to the new hire employee's YCC email address, which suggests some pre-employment suitability assessments are being conducted after the employee's hire date.
For any applicant that did not pass the initial suitability assessment, there was evidence that the applicant retook the assessment and passed within five (5) business days of the initial attempt, not exceeding three (3) attempts within thirty (30) days.	**Compliance**	An interview with the HR Director indicated that the 2nd attempt is usually made on the same day and evidence that six of eight employees passed the suitability assessment on the second attempt. The remaining two employees passed the suitability assessment on the third attempt which occurred within thirty days.	
Agency has evidence for employees who have had a break in service for 18 months or more, and/or when the agency had a change or update in the suitability assessment tool used was different from the employee's original assessment, that a new suitability assessment and background screening was completed as required.	**No eligible items for review**	None of the employees had a break in service for 18 months or more.	

Background screening completed prior to hire/start date (or exemption obtained prior to working with youth if rated ineligible) for new hires, volunteers/interns, and contractors. *(Employees who have had a break in service and are in good standing may be reemployed with the same agency without background screening if the break is less than 90 days.)*	**Exception**	Thirty-eight of forty new-hire employees/ interns had evidence of background screening completed prior to hire/ start date. Interview with the HR director indicates that new hires are in training for the first seven days and do not have access to youth during this period.	Two of thirty-eight new-hire employees did not have evidence of background screening completed prior to hire/start date. One employee hire date was 03/05/2024 and background screening was completed 03/12/2024 and one employee hire date was 04/22/2024 and background screening was completed 04/23/2024.
Five-year re-screening is completed every 5 years from the date of the last screening or prior to retained fingerprints expiration date.	**Compliance**	Seven of seven five year re-screenings were completed prior to the retained fingerprint expiration date.	
Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?	**Compliance**	A completed annual affidavit of compliance with level 2 screening standards was emailed to the background screening unit on 01/08/2024.	
Proof of E-Verify for all new employees obtained from the Department of Homeland Security	**Compliance**	Proof of E-Verify from the Department of Homeland was present in new employee files reviewed.	
Additional Comments: **There are no additional comments for this indicator.**			
1.02: Provision of an Abuse Free Environment			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 1.02		**YES** If NO, explain here: The agency has a policy 5.02 Provision for abuse free environment, reviewed 2/20/2024 by 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)* **: Chief Clinical Officer, Staff Trainer** **Type of Documentation(s) Reviewed: Policies, Personnel Training Files, Monthly & Quarterly Reports, Board Meeting Minutes, Log Book**			
Agency has a code of conduct of policy and there is evidence that staff are aware of agency's code of conduct.	**Compliance**	YCC has a code of conduct policy. Evidence that the staff is aware of the policy was present in the personnel files.	
The agency has a process in place for reporting and documenting child abuse hotline calls.	**Compliance**	Every staff is trained on Child Abuse Reporting as it is documented in their training log. If a child reports that they are being abused, the child would be allowed to call the hotline or the staff would call for them if they were unwilling to make the call. The staff would also do an incident report and document it in the electronic log and place it in the Incident book.	
Youth were informed of the Abuse and Contact Number	**Compliance**	During the intake process the youth is informed of the abuse and contact number. It is documented in the youth case file along with the youth signature.	

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**	YCC has a grievance process that is accessible and responsive for the youth to provide feedback and make a complaint. The youth are free to make a complaint when needed. The supervisors are the ones who have access to and manage grievances unless its towards themselves. The supervisors check the grievance boxes daily and document it in the electronic log book.	
Shelter only: Grievances are maintained on file at minimum for 1 year.	**Compliance**	The program maintains grievances in a file for one year. Review of the grievance file indicates the last grievance was filed in 2019. Review of the programs electronic log book indicates, each day that the grievance box has been checked and there are no grievances The program's policy also states they will maintain grievances for a year.	
Shelter only: There are formal grievance procedures for youth, including grievance forms, and a locked box which are easily accessible to youth in a common area.	**Compliance**	YCC has a grievance process for the youth to make a complaint. There are two (2) grievance boxes, with grievance forms on the front of the boxes, located in the hallway of the girls and boys dorms. The youth are allowed to make a complaint when needed.	
Shelter only: There is evidence that grievance boxes are checked by management or a designated supervisor at least daily as evidenced in the program logbook.	**Compliance**	The supervisors are checking the grievances boxes daily as evidence of the documentation in the electronic log book.	
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.	**No eligible items for review**	There have been no grievances filed during this review period or back to the date of the last review. The program's policy indicates that all grievances shall be resolved within 72 hours and documented by the program director/ supervisor or escalated to higher leadership if grievance involves themselves.	
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 5.01, Incident reporting, last reviewed 2/20/2024 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)* **: Chief Clinical Officer, Shelter Director** **Type of Documentation(s) Reviewed: Incident Policy, Log Book**			
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**	There were a total of 28 incident reports during this review period and all of them were reported within two hours of the incident.	

The program completes follow-up communication tasks/special instructions as required by the CCC	**Compliance**	A review of the incident forms showed evidence that follow-up communication tasks/ special instructions were completed when indicated by the CCC.	
Agency internal incidents are documented on incident reporting forms and all CCC reportable incidents were consistently reported to CCC as required.	**Compliance**	It was observed that all incidents reported during this review period were documented on the incident reporting forms and were reported to CCC as documented on the reporting forms.	
Incidents are documented in the program logs and on incident reporting forms	**Compliance**	All the incidents reported during the review period were observed to be documented on the incident reporting form and in the program log.	
All incident reports are reviewed and signed by program supervisors/ directors	**Compliance**	There were a total of 28 incidents reported during the review period. The incidents include: 10 abscondments, 10 medical, one substance abuse, one complaint against staff and six youth behavior incidents.	
1.04: Training Requirements (*Staff receives training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions*)			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 1.04		**YES** If NO, explain here: The agency has a policy 1.04, Training requirement, reviewed 2/20/2024 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 Staff Files: Six (6) Total number of Annual In-Service Staff Files: Four (4) **Total number of Non-Licensed Mental Health Clinical Shelter Staff Files: One (1)** **Annual Training Plan Timeframe** (*Program timeframe for annual trainings*)**: 7/1/2022 to 6/30/2023** **Staff Position(s) Interviewed** *(No Staff Names)* **: Chief Clinical Officer and Staff Trainer** **Type of Documentation(s) Reviewed: Training Case Files**			
First Year Direct Care Staff			
All direct care staff have completed new hire pre-service training requirements for safety and supervision as required.	**Compliance**	All direct care new hire staff completed their pre-service training requirements as seen on their training log and training certificates.	
All staff completed the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days from date of hire.	**Compliance**	The six (6) first year staff all completed their Civil Rights & Federal Funds training within 30 days of hire date. One (1) of the six (6) staff was an intern and completed it within 30 days of her internship and is now hired as a staff member. She was not required to take it again but completed it within the required time frame of her internship.	

All direct care CINS/FINS staff (full time, part time, or on-call) demonstrated a minimum of 80 hours of training or more for the first full year of employment.	**Compliance**	All CINS/FINS Direct care staff completed more than 80 hours of training their first year training per their training log and training certificates.	
All staff receives all mandatory training during the first 90 days of employment from date of hire.	**Compliance**	All staff received their mandatory trainings within 90 days of employment per their training log and training certificates.	
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**	There were three staff required to complete the Nirvana Assessment and each was trained within the required time frame. It was the Residential Therapist, Fatherhood Case Manager and Intensive Case Manager.	
Staff Participating in Case Staffing & CINS Petitions (within first year of employment)			
Documentation of instructor led FL Statute 984 CINS Petition Training by a local DJJ Attorney. *Effective for staff hired after 7/1/23*	**No eligible items for review**	No evidence of Petition Training by a local DJJ Attorney. The staff still have time to complete it by June 1, 2024.	
Non-licensed Mental Health Clinical Shelter Staff (within first year of employment)			
Documentation of non-licensed mental health clinical staff person's training in Assessment of Suicide Risk form or written confirmation by a licensed mental health professional of training (includes date, signature and license number of the licensed mental health professional supervisor).	**Compliance**	There was one (1) Non-Licensed Mental Health Clinical Staff in their first year of training that had documentation of completing the training in Assessment of Suicide Risk by a license mental health therapist which included the date, signature and license number of the license clinical supervisor.	
In-Service Direct Care Staff			
Direct care staff completes 24 hours of mandatory refresher Florida Network, SkillPro, and job-related training annually *(40 hours if the program has a DCF child caring license).*	**Compliance**	The Direct care staff completed more than 40 hours of mandatory refresher Florida Network, Skill Pro and job-related training as evidence of their training log and training certificates.	
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**	It was observed that YCC has a training plan that includes all the required training topics which includes 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**	YCC has a staff hired to be responsible for managing all employee's individual training flies and to track and review staff flies. The trainer has done an awesome job this year in tracking, monitoring and reviewing staff flies.	

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**	YCC maintains individual training files for their employees and has a training log that includes all the required training. The training log includes the annual training hours, the number of training hours completed, tracking form, certificates, sign-in sheets and agendas for each training attended. The above was observed while reviewing the employee's 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 program has a policy, 6.01 Quality improvement/ Analyzing and reporting, last reviewed 02/20/2024 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)* **: Chief Clinical Officer** **Type of Documentation(s) Reviewed: End of Month Meeting Minutes**			
Case record review reports demonstrate reviews are conducted quarterly, at a minimum	**Compliance**	Minutes from the last six months (December 2023 through May 2024) of staff's end of month reviews, indicate that case record reviews are being conducted on a monthly basis.	
The program conducts reviews of incidents, accidents, and grievances quarterly, at a minimum	**Compliance**	The program conducts monthly reviews of incidents, accidents, and grievances.	
The program conducts an annual review of customer satisfaction data	**Compliance**	The program conducts an annual review of customer satisfaction data.	
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**	YCC showed written proof that they have monthly reviews of the statewide End of the Month reports generated by Florida Network which includes monthly data, fiscal year to date data, benchmarks for residential and community counseling, screening data, report card measures, and follow-up reporting measures.	
The program has a process in place to review and improve accuracy of data entry & collection	**Compliance**	A review of the staff's monthly meeting minutes, shows evidence of a process in place to review and improve accuracy of data entry and collection within the program.	
There is documentation that findings are regularly reviewed by management and communicated to staff and stakeholders.	**Compliance**	A review of meeting minutes show that findings are regularly reviewed by management and communicated to staff and stakeholders.	

There is evidence the program demonstrates that program performance is routinely reviewed with the Board of Directors. All final reports that include a Limited or Failed score is submitted electronically or by mail to the providers Executive Committee on the Board of Directors.	**Compliance**	A review of board meeting minutes demonstrates that program performance is routinely reviewed with the Board of Directors. All final reports that include a Limited or Failed score communicated to the executive committee of the board of directors.	
There is evidence that strengths and weaknesses are identified, improvements are implemented or modified, and staff are informed and involved throughout the process.	**Compliance**	Strengths and weaknesses are identified, improvements are implemented or modified, and staff are informed and involved throughout the process during the monthly staff meetings.	
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 program has a policy, 5.05 Transportation of youth, last reviewed 02/20/2024 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: December 2023 to May 2024 **Staff Position(s) Interviewed** *(No Staff Names)***: HR Director, Director of Residential Services** **Type of Documentation(s) Reviewed: Transportation Logs, Drivers' Licenses, Certificate of Insurance, Policy and Procedures** **Describe any Observations: Observed the two vehicles used for client transportation.**			
Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	**Compliance**	The program has a list of approved agency drivers that have been approved by administrative personnel to drive client(s) in agency vehicles. The agency uses two 2019, white, 12-passenger, Ford Transit vans to transport youth.	
Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	**Compliance**	Valid driver's licenses were reviewed for all approved drivers and proof of insurance coverage under the company insurance policy was observed.	
Agency's Transportation policy prohibit transporting a client without maintaining at least one other passenger in the vehicle during the trip and include exceptions in the event that a 3rd party is NOT present in the vehicle while transporting	**Compliance**	The agency's transportation policy prohibits transporting a client without maintaining at least one other passenger in the vehicle during the trip and include exceptions in the event that a 3rd party is NOT present in the vehicle while transporting.	
In the event that a 3rd party cannot be obtained for transport, the agency's supervisor or managerial personnel consider the clients' history, evaluation, and recent behavior	**Compliance**	The agency's policy states: In the event that a 3rd party cannot be obtained for transport, the agency's supervisor or managerial personnel consider the clients' history, evaluation, and recent behavior.	
The 3rd party is an approved volunteer, intern, agency staff, or other youth	**Compliance**	The agency's policy states: 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 transportation logs. A review of the transportation logs for the past six months indicates 46 single transports. All of the single transports has written verification that supervisor approval was obtained prior to the single youth transports taking place.	
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 transportation logs contain: name or initials of driver, date and time, mileage, number of passengers, purpose of travel and location.	
Additional Comments: **There are no additional comments for this indicator.**			
1.07 - Outreach Services			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 1.07		**YES** If NO, explain here: The program has a policy, 1.02 Interagency agreements and Outreach services, last reviewed 02/20/2024 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)* **: Chief Clinical Officer** **Type of Documentation(s) Reviewed: Board Meeting Notes, Program Meeting Notes, Circuit Meeting Notes, Outreach Information in NETMIS and Community Partnership Agreements**			
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 lead designated to participate in local DJJ Board events is the Chief Clinical Officer. There was evidence that the Chief Clinical Officer attended the DJJ Board and Circuit/Council meeting during this reporting period by the meeting minutes and the Outreach Notes in NETMIS.	
The program maintains written agreements with other community partners which include services provided and a comprehensive referral process.	**Compliance**	There was evidence of written community partnership agreements which included service provided and the referral process.	

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**	YCC maintained outreach activities in NETMIS which included title, date, duration, zip code, location, estimated number of attendees, modality target audience and topic. YCC also maintained written copies of the same events.	
The program has designated staff that conducts outreach which is defined in their job description.	**Compliance**	The Chief Clinical Officer is designated to conduct outreach as defined in the job description.	
Additional Comments: **There are no additional comments for this indicator.**			
2.01 - Screening and Intake			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.01		**YES** If NO, explain here: The agency has a policy, 2.01 - Screening Eligibility for Services, reviewed on 2/20/2024 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)* **: Chief Clinical Officer** **Type of Documentation(s) Reviewed: Policy & Case Files** **Describe any Observations: Staff was friendly and professional, answered all questions and provided requested items and the files were organized.**			
Shelter youth: Eligibility screening form is completed immediately for all shelter placement inquiries.	**Compliance**	Completed eligibility screening forms were present in all shelter files reviewed. Interview with the Chief Clinical Officer also indicated that eligibility screening forms are completed immediately for all shelter placement inquires.	
Community counseling: Eligibility screening form is completed within 3 business days of referral by a trained staff using the Florida Network screening form.	**Compliance**	Interview with the Chief Clinical Officer indicated that eligibility screening forms for community counseling youth are completed at the time of contact. Evidence of the eligibility screening forms completed at the time of contact was present in the youth files reviewed.	
There is evidence all referrals for service is screened for eligibility and is logged in NetMIS within 72 hours of screening completion.	**Compliance**	Observation of the NetMIS entries showed that all referrals for service was logged into the system within 72 hours of screening completion.	
Youth and parents/guardians receive the following in writing: a. Available service options b. Rights and responsibilities of youth and parents/guardians	**Compliance**	All files reviewed show evidence of the youth and parent signatures verifying receiving information regarding available service options and rights and responsibilities for parent and youth were received.	

The following is also available to the youth and parents/guardians: a. Possible actions occurring through involvement with CINS/FINS services (case staffing committee, CINS petition, CINS adjudication) b. Grievance procedures	**Compliance**	All files reviewed show evidence of the youth and parent signatures verifying receipt of information regarding possible actions occurring through involvement with CINS/FINS services and the grievance procedures.	
During intake, all youth were screened for suicidality and correctly assessed as required if needed.	**Compliance**	All files reviewed contained a screening for suicidality. One youth required the completion of an assessment and was correctly assessed as required.	
Additional Comments: **There are no additional comments for this indicator.**			
2.02 - Needs Assessment			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.02		**YES** If NO, explain here: The agency has a policy, 3.05 - NIRVANA and Re-Classification Alert Form, reviewed 2/20/2024 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): Chief Clinical Officer** **Type of Documentation(s) Reviewed: Policy & Case Files** **Describe any Observations: Staff was friendly and professional, answered all questions and provided requested items and the files were organized.**			
Shelter Youth: NIRVANA is initiated within 72 hours of admission	**Compliance**	The policy was reviewed as well as three residential files, one file did not have a completed NIRVANA because the youth eloped shortly after intake.	
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**	The policy was reviewed as well as two community counseling services files and both NIRVANAs were completed within two to three contacts after intake. Neither of the files indicate a stay over six months.	
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**	The policy was reviewed as well as five files, four files show evidence of the supervisor's signature and one file does not include the NIRVANA because the youth eloped prior to it being completed.	
(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**	Evidence of NIRVANA self-assessments completed within 24 hours of youth being admitted into shelter was present in all residential files reviewed.	

A NIRVANA Post-Assessment is completed at discharge for all youth who have a length of stay that is greater than 30 days.	**No eligible items for review**	Five files were reviewed, all files reflect the youth had a stay less than thirty days. Therefore a post assessment was not completed at discharge.	
A NIRVANA Re-Assessment is completed every 90 days excluding files for youth receiving SNAP services.	**No eligible items for review**	Five files were reviewed, all files reflect the youth had a stay less than thirty days.	
All files include the interview guide and/or printed NIRVANA.	**Compliance**	Five files were reviewed, one file did not have a completed NIRVANA because the youth eloped shortly after intake and a therapist was not assigned.	
Additional Comments: **There are no additional comments for this indicator.**			
2.03 - Case/Service Plan			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.03		**YES** If NO, explain here: The agency has a policy, 3.05 NIRVANA and Re-Classification Alert Form, last reviewed 2/20/2024 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): Chief Clinical Officer** **Type of Documentation(s) Reviewed: Policy & Case Files** **Describe any Observations: Staff was friendly and professional, answered all questions and provided requested items and the files were organized.**			
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**	The program uses a case/service plan which is through NetMIS and based on the information gathered during the initial screening, intake and NIRVANA.	
Case/Service plan is developed within 7 working days of NIRVANA	**Compliance**	Five files were reviewed, of the five files, three contained case/ service plans that were developed within seven working days of NIRVANA. One residential file did not have a case/service plan because the youth eloped prior to a therapist being assigned. In one community counseling service's file, the youth and mother were not available after the counselor attempted several times.	

Case plan/service plan includes: 1. Individualized and prioritized need(s) and goal(s) identified by the NIRVANA 2. Service type, frequency, location 3. Person(s) responsible 4. Target date(s) for completion and actual completion date(s) 5. Signature of youth, parent/guardian, counselor, and supervisor 6. Date the plan was initiated	**Compliance**	Five files reviewed, of the five files, three case/service plans were completed and included the required information. Two files, one youth eloped and the other family was not available.	
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**	Five files reviewed, of the five files; one youth eloped within the first 30 days, one file contained a completed 30 day review, two files contained completed 30 day review and shows evidence of the counselor's efforts to contact the parents, and one file the youth has not reached her 30 day review period.	
Additional Comments: **There are no additional comments for this indicator.**			
2.04 - Case Management and Service Delivery			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.04		**YES** If NO, explain here: The agency has a policy, 4.05 Case Management and Service Delivery, last reviewed 2/20/2024 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): Chief Clinical Officer** **Type of Documentation(s) Reviewed: Policy & Case Files** **Describe any Observations: Staff was friendly and professional, answered all questions and provided requested items and the files were organized.**			
Counselor/Case Manager is assigned	**Compliance**	Of the five files reviewed, evidence of a counselor being assigned was present in four of the files by indication of the case plans. One file indicated the youth eloped shortly after intake and was not applicable for having 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**	Of five files reviewed, one youth eloped prior to the assignment of the counselor/ case manager. Four youth files reviewed contained evidence of 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. One of the files reviewed contained evidence of follow-up after 30 and 60 days post discharge. This did not apply in the other cases reviewed. None of the files reviewed were applicable for the following indicators: 1. Monitoring progress of court ordered youth in shelter 2. Makes referrals to the case staffing to address problems and needs of the youth/family 3. Accompanies youth and parent/guardian to court hearings and related appointments 4. Refers the youth/family for additional services when appropriate 5. Provides case monitoring and reviews court orders 6. Provides case termination notes	
The program maintains written agreements with other community partners that include services provided and a comprehensive referral process	**Compliance**	The program has written agreements with other community partners that include services provided and a comprehensive referral process. There is also program that come to the shelter to do dance and art with the youth. The program also submits referrals to other agencies for follow up services if needed.	
Additional Comments: **There are no additional comments for this indicator.**			
2.05 - Counseling Services			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 2.05		**YES** If NO, explain here: The agency has a policy. 4.03 Counseling Services, last review 2/20/2024 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): Chief Clinical Officer** **Type of Documentation(s) Reviewed: Policy, group log books & Case Files** **Describe any Observations: Staff was friendly and professional, answered all questions and provided requested items and the files were organized.**			
Shelter Program			
Shelter programs provides individual and family counseling	**Compliance**	The program provides individual and family counseling.	

Group counseling sessions held a minimum of five days per week	**Exception**	The program maintains a group log book which contains documentation of group counseling sessions.	The files reviewed did not have evidence of the group sessions being held at least five times a week.
Groups are conducted by staff, youth, or guests and group counseling sessions consist of : 1. A clear leader or facilitator 2.Relevant topic - educational/informational or developmental 3. Opportunity for youth to participate 4. 30 minutes or longer	**Exception**	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	The group log book had group logs but did not indicate the duration of the session so it could not be determined if groups are 30 minutes or longer.
Documentation of groups must include date and time, a list of participants, length of time, and topic.	**Exception**	The group log books were reviewed. Group form used to document group sessions, included a list of participants and topic.	The group log books have old forms from 5/8/13 that does not include the date and time. There are updated forms from 1/2024 which includes the date and time, however, not all forms include the duration of the 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**	The community counseling program provides therapeutic community-based services designed to provide the intervention necessary to stabilize the family and services are provided in the local provider's counseling office. No services are provided virtually.	
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**	The program completes reviews of all case files for coordination between presenting problem(s), psychosocial assessment, case/service plan, case/service plan reviews, case management, and follow-up.	
Maintain individual case files on all youth and adhere to all laws regarding confidentiality.	**Compliance**	The program maintains individual case files on all youth and adhere to all laws regarding confidentiality.	
Case notes maintained for all counseling services provided and documents youth's progress.	**Compliance**	Case notes are maintained for all counseling services in each file reviewed and documents youth's progress.	
On-going internal process that ensures clinical reviews of case records and staff performance.	**Compliance**	Of the files reviewed, there was evidence indicating the counselor and supervisor completed clinical reviews in each file.	

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**	Intakes are not conducted through 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 agency has several policies, 4.06 CINS Adjudication Services and 4.07 CINS Petition Process, last reviewed on 2/20/2024 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: Zero **Total number of Closed (Residential & Community) Files: Zero** **Staff Position(s) Interviewed (No Staff Names): Chief Clinical Officer** **Type of Documentation(s) Reviewed: Policy & Case Files** **Describe any Observations: Staff was friendly and professional, answered all questions and provided requested items and the files were organized.**			
Must include: a. DJJ rep. or CINS/FINS provider b. Local school district representative	**Compliance**	The Chief Clinical Officer was interviewed and policy reviewed. The Chief Clinical Officer indicated they did not have any files to review for this standard, however she hosts the case staffing meetings until the Intensive case manager is properly trained. There is representation from DJJ and the CINS/ FINS provider as well as the local school districts at meetings.	
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 Chief Clinical Officer indicated that other members involved are the state attorney's office, representatives from Baker and Clay County Truancy courts. The Chief Clinical Officer also attend Duval county truancy meetings.	
The program has an established case staffing committee, and has regular communication with committee members	**Compliance**	The program has an established case staffing committee and regular communication with committee members.	
The program has an internal procedure for the case staffing process, including a schedule for committee meetings	**Compliance**	There is an internal procedure for case staffing process, including scheduled meetings.	
The youth and family are provided a new or revised plan for services	**No eligible items for review**	There are no case staffing cases to review back to the date of the last review.	

Written report is provided to the parent/guardian within 7 days of the case staffing meeting, outlining recommendations and reasons behind the recommendations	**No eligible items for review**	There are no case staffing cases to review back to the date of the last review.	
If applicable, the program works with the circuit court for judicial intervention for the youth/family	**No eligible items for review**	There are no case staffing cases to review back to the date of the last review.	
Case Manager/Counselor completes a review summary prior to the court hearing	**No eligible items for review**	There are no case staffing cases to review back to the date of the last review.	
Additional Comments: **There are no additional comments for this indicator.**			

2.07 - Youth Records		**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.07	**YES**	
	If NO, explain here:	
	The agency has a policy, 6.00.01 - Youth Records, last reviewed 02/20/2024 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)* **: Chief Clinical Officer & Residential supervisor**
Type of Documentation(s) Reviewed: Case files
Describe any Observations: Staff was friendly and professional, answered all questions and provided requested items and the files were organized.

All records are clearly marked 'confidential'.	**Compliance**	All case files are marked confidential.	
All records are kept in a secure room or locked in a file cabinet that is marked "confidential"	**Compliance**	All case files are kept in a secure room in locked file cabinets marked confidential.	
When in transport, all records are locked in an opaque container marked "confidential"	**Compliance**	The agency's policy states that when in transport, all records are locked in an opaque container marked "confidential. The residential supervisor indicated that files are not transported off site.	
All records are maintained in a neat and orderly manner so that staff can quickly and easily access information	**Compliance**	Observation was made of youth records which are maintained in a neat and orderly manner. Staff can quickly and easily access information in the records.	
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**	The agency has several policies, 4.08.01 - Staff Secure Facility & Staff Secure Beds - Staffing, 4.08.02 - Domestic Minor Sex Trafficking Program Services, 4.08.04 - Domestic Violence Respite, 4.08.05 - Probate Respite Services, 4.08.07 - Intensive Case Management Services, 4.08.06 - Family/Youth Respite Aftercare Services, last reviewed 2/20/2024 by the CEO.	
	If NO, explain here:		
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 (Residential & Community) Files: Zero** **Staff Position(s) Interviewed (No Staff Names): Chief Clinical Officer** **Type of Documentation(s) Reviewed: Policy & Case Files** **Describe any Observations: Staff was friendly and professional, answered all questions and provided requested items and the files were organized.**			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? **(If no, select rating "No eligible items for review")**	**No eligible items for review**	The agency had no cases of staff secure 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	**No eligible items for review**	The agency has a policy and procedure that is in compliance with all of the requirements listed.	
Program only accept youth that meet legal requirements of F.S. 984 for being formally court ordered in to Staff Secure Services	**No eligible items for review**	The agency had no cases of staff secure 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 agency had no cases of staff secure 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 agency had no cases of staff secure 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 (Residential & Community) Files: Zero
Staff Position(s) Interviewed (No Staff Names): Chief Clinical Officer
Type of Documentation(s) Reviewed: Policy and Procedures

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: Zero
Total number of Closed (Residential & Community) Files: Two
Staff Position(s) Interviewed (No Staff Names): Chief Clinical Officer
Type of Documentation(s) Reviewed: Policy & Case Files
Describe any Observations: Staff was friendly and professional, answered all questions and provided requested items and the files were organized.

Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	**Yes**	A total of two close domestic violence files were reviewed.	
Youth admitted to DV Respite placement have evidence in the file of a pending DV charge	**Compliance**	Two of two files reviewed contained evidence that youth admitted to DV Respite placement have pending DV charge.	
Data entry into NetMIS within (3) business days of intake and discharge	**Compliance**	The Chief clinical officer showed evidence in NetMIS that youth were entered into NetMIS, at intake and discharge, by the supervisor on shift.	
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**	Length of stay in two of two DV Respite files indicated that placement does not exceed 21 days.	
Case plan in file reflects goals for aggression management, family coping skills, or other intervention designed to reduce propensity for violence in the home	**Compliance**	Case plan in two of two files reflects goals for aggression management, family coping skills, or other intervention designed to reduce propensity for violence in the home.	
All other services provided to Domestic Violence Respite youth are consistent with all other general CINS/FINS program requirements	**Compliance**	All other services provided to Domestic Violence 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)* **: Chief Clinical Officer**
Type of Documentation(s) Reviewed: Policy and Procedures

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.*			
Total number of Open Files: Zero **Total number of Closed Files: One** **Staff Position(s) Interviewed** *(No Staff Names)* **: Chief Clinical Officer** **Type of Documentation(s) Reviewed: Youth file, Policy and Procedures**			
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**	There was one intensive case management file review during this QI visit.	
Youth receiving services were deemed chronically truant and/or runaway and require more intensive and lengthy services. The youth was determined to be eligible because they have gone through petition and/or case staffing and was in need of case management services.	**Compliance**	One youth file reviewed showed evidence that the youth was deemed chronically truant and/or runaway and required 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.	
Services for youth and family include: a. Two (2) direct contacts per month b. Two (2) collateral contacts per week c. Direct and collateral contacts not obtained must have documentation to support attempts made to obtain them. All reasonable attempts (at minimum of three) must be made to reach all contacts (direct and collateral) and documented in the case file and NetMIS.	**Compliance**	One file reviewed contained proof of 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.	
Assessments include a. NIRVANA at intake b. NIRVANA Re-Assessment every 90 days c. Post NIRVANA at discharge as aligned with timeframe requirements	**Compliance**	One file reviewed. A NIRVANA was completed at intake and the file did not require a 90 day NIRVANA. Post NIRVANA at discharge was aligned with timeframe requirements.	
Service/case plan demonstrates a strength-based, trauma-informed focus	**Compliance**	Service/case plan in one youth file reviewed demonstrated a strength-based, trauma-informed focus.	
For any virtual services provided, there is written documentation in the youths' file as to why virtual contact is in the best interest of the youth and family	**Compliance**	There are no virtual services provided.	

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)* **: Chief Clinical Officer** **Type of Documentation(s) Reviewed: Policy and Procedures**			
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 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 had 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 had 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 had 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 had 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 had 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 had 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 had 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 had 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 had 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 had 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)		**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 2.09	**YES** If NO, explain here: The agency has several policies; 4.15 SNAP Intake requirements, 4.16 SNAP Group Delivery, 4.17 SNAP Fidelity Adherence Monitoring, 4.18 SNAP Discharge Requirements, and 4.19 SNAP in Schools and Communities, last reviewed February 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: Three closed and two open youth files and two completed SNAP in Schools sessions
Staff Position(s) Interviewed *(No Staff Names)* **: Staff Coordinator**
Type of Documentation(s) Reviewed: All related SNAP documentation

SNAP Clinical Groups Under 12			
Youth are screened to determine eligibility of services.	**Compliance**	Five of five SNAP files reviewed all contained proof of screening to determine eligibility of services.	
The NIRVANA was completed at initial intake, or within two sessions.	**Compliance**	Five of five files reviewed all contained a NIRVANA which was completed at initial intake or within two sessions.	
There is evidence of the completed Child Behavior Checklist (CBCL) by the caregiver (pre and post) and is located within the file.	**Compliance**	There was a (pre) Child Behavior Checklist located in all the open SNAP files reviewed and a (post) Child Behavior Checklist in the closed SNAP files reviewed.	

There is evidence of the completed Teacher Report Form (TRF) is completed by the teacher (pre and post) and is located within the file.	**Exception**	Documentation of efforts to obtain (pre and post) Teacher Report Forms was located in four of five SNAP youth files reviewed.	One SNAP file did not contain a (pre or post) Teacher Report Form and there was no documented efforts to obtain the forms located in the file.
There is evidence of the completed TOPSE is completed by the caregiver (pre and post) and is located within the file.	**Compliance**	A completed pre TOPSE was present in each of the SNAP files reviewed and a post TOPSE was present in the closed files reviewed.	
SNAP Clinical Groups Under 12 - Discharge			
There is evidence of the completed SNAP Discharge Report located within the file for any discharged youth.	**Compliance**	There was a completed SNAP discharge report located in three out of three closed files reviewed.	
There is evidence of the SNAP Boys/SNAP Girls Child Group Evaluation Form located in the file.	**Compliance**	Completed SNAP boys/ SNAP girls group evaluation forms were located in all three closed files reviewed.	
There is evidence of the SNAP Boys/SNAP Girls Parent Group Evaluation Form located in the file.	**Compliance**	Completed SNAP boys/ SNAP girls parent group evaluation forms were located in three closed files reviewed.	
SNAP Clinical Groups for Youth 12-17			
Youth are screened to determine eligibility of services.	**No eligible items for review**	The program does not provide SNAP Clinical Groups for youth 12-17.	
The Consent to Treatment and Participation in Research Form is completed and located within the file.	**No eligible items for review**	The program does not provide SNAP Clinical Groups for youth 12-17.	
The NIRVANA was completed at initial intake, or within two sessions.	**No eligible items for review**	The program does not provide SNAP Clinical Groups for youth 12-17.	
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.	**No eligible items for review**	The program does not provide SNAP Clinical Groups for youth 12-17.	
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.	**No eligible items for review**	The program does not provide SNAP Clinical Groups for youth 12-17.	
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.	**No eligible items for review**	The program does not provide SNAP Clinical Groups for youth 12-17.	
SNAP for Schools & Communities			
The program demonstrated all of the required weekly attendance sheets that included youth names and/or identifying numbers completed with the teacher and trained SNAP Facilitator signatures. (*This must include a total of 13 attendance sheets for a full cycle*)	**Compliance**	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.	

The program maintained evidence of a completed "Class Goal" Document for the class reviewed.	**Compliance**	The program maintained evidence of a completed "Class Goal" Document for the class reviewed.	
The program maintained evidence of both pre AND post Measure of Classroom Environment (MoCE) completed documents for the class reviewed.	**Compliance**	The program maintained evidence of both pre and post Measure of Classroom Environment (MoCE) completed documents for the class reviewed.	
The program maintained evidence of completed pre and post evaluation documents for the class reviewed.	**Compliance**	A completed pre and post evaluation document for each class reviewed was present in both SNAP in Schools file.	
There is evidence of the fidelity adherence checklist maintained in the file for each class reviewed.	**Compliance**	Two of two SNAP in Schools files reviewed contained evidence of the fidelity adherence checklist maintained within each file for each class reviewed.	
Additional Comments: **There are no additional comments for this indicator.**			
3.01 - Shelter Environment			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 3.01		**YES** If NO, explain here: The program has several policies, 8.03 Facility Environment & Safety and 4.25 Daily Programming reviewed 02/20/2024 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 Services, Chief Operating Officer** **Type of Documentation(s) Reviewed: Policy and Procedures, Residential Files, Inspection Reports, Licenses, Posted Signs, NoteActive log.** **Describe any Observations: Tour of Shelter, Newly renovated movie theater and game room, other agency programs and buildings, facility grounds, SNAP program area and agency vehicles.**			
Facility Inspection: a. Furnishings are in good repair. b. The program is free of insect infestation. c. Bathrooms and shower areas are clean and functional, free of foul odors, leaks, dust, and mildew and in good working order. d. There is no graffiti on walls, doors, or windows. e. Lighting is adequate for tasks performed there. f. Exterior areas are free of debris; grounds are free of hazards. g. Dumpster and garbage can(s) are covered. h. All doors are secure, in and out access is limited to staff members and key control is in compliance. i. Detailed map and egress plans of the facility, general client rules, grievance forms, abuse hotline information, DJJ Incident Reporting Number and other related notices are posted. j. Interior areas (bedrooms, bathrooms, common areas) do not contain contraband and are free from hazardous unauthorized metal/foreign objects.	**Compliance**	The shelter is in excellent shape. It is very clean, safe and inviting. There was nothing noted that needed repairs. There are four bathrooms, two on the boys side and two on the girls side. They are clean and free of mildew and dust. There was no graffiti found. The lighting is adequate for each space. The exterior is clean and well-kept with lovely landscaping. No debris or hazards were noted outdoors. Entrance to the facility is limited to staff. Maps of the building are posted in multiple places that show the egress plan and the location of fire extinguishers. Bulletin boards in the shelter contain information for grievances, the Abuse Hotline number, DJJ Incident Reporting number. No contraband was noted in the interior areas and they were free from hazardous, unauthorized metal/foreign objects.	

Facility Inspection: a. All agency and staff vehicles are locked. b. Agency vehicles are equipped with major safety equipment including first aid kit, (all items in the first aid kit are current and do not have expired items; all expired items should be replaced regularly), fire extinguisher, flashlight, glass breaker and, seat belt cutter.	**Compliance**	Staff vehicles and agency vans are locked. There are two vans, both 2019 Ford Transit 350, Both vans contained all of the required safety equipment. The vans are very clean and appear to be in excellent repair.	
Facility Inspection: All chemicals are listed, approved for use, inventoried weekly and perpetually, stored securely and Material Safety Data Sheets (MSDS) are maintained on each item (minimum 1 time per week or per agency policy). A perpetual inventory will be the primary means of maintaining a current and real-time inventory. The weekly inventory will be conducted weekly at a minimum to ensure that a perpetual inventory is being maintained consistently and accurately. If more than one location is used to store chemicals, there is an inventory wherever chemicals are stored that is current and well maintained unless previously approved by the Network.	**Compliance**	The chemicals are approved and inventoried weekly and perpetually. They are stored in a maintenance room where clients have no access. There is a notebook outside of the maintenance room with all of the MSDS for the chemicals.	
Facility Inspection: Washer/dryer are operational & general area/lint collectors are clean. Agency has a current DCF Child Care License which is displayed in the facility. Each youth has own individual bed with clean covered mattress, pillow, sufficient linens and blanket. Youth have a safe, lockable place to keep personal belongings, if requested.	**Compliance**	The laundry room is clean and the dryers are free of lint. The DCF license was issued on May 11, 2024. Each youth is provided with clean, individual bed with linens, a pillow and blanket. The clients are provided with a place to keep personal belongings and also have the ability to store smaller items in the safe.	
Additional Facility Inspection Narrative (if applicable)			

Fire and Safety Health Hazards: a. Annual facility fire inspection was conducted, and the facility is in compliance with local fire marshal and fire safety code within jurisdiction. b. Agency completes a minimum of 1 fire drill on each shift monthly (within 2 minutes or less). c. Completes 1 mock emergency drill per shift per quarter. d. All annual fire safety equipment inspections are valid and up to date (extinguishers, sprinklers, alarm system and kitchen overhead hood, including fire extinguishers in all vehicles).	**Compliance**	The fire inspection, done by the City of Jacksonville, Florida was completed on 8-17-23 with no violations noted. Fire drills were completed on each shift, each month. First shift completed drills on: 12-24-23, 1-28-24, 2-28-24, 2-28-24, 3-17-24, 4-3-24, 5-4-24; 2nd Shift: 12-27-23, 1-31-24, 2-27-24, 3-13-24, 4-11-24, 5-10-24; 3rd Shift: 12-1-23, 1-30-24, 2-26-24,3-26-24,4-26-24. Mock emergency drills were completed on each shift each month, exceeding the requirement. 1st Shift: 12-26-23, 1-24-24, 2-7-24,2-28-24,3-2-24, 3-14-24, 4-28-24, 5-12-24; 2nd Shift: 12-27-23, 1-31-23, 2-27-24, 3-18-24, 4-23-24, 5-10-24; 3rd Shift: 12-29-23, 12-30-23, 1-31-24, 1-25-24, 2-7-24, 2-26-24, 2-27-24, 2-10-24, 3-8-24, 3-11-24, 3-12-24, 4-22-24,4-15-24, 5-11-24, 5-9-24. All fire extinguishers, including those in the vans, were inspected in September 2023 and had monthly inspections noted on the annual tag on each extinguisher. All of the fire and safety equipment (sprinklers, alarm system and kitchen overhead hood were also inspected in September 2023.	
Fire and Safety Health Hazards: a. Agency has a current Satisfactory Residential Group Care inspection report from the Department of Health. b. Agency has a current Satisfactory Food Service inspection report from the Department of Health and food menus are posted, current and signed by Licensed Dietician annually. c. All cold food is properly stored, marked and labeled and dry storage/pantry area is clean and food is properly stored. d. Refrigerators/Freezers are clean and maintained at required temperatures and all small and medium sized appliances are operable and clean for use as needed.	**Compliance**	The Department of Health Residential Group Care inspection and Food Service inspections were completed on 5-6-24 , and were both satisfactory. The kitchen and food pantry are clean and well maintained at appropriate temperatures. The food in the pantry is rotated, first in, first out, to make certain that the older items are used first. The refrigerator was clean and the temperature was at 35 degrees. The freezer was also clean with a temperature of 32 degrees.	
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**	Youth are provided with a variety of both indoor and outdoor activities including, dancing, outside sports and exercise, table games, time for reading and quiet time, life skills, educational outings, and video games and off site activities. Physical activities are provided daily. Each week faith based activities are provided for those who want to participate. The daily schedule is posted where staff and clients can see it.	

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 program has a policy 4.01 Shelter Program and Orientation reviewed by the CEO 02/20/24.	

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 Files: Two
Total number of Closed Files: Three
Staff Position(s) Interviewed *(No Staff Names)* **: Director of Residential Services**
Type of Documentation(s) Reviewed: Client files, Policy & Procedure, Client Orientation Handbook

Youth received a comprehensive orientation and handbook provided within 24 hours	**Compliance**	The Client Orientation Handbook is comprehensive, containing the information that a client needs.	
Orientation includes the following: a. Youth is given a list of contraband items b. Disciplinary action is explained c. Dress code explained d. Review of access to medical and mental health services e. Procedures for visitation, mail and telephone f. Grievance procedure g. Disaster preparedness instructions h. Physical layout of the facility i. Sleeping room assignment and introductions j. Suicide prevention- alerting staff of feelings or awareness of others having suicidal thoughts	**Compliance**	Two open and three closed files were reviewed. All of the files showed that the client orientation includes all of the requirements and the information is also given to them in their client handbook. Contraband, disciplinary action, dress code, access to medical and mental health services, procedures for visitation, mail and telephone, grievance procedures, and disaster preparedness are explained. The layout of the facility, introductions and sleeping room assignment are gone over. Alerting staff of their own or others suicidal thoughts are explained.	
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**	All records reviewed contained documentation of all components of orientation, including: topics and dates of presentation, as well as signatures of the youth and staff involved.	

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 program has a policy 4.26 Classification/ Room Assignment reviewed 02/20/2024 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: Two **Total number of Closed Files: Three** **Staff Position(s) Interviewed** *(No Staff Names)* **: Director of Residential Services** **Type of Documentation(s) Reviewed: Client files, Policy & Procedure**			
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**	Two open and three closed files were reviewed. Youth are screened during intake to determine their history and needs. There are six two-bed bedrooms and eighteen one bed bedrooms, allowing new clients to be placed in a room by themselves. This allows older and younger youth to be separated and violent and non-violent youth to be separated.	
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**	Alerts are entered in the log. There are two bedrooms designated for youth at risk. These rooms have windows for staff to be able to observe them throughout the night.	
Additional Comments: **There are no additional comments for this indicator.**			
3.04 - Log Books			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 3.04		**YES** If NO, explain here: The program has a policy 4.14 Log Books, last reviewed 02/20/2024 and signed 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: Various times between December 2023 and May 2024 **Staff Position(s) Interviewed** *(No Staff Names)* **: Director of Residential Services** **Type of Documentation(s) Reviewed: NoteActive log** **Describe any Observations: All log book entries are electronic**			
Log book entries that could impact the security and safety of the youth and/or program are highlighted	**Compliance**	Log book entries from December 2023 through May 2024 were reviewed. Log book entries that could impact the security and safety of the youth and/or program are highlighted. Weather alerts and incident reports are highlighted.	
All entries are brief, legibly written in ink and include: • Date and time of the incident, event or activity • Names of youth and staff involved • Brief statement providing pertinent information • Name and signature of person making the entry	**Compliance**	All log book entries are brief, legibly written and include: the date and time of the incident, event or activity, names of youth and staff involved, brief statement providing pertinent information, and name and signature of person making the entry.	

Recording errors are struck through with a single line. The staff person must initial and date the correction. The use of whiteout and erasures is prohibited.	**Compliance**	Log book entries are electronic. The program uses the NoteActive system. A review of entries from December 2023 to May 2024 showed evidence of single line strike throughs utilized in the logbook. The staff persons' initials and the date of the correction is noted, when entries of correction are made.	
The program director or designee reviews the facility logbook(s) every week and makes a note chronologically in the logbook indicating the dates reviewed and if any correction, recommendations and follow-up are required and sign/date the entry	**Compliance**	The program director or designee is reviewing the facility log book on a weekly basis. The program director did the reviews in December, January and February. From March forward the review has been conducted by the shift supervisors. Notes were observed indicating the dates the log book was reviewed, if any corrections, recommendations and follow-ups were required and the notes are signed and dated.	
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**	When signing on shift, staff indicate that they have read the last two shifts.	
At the beginning of their shift, oncoming supervisor and shelter counselor reviews the logbook of all shifts since their last log entry and makes a signed and dated entry and into log book indicating the dates reviewed.	**Exception**	Documentation of the oncoming shift supervisors entries were reviewed in the log book from December 2023 to May 2024. The oncoming shift supervisor's entries, at the beginning of their shift, reflect a review of the status of the shelter, including accounting for items such as keys, radios, cell phones and sharps.	Oncoming supervisor entries reviewed in the program's logbook did not address a review of the logbook for all shifts since their last log entry with dates reviewed.
Logbook entries include: a. Supervision and resident counts b. Visitation and home visits	**Compliance**	Counts are noted in the log on each bed check. Home visits are noted.	
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 program has a policy, 4.29 Behavior Management Strategies, last reviewed 02/20/2024 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 Services** **Type of Documentation(s) Reviewed: Policy and Procedures, Point Sheets** **Describe any Observations: Information regarding the behavior management system in the client handbook**			
The program has a detailed written description of the BMS and it is explained during program orientation	**Compliance**	Youth are oriented to the BMS and are given a written description in their client handbook.	
Behavior Management Strategies must include:			

a. BMS is designed to teach youth new behaviors and help youth understand the natural consequences for their actions b. Behavioral interventions are applied immediately, with certainty, and reflect the severity of the behavior c. BMS uses a wide variety of awards/incentives to encourage participation and completion of the program d. Appropriate consequences and sanctions are used by the program and consequences for behavior are logical and designed to promote skill-building for the youth e. Counseling, verbal intervention and de-escalation techniques are used prior to physical intervention (Only techniques approved by the Florida Network and DJJ are used if physical intervention is required) f. Only staff discipline youth. Group discipline is not imposed g. Room restriction is not used as part of the system or for youth who are physically and/or emotionally out of control h. Youth should never be denied basic rights such as meals, clothing, sleep, services, exercise, or correspondence privileges	**Compliance**	The Behavior Management System (BMS) is a point based system that teaches youth that behaviors have benefits and consequences. The system has three levels that allow a youth to progress to better benefits by earning positive points. Consequences for behaviors are point based which then results in fewer benefits. Basic rights are not denied nor is room restriction used. Youth do not discipline youth. Verbal intervention is used to redirect youth.	
Program's use of the BMS			
All staff are trained in the theory and practice of administering BMS rewards and consequences	**Compliance**	The evidence of training on the behavior management system being provided to all staff was reviewed.	
There is a protocol for providing feedback and evaluation of staff regarding their use of BMS rewards and consequences	**Compliance**	Feedback regarding the use of the behavior management system is given by the director of residential services at the monthly staff meetings. Evaluation of the staff's use of the behavior management system rewards and consequences is conducted on a one on one basis between the director of residential services and shelter staff.	
Supervisors are trained to monitor the use of rewards and consequences by their staff	**Compliance**	Supervisors are trained to monitor how the system is being used by the staff in the giving of rewards and consequences.	
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 program has a policy: 4.02 Staffing and Youth Supervision reviewed 02/20/2024 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: Most recent six months of bed checks on the electronic log, most recent 30 days of bed checks on the video surveillance system
Staff Position(s) Interviewed (No Staff Names): Director of residential services
Type of Documentation(s) Reviewed: Fifteen minute bed checks
Describe any Observations: The program's policy does not permit personal cell phones in the mod and observation, of staff using a cell phone while supervising youth in the mod, was while reviewing surveillance video. Also observed late and falsified documentation of completion of bed checks.

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**	Documents reviewed as well as observations during the review found the program maintained the required minimum staffing rations required by Florida Administration Code and contract of one staff to six staff during the awake hours and community activities and one staff to twelve youth during sleep periods.	
All shifts must always provide a minimum of two direct care staff present that have met the minimum training requirements	**Compliance**	A review of schedules from the past six months showed evidence that all shifts always provide a minimum of two direct are staff present who have met the required training requirements.	
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**	Documentation reviewed in employee files, found all program staff included in supervision ratio were background screened and properly trained youth care workers, supervision staff, and treatment staff.	
The staff schedule is provided to staff or posted in a place visible to staff	**Compliance**	The staff schedule is kept in both the administration office as well as in master control, which is accessible to all 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**	The program maintains a holdover rotation roster which also includes an overtime roster containing staff and contact information when additional coverage is needed. Additionally, the program utilizes trained staff from other programs, within the agency, when additional coverage is needed.	

Staff observe youth at least every 15 minutes while they are in their sleeping room, either during the sleep period or at other times, such as during illness or room restriction	**Exception**	The program maintains the fifteen-minute checks on the electronic log. Four random dates, within the past thirty days, were selected for review. Additionally, an hour of one day a month for the previous five month were reviewed on both male and female dorms of the electronic fifteen-minute check log. An observation was made during the review of the program's video surveillance system, of a staff member using a cell phone while supervising youth in a mod of the residential program which doesnt adhere to the program's internal policy. The program has a policy, 8.03 Facility Environment and Safety, last reviewed 07/2023. The program's policy states; Personal cell phones, smart watches and electronic devices capable of taking pictures or video must not be introduced into the mod or residential. Staff, providers, visitors, volunteers, and vendors may be subject to legal or disciplinary action if they introduce contraband into the secure area of the facility. Please refer to YCC Operations Manual Policy 5.07 for a comprehensive review of contraband.	A review of the fifteen-minute checks (over the last six months) in the electronic log, found an overall total of ten missed checks, several late checks and three logged falsification checks. A review of video with corresponding electronic fifteen-minute logs for four random days of fifteen-minute checks within the last thirty days confirmed three incidents of falsification of completed checks logged however, not being seen on video, eight missed checks, and eleven late checks (the late checks ranged from one to five minutes late). December checks documented two of five completed as required on male dorms, with one missed check, one check being only one minute late, and one check being five minutes late. December checks documented four of five completed as required on female dorms, with one check being one minute late. January checks documented three of five completed as required on male dorms, with one missed check, and one check being two minutes late. January checks documented three of five completed as required on female dorms, with two checks being one minute late, and one check being five minutes late. February checks documented three of five completed as required on male dorms, with two checks being three minutes late. February checks documented four of five completed as required on female dorms, with one check being one minute late. March checks documented three of five completed as required on male dorms, with one check being three minutes late, and one check being five minutes late. March checks documented four of five completed as required on female dorms, with one check being one minute late. April checks documented three of five completed as required on male dorms, with one check being six minutes late, and one check being three minutes late. April checks documented four of five completed as required on female dorms, with one check being one minute late.
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 program has a policy: 4.13, Security Cameras signed by the CEO on 02/20/2024.	

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: Most recent six months
Staff Position(s) Interviewed (No Staff Names): Director of residential services
Type of Documentation(s) Reviewed: Supervisor video review log, video surveillance access list, posted surveillance notices

Surveillance System			
The agency, at a minimum, shall demonstrate: a. A written notice that is conspicuously posted on the premises for the purpose of security b. System can capture and retain video photographic images which must be stored for a minimum of 30 days c. System can record date, time, and location; maintain resolution that enables facial recognition d. Back-up capabilities consist of cameras' ability to operate during a power outage e. Have cameras placed in interior (e.g. intake office, counseling office, cafeteria, day room) and exterior (e.g. entrance/exit, recreation area, parking lot) general locations of the shelter where youth and staff congregate and where visitors enter and exit; to include locations where youth searches are conducted. Cameras are never placed in bathrooms or sleeping quarters. f. All cameras are visible	**Compliance**	The program has written notice conspicuously posted on the premises of a surveillance system for the purpose of security. The system records date, time, and location, maintains resolution enabling facial recognition, and can capture and retain video for a minimum of thirty days. The system has a two-hour battery back-up to be able to operate during a power outage. Cameras were visible placed in all required interior and exterior locations and were never placed in bathrooms or sleeping quarters.	
A list of designated personnel who can access the video surveillance system is maintained (includes off-site capability per personnel)?	**Compliance**	The program maintains a list of designated personnel who can access the video surveillance system. The personnel who have access to recorded footage and have off-site capabilities include the chief operating officer, chief developmental officer, residential director, marketing compliance analyst and human resources director. This list as well as all residential staff and the transition living specialist have access to the live video footage.	
Supervisory review of video is conducted a minimum of once every 14 days and timeframes reviewed are noted in the logbook.	**Compliance**	The program maintains a supervisory review log which shows that video reviews are conducted at a minimum, once every 14 days and timeframes reviewed are noted in the a separate video review log.	
The reviews assess the activities of the facility and include a review of random sample of overnight shifts	**Compliance**	The program's video review log accesses the activities of the facility and includes a review of random dates and times including 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**	The program is able to grant requests of video recordings within twenty-four to seventy-two hours, or sooner, for program quality improvement visits or investigations pursued after an allegation of an incident.	
Camera service order/requests will be made within 24 hours of discovery of camera malfunctioning or being inoperable. All efforts made to obtain repairs are documented and maintained	**Compliance**	The agency's policy indicates, camera service order/ requests will be made within 24, hours of discovery of camera malfunctioning. Interview with the director of residential services indicated that in the event of camera malfunctioning or is inoperable, the program completes a service order within twenty-four hours of discovery and all efforts are documented and maintained.	
Additional Comments: **There are no additional comments for this indicator.**			

4.01 - Healthcare Admission Screening			Satisfactory with Exception
Provider has a written policy and procedure that meets the requirement for Indicator 4.01	**YES**		
	If NO, explain here:		
	The program has a policy 2.02: Healthcare Admission Screening, last reviewed on 07/2023 and signed 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: Two
Staff Position(s) Interviewed *(No Staff Names)* **: Director of Residential Services**
Type of Documentation(s) Reviewed: Youth Records; Admission forms

Preliminary Healthcare Screening			
Screening includes : a. Current medications b. Existing (acute and chronic) medical conditions c. Allergies d. Recent injuries or illnesses e. Presence of pain or other physical distress f. Observation for evidence of illness, injury, physical distress, difficulty moving, etc. g. Observation for presence of scars, tattoos, or other skin markings h. Acute health symptoms requiring quarantine or isolation	**Exception**	The program completes screening through the use of the Admission form completed by the direct care staff which included all required elements of current medications, existing medical conditions, allergies, recent injuries or illnesses, presence of pain or other physical distress, observation for evidence of illness, injury, physical distress, difficulty of moving, etc., observations of markings, and acute health symptoms requiring quarantine or isolation. The form is reviewed by medical and mental health and follow-up on if needed. Five case records were reviewed. Two case records included current medications, one of which notated existing medication conditions. Three records were not applicable for an existing medical condition. The one youth record indicated a known allergy, as documented on the admission form. One applicable youth presented with scars or tattoos as documented on the admission form. None of the records reviewed were applicable for recent injuries or illnesses, presence of pain or other physical distress, observation for evidence of illness, injury, physical distress, difficulty of moving, etc., and acute health symptoms requiring quarantine or isolation.	Admission/healthcare screening form does not list medication or acute chronic conditions though checked for both, in one youth record reviewed. Medication was noted on the NetMIS screening form and in the initial case note however was noted on the admission/healthcare screening form in one youth record reviewed.
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 program has a policy in place to ensure all youth with chronic medical conditions are referred for medical care. None of the records reviewed were applicable for needing a referral for a chronic condition.	
When needed, the parent is involved with the coordination and scheduling of follow-up medical appointments	**Compliance**	Three of five reviewed records documented a need for a follow-up medical appointments in which the program coordinated the scheduling with the parent/guardian.	
All medical referrals are documented on a daily log.	**Compliance**	Documentation of coordination of medical referrals was present in the program's daily log. Notation of coordinating follow-up medical appointments was observed in the program's daily log.	

The program has a thorough referral process and a mechanism for necessary follow-up medical care as required and/or needed	**Compliance**	The program has a thorough referral process and mechanism for necessary follow-up medical care as required and/or needed.	
Additional Comments: **There are no additional comments for this indicator.**			
4.02 - Suicide Prevention			**Limited**
Provider has a written policy and procedure that meets the requirement for Indicator 4.02		**YES** If NO, explain here: The program has a policy, 3.02: Suicide Prevention, reviewed on 07/23 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: Three **Total number of Closed (Residential & Community) Files: Two** **Staff Position(s) Interviewed** *(No Staff Names)* **: Director of Residential Services** **Type of Documentation(s) Reviewed: Youth records: Admission Forms for screening, Precautionary Observations Logs, Suicide Risk Assessments**			
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**	Five youth records were reviewed, three open and two closed. Each record contained an suicide risk screening which occurred during the initial intake and screening process and signed by the supervisor.	
The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	**Compliance**	The program is using an approved risk assessment.	
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.	**Exception**	All five records reviewed indicated each youth was placed on the appropriate level of supervision based on the result of the suicide risk screening assessment.	Three of the five reviewed suicide risk assessments were not completed in accordance with the 24 hour protocols set forth in the Florida Network Youth and Family Services QI standard. Each of the screenings were completed before 5:00pm on a Friday, therefore assessment for suicidality was required within 24 hours. One youth was admitted on 04/19/2024 at 10:00am and an assessment was completed on 04/20/2024 at 3:45p.m. The assessment for suicidality was completed 5 hours and 45 minutes late. One youth was admitted on 05/03/2024 at 8:00am and an assessment was completed on 05/04/2024 at 10:57 am. The assessment for suicidality was completed 2 hours and 57 minutes late. One youth was admitted on 05/01/2024 at 8:00am and an assessment was completed on 05/03/2024 at 1:07pm. The assessment for suicidality was completed 53 hours and 7minutes late. It was reported that the program believed the 24 hour protocol referenced in the standard was equivalent to completing within one day.

Staff person assigned to monitor youth maintained one-to-one supervision or constant supervision and documented his/her observations of the youth's behavior at 30 minute or less intervals	**Exception**	Four of the five reviewed records contained evidence that staff persons assigned to monitor youth maintained one-to-one supervision or constant supervision and documentation was present of the observations of the youth's behavior at 30 minute or less intervals.	One record did not contain documentation of the entire period that the youth was placed on PO as required.
Documentation includes the time of day, behavioral observations, any warning signs observed, and the observers' initials and was maintained in either an observation log or in the shelter daily log.	**Compliance**	Documentation on reviewed PO logs included all required elements.	
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**	Each reviewed record indicated the level of supervision was not reduced until a licensed professional or a non-licensed mental health professional under the supervision of a licensed professional completed an assessment or a Baker Act was enacted by local law enforcement.	
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.	**Exception**	A review of four PO logs indicated that supervisory reviews were completed by shift supervisor each shift and documentation maintained in the youth's record.	One record was missing PO documentation for a period of time from 05/03/2024,11:30am to 05/04/2024 at 7:00 while the youth was still on PO.
Youth with Suicide Risk *(Community Counseling Only)*			
Youth identified for suicide risk during intake was immediately assessed by a licensed professional or non-licensed professional (under the direct supervision of a licensed mental health professional) and the parents and supervisor were both notified of the results.	**No eligible items for review**	The program reported they had no community counseling youth identified for suicide risk during intake for the period reviewed or back to the date of the last review.	
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**	The program had no community counseling youth identified for suicide risk during intake for the period reviewed or back to the date of the last review.	
Information on resources available in the community for further assessment was provided to the parent/guardian and is documented in the youth's file and signed by the parent/guardian OR a written follow-up notification was sent by certified mail if the parent/guardian was not present during the screening and was notified by telephone.	**No eligible items for review**	The program had no community counseling youth identified for suicide risk during intake for the period reviewed or back to the date of the last review.	
If the parent/guardian cannot be contacted, all efforts to contact them are documented in the case file.	**No eligible items for review**	The program had no community counseling youth identified for suicide risk during intake for the period reviewed or back to the date of the last review.	
When the screening was completed during school hours on school property, the appropriate school authorities were notified.	**No eligible items for review**	The program had no community counseling youth identified for suicide risk during intake for the period reviewed or back to the date of the last review.	
Additional Comments: **There are no additional comments for this indicator.**			

4.03 - Medications			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 4.03	**YES**		
	If NO, explain here:		
	The program has a policy 5.04: Medication Management and Distribution, last reviewed 07/2023, signed 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: Two
Staff Position(s) Interviewed *(No Staff Names)***: registered nurse**
Type of Documentation(s) Reviewed: Medication Distribution Logs, Pyxis logs and manual, training information
Describe any Observations: observed medication pass which was completed as required

The agency has a Registered Nurse (RN) and/or a Licensed Practical Nurse (LPN) that is being supervised by RN and all of their credentials have been verified.	**Compliance**	The program has a two Registered Nurses (RN) which all credentials have been verified.	
The agency has evidence of the following for all non-nursing shelter staff designated to assist with the self-administration of medication: a. Documentation of in-person self-administration of medication distribution training provided by a Registered Nurse b. Evidence demonstrating their competency to assist with self-administration of medication distribution c. Maintenance of their annual medication training re-certification	**Compliance**	The program has policy and procedures in place addressing non-nursing staff who assist with the self-administration of medication. Reviewed training documentation verified all applicable staff received annual medication distribution training was provided by a RN, who completed drills and any necessary training to demonstrate competency.	
The agency held at least quarterly staff meetings conducted by RN and/or Shelter Manager to review and assess: a. strategies implemented to reduce medication errors shelter wide b. analyze factors that contributed to medication errors c. allow staff the opportunity to practice and role-play solutions	**Compliance**	A review of documentation, verified the RN supervisor conducts quarterly meetings with the shelter manager and appropriate administration team members to review and assess strategies implemented to reduce medication errors, analyze factors which contribute to medication errors, and allow staff the opportunity to practice and role-play solutions.	
The agency has strategies implemented to ensure medications are provided within the 2-hour time frame.	**Compliance**	The program has strategies (scheduled reminders and alarms) implemented to ensure medications are provided within the two-hour required timeframe.	
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**	A review of the program schedule verified all non-licensed staff members who assist with medication administration are clearly identified and designated. Medical staff also maintains a list of all staff who are trained to provide assistance in the administration of medication.	

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 program communicated which youth are on medication through the use of the alert board maintained in administration office, an alert binder and medication board maintained in medical, and alert forms maintained in youth records. The dosage and times are clearly discernable by all staff on each staff on the Medication Administration Log.	
The delivery process of medications is consistent with the FNYFS Medication Management and Distribution Policy and the agency has an internal quality assurance process to include the following: a. to ensure appropriate medication management and distribution methods b. to track medication errors c. to identify systemic issues and implement mitigation strategies, as appropriate.	**Compliance**	The program has an internal quality assurance process which ensures appropriate medication management and distribution methods, track medication errors, and identify systemic issues and implement mitigation strategies, as appropriate. The program's delivery process of medications is consistent with the FNYFS Medication Management and Distribution Policy.	
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**	Five reviewed records, three opened and two closed, confirmed during admission the youth and parent/guardian (if available) were interviewed by the RN about each youth's current medications as part of the 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. Reviewed documentation showed evidence the on-shift certified supervisor of higher level staff did review all medication forms by the next business day.	
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**	All medication are stored in the Pyxis ES Medication Cabinet, with the exception of any refrigerated medications, and are inaccessible to youth at all times. The Pyxis machine is stored in accordance with the Florida Statute guidelines and program policy. Oral medication are stored separate from injectable epi-pen and topical medications. Medication requiring refrigeration are stored in a secure refrigeration used only for this purpose and within the required temperature range.	
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**	A review of the program policy and training documentation verified the program maintains a minimum of two site-specific System Managers for the Pyxis ES Station and only designated staff delineated in User Permissions have access to secured medication, with limited access to controlled substances. A Medication Distribution Log is utilized for the distribution of medication by both non-licensed and licensed staff. The program policy and nurse confirmed the use of one of the three approved methods to verify medications. Medication processes are always completed by the nurse when on-site, or completed by the designated staff, trained by a licensed registered nurse (RN), when the nurse is not on-site. Except for the use of an Epi-pen, the program does not accept youth currently prescribed injectable medications. Reviewed training documentations verified all staff have been trained in the use of epi-pens by the RN.	
The medication distribution log documentation includes: a. the time of medication administration b. evidence of youth initials that the dosage was given c. evidence of staff initials that the dosage was given	**Compliance**	Five reviewed records, three opened and two closed, confirmed the program utilized a Medication Distribution Log by non-licensed and licensed staff which included the time of the medication administrations and youth and staff initials indicating the dosage was given.	
There is evidence that staff provide youth with medications within one hour of the scheduled time of delivery as ordered by the medication. Documentation is provided for instances this does not occur within the required timeframe.	**Compliance**	Five reviewed records, three opened and two closed, verified the staff provided each youth with medications within one hour of the scheduled time of delivery as ordered by the prescription. There were no documentation of instances of a medication not being provided withing the required timeframe within the annual compliance review period.	

During the review period, there were no instances where youth missed their medication due to failure to open the pyxis machine.	**Compliance**	There were no reported instances of where youth missed medications due to failure to open the pyxis machine during the annual compliance review period.	
If applicable: Any staff member deemed responsible for a medication error, there was evidence that the staff member received refresher training from an RN and demonstrated competency prior to being assigned future medication administration responsibilities. There is evidence that any staff member deemed responsible for 3 errors within a 1-year time frame, had their certification suspended and was not recertified until the completion of the full **in-person** medication administration training, demonstrating competency and re-certification from an RN.	**No eligible items for review**	There was no evidence and medication error had occurred within the annual compliance review period. At the time of the annual compliance review, the Central Communication Center module was not available to be reviewed. The nurse reported there have not been any medication errors during the 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	**Compliance**	An observation of medication pass verified there is a perpetual inventory with running balance maintained through Pyxis as well as a shift-to shift count through reviewed documentation for controlled substances. All over-the-counter medications are accessed regularly and inventoried weekly. The program only maintains scissors on-site which are documented weekly.	
There are monthly reviews of the Pyxis reports to monitor medication management practice.	**Compliance**	Documentation reviewed found monthly reviews are conducted of the Pyxis reports to monitor medication management practice.	
Medication discrepancies are cleared after each shift.	**Compliance**	Medication discrepancies are cleared after each shift, when applicable.	
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 program has a policy, 5.03.01: Medical and Mental Health Alert Process, last reviewed on 07/2023 signed 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: One
Total number of Closed Files: Two
Staff Position(s) Interviewed *(No Staff Names)* **: registered nurse, direct care staff supervisor**
Type of Documentation(s) Reviewed: alert documentation
Describe any Observations: alert boards

Youth with a medical, mental health, or food allergy was appropriately placed on the program's alert system	**Compliance**	Three youth records reviewed, two closed and one open, for the program's alert process. A review of the alert board and alert documentation in the youth case records verified all youth with a medical, mental health, and/or food allergy was appropriately placed on the program's alert system.	
Alert system includes precautions concerning prescribed medications, medical/mental health conditions	**Compliance**	The programs alert system included precautions concerning prescribed medications and medical/mental health conditions.	
Staff are provided sufficient training, information and instructions to recognize/respond to the need for emergency care for medical/mental health problems	**Compliance**	Reviewed documentation confirmed the staff were provided sufficient training, information, and instructions to recognize/ respond to the need for emergency care.	
A medical and mental health alert system is in place that ensures information concerning a youth's medical condition, allergies, common side effects of prescribed medications, foods and medications that are contraindicated, or other pertinent mental health treatment information, is communicated to all staff	**Compliance**	The program maintains a medical and mental health alert system which ensures information is communicated to all staff concerning a youth's medical condition, allergies, common side effects of prescribed medications, contraindicated foods and medications, or other pertinent mental health treatment information.	

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 program has a policy, 5.03.02: Episodic/ Emergency Care, last reviewed on 07/2023 and signed 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: Two
Total number of Closed Files: Two
Staff Position(s) Interviewed *(No Staff Names)* **: Direct care staff supervisor**
Type of Documentation(s) Reviewed: Episodic/ emergency care log, Incident reports, medical discharge documentation and follow-up
Describe any Observations: Location for knife for life

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**	Four youth records were reviewed, two open and two closed, for emergency care. All received records contained an incident report submitted for medical or dental care. Two youth were applicable for off-site care, the other two youth received medical care on-site, one by nursing staff and one by emergency response team. Reviewed records indicated both applicable off-site emergency care youth returned with a receipt of medical clearance of a discharge instructions and follow-up instructions, if applicable, and maintained in the records. Two youth were applicable for parent notifications, who were contacted by program staff. All incidents were documented in the daily log.	
All staff are trained on emergency medical procedures	**Compliance**	Reviewed documentation confirmed all staff were trained in emergency medical procedures.	
The program has a Knife-for-life and wire cutters accessible to staff in a secure location(s)	**Compliance**	The program maintains a knife-for-life and wire cutters kit which is accessible to all staff in a secure box located in master control.	
Additional Comments: **There are no additional comments for this indicator.**			