Florida Network for Youth and Family Services
Compliance Monitoring Report for

Lutheran Services Florida NW – HOPE House

5127 Eastland Street
Crestview, FL 32539

September 18-19, 2024

Compliance Monitoring Services Provided by

FOREFRONT

EXECUTIVE SUMMARY

Forefront LLC conducted a Quality Improvement (QI) monitoring visit on behalf of the Florida Network of Youth and Family Services (FNYFS) for the Lutheran Services Florida NW HOPE House (LSF NW HOPE House) for the FY 2024-2025 at its program office located at 5127 Eastland Street, Crestview, FL 32539. Forefront LLC (Forefront) is an independent compliance monitoring firm that is contracted by the FNYFS to perform onsite program reviews to assess the agency's adherence to fiscal, programmatic and overall contract requirements. LSF NW HOPE House is contracted with the Florida Network of Youth and Family Services (FNYFS) to provide direct services to Children/Families in Need of Services (CINS/FINS). The services to be provided are identified in Contract Section A - Descriptions and Specifications and Section B - Delivery and Performance, and are funded with General Revenue Funds effective from July 1, 2024 through June 30, 2025.

The compliance monitoring review was conducted by Keith Carr, Consultant for Forefront LLC. Agency representatives from LSF NW HOPE House present for the entrance interview were Cari Still, PhD, LCSW, MPH Associate Vice President of Quality Assurance, Chrissy Baker, LCSW, and LSF NW HOPE House Residential, Community Counseling and Administrative staff members. The last onsite QI visit was conducted on March 20-21-2024.

In general, the Reviewer found that LSF NW HOPE House is in compliance with specific contract requirements. LSF NW HOPE House **received an overall compliance rating of 100% for achieving full compliance with 12 of the 14 compliance indicators** of the CINS/FINS Monitoring Tool. There were no recommendations or corrective actions as a result of the monitoring visit.

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

2024-2025 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 9-8-19-2024-2025

Agency Name:	**Monitor Name: Keith Carr, Lead Reviewer**
Contract Type : CINS/FINS	**Region/Office: 5127 Eastland Street , Crestview, FL 32539**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): September 18-19, 2024**

Major Programmatic Requirements	**Explain Rating**					**Ratings Based Upon:** **I = Interview** **O = Observation** **D = Documentation** **PTV = Submitted Prior To Visit** **(List Who and What)**	**Notes** **Explain Unacceptable or Conditionally Acceptable:**
	Unacceptable	**Conditionally Acceptable**	**Fully Met**	**Exceeded**	**Not Applicable**		
I. Administrative and Fiscal							
DJJ Quality Improvement Peer Reviewer a. Provider shall demonstrate that a minimum of two (2) staff members have been trained to be certified as DJJ QI Peer reviewers. Provider shall participate in a minimum of one (1) on-site quality assurance review of a similar type of program in another judicial circuit during each 12-month period of the contract, if requested.	☐	☐	☒	☐	☐	Interview/Documentation: The program currently has two staff members certified as DJJ QI Peer reviewers for this location that cover the LSF NW HOPE House programs: Sherri Kilpatrick and Chrissy Baker. The regional director resigned from her role with the agency a few days prior to the program review. One of two staff have are scheduled for peer reviews this fiscal year. The agency has requested to be notified when the next Quality Improvement (QI) Peer Reviewer training is announced.	**No recommendation or Corrective Action.**
Additional Contracts a. Provider shall provide a listing of all current federal, state, or local government contracts, as well as other contracts entered into with for profit and not-for-profit organizations. Such a listing shall identify the awarding entity and contract start & end dates. **PTV**	☐	☐	☒	☐	☐	Documentation: A list of additional grant contracts for FY 2024-2025 was provided by the provider. The list includes fund identification number, program name, funding source name, contract period start and end dates and contract amount. Further the agency has numerous grants providing various	**No recommendation or Corrective Action.**

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Major Programmatic Requirements	Explain Rating: Unacceptable	Conditionally Acceptable	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:
						services including SAMH, Head Start, Food Programs, Case Management, Emergency Shelter, Immigration-Refugee Services, Guardianship and others.	
Limits of Coverage a. Provider shall provide and maintain during this contract, the following minimum kinds of insurance: Worker's Compensation and Employer's liability insurance as required by Chapter 440, F.S. with a minimum of $100,000 per accident, $100,000 per person and $500,000 policy aggregate. Commercial General Liability with a limit of $500,000 per occurrence, and $1,000,000 policy aggregate. Automobile Liability Insurance shall be required and shall provide bodily injury and property damage liability covering the operation of all vehicles used in conjunction with performance of this contract, with a minimum limit for bodily injury of $250,000 per person; with a minimum limit for bodily injury of $500,000 per accident; with a minimum limit for property damage of $100,000 per accident and with a minimum limit for medical payments or $5,000-$10,000 per person. Florida Network is listed as payee or co-payee. **PTV**	☐	☐	☒	☐	☐	Documentation: The provider has a policy with Market Global Reinsurance Company for General Liability insurance with limits of coverage of $1,000,000 each/$3,000,000 aggregate and $10,000 each for medical expenses. Additional policies with this carrier include Professional Liability insurance provides limits of coverage of $1,000,000 each/$3,000,000 aggregate and Abuse/Molestation insurance provides limits of coverage of $1,000,000 each/$3,000,000 aggregate. The provider has a policy with Florida Insurance Trust for Automobile insurance that provides limits of coverage of $1,000,000 combined for	**No recommendation or Corrective Action.**

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	Unacceptable	**Conditionally Acceptable**	**Fully Met**	**Exceeded**	**Not Applicable**		
						each accident. The provider has a policy with Century Surety Company for Excess/Umbrella Liability insurance which provides limits of coverage of $1,000,000 each/aggregate. Coverage for the above policies is in effect for the current FY 6/01/2024-6/01/2025. The certificate does list the Florida Network on the consolidate certificate of liability as a certificate holder.	
External/Outside Contract Compliance a. Provider has corrective action item(s) cited by an external funding source (Fiscal or Non-Fiscal). **ON SITE**	☐	☐	☐	☐	☒	Documentation/Interview: N/A – Regional Director indicated that there are no outstanding corrective action item(s) cited by an external funding source.	**Not Applicable.**
Fiscal Practice a. Agency must have employee and fiscal policy/procedures manuals that are in compliance with GAAP and provide sound internal controls. Agency maintains fiscal files that are audit ready. **PTV**	☐	☐	☒	☐	☐	Documentation: The provider has existing policies which address general accounting practices which are maintained by the Chief Financial Officer for the agency.	**No recommendation or Corrective Action.**

2024-2025 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
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Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): September 18-19, 2024**

Major Programmatic Requirements	Explain Rating: Unacceptable	Conditionally Acceptable	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:
						Fiscal policies and procedures are contained in the agency's Financial Services Policy and Procedures Manual. The procedures appear to be consistent with GAAP and provide for limited internal controls. Provider provided 45 policies which include procedures for general ledger, cost accounting, payroll, petty cash, computer backup, and other relevant financial processes.	
b. Agency maintains a general ledger and the corresponding source documents. A general ledger must be set up to track the activity of the grant separately (standard account numbers / separate funds for each revenue source, etc.). **PTV**	☐	☐	☒	☐	☐	Documentation: Detailed General Ledger for the current FY2024-2025 for July 2024 – September 2024. Provider maintains a detailed general ledger that includes breakdown of GL code, GL title, effective date, Doc number, ID number, Name of funding source, transaction description, fund code, year code, program code, location code, and debit and credit columns. Ledgers included current balances and differences.	**No recommendation or Corrective Action.**

2024-2025 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
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Major Programmatic Requirements	**Explain Rating**					**Ratings Based Upon:** **I = Interview** **O = Observation** **D = Documentation** **PTV = Submitted Prior To Visit** **(List Who and What)**	**Notes** **Explain Unacceptable or Conditionally Acceptable:**
	Unacceptable	**Conditionally Acceptable**	**Fully Met**	**Exceeded**	**Not Applicable**		
c. Petty cash ledger system is balanced and all cash disbursements are compliant with financial policies and allowable under the contract. (Disbursements/invoices are approved & monitored by management.) –**ON SITE**	☐	☐	☒	☐	☐	Observation/Documentation: The agency utilizes a system of managing petty cash. The agency has not implemented any revisions to the petty cash system since the last onsite program review. Petty cash is stored in a secure locked location and must be verified and approved monthly by management. At the time of this program review, the agency's Residential Supervisor is responsible for the petty cash. The agency's Regional Director is the only other staff members with access to the petty cash drawer. The petty cash on hand, checks, and receipts were reconciled onsite during the onsite program review and was verified to be consistent with September 2024 petty cash reconciliation documentation onsite.	**No recommendation or Corrective Action.**
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	☐	☐	☒	☐	☐	Documentation: Reviewed Bank Statements and Bank Reconciliations for months March 2024-August 2024 for one account	**No recommendation or Corrective Action.**

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monthly basis with supporting documentation and documentation provided contained 2 signatures. (Disbursements/invoices are approved & monitored by management). **ON SITE**						with Ameris Bank. Bank reconciliations are conducted each month for the activities and bank statements for the preceding month and are reviewed by two parties. Invoices are submitted on a monthly basis with supporting documentation.	
e. Agency maintains inventory in accordance with a written policy and FNYFS contractual requirements. If over $1,000 inventory has DJJ Property Inventory Number/Tag. In the event the provider has purchased computer equipment an Informational Resources Request (IRR) has been submitted to DJJ. **PTV/ON SITE**	☐	☐	☐	☐	☒	Documentation/Interview: N/A – The agency has not purchased any items with FNYFS funds since the last time on-site.	**Not Applicable.**
f. Agency submits payroll taxes and deposits (and retirement deposits as applicable), Employee IRS Form W-2 and Independent Contractors IRS Form 1099 forms prior to federal requirements. **ON SITE**	☐	☐	☒	☐	☐	Documentation: Provider submitted evidence of payroll taxes and deposits for first and second quarters for calendar year 2024. A formal list of agency bank deposits report showed being deposited via electronic funds transfer or check payments.	**No recommendation or Corrective Action.**
g. Budget to actual reports prepared and reviewed by appropriate management. Variance from the budget are investigated and explained. **PTV/ON SITE**	☐	☐	☒	☐	☐	Documentation: Agency provided a detailed CINS/ FINS Budget Report which included	**No recommendation or Corrective Action.**

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Major Programmatic Requirements	Explain Rating: Unacceptable	Conditionally Acceptable	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:
						months including March 2024 through August 2024. The report tracks all budget categories by current period actual and current period contract separately. Variances if applicable are identified.	
h. A Single Audit is performed as part of the annual audit if expenses are greater than $750,000. The agency must submit a Corrective Action Plan for findings cited in the management letter and single audit. An annual financial audit was completed within 120 days after the previous fiscal year/calendar year and that a copy was provided to the Network unless and extension has been requested and approved in writing. Copy of Audit is submitted to the FNYFS by December 31st. **Can obtain from FNYFS**	☐	☐	☒	☐	☐	Documentation: Financial audit was conducted for the fiscal year beginning June 30, 2023 – 2022 by RSM US LLP. A letter dated March 29, 2024, stated no corrective action was needed. A copy was submitted directly to the Florida Network of Youth and Family Services.	**No recommendation or Corrective Action.**
i. Agency maintains confidentiality policy with written policies and procedures to ensure the security and privacy of all employee and client data. Personal information is not easily accessible. Agency maintains a backup system in case of accidental loss of financial information. Security procedures are in place to protect laptops. Obsolete documents are shredded and computer hard drives are wiped prior to discarding. **ON SITE**	☐	☐	☒	☐	☐	Documentation: The agency maintains a procedure manual with several sections (Information Technology, Risk Prevention and Management) to address security and privacy of employee and client data. The agency provided 7 Policies and Procedures for review including: Confidentiality of	**No recommendation or Corrective Action.**

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						Clients, Records Retention, IT Disposal of Hardware, IT Security and information storage.	
j. Agency provided evidence that every direct care staff employee, as of October 1, 2023, is being paid at least $19.00 per hour. This also includes funding for additional staff as approved by the Department. **ON SITE**	☐	☐	☒	☐	☐	Documentation: The agency provided documented evidence of staff members' hourly pay rate being a minimum of $19.The agency provided staff member pay rates effective as of October 1, 2023 to present.	**No recommendation or Corrective Action.**

CONCLUSION

Lutheran Services Florida NW HOPE House has met the requirements for the CINS/FINS contract as a result of full compliance with 12 applicable indicators of the Administrative and Fiscal Contract Monitoring Tool. Two of fourteen indicators were not applicable because 1) the provider does not have any outstanding corrective action item(s) cited by an external funding source, and 2) does not have any current inventory purchased with DJJ/FN Funds. Consequently, **the overall compliance rate for this contract monitoring visit is 100%.** There are no corrective actions or recommendations cited as a result of the contract monitoring visit. Overall, the provider is performing satisfactorily in meeting the fiscal and administrative terms of its contract. In addition, the majority of indicators reviewed were carried out in a manner which meets the standard described in the report findings.

SUMMARY OF CORRECTIVE ACTIONS or RECOMMENDATIONS

No Corrective Actions or Recommendations.

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

Florida Network of Youth and Family Services
Quality Improvement Program Report

Lutheran Services Florida NW – HOPE House

5127 Eastland Street
Crestview, FL 32539

September 18-19, 2024

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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	Limited
1.03 Incident Reporting	Satisfactory
1.04 Training Requirements	Failed
1.05 Analyzing and Reporting Information	Limited
1.06 Client Transportation	Satisfactory
1.07 Outreach Services	Satisfactory

Percent of indicators rated Satisfactory: 57.14 %
Percent of indicators rated Limited: 28.57 %
Percent of indicators rated Failed: 14.29 %

Standard 2: Intervention and Case Management

2.01 Screening and Intake	Satisfactory
2.02 Needs Assessment	Limited
2.03 Case/Service Plan	Limited
2.04 Case Management & Service Delivery	Satisfactory
2.05 Counseling Services	Satisfactory
2.06 Adjudication/Petition Process	Satisfactory
2.07 Youth Records	Satisfactory
2.08 Special Populations	Satisfactory
2.09 Stop Now and Plan (SNAP)	Not Applicable

Percent of indicators rated Satisfactory: 77.78 %
Percent of indicators rated Limited: 22.22 %
Percent of indicators rated Failed: 0 %

Standard 3: Shelter Care & Special Populations

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

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

Standard 4: Mental Health/Health Services

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

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

Overall Rating Summary

Percent of indicators rated Satisfactory: 82.14 %
Percent of indicators rated Limited: 14.29 %
Percent of indicators rated Failed: 3.57 %

Rating Definitions

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

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

Reviewers

Members

Keith Carr - Lead Reviewer Consultant, Forefront LLC/Florida Network of Youth and Family Services
Stephanie Solano – Regional Monitor, Department of Juvenile Justice
Naret Morales – Community Counseling Director, Anchorage Children's Home of Bay County
Robert Ashley – Residential Supervisor, Anchorage Children's Home of Bay County
Wendy Pierre-McNealy – Training Coordinator, Florida Network of Youth and Family Services
Cioanna Allen – Regional Monitor, Department of Juvenile Justice

Methodology

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

Persons Interviewed

	Chief Executive Officer	X	Case Manager		Nurse – Full time
	Chief Financial Officer	X	Counselor Non-Licensed	X	Nurse – Part time
	Chief Operating Officer		Advocate	1	# Case Managers
X	Executive Director	X	Direct – Care Full time		# Program Supervisors
	Program Director	X	Direct – Part time	1	# Food Service Personnel
	Program Manager		Direct – Care On-Call		# Healthcare Staff
	Program Coordinator		Intern	1	# Maintenance Personnel
X	Clinical Director		Volunteer	4	# Other (listed VP of QI, YCS Staff, Admin. Asst.
X	Counselor Licensed		Human Resources		

Documents Reviewed

X	Accreditation Reports	X	Table of Organization	X	Visitation Logs
X	Affidavit of Good Moral Character	X	Fire Prevention Plan	X	Youth Handbook
X	CCC Reports	X	Grievance Process/Records	5	# Health Records
X	Logbooks	X	Key Control Log	5	# MH/SA Records
X	Continuity of Operation Plan	X	Fire Drill Log	8	# Personnel /Volunteer Records
X	Contract Monitoring Reports	X	Medical and Mental Health Alerts	8	# Training Records
X	Contract Scope of Services	X	Precautionary Observation Logs	5	# Youth Records (Closed)
X	Egress Plans	X	Program Schedules	5	# Youth Records (Open)
X	Fire Inspection Report	X	List of Supplemental Contracts	12	# Other: Medication, Suicide Prevention, ICM, Health A
X	Exposure Control Plan	X	Vehicle Inspection Reports		

Observations During Review

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

Surveys

4	# of Youth	10	# 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.

Narrative Summary

Lutheran Services Florida Inc. operates six crisis shelters in the State of Florida that are contracted with Florida Network of Youth & Family Services, Inc. The HOPE House and Community Counseling programs primarily provide services in Okaloosa and Walton Counties. The shelter is licensed for 8 beds and offers 24-hour availability, youth supervision, food and clothing, life skills education, crisis counseling, individual and family counseling, recreation and leisure activities, and case management services. Educational services are provided by the local school district, in the county in which the shelter is located. The Community Counseling North team for CINS/FINS also serves youth and families in the same counties and coordinate the delivery of community services to families and children in care. Funding through CINS/FINS allows the agency to serve both male and female youth up to seventeen years old that are locked out, runaway, ungovernable and/or truant, homeless, abuse, neglected, or at-risk. The agency also provides specialized services to youth who meet the criteria for Staff Secure shelter, Domestic Minor Sex Trafficking, and youth referred by the Juvenile Justice Court System for domestic violence, probation respite, and Intensive Case Management (ICM). LSF-NW is currently accredited by the Council of Accreditation (COA) and was recently re-accredited through February 28, 2026.

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 **Limited.**
Indicator 1.03 Incident Reporting was rated **Satisfactory with Exception.**
Indicator 1.04 Training Requirements was rated **Failed.**
Indicator 1.05 Analyzing and Reporting Information was rated **Limited.**
Indicator 1.06 Client Transportation was rated **Satisfactory.**
Indicator 1.07 Outreach Services was rated **Satisfactory.**

Standard 2: There are nine indicators for Standard 2.
Indicator 2.01 Screening and Intake was rated **Satisfactory with Exception.**
Indicator 2.02 Needs Assessment was rated **Limited.**
Indicator 2.03 Case/Service Plan was rated **Limited.**
Indicator 2.04 Case Management and Service Delivery was rated **Satisfactory with Exception.**
Indicator 2.05 Counseling Services was rated **Satisfactory with Exception.**
Indicator 2.06 Adjudication/Petition Process was rated **Satisfactory.**
Indicator 2.07 Youth Records was rated **Satisfactory with Exception.**
Indicator 2.08 Specialized Additional Program Services was rated **Satisfactory.**
Indicator 2.09 Stop Now and Plan (SNAP) was rated **Not Applicable**.

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

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

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

Standard 1:

Indicator 1.02 Limited

Nine (9) grievance forms were completed within the last six (6) months. One (1) grievance dated July 11, 2024, did not have the Program Manager (PM) or Program Supervisor (PS) signature. The grievance had a youth care specialist staff name on it, but it could not be determined if the staff or youth wrote the name. One (1) grievance dated July 3, 2024 was missing the action taken and PM/PS signature. Five (5) grievances dated March 19, 2024, July 3, 2024, July 11, 2024, August 2, 2024, and August 9, 2024, were missing evidence of the client signature.

Additionally, a review of Note Active custom report revealed daily grievance box checks were conducted as follows: April: week 8th-12th (10th and 12th missing), week 15th-19th (no issues), week 22nd-26th (24th missing). May: week 13th – 17th (15th and 16th missing), week 20th-24th (no issues), week 27th – 31st (27th – 29th missing). June: week 10th-14th (11th and 14th missing), week 17th – 21st (no issues), week 24th-28th (28th missing). July: week 8th-12th (8th and 10th missing), week 15th-19th (19th missing), week 22nd-26th (no issues). August: week 5th-9th (5th missing), week 12th – 16th (no issues), week 19th – 23 (20th – 22nd missing), September: week 30th – 4th (1st, 2nd, 4th missing).

Too, a review of nine (9) on-site grievances was conducted. It could not be determined if any of the nine (9) grievances were resolved within seventy-two (72) hours on the grievance form. None of the grievance forms contained a date or time of when the grievance was resolved. A review of Note Active revealed four (4) grievances were resolved within seventy-two (72) hours. The remaining five (5) were not documented by the Program Manager (PM) or Program Supervisor (PS) within seventy-two (72) hours and it could not be determined if they were resolved within seventy-two (72) hours.

Indicator 1.04 Failed

Deficiencies were noted in the following training categories: First Year Direct Care Staff for New Hire Pre-Service Training Provider Orientation; United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days; CINS/FINS staff for shelter and community counseling services, including independent contractors (full-time, part-time, and on-call) and interns not meeting the minimum requirement of 80 hours; Mandatory Training During the first 90 days of Employment from Date of Hire: FL Statute 984 CINS Petition Training; the required annual or 2-year mandatory refresher Florida Network, SkillPro, or other job-related Trainings; Community Counseling Direct Care Staff Completion of 24 hours of Mandatory Refresher Florida Network, SkillPro, and Job-Related Training; Shelter Program Direct Care Staff Completion of 40 Hours of Mandatory Refresher Florida Network, SkillPro, and job-related training annually; and Training Plan.

Indicator 1.05 Limited
Due to the new implementation of data collecting, the agency is behind on file review for the months of April, May, June, July, and August of 2024. Due to the agency making changes in data collecting, July's monthly CQI meeting was utilized as training and technical assistance with new processes of reporting out. The months July, August, and September will be combined for the CQI meeting. The agency did not provide the sufficient amount of information on the process it maintains to ensure the accuracy, timeliness, and completeness of data collected and entered into JJIS and NetMIS. It could not be determined if identified differences or errors in JJIS and NetMIS were reconciled in a timely manner once identified.

Standard 2:
Indicator 2.02 Limited
Three of four files reviewed did not have evidence of Post-NIRVANAs in the file or in NETMIS.

Indicator 2.03 Limited
One of ten files did not have service type, frequency, or location on the plan. Eight of ten files did not have persons responsible listed on the plan. Four of ten did not have target dates of completion. Two of ten files did not have actual completion dates. Two of ten files did not have youth's signature on the plan. Two of ten files did not have parent/guardian's signature. One of ten files did not have the counselor's signature. Two of ten files did not have supervisor's signatures. Four out of ten files did not have plans reviewed by counselor and parent (if available) every 30 days for the first three months and every six months after.

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 called 1.01 Background Screening. The policy contains provisions to address all the requirements of the indicator. The policy was reviewed and approved by the Regional Director on August 1, 2024.	
All positions providing direct services to youth has successfully passed pre-employment suitability assessment on the initial attempt.	**Compliance**	Six (6) staff member personnel files were reviewed for this indicator. Only five (5) were applicable, one staff is a counselor and was hired prior to the pre-employment assessment being mandatory. All five (5) staff had passed the pre-employment suitability assessment on the initial attempt. The agency utilizes the PI Cognitive Assessment. The assessment measures a person's general mental ability and capacity for critical thinking.	
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.	**Not Applicable**	The agency reported they did not have any applicant prospects that did not pass the suitability assessment on the first attempt prior to being hired.	
Agency has evidence for employees who have had a break in service for 18 months or more, and/or when the agency had a change or update in the suitability assessment tool used was different from the employee's original assessment, that a new suitability assessment and background screening was completed as required.	**Not Applicable**	The agency did not have any employees with a break in service for eighteen (18) months or more during this review period.	
Background screening completed prior to hire/start date (or exemption obtained prior to working with youth if rated ineligible) for new hires, volunteers/interns, and contractors. *(Employees who have had a break in service and are in good standing may be reemployed with the same agency without background screening if the break is less than 90 days.)*	**Exception**	Six (6) staff member files were reviewed for this indicator. Only five (5) staff were applicable, one staff was due for a five year rescreening. Four (4) of the five (5) applicable staff background screening contained evidence each was completed prior to hire/start date and all were deemed 'eligible' on the screening form.	One (1) of the five (5) applicable staff was hired two (2) days before the results of the background screening were obtained. The date of hire is January 23, 2024, and the background screening was completed on January 25, 2024.
Five-year re-screening is completed every 5 years from the date of the last screening for all applicable employees and volunteers.	**Compliance**	One (1) staff member was applicable for a five (5) year rescreening. The rescreening was completed and cleared as required.	

Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?	**Exception**	The agency provided proof of submitting an Annual Affidavit of Compliance to the Florida Department of Juvenile Justice (DJJ) Background Screening Unit (BSU).	The Annual Affidavit of Compliance with Level 2 Screening Standards was signed and notarized on March 8th, 2024. The email provided contained the same date. The Affidavit was submitted thirty-seven (37) days late from the due date of January 31, 2024.
Proof of E-Verify for all new employees obtained from the Department of Homeland Security	**Compliance**	Six (6) staff reviewed had proof of completion of E-Verify. A review was conducted of each staff record and a copy of the E-Verify from Department of Homeland Security was found.	
1.02: Provision of an Abuse Free Environment			**Limited**
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 called 1.02 Provision of an Abuse Free Environment. The policy contains provisions to address all the requirements of the indicator - number 1.02 DCF-LS 65C-14.017, FS 39.201, FDJJ-1100 Florida Network YFS-PPM 2020 - 5.02. The policy was reviewed and approved by the Regional Director on July, 31, 2024.	
Agency has a code of conduct of policy and there is evidence that staff are aware of agency's code of conduct.	**Compliance**	The program has a code of conduct policy in place that prohibits the use of physical abuse, profanity, threats, or intimidation. A review of eleven (11) staff records revealed all had signed a Lutheran Services staff code of conduct document understanding to abide by the program rules. An informal interview with Associate Vice President of Quality Assurance revealed the Employee Handbook is available to all staff online.	
The agency has a process in place for reporting and documenting child abuse hotline calls.	**Not Applicable**	The agency indicated a total of zero (0) child abuse calls have been reported to Florida Department of Children and Families (DCF) within the last six (6) months.	
Youth were informed of the Abuse and Contact Number	**Compliance**	One (1) of four (4) youth reported having heard a Youth Care Worker (YCW) use curse words when speaking with youth. All four (4) youth reported feeling safe.	
Grievance			

The program(s) have an accessible and responsive grievance process for youth to provide feedback and address complaints. Program director/ supervisor has access to and can manage grievances unless it is towards themselves.	**Exception**	A review of nine (9) on-site grievances was conducted. Eight (8) of the nine (9) grievances were reviewed by the Program Manager (PM). Eight (8) of the nine (9) grievances had action steps taken and completed as required.	Nine (9) grievance forms were completed within the last six (6) months. One (1) grievance dated July 11, 2024 did not have the Program Manager (PM) or Program Supervisor (PS) signature. The grievance had a youth care specialist staff name on it, but it could not be determined if the staff or youth wrote the name. One (1) grievance dated July 3, 2024 was missing the action taken and PM/PS signature. Five (5) grievances dated March 19, 2024, July 3, 2024, July 11, 2024, August 2, 2024, and August 9, 2024, were missing evidence of the client signature.
Shelter only: Grievances are maintained on file at minimum for 1 year.	**Compliance**	The agency maintains all grievances in a binder for a minimum of one (1) year.	
Shelter only: There are formal grievance procedures for youth, including grievance forms, and a locked box which are easily accessible to youth in a common area.	**Compliance**	The grievance box is located in the common day room of the youth shelter.	
Shelter only: There is evidence that grievance boxes are checked by management or a designated supervisor at least daily (excluding weekends and holidays) and documented in the program logbook.	**Exception**	A review of Note Active custom report revealed daily grievance box checks were conducted twelve (12) of fifteen (15) days in April, ten (10) out of fifteen (15) days in May, twelve (12) out of fifteen (15) days in June, twelve (12) out of fifteen (15) day in July, eleven (11) out of fifteen (15) days in August, and two (2) out of five (5) days in September.	A review of Note Active custom report revealed daily grievance box checks were conducted as follows: April: week 8th-12th (10th and 12th missing), week 15th-19th (no issues), week 22nd-26th (24th missing). May: week 13th – 17th (15th and 16th missing), week 20th-24th (no issues), week 27th – 31st (27th – 29th missing). June: week 10th-14th (11th and 14th missing), week 17th – 21st (no issues), week 24th-28th (28th missing). July: week 8th-12th (8th and 10th missing), week 15th-19th (19th missing), week 22nd-26th (no issues). August: week 5th-9th (5th missing), week 12th – 16th (no issues), week 19th – 23 (20th – 22nd missing), September: week 30th – 4th (1st, 2nd, 4th missing).

Shelter only: Grievances are resolved within 72 hours of being submitted or there was documentation explaining the cause for the delay in providing a resolution.	**Exception**	A review of nine (9) on-site grievances was conducted. A review of Note Active documentation platform revealed four (4) grievances were documented by the Program Manager (PM) and resolved within seventy-two hours.	A review of nine (9) on-site grievances was conducted. It could not be determined if any of the nine (9) grievances were resolved within seventy-two (72) hours on the grievance form. None of the grievance forms contained a date or time of when the grievance was resolved. A review of Note Active revealed four (4) grievances were resolved within seventy-two (72) hours. The remaining five (5) were not documented by the Program Manager (PM) or Program Supervisor (PS) within seventy-two (72) hours and it could not be determined if they were resolved within seventy-two (72) hours.
1.03: Incident Reporting			**Satisfactory with Exception**
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 called 1.02 Incident Reporting. The policy contains provisions to address all the requirements of the indicator. The policy was reviewed and approved by the Regional Director on July 31, 2024.	
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	**Exception**	The agency had a total of five (5) DJJ Central Communications Center (CCC) reports during the annual compliance review period.	Two (2) of five (5) CCC's were reported past the two (2) hour limit. CCC report # 202402450 was reported two (2) hours and ten (10) minutes late. CCC report # 202402449 was reported thirty-three (33) minutes late.
The program completes follow-up communication tasks/special instructions as required by the CCC	**Compliance**	Whenever a reportable incident occurs, the program notifies the DJJ CCC within two hours of the incident, or within two hours of becoming aware of the incident. The program completes follow-up communication tasks as required by the CCC in order to address specific cases. During the annual compliance review there was one follow up completed.	
Agency internal incidents are documented on incident reporting forms and all CCC reportable incidents were consistently reported to CCC as required.	**Compliance**	The agency no longer completes incident reports on paper documents. Incidents are logged online by staff then are reviewed by the Program Manager.	
Incidents are documented in the program logs and on incident reporting forms	**Compliance**	Incidents were reviewed via the online process. There was evidence of staff writing the incident report and Program Manager signing off or making edits as required.	
All incident reports are reviewed and signed by program supervisors/ directors	**Compliance**	There were a total of twelve incident reports conducted during the annual compliance review period. The type of incidents are as follows: one program disruption, two escape/abscond, seven medical, one mental health and substance abuse, and one youth behavior incident.	

1.04: Training Requirements (*Staff receives training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions*)			**Failed**
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 called 1.04 Training Requirements. The policy contains provisions to address all the requirements of the indicator. The policy was reviewed and approved by the Regional Director on August 1, 2024.	
First Year Direct Care Staff			
All direct care staff have completed a new hire pre-service training provider orientation before they work independently. At a minimum, the orientation included the following: • Agency policies and procedures • Behavior Management (Shelter Only) • Building/Facility layout • File Documentation/development of paperwork requirements and confidentiality • CCC & Incident Reporting • Child Abuse Reporting • Client Intake & Screening • Client Orientation (direct care staff training on delivering new client orientation) • Fire Equipment Safety • Medical and Mental Health Alert System (Shelter) • Risk Management--Including but not limited to the following: - Disaster Preparedness and Emergency Response - First Aid/CPR - Universal Precautions • Video Camera Surveillance & Equipment • All other necessary information to orient a new hire to perform their job role and duties.	**Exception**	New hire required training requirements were reviewed. Overall files indicate certain training topics were completed, but documentation and placement of training documentation is not consistent in files reviewed. .	•Missing Building facility layout training not listed for both files reviewed. •CCC & Incident Reporting 1 of 2 not completed/listed. •Client Intake & Screening training not listed nor completed by both files reviewed. This topic is listed as a training during a meeting; however staff of the reviewed files did not attend or documentation was not placed in each attendee training files. •Client Orientation training not listed nor completed by both files reviewed. This topic is listed as a training during a meeting; however staff of the reviewed files did not attend or documentation was not placed in each attendee training files. •Medical and Mental Health Alert System training not listed nor completed by both files reviewed. •Video Camera Surveillance & Equipment training not listed nor completed by both files reviewed.
All staff completed the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days from date of hire.	**Exception**	New hire required trainings and Skill Pro required trainings were completed by both reviewed files.	Skill Pro required trainings were completed by both reviewed files; however, one staff completed the required Civil Rights & Federal Funds training 10 days late. This training is required within 30 days of hire.

All direct care CINS/FINS staff for shelter and community counseling services, including independent contractors (full-time, part-time, and on-call) and interns met the minimum requirement of 80 hours of training for the first full year of employment.	**Exception**	In Service Required Trainings •Of the eight reviewed files for in-service trainings, five did not have all of the elements required for the training trackers, to include all required and non-required/attended trainings, as well as the total training hours. Some files were missing or had partial a tracker for FY 2023-2024, as well as calculating and displaying the total completed hours. Reviewer had to manually calculate and verify documentation of completion. •For the DJJ required trainings, three of the eight reviewed files did not have the annual and/or biennial training such as Human Trafficking, Information Security Awareness, and Trauma Informed Care. •For the FNYFS required trainings, five of the eight reviewed files indicated late or missed trainings. •Two of the eight reviewed files did not complete Youth Suicide Prevention as required. •Three of the eight reviewed files did not have documentation of CPR/First Aid trainings; of which one had an outdated certificate completed on 8/15/22. •Five of the eight reviewed files did not include any MAB training or refresher training, as required. •Medication Management was completed for all designated staff, with the exception of one staff who was on FMLA (which was documented) and scheduled for next week by the program's RN. •Naloxone Overdose Prevention was facilitated by the RN for both programs, however the reviewed staff were not in attendance. Future trainings will be held by the RN. •Five of the eight reviewed files did not have Fire Safety training completed as required. •Two of the three applicable community counseling staff did not have the required annual 24 training hours completed/documented. •One of the five applicable shelter staff did not have the required annual 40 training hours completed/documented.	Reviewer cross referenced files provided to review documented sign-in sheets, as all sign-in sheets were not copied and placed in each attended staff training file. The training tracker lists trainings beginning from the date of hire, but is missing some required trainings outlined in the policy. No access to electronic tracker, where some displays total training hours and others did not list the total training hours. Thus, the reviewer had to manually calculate training hours within the FY 2023-2024 and review period. The agency's training files were paper clipped together, some did not have a folder, and were not sorted in any manageable order (alphabetical). Some sign-in sheets included no training topic listed or dates; only signatures for some signed sheets which made it challenging for the reviewer to identify and validate staff names. Staff training files contained certificates printed front and back with two different staff names in file. Several documented staff meetings/trainings were not included in training log or documentation placed in all attendee files.

All direct care CINS/FINS staff for shelter and community counseling services, including independent contractors (full-time, part-time, and on-call) and interns met the minimum requirement of 80 hours of training for the first full year of employment. **CONTINUED**	**Exception**	•One of the applicable three community counseling staff did not have the 984 CINS/FINS Petition training completed/documented. •Training tracking logs are not consistent with all required trainings, and to include all of the data points listed in the FNYFS policy and procedures, including tabulating the total completed hours, and to break out trainings by fiscal year and/or calendar year.	

All staff receives all mandatory training during the first 90 days of employment from date of hire.	**Exception**	A review of the files of agency staff members was conducted to determine if all staff received all training during the first 90 days. The DJJ CCC & Incident Reporting is completed in one out of two completed/listed. Skill Pro required trainings were completed by both files reviewed.	•Building Facility Layout training not listed for both files reviewed. •CCC & Incident Reporting, one of two not completed/listed. •Client Intake & Screening training not listed nor completed by both files reviewed. This topic is listed as a training during a meeting; however staff of the reviewed files did not attend or documentation was not placed in each attendee training files. •Client Orientation training not listed nor completed by both files reviewed. This topic is listed as a training during a meeting; however staff of the reviewed files did not attend or documentation was not placed in each attendee training files. •Medical and Mental Health Alert System training not listed nor completed by both files reviewed. •Video Camera Surveillance & Equipment training not listed nor completed by both files reviewed. •Skill Pro required trainings were completed by both reviewed files; however, only one staff completed the required Civil Rights & Federal Funds training.
Non Licensed Staff Assisting with Medication Distribution			
Any staff without a medical license that assists with Medication Distribution received in-person training from a Registered Nurse prior to administering medication to a shelter youth.	**Compliance**	Medication Management was completed for all designated staff, with the exception of one staff who was on FMLA (which was documented) and scheduled for next week by the program's RN.	
Staff that are Utilizing NETMIS			
Any staff that is utilizing NETMIS has evidence of completing NetMIS Training in their training file.	**Not Applicable**	The agency did not have any staff members that are utilizing NETMIS has evidence of completing NETMIS Training in their training file.	
Staff Participating in Case Staffing & CINS Petitions (within the first year of employment BUT no later 7/1/24 for previous staff)			
Documentation of instructor-led FL Statute 984 CINS Petition Training by a local DJJ Attorney within 1 year of employment or no later than 7/1/24 if hired before 7/1/23. (*Policy went into effect 7/1/23).*	**Exception**	Two of the applicable three community counseling staff member files did have evidence of the 984 CINS/FINS Petition training completed/documented.	One of the applicable three community counseling staff did not have the 984 CINS/FINS Petition training completed/documented.
Non-licensed Mental Health Clinical Shelter Staff (within first year of employment)			

Documentation of non-licensed mental health clinical staff person's training in Assessment of Suicide Risk form or written confirmation by a licensed mental health professional of training (includes date, signature and license number of the licensed mental health professional supervisor).	**No eligible items for review**	The agency did not have any staff members that were required to receive this training.	
In-Service Direct Care Staff			
In-service staff completes all of the required annual or 2-year mandatory refresher Florida Network, SkillPro, or other job-related trainings within the required timeframe.	**Exception**	For the DJJ required trainings, five of the eight reviewed files did have the annual and/or biennial training such as Human Trafficking, Information Security Awareness, and Trauma Informed Care. For the FNYFS required trainings, three of the eight reviewed files indicated were completed as required. Six of the eight reviewed files did complete Youth Suicide Prevention as required. Five of the eight reviewed files did have documentation of CPR/First Aid trainings. Three of the eight reviewed files did include all MAB training or refresher training as required. Medication Management was completed for all designated staff. Naloxone Overdose Prevention was facilitated by the RN for both programs, however the reviewed staff were not in attendance. Future trainings will be held by the RN. Three of the eight reviewed files did have Fire Safety training completed as required.	For the DJJ required trainings, three of the eight reviewed files did not have the annual and/or biennial training such as Human Trafficking, Information Security Awareness, and Trauma Informed Care. For the FNYFS required trainings, five of the eight reviewed files indicated late or missed trainings. Two of the eight reviewed files did not complete Youth Suicide Prevention as required. Three of the eight reviewed files did not have documentation of CPR/First Aid trainings; of which one had an outdated certificate completed on 8/15/22. Five of the eight reviewed files did not include any MAB training or refresher training, as required. Medication Management was completed for all designated staff, with the exception of one staff who was on FMLA (which was documented) and scheduled for next week by the program's RN. Naloxone Overdose Prevention was facilitated by the RN for both programs, however the reviewed staff were not in attendance. Future trainings will be held by the RN. Five of the eight reviewed files did not have Fire Safety training completed as required.
Community Counseling Direct Care staff completes 24 hours of mandatory refresher Florida Network, SkillPro, and job-related training annually.	**Exception**	One of the three applicable community counseling staff did have the required annual 24 training hours completed/documented. Two of the applicable three community counseling staff did have the 984 CINS/FINS Petition training completed/documented.	Two of the three applicable community counseling staff did not have the required annual 24 training hours completed/documented. One of the applicable three community counseling staff did not have the 984 CINS/FINS Petition training completed/documented.
Shelter Program Direct Care staff completes 40 hours of mandatory refresher Florida Network, SkillPro, and job-related training annually *(E.g. the program has a DCF child caring license)*.	**Exception**	Four of the five applicable shelter staff did have evidence of the required annual 40 training hours completed/documented.	One of the five applicable shelter staff did not have the required annual 40 training hours completed/documented.
Required Training Documentation			

The agency has a training plan that includes all of the required training topics including the pre-service and in-service.	**Exception**	Of the eight training files reviewed for in-service trainings, three had evidence of containing all of the elements required for the training trackers, to include all required and non-required/attended trainings, as well as the total training hours. These three files had evidence of a training topics tracker for FY 2023-2024, as well as calculating and displaying the total completed hours.	Five did not have all of the elements required for the training trackers, to include all required and non-required/attended trainings, as well as the total training hours. Some files were missing or had a partial tracker for FY 2023-2024, as well as calculating and displaying the total completed hours. Reviewer had to manually calculate and verify documentation of completion.
The agency has a designated staff member responsible to manage all employee's individual training files and completes routine tracking and reviews of staff files to ensure compliance.	**Compliance**	The agency has a staff member responsible for managing all staff member training files and completes tracking and reviews of staff files on a scheduled basis to ensure compliance.	
The program maintains an individual training file or employee file AND a FLN Training Log (or similar document that includes all requirements) for each staff, which includes an annual employee training hours tracking form and related documentation, such as electronic record/transcript, training certificates, sign-in sheets, and agendas for each training attended.	**Compliance**	The agency has evidence of individual training files for each staff member and also tracks the FLN Training courses. The training log tracks annual employee training hours. The form includes training topics, hours and related documentation such as training certificates, sign-in sheets, and agendas for each training attended.	
Additional Comments: **MAB Certificates for the 2/26/24 and 6/27/24 training sessions were provided, but only included two of the ten reviewed staff. There was no demonstration or explanation provided on the tracking and scheduling of routine training for new hires and refresher (due every two years) trainings for existing staff.**			
1.05 - Analyzing and Reporting Information			**Limited**
Provider has a written policy and procedure that meets the requirement for Indicator 1.05		**YES** If NO, explain here: The agency has a policy called 1.05 Analyzing and Reporting. The policy contains provisions to address all the requirements of the indicator. The policy was reviewed and approved by the Regional Director on August 1, 2024.	
Case record review reports demonstrate reviews are conducted quarterly, at a minimum. *(A summary report of case record reviews, identifying compliance with the CINS/FINS requirements, which is reviewed by management and communicated with staff on a quarterly basis at minimum.)*	**Exception**	The agency is implementing a new process by collecting data using an online tool. This has been a learning process for the agency and by trial and error they have worked on how to better improve the speed of completing this process. A review of the agency's quarterly client case record review practice was conducted. The Currie House and Hope House Quality Assurance File review charts for September 2024 were reviewed. Additionally, case file review documents covering cases in January through March 2024 were also provided to be assessed by the monitor.	Due to the new implementation of data collecting, the agency is behind on file review for the months of April, May, June, July, and August of 2024.

The program conducts reviews of incidents, accidents, and grievances quarterly, at a minimum	**Exception**	The agency utilizes the Cycle Quality Improvement (CQI) monthly reports to keep track of incident, accidents, grievances, customer satisfaction and other trackable data. The document also provides the "benchmark" to achieve with a "target" application and duration/output/outcome. Additionally, the monthly review of this report enables the provider to identify effectiveness of intervention or areas for improvement. Once an issue is identified (area), the agency is able to set "goals" with action (steps) and reasonable timeframes and accountability for completion. The Plan, Do, Study, Act (PDSA) Worksheet is completed weekly for tracking specific initiatives and maintaining updates to agency goals.	Due to the agency making changes in data collecting, July's monthly CQI meeting was utilized as training and technical assistance with new processes of reporting out. The months July, August, and September will be combined for the CQI meeting.
The program conducts an annual review of customer satisfaction data	**Compliance**	The agency reviews monthly reports focused on the agency's client satisfaction, incidents, accidents, and grievances. These reports are reviewed on a monthly basis during monthly meetings. The agency has recently started collecting customer satisfaction data through electronic forms for easier assessment at monthly meetings.	
The program demonstrates a monthly review of the statewide End-of-Month ("EOM") report generated by the Florida Network Office. This includes monthly data, fiscal year to date data, benchmarks for residential and community counseling, screening data, report card measures, follow-up reporting measures.	**Compliance**	The agency receives FNYFS data extracts on numerous performance indicators. The agency reviews these measures with designated staff to ensure the agency meets minimum requirements at least once a month on Cycle Quality Improvement (CQI) meetings. If performance is detected to be below the standard, the agency implements a corrective action or intervention plan to address the performance issue on the PDSA worksheet. The PDSA worksheet is tracked weekly until the matter is corrected.	
The program has a process in place to review and improve accuracy of data entry & collection	**Exception**	A review of the current process found that the agency has a process in place to review and improve accuracy of data entry, timeliness and accuracy of collection.	The agency did not provide the sufficient amount of information on the process it maintains to ensure the accuracy, timeliness, and completeness of data collected and entered into JJIS and NetMIS. It could not be determined if identified differences or errors in JJIS and NetMIS were reconciled in a timely manner once identified.
There is documentation that findings are regularly reviewed by management and communicated to staff and stakeholders.	**Compliance**	The agency provided documentation of monthly meetings. The agency addresses identified program performance issues through meeting minutes. All findings are shared with key staff members and stakeholders.	

There is evidence the program demonstrates that program performance is routinely reviewed with the Board of Directors. All final reports that include a Limited or Failed score is submitted electronically or by mail to the providers Executive Committee on the Board of Directors.	**Compliance**	The agency has all reports submitted to leadership staff and governance boards. Regardless of the rating, all Executive Committee members are provided with annual performance reports.	
There is evidence that strengths and weaknesses are identified, improvements are implemented or modified, and staff are informed and involved throughout the process.	**Compliance**	There is evidence that monthly residential and community counseling meeting minutes are routinely shared on a monthly basis. All major strengths and weaknesses are identified and interventions are planned and implemented to address specific issues. Staff members are involved in all action plans and intervention efforts from the start of the process to its conclusion.	
Additional Comments: **There are no additional comments for this indicator.**			
1.06: Client Transportation			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 1.06		**YES** If NO, explain here: The agency has a policy called 1.06 Client Transportation. The policy contains provisions to address all the requirements of the indicator. The policy was reviewed and approved by the Regional Director on August 1, 2024.	
Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	**Compliance**	The program uses two vans for transporting youth. Both vehicles were found to have automobile insurance located inside each van. The program has an approved driver's list of all staff members authorized to drive.	
Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	**Compliance**	The agency provided proof of insurance which includes provisions for insurance coverage for all approved agency drivers with a valid State of Florida driver's license.	
Agency's Transportation policy prohibit transporting a client without maintaining at least one other passenger in the vehicle during the trip and include exceptions in the event that a 3rd party is NOT present in the vehicle while transporting	**Compliance**	The program has a transportation policy which addresses approved drivers. The policy is in place to avoid instances which may place a youth or staff in danger of real or perceived harm, and/or allegations of inappropriate misconduct. The noted best practice to prevent any situation from occurring is to have a third-party present in the vehicle for all transports. The policy addresses approved agency drivers which are approved by administrative personnel.	
In the event that a 3rd party cannot be obtained for transport, the agency's supervisor or managerial personnel consider the clients' history, evaluation, and recent behavior	**Compliance**	In the event that a third party cannot be obtained for transport, the agency's supervisor or managerial personnel does consider the client's history, evaluation and recent behavior. However, the agency's third-party accommodations include an additional staff member, a volunteer, intern, or an additional youth.	

The 3rd party is an approved volunteer, intern, agency staff, or other youth	**Compliance**	The agency has a policy in place and a current practice that includes approval of designated third parties as staff members, youth, interns, and volunteers.	
The agency demonstrated evidence via logbook or other written verification that supervisor approval was obtained prior to all single youth transports.	**Compliance**	A review of the transportation logbook revealed a completed number of 41 single transports documented as being approved by the Supervisor prior to transporting the youth.	
There is documentation of use of vehicle that notes name or initials of driver, date and time, mileage, number of passengers, purpose of travel and location.	**Compliance**	A review of the transportation logbook documented each occurrence of the vans being used. Inside of each van was a van logbook that consisted of the drivers name, date, time, starting and ending mileage, number of passengers, purpose of trip, and destination.	
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 agency has a policy called 1.07 Outreach Services. The policy contains provisions to address all the requirements of the indicator. The policy was reviewed and approved by the Regional Director on August 1, 2024.	
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 agency has a designated lead staff member assigned to participate in local DJJ board, Circuit and Council meetings. The position title of lead staff reviewed for both locations in Pensacola and Crestview. Juvenile Justice Council disbanded notification sent via email on 4/4/2024. Email indicated CAB meetings would resume 07/2024. The Outreach Coordinator provided evidence of email inquiry, however, there were no updates from DJJ.	

The program maintains written agreements with other community partners which include services provided and a comprehensive referral process.	**Compliance**	The reviewer requested the agency's Outreach representative to provide written agreements via email and phone call. A discussion onsite was conducted with the Vice President of QI and the licensed clinician during QI Day 2 Debrief session. The agency indicated they will review records and forward proof of agreements. The agency did not provide documentation of formal interagency agreements. However, there is an ongoing partnership with First Methodist Church where staff conducts routine outreach activities such as Vacation Bible School. There is an ongoing partnership with First Methodist Church where staff conducts routine outreach activities such as Vacation Bible School. 9/20/24 email from Outreach Coordinator included attached agreements to include: MOU with Opening Doors Northwest Florida (dated 4/26/24), MOA with Children's Home Society (dated 5/28/24), Escambia County Sheriff's Office (dated 9/6/24), CDAC Behavioral Healthcare Inc. (dated 3/13/19), Gulf Coast Kid's House (dated 3/11/24), and the Pensacola Police Department (dated 4/23/19) . Letters of support from The Center for Excellence of Pensacola (dated 6/11/24), Re-Entry Alliance Pensacola Inc. Max-Well Respite Center (dated 9/9/23), and Opening Doors Northwest Florida (dated 8/23/24) was provided with the Outreach Coordinator. A 9/23/24 email from Lead Reviewer contained three Memorandums of Understanding (MOU) to include: MOU with Children's Home Society (dated 5/29/24), Cooperative Agreement with Achieve Academy of Escambia County (dated 9/6/24), and MOU with Escambia County Sherriff's Department (dated 9/6/24).	

The program will maintain documentation of outreach activities and enter into NetMIS the title, date, duration (hours), zip code, location description, estimated number of people reached, modality, target audience and topic.	**Compliance**	Reviewed NetMIS, which indicated 18 entered outreach activities. Interviewed both the Outreach Coordinator and the licensed clinician who provided additional outreach efforts and events. Social Media Outreach • 08/21/24 – job and volunteer opportunities • 08/22/24 – wish list and general overview of services provided • 08/18/24 - general overview of services provided • 08/20/24 - volunteer opportunities • 08/2024 back to school trainings and LSF presentation (annually) • Two high schools – back to school events – Crestview High School and Baker High School. • West Florida University event with life skills coach on 06/2024. • First Methodist Church – routine Sunday service outreach promotions/ Vacation Bible School on 07/2024. • 06/2024 end of school year packet for parents on services available	
The program has designated staff that conducts outreach which is defined in their job description.	**Compliance**	The position title of lead staff reviewed for both locations in Pensacola and Crestview. Through an interview with licensed clinician, the following were additional outreach activities to include social media posting of services and volunteer opportunities; back to school events with Crestview High School and Baker High School; and West Florida University event with the life skills coach in June 2024. The Outreach Coordinator also noted a QR Code was created and shared at outreach events. An end-of-school year packet was also distributed to parents on services available year round. The position title of lead staff reviewed (JL) for both locations in Pensacola and Crestview.	
Additional Comments: **There are no additional comments for this indicator.**			
2.01 - Screening and Intake			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 2.01		**YES** If NO, explain here: The agency has a policy called 2.01. The policy contains provisions to address all the requirements of the indicator. The policy was reviewed and approved by the Regional Director on August 1, 2024.	
Shelter youth: Eligibility screening form is completed immediately for all shelter placement inquiries.	**Compliance**	Five of five shelter files reviewed eligibility screening form is 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**	Five of five community counseling files reviewed had eligibility screening forms completed within three business days of referral by a trained staffed using the Florida Network screening form.	
There is evidence all referrals for service is screened for eligibility and is logged in NetMIS within 72 hours of screening completion.	**Exception**	Two of ten files reviewed had a date documented when screening was entered into NETMIS or a NETMIS print out with time/date stamped.	Eight of ten files did not have a date for when screening was entered into NETMIS or documentation of that in the file.
Youth and parents/guardians receive the following in writing: a. Available service options b. Rights and responsibilities of youth and parents/guardians	**Exception**	Nine of ten files reviewed received available service options and rights and responsibilities of youth and parents/guardians in writing.	One of ten files reviewed found the youth did not sign to confirm nor was there documentation explaining why youth did not sign to confirm.
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**	A total of ten of ten files reviewed were given information about possible actions occurring through involvement with CINS/FINS services (case staffing committee, CINS petition, CINS adjudication) and grievance procedures.	
During intake, all youth were screened for suicidality and correctly assessed as required if needed.	**Compliance**	A total of ten of ten files reviewed had screened youth for suicidality and correctly assessed as required.	
Additional Comments: **There are no additional comments for this indicator.**			
2.02 - Needs Assessment			**Limited**
Provider has a written policy and procedure that meets the requirement for Indicator 2.02		**YES** If NO, explain here: The agency has a policy called Network Inventory of Risks, Victories and Needs Assessment. Policy 2.0 2 was reviewed and approved by the Regional Director on 7/31/24.	
Shelter Youth: NIRVANA is initiated within 72 hours of admission	**Compliance**	A total of five of the five shelter files reviewed initiated NIRVANA within 72 hours of admission.	
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**	A total of five of five community counseling files reviewed initiated the NIRVANA at intake and completed within two to three face-to-face contacts.	
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**	Ten of ten files reviewed has supervisor signatures documented on the completed NIRVANA in the youth's file.	
(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**	Five of the five shelter files reviewed had the NSR completed within 24 hours of youth being admitted into shelter.	

A NIRVANA Post-Assessment is completed at discharge for all youth who have a length of stay that is greater than 30 days.	**Exception**	Four of ten files needed Post-NIRVANAS. One of four files reviewed had a Post-NIRVANA completed in the file (after document was requested by reviewer).	Three of four files reviewed did not have evidence of Post-NIRVANAs in the file or in NETMIS.
A NIRVANA Re-Assessment is completed every 90 days excluding files for youth receiving SNAP services.	**Compliance**	One of ten files needed a NIRVANA Re-assessment and it was completed.	
All files include the interview guide and/or printed NIRVANA.	**Compliance**	Ten out of ten files included the printed NIRVANA.	
Additional Comments: **Six of the ten files had NIRVANAs completed by a counselor that did not have documentation of completing MI Training or having a letter of exemption.**			
2.03 - Case/Service Plan			**Limited**
Provider has a written policy and procedure that meets the requirement for Indicator 2.03		**YES** If NO, explain here: The agency has a policy called Case / Service Plan. The Policy 2.03 was reviewed and approved by the Regional Director on 7/31/24.	
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**	Nine of ten files reviewed had a plan developed on a local provider approved form or through NETMIS based on information gathered during initial screening, intake, and NIRVANA. One file did not have a plan, but it was documented that youth was discharged to his mother after three days.	
Case/Service plan is developed within 7 working days of NIRVANA	**Compliance**	Nine out of ten files reviewed has a plan developed within seven days of NIRVANA. One file did not have a plan, but it was documented that youth was discharged to his mother after three days.	
Case plan/service plan includes: 1. Individualized and prioritized need(s) and goal(s) identified by the NIRVANA 2. Service type, frequency, location 3. Person(s) responsible 4. Target date(s) for completion and actual completion date(s) 5. Signature of youth, parent/guardian, counselor, and supervisor 6. Date the plan was initiated	**Exception**	One of ten files did not have a plan, but documented that youth was discharged to his mother after three days. Nine of ten files had individualized and prioritized needs and goals identified by NIRVANA. Eight of ten files had service type, frequency, and location on the plan. One of ten files had persons responsible on the plan. Five of ten files had target dates for completion and actual completion dates. Seven of ten files had signatures from the youth, parent/guardian, counselor, and supervisor. Six of ten files had initiated dates on the plan.	One of ten files did not have service type, frequency, or location on the plan. Eight of ten files did not have persons responsible listed on the plan. Four of ten did not have target dates of completion. Two of ten files did not have actual completion dates. Two of ten files did not have youth's signature on the plan. Two of ten files did not have parent/guardian's signature. One of ten files did not have the counselor's signature. Two of ten files did not have supervisor's signatures.
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	**Exception**	A total of six of the ten files were within compliance of the 30 day reviews.	Four out of ten files did not have plans reviewed by counselor and parent (if available) every 30 days for the first three months and every six months after.
Additional Comments: **There are no additional comments for this indicator.**			
2.04 - Case Management and Service Delivery			**Satisfactory with Exception**
		YES	

Provider has a written policy and procedure that meets the requirement for Indicator 2.04		If NO, explain here: The agency has a policy 2,04 called Case Management / Service Delivery. The policy 2.04 was reviewed and approved by the Regional Director on 7/31/24.	
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open (Residential & Community) Files: 5 **Total number of Closed (Residential & Community) Files:5** **Staff Position(s) Interviewed** *(No Staff Names)* **: Counselor II (Res), ICM Coordinator, and Counselor II (CC)** **Type of Documentation(s) Reviewed: reviewed 10 case files, Group Log Binder, NETMIS, and 3 staff training files** **Describe any Observations: Observed a group in shelter at 4pm. Observed case managers/counselors transport their files in opaque lock boxes marked confidential. Observed file room with door marked confidential and each file cabinet locked and marked with confidential. Observed open shelter files locked in file cabinet in youth care specialists' office and marked confidential.**			
Counselor/Case Manager is assigned	**Compliance**	Ten of ten files reviewed has a case manager/counselor 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	**Exception**	Ten of ten files had established referral needs and coordinated referrals to services based upon ongoing assessment of the youth's/family's problems and needs. Nine of ten files had a case manager/counselor coordinate service plan implementation. One of ten files did not have a service plan and documented that youth was discharged to mother after three days. Nine of ten files reviewed a case manager/counselor monitored youth's/family's progress in services in their case file session notes. Ten of ten files reviewed provided support for families. No cases applicable. No cases applicable. No cases applicable. Ten out of ten files reviewed made referrals as needed for additional services. Ten of ten files reviewed provided case monitoring and reviews court orders. Two of five closed files had discharge summaries. Two out of five closed files had 30 day and 60 day follow-ups. Three of five closed files were closed within the last 30 days.	Three of five closed files reviewed did not have a discharge summary. One of five closed files reviewed was not staffed closed. Two of five closed files reviewed were not discharged in NETMIS. The counselor reports they discharged all cases at the end of each month.
The program maintains written agreements with other community partners that include services provided and a comprehensive referral process	**Compliance**	Community counselor and residential counselor were able to describe their referral process and connect with internal referrals for additional available services to continue to provide support to clients and their families.	
Additional Comments: **There are no additional comments for this indicator.**			
2.05 - Counseling Services			**Satisfactory with Exception**
		YES If NO, explain here:	

Provider has a written policy and procedure that meets the requirement for Indicator 2.05		The agency has a policy 2.05 called Counseling Services. The policy meets all the requirements of the indicator. The policy 2.05 was reviewed and approved by the Regional Director on 7/31/24.	
Shelter Program			
Shelter programs provides individual and family counseling	**Compliance**	Five of five shelter files provided individual and family counseling evident by their session notes.	
Group counseling sessions held a minimum of five days per week	**Compliance**	Five of five shelter files showed attendance of groups by youth. Group Log Binder showed group sessions at least five days 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	**Compliance**	The agency's Group Log Binder displayed evidence of a clear leader/facilitator, relevant topic (educational/informational or developmental), showed attendance of each youth, and had the start times and end times.	
Documentation of groups must include date and time, a list of participants, length of time, and topic.	**Compliance**	Group Log Binder included date and time, list of participants, length of time, and topic.	
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**	Five of five community counseling files reviewed provided therapeutic community-based services designed to provide the intervention necessary to stabilize the family. Services were provided in the youth's home, community location, 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.	
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**	Ten of ten files continued evidence that the program completed reviews of all case files for coordination between presenting problems, psychosocial assessment, service plan, case reviews, case management and follow-up as documented in their staffing notes.	
Maintain individual case files on all youth and adhere to all laws regarding confidentiality.	**Exception**	Eight of ten files maintained individual case files on all youth and adhere to all laws regarding confidentiality.	Two of ten files reviewed did not adhere to all laws regarding confidentiality. Two files did not have "confidential" stamped on the outside of the file.
Case notes maintained for all counseling services provided and documents youth's progress.	**Compliance**	Ten of ten files reviewed had case notes maintained for all counseling services provided and documents youth's progress.	
On-going internal process that ensures clinical reviews of case records and staff performance.	**Compliance**	Ten of ten files reviewed had on-going internal process that ensures clinical reviews of case records and staff performance as evident in staffing notes.	

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**	The agency reported that no cases were primarily served via 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 a policy that is called Adjudication / Petition. The policy meets all the requirements of the indicator. The policy 2.06 was reviewed and approved by the Regional Director on 7/31/24.	
Must include: a. DJJ rep. or CINS/FINS provider b. Local school district representative	**No eligible items for review**	The agency has a comprehensive process for operating the CINS/FINS staff and petition process to serve children and families. The agency's current process includes DJJ, and other area system partners.	
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	**No eligible items for review**	The agency's current process includes DJJ, and numerous other area system partners.	
The program has an established case staffing committee, and has regular communication with committee members	**No eligible items for review**	At the time of this onsite program review, there were no samples available for review.	
The program has an internal procedure for the case staffing process, including a schedule for committee meetings	**No eligible items for review**	The agency has a comprehensive process for operating the CINS/FINS staff and petition process to serve children and families.	
The youth and family are provided a new or revised plan for services	**No eligible items for review**	The agency has a comprehensive process for operating the CINS/FINS staff and petition process to serve children and families.	
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**	The agency has a comprehensive process for operating the CINS/FINS staff and petition process to serve children and families. At the time of this onsite program review, there were no samples available for review.	
If applicable, the program works with the circuit court for judicial intervention for the youth/family	**No eligible items for review**	The agency has a comprehensive process for operating the CINS/FINS staff and petition process to serve children and families. At the time of this onsite program review, there were no samples available for review.	

Case Manager/Counselor completes a review summary prior to the court hearing	**No eligible items for review**	The agency has a comprehensive process for operating the CINS/FINS staff and petition process to serve children and families.	
Additional Comments: **There are no additional comments for this indicator.**			
2.07 - Youth Records			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 2.07		**YES** If NO, explain here: The agency has a policy called Youth Records. The policy meets all the requirements of the indicators. The policy 2.07 was reviewed and approved by the Regional Director on 7/31/24.	
All records are clearly marked 'confidential'.	**Exception**	A total of eight of the ten files are clearly marked "confidential." Four of four ICM files are clearly marked "confidential."	Two of ten files are not clearly marked "confidential" as required.
All records are kept in a secure room or locked in a file cabinet that is marked "confidential"	**Compliance**	A review of the records were conducted by the reviewer. The reviewer observed the file room with the door marked "confidential" and locked. File cabinets were locked and marked "confidential." Open shelter files were observed to be locked in file cabinet in youth care specialists' office and marked "confidential."	
When in transport, all records are locked in an opaque container marked "confidential"	**Compliance**	A review of the records were conducted by the reviewer. It was observed that case managers and counselors transported their files in an opaque lock box and marked "confidential."	
All records are maintained in a neat and orderly manner	**Exception**	Eight of ten files were maintained in a neat and orderly manner. Four of four Intensive Case Management (ICM) files were maintained in a neat and orderly manner.	
SHELTER FILES contain the following: Table of Contents that outlines documents in each section: •Screening •Informed Consent • Photograph of the youth • Shelter Intake Form • Suicide Assessment (if needed) • NIRVANA Self Report (NSR) • NIRVANA full Assessment • Plan of Service • Chronological Notes • Medication Inventory Form • Approved contact list • Copies of referrals made & Follow-Up (if needed) • Discharge summary once case is closed	**Compliance**	Five of five shelter files reviewed had a table of contents that outlined documents in each section. All files contained all the required file documents across all file sections.	

COMMUNITY COUNSELING FILES contain the following: Table of Contents that outlines documents in each section: • Screening • Informed Consent • Community Counseling Intake Form • Suicide Assessment (if needed) • NIRVANA full Assessment • Plan of Service • Chronological case notes • Copies of referrals made & Follow-Up (if needed) • Discharge summary once the case is closed	**Compliance**	Five of five community counseling files reviewed has a table of contents that outlines documents in each section. Four of four ICM files reviewed has a table of contents in each section.	
All records kept electronically, are maintained securely and can be made immediately available upon request for audit purposes.	**Not Applicable**		
Records are retained for the duration of the time specified by the contract.	**Compliance**	Records are retained for the duration of the time of specified contract as evident by Counselor interview and file room.	
Additional Comments: **There are no additional comments for this indicator.**			
2.08 - Specialized Additional Program Services			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.08		**YES** If NO, explain here: The agency has a policy called Specialized Additional Program Services. The policy meets all the requirements of the indicators. Policy 2.08 reviewed and approved by the Regional Director on 7/31/24.	
Staff Secure			
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**	There are no eligible cases to 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 policy, Specialized Additional Program Services, meets all the requirements of the indicator.	
Program only accept youth that meet legal requirements of F.S. 984 for being formally court ordered in to Staff Secure Services	**No eligible items for review**	The agency policy, Specialized Additional Program Services, meets all the requirements of the indicator.	

Staff Assigned: a. One staff secure bed and assigned staff supervision to one staff secure youth at any given time b. Program assign specific staff during each shift to monitor location/ movement of staff secure youth c. Agency clearly documents the specific staff person assigned to the staff secure youth in the logbook or any other means on each shift	**No eligible items for review**	There are no eligible cases to review.	
Agency provides a written report for any court proceedings regarding the youth's progress	**No eligible items for review**	There are no eligible cases to review.	
Domestic Minor Sex Trafficking (DMST)			
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**	There are no eligible cases to review.	
Agency has evidence that the FNYFS was contacted for approval prior to admission for all Domestic Minor Sex Trafficking (DMST) placements.	**No eligible items for review**	There are no eligible cases to 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**	There are no eligible cases to review.	
Services provided to these youth specifically designated services designed to serve DMST youth	**No eligible items for review**	There are no eligible cases to 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**	There are no eligible cases to 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**	There are no eligible cases to 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**	There are no eligible cases to review.	

All other services provided to DMST youth are consistent with all other general CINS/FINS program requirements	**No eligible items for review**	There are no eligible cases to review.	
Domestic Violence			
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**	There are no eligible cases to review.	
Youth admitted to DV Respite placement have evidence in the file of a pending DV charge	**No eligible items for review**	There are no eligible cases to review.	
Data entry into NetMIS within (3) business days of intake and discharge	**No eligible items for review**	There are no eligible cases to review.	
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.	**No eligible items for review**	There are no eligible cases to review.	
Case plan in file reflects goals for aggression management, family coping skills, or other intervention designed to reduce propensity for violence in the home	**No eligible items for review**	There are no eligible cases to review.	
All other services provided to Domestic Violence Respite youth are consistent with all other general CINS/FINS program requirements	**No eligible items for review**	There are no eligible cases to review.	
Probation Respite			
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**	There are no eligible cases to review.	
All probation respite referrals are submitted to the Florida Network.	**No eligible items for review**	There are no eligible cases to 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**	There are no eligible cases to review.	
Data entry into NetMIS and JJIS within (3) business days of intake and discharge	**No eligible items for review**	There are no eligible cases to 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**	There are no eligible cases to review.	

All case management and counseling needs have been considered and addressed	**No eligible items for review**	There are no eligible cases to review.	
All other services provided to Probation Respite youth are consistent with all other general CINS/FINS program requirements	**No eligible items for review**	There are no eligible cases to review.	
Intensive Case Management (ICM)			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	**Yes**	The agency has a contract to perform ICM services in specific areas of its service region. At the time of the review, there were two open files and two closed files.	
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**	Four of four files reviewed were deemed chronically truant and required more intensive and lengthy services. Each youth was determined to be eligible because they have thorough case staffings and were 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**	Four of four files reviewed had services for youth and family that included two direct contacts per month, two collateral contacts per week, and direct and collateral contacts not obtained were documented in contact log 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**	Four of four files reviewed included NIRVANA at intake and NIRVANA Re-assessments every 90 days, and Post NIRVANA at discharge when applicable.	
Service/case plan demonstrates a strength-based, trauma-informed focus	**Compliance**	Four of four files' service plans 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	**Not Applicable**		
Family and Youth Respite Aftercare Services (FYRAC)			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	**Yes**	The agency has one closed case since the last QI review.	

Youth is referred by DJJ for a domestic violence arrest on a household member, and/or the youth is on probation regardless of adjudication status and at risk of violating.	**Compliance**	Youth was referred by DJJ for domestic violence arrest on a household member and youth was on probation.	
Agency has evidence that all FYRAC referrals have documented approval from the Florida Network office	**Compliance**	The file has evidence that the FYRAC referral was documented approval from the Florida Network Office.	
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.	**Compliance**	The file has intake and initial assessment sessions that meets all the criteria listed.	
Life Management Sessions meets the following criteria: a. Sessions are face-to-face, sixty (60) minutes in length and focus on strengthening the family unit b. Services are highly supportive, individualized, and flexible and require a "whole family" approach to dealing with the problems affecting the youth and family.	**Not Applicable**	The youth and family in the closed case did not engage with the counselor after intake. There are several attempts documented for reengagement.	
Individual Sessions: a. The program conducted sessions with the youth and family to focus on work to engage the parties and identify strengths and needs of each member that help to improve family functioning. b. Issues to be covered through each session include but are not limited to: Identifying emotional triggers; body cues; healthy coping strategies through individual, group and family counseling; understanding the cycle of violence and the physical and emotional symptoms of anger; developing safety plans; and educating families on the legal process and rights.	**Not Applicable**	The youth and family in the file reviewed did not engage with the counselor after intake. There are several attempts documented for reengagement.	

Group Sessions: a. Focus on the same issues as individual/family sessions with application to youth pulling on similar experiences with other group members with the overall goal of strengthening relationships and prevention of domestic violence. b. Shall be no more than eight (8) youth at one (1) time and shall be for a minimum of sixty (60) minutes per session	**Not Applicable**	The youth and family in the file reviewed did not engage with the counselor after intake. There are several attempts documented for reengagement.	
There is evidence of completed 30 and/or 60 day follow-ups and is documented in NetMIS following case discharge.	**Compliance**	The file contained NETMIS print outs of 30 day and 60 day follow ups.	
Youth and family participate in services for thirteen (13) sessions or ninety (90) consecutive days of services, or there is evidence in the youth's file that an extension is granted by DJJ circuit Probation staff	**Not Applicable**	The youth and family in the file reviewed did not engage with the counselor after intake. There are several attempts documented for reengagement.	
Any service that is offered virtually, is documented in the youth's file why it was in the youth and families best interest.	**Not Applicable**	The youth and family in the file reviewed did not engage with the counselor after intake. There are several attempts documented for reengagement.	
All data entry in NetMIS is completed within 3 business days as required.	**Compliance**	The file documented data entry in NETMIS was completed within three business days in the contact log.	
Additional Comments: **There are no additional comments for this indicator.**			
2.09- Stop Now and Plan (SNAP)			**Not Applicable**
Provider has a written policy and procedure that meets the requirement for Indicator 2.09		**N/A** If NO, explain here: Indicate policy number, authorized signee, date(s) of last review/revision/approval:	
SNAP Clinical Groups Under 12			
Youth are screened to determine eligibility of services with the (Florida Network Youth Screening Form and SNAP Child Screening Interview Report).	**Not Applicable**	SNAP is not applicable to this program.	

The file contains the following required documents: a. SNAP® Brief Intake Screening Checklist (BISC) b. Florida Network Community Counseling Intake Form c. Reinforcement Trap/Coercive Cycle Diagram d. SNAP® Parent Goal Sheet e. Child Way To Go Goal Sheet f. Consent to Treatment and Participation in Research Form	**Not Applicable**	SNAP is not applicable to this program.	
The NIRVANA was completed at initial intake, or within two sessions.	**Not Applicable**	SNAP is not applicable to this program.	
There is evidence of the completed the Pre - Child Behavior Checklist (CBCL) by the caregiver and is located within the file.	**Not Applicable**	SNAP is not applicable to this program.	
There is evidence of the completed Pre - TOPSE is completed by the caregiver and is located within the file.	**Not Applicable**	SNAP is not applicable to this program.	
SNAP Clinical Groups Under 12 - Discharge			
There is evidence of the completed the Post - Child Behavior Checklist (CBCL) by the caregiver and is located within the file.	**Not Applicable**	SNAP is not applicable to this program.	
There is evidence of the completed Post - TOPSE is completed by the caregiver and is located within the file.	**Not Applicable**	SNAP is not applicable to this program.	
There is evidence of the completed SNAP Discharge Report located within the file for any discharged youth.	**Not Applicable**	SNAP is not applicable to this program.	
There is evidence of the SNAP Boys/SNAP Girls Child Group Evaluation Form located in the file.	**Not Applicable**	SNAP is not applicable to this program.	
There is evidence of the SNAP Boys/SNAP Girls Parent Group Evaluation Form located in the file.	**Not Applicable**	SNAP is not applicable to this program.	
SNAP Clinical Groups for Youth 12-17			

Youth are screened to determine eligibility of services.	**Not Applicable**	SNAP is not applicable to this program.	
The file contains the Florida Network Community Counseling Intake Form is completed and located within the file.	**Not Applicable**	SNAP is not applicable to this program.	
The Consent to Treatment and Participation in Research Form is completed and located within the file.	**Not Applicable**	SNAP is not applicable to this program.	
The NIRVANA was completed at initial intake, or within two sessions.	**Not Applicable**	SNAP is not applicable to this program.	
There is evidence of the completed 'How I Think Questionnaire' (HIT) form located within the file or evidence of at least three (3) documented attempts in the youths' file to obtain this information.	**Not Applicable**	SNAP is not applicable to this program.	
There is evidence of the completed Social Skills Improvement System (SSIS) Student form located within the file or evidence of at least three (3) documented attempts in the youths' file to obtain this information.	**Not Applicable**	SNAP is not applicable to this program.	
There is evidence of the completed Social Skills Improvement System (SSIS) Teacher/Adult form located within the file or evidence of at least three (3) documented attempts in the youths' file to obtain this information.	**Not Applicable**	SNAP is not applicable to this program.	
SNAP for Schools & Communities			
The program demonstrated all of the required weekly attendance sheets that included youth names and/or identifying numbers completed with the teacher and trained SNAP Facilitator signatures. (*This must include a total of 13 attendance sheets for a full cycle*)	**Not Applicable**	SNAP is not applicable to this program.	
The program maintained evidence of a completed 'Way to Go Goal Sheet' within the file.	**Not Applicable**	SNAP is not applicable to this program.	
The program maintained evidence of both pre AND post Measure of Classroom Environment (MoCE) completed documents for the class reviewed.	**Not Applicable**	SNAP is not applicable to this program.	

The program maintained evidence of completed pre and post evaluation documents for the class reviewed.	**Not Applicable**	SNAP is not applicable to this program.	
There is evidence of the SNAP® for Schools & Communities Feedback Form completed by the supervisory adult responsible for the support of the youth receiving services and entered into NetMIS.	**Not Applicable**	SNAP is not applicable to this program.	
Additional Comments: **There are no additional comments for this indicator.**			
3.01 - Shelter Environment			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 3.01		**YES** If NO, explain here: The agency has a policy called 3.01 Shelter Environment. The policy was last reviewed and approved by the Regional Director on August 1, 2024.	
Facility Inspection: a. Furnishings are in good repair. b. The program is free of insect infestation. c. Bathrooms and shower areas are clean and functional, free of foul odors, leaks, dust, and mildew and in good working order. d. There is no graffiti on walls, doors, or windows. e. Lighting is adequate for tasks performed there. f. Exterior areas are free of debris; grounds are free of hazards. g. Dumpster and garbage can(s) are covered. h. All doors are secure, in and out access is limited to staff members and key control is in compliance. i. Detailed map and egress plans of the facility, general client rules, grievance forms, abuse hotline information, DJJ Incident Reporting Number and other related notices are posted. j. Interior areas (bedrooms, bathrooms, common areas) do not contain contraband and are free from hazardous unauthorized metal/foreign objects.	**Exception**	There was a full tour and inspection of the youth shelter. The facility and overall furnishings appeared to be in good repair. There was no visible evidence of insect infestation at the time of the review. There were two bathrooms upstairs in the sleeping quarters for the youth to use. The bathrooms included a shower and toilet in each bathroom. There are two sinks in one bathroom and one sink in the other. Both bathrooms were in working order during the tour and throughout the program review. The facility was observed to be secured and no obvious graffiti was noted. Staff granted reviewers access to requested areas with assigned keys. Egress plans were posted throughout the facility in areas accessible to visitors and youth living areas. Other important information such as program rules, grievance forms and procedures, DJJ and Abuse Reporting Hotlines were posted prominently in the day room, as well as several other areas within the facility.	A broken container that houses the fire safety ladder for one of the youth bedrooms was replaced on day two of the review.

Facility Inspection: a. All agency and staff vehicles are locked. b. Agency vehicles are equipped with major safety equipment including first aid kit, (all items in the first aid kit are current and do not have expired items; all expired items should be replaced regularly), fire extinguisher, flashlight, glass breaker and, seat belt cutter.	**Exception**	The agency uses two Chrysler Pacifica vans for transporting clients. Both vehicles were found to be secured when not in use. Upon inspection, both were observed to have the required first aid kit, fire extinguisher, flashlight, glass breaker and seatbelt cutter present.	Agency vehicle tag #6343 has a crack in the windshield on the passenger side.
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**	All chemicals are listed, approved for use, inventoried weekly and perpetually, stored securely and Material Safety Data Sheets (MSDS) are maintained on each item. A perpetual inventory is kept as the primary means of maintaining a current and real-time inventory.	
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.	**Exception**	At the time of the onsite program review, both washer and dryer were functional. The agency had recently renewed their DCF license which is for a capacity of eight youth and valid 8/28/24 through 8/23/25. (The license is currently in progress.) The bedrooms have extra beds to accommodate each youth. The beds were made with appropriate linens and there were extra sheets and blankets in a designated closet in the upstairs hallway/landing area.	The dryer lint collector needed cleaning on day one of the review.

Additional Facility Inspection Narrative (if applicable)			
Fire and Safety Health Hazards: a. Annual facility fire inspection was conducted, and the facility is in compliance with local fire marshal and fire safety code within jurisdiction. b. Agency completes a minimum of 1 fire drill on each shift monthly (within 2 minutes or less). c. Completes 1 mock emergency drill per shift per quarter. d. All annual fire safety equipment inspections are valid and up to date (extinguishers, sprinklers, alarm system and kitchen overhead hood, including fire extinguishers in all vehicles).	**Exception**	The facility was found to be in compliance with local fire safety guidelines. There was a current fire inspection from the local fire official (8.22.24).The agency has a practice of conducting required fire and mock emergency drills.	During the walk-through of the facility, three of the emergency lights were constantly on. This was brought to the program's attention and an inspector confirmed that was not of normal operation. One emergency light was repaired by day two of the review. The program needs to replace or repair two emergency lights. A fire drill on April 24th, 2024 at 11:55pm was conducted over the two minute mark. A second fire drill conducted on July 31st at 11:59pm was conducted over the two minute mark. Disaster drills seem to be recorded across a combination of episodic care drill logs and disaster drill logs.
Fire and Safety Health Hazards: a. Agency has a current Satisfactory Residential Group Care inspection report from the Department of Health. b. Agency has a current Satisfactory Food Service inspection report from the Department of Health and food menus are posted, current and signed by Licensed Dietician annually. c. All cold food is properly stored, marked and labeled and dry storage/pantry area is clean and food is properly stored. d. Refrigerators/Freezers are clean and maintained at required temperatures and all small and medium sized appliances are operable and clean for use as needed.	**Compliance**	The Group Care Inspection Report was most recently completed on 9/12/24 and was rated "Satisfactory." The kitchen underwent a health inspection on 4/1/2024. The menu was posted in the kitchen and in the living area. The menus were signed by a licensed dietician and the dietician's credentials were posted alongside the menus. There were two clean and neatly organized refrigerators and a large upright freezer in the kitchen/dining area. All appliances were clean and organized. The temperature readings in the refrigerators were 36 degrees and 18 degrees Fahrenheit. The leftover food was observed stored in the refrigerator in plastic containers with fitted lids dated appropriately and were within two days of date recorded. Dry goods were neatly stored in appropriate containers in the kitchen cabinets or on the countertop. The microwave and countertops appeared clean.	
Additional Fire and Safety Health Hazards Narrative (if applicable)			
Youth Engagement			

a. Youth are engaged in meaningful, structured activities (e.g., education, recreation, counseling services, life and social skill training) seven days a week during awake hours. Idle time is minimal. b. At least one hour of physical activity is provided daily. c. Youth are provided the opportunity to participate in a variety of faith-based activities. Non-punitive structured activities are offered to youth who do not choose to participate in faith-based activities. d. Daily programming includes opportunities for youth to complete homework and access a variety of age appropriate, program approved books for reading. Youth are allowed quiet time to read. e. Daily programming schedule is publicly posted and accessible to both staff and youth.	**Compliance**	The schedule of activities were posted in the day room and the kitchen. There is a separate "weekday" schedule and a "weekend and holiday" schedule included in the resident handbook as well. There are structured times and activities to include personal hygiene, educational time, job skills, character building, recreation, free time, independent living skills, library skills, etc. Reading/homework time and physical activity time are designated daily. The Alateen program provides substance use education each Thursday. Youth participate in Bible study each Tuesday. Youth are also provided opportunities to go to local parks and cultural events in the community. Youth participate in group activities five days a week and participate in life skills such as cooking.	
Additional Comments: **There are no additional comments for this indicator.**			
3.02 - Program Orientation			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 3.02		**YES** If NO, explain here: The agency has a policy 3.02 called Program Orientation. The policy meets all requirements of the indicator. 3.02 - DCF FAC 65C-14.118, Florida Network YFS PPM 2020-4.01. The policy was reviewed and approved by the Regional Director on August 1, 2024.	
Youth received a comprehensive orientation and handbook provided within 24 hours	**Exception**	The intake process consists of each youth participating in orientation given by staff that includes program information, policies, and procedures. The youth is given a client/resident handbook that also contains this information. There are individual forms in the client files that the youth signs acknowledging various topics (Youth Contract, Grievance Process, Safety Contract). Each file contains a "Client Intake Checklist" that lists the intake steps and topics covered with youth. Each step and topic is acknowledged with staff initials beside each listed item to indicate that it was done and the youth signs the form upon completion.	One of eight youth files review did not contain a signature acknowledging completing the Orientation process and receiving a copy of the handbook.

Orientation includes the following: a. Youth is given a list of contraband items b. Disciplinary action is explained c. Dress code explained d. Review of access to medical and mental health services e. Procedures for visitation, mail and telephone f. Grievance procedure g. Disaster preparedness instructions h. Physical layout of the facility i. Sleeping room assignment and introductions j. Suicide prevention- alerting staff of feelings or awareness of others having suicidal thoughts	**Compliance**	All (four) youth surveyed answered that when they entered the program, they were given an orientation about the program, the behavior management system, and the major rules they were expected to follow. All youth had been instructed on what to do in case of a fire. Two of four youth advised witnessing staff using curse words when speaking with youth. Three of the four youth offered commentary on the orientation experience.	
Documentation of each component of orientation, including orientation topics and dates of presentation, as well as signatures of the youth and staff involved is maintained in the individual youth record	**Exception**	Total of eight files included the "Client Intake Checklist" that consists of elements of the intake and indicated that the youth received a client handbook.	In one of the eight files reviewed, the youth had not signed the Client Intake Checklist.
Additional Comments: **There are no additional comments for this indicator.**			
3.03 - Youth Room Assignment			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 3.03		**YES** If NO, explain here: The agency has a policy 3.03 called Youth Room Assignment. The policy meets all requirements of the indicator. 3.03 - DCF FAC 65C-14 040 Florida Network YFS PPM 2020 -- 4.01. The policy was reviewed and approved by the Regional Director on August 1, 2024.	
A process is in place that includes an initial classification of the youths, to include:			

a. Review of available information about the youth's history, status and exposure to trauma b. Initial collateral contacts, c. Initial interactions with and observations or the youth d. Separation of younger youth from older youth, e. Separation of violent youth from non-violent youth f. Identification of youth susceptible to victimization g. Presence of medical, mental or physical disabilities h. Suicide risk i. Sexual aggression and predatory behavior j. Acute health symptoms requiring quarantine or isolation	**Exception**	A screening is conducted to assess each youth to make room assignments based on the elements indicated in the indicator. During the intake process, information is gathered pertaining to the youth's age, physical and mental health needs/conditions, suicide risk, collateral contacts, history of aggression, presenting demeanor, etc. The intake staff consults with the Regional Director regarding information and concerns about each youth. A youth's room assignment may be changed based on further assessment.	On the Residential Intake Form there is a column to notate the Room assignment as well as on the Client Intake Checklist. Only four of eight youth were assigned a room and bed. Six of eight youth were only assigned a room. In two of the eight files reviewed, a specific room/bed assignment was not recorded on the Residential Intake Form.
An alert is immediately entered into the program's alert system when a youth is admitted with special needs and risks such as risk of suicide, mental health, substance abuse, physical health or security risk factors	**Compliance**	The program provides an assigned room for youth who are on sight and sound. The policy and procedure outline process of alerts. See 4.04.	
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 agency has a policy called 3.04 Logbooks (Electronic). The policy was reviewed and approved by the Regional Director on August 1, 2024.	
Log book entries that could impact the security and safety of the youth and/or program are highlighted	**Compliance**	The logbook was reviewed where potential safety and security issues were noted. In addition to emergency drills, such things as escalations and behaviors were noted. Entries were observed to be highlighted in either pink or yellow based on the type/importance level of the entry.	

All entries are brief, legibly written in ink and include: • Date and time of the incident, event or activity • Names of youth and staff involved • Brief statement providing pertinent information • Name and signature of person making the entry	**Compliance**	All entries are recorded in an electronic logbook and neatly type written. Entries consistently contained the date and time, the youth involved, a brief statement (and/or a standard symbol representing the event or information). Each entry is signed and dated by the person making the entry.	
Recording errors are struck through with a single line. The staff person must initial and date the correction. The use of whiteout and erasures is prohibited.	**Compliance**	Recording errors are struck through with a single line. A Strike through was noted on August 31st 2024 at 7:01pm.	
The program director or designee reviews the facility logbook(s) every week and makes a note chronologically in the logbook indicating the dates reviewed and if any correction, recommendations and follow-up are required and sign/date the entry	**Exception**	Evidence shows that the grievance box is checked by the Shelter Manager and documented daily. Camera reviews are also noted in the logbook.	The logbook lacks evidence that shows where the Program Director or designee has documented that the logbook has been reviewed on July 1st, 2024 to August 31st, 2024.
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**	Evidence shows that all staff review the logbook of the previous two shifts and makes an entry which is signed and dated into the logbook indicating the dates.	
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**	Staff are consistently recording review of the logbook.	The logbook lacks evidence that shows where the oncoming supervisor has reviewed the logbook (July 1st, 2024 to August 31st, 2024.)The logbook lacks evidence that shows where the counselor has reviewed the logbook (July 1st, 2024 to August 31st, 2024.) The logbook lacks evidence that shows where the Program director or designee has documented that the logbook has been reviewed (July 1st, 2024 to August 31st, 2024.)
Logbook entries include: a. Supervision and resident counts b. Visitation and home visits	**Compliance**	Census notations, client whereabouts, visitations, phone calls, activities/outings etc. are routinely noted in the logbook.	
Additional Comments: **There are no additional comments for this indicator.**			
3.05 - Behavior Management Strategies			**Satisfactory**
	YES		

Provider has a written policy and procedure that meets the requirement for Indicator 3.05		If NO, explain here: The agency has a policy called 3.05 Behavior Management Strategies. The policy has not been signed at the time of initial review. The Regional Director signed the policy on August 1, 2024 when brought to attention by the review team.	
The program has a detailed written description of the BMS and it is explained during program orientation	**Compliance**	The Behavior Management System is explained as part of the intake orientation and the youth sign the orientation checklist which acknowledges they received the explanation.	
Behavior Management Strategies must include:			
a. BMS is designed to teach youth new behaviors and help youth understand the natural consequences for their actions b. Behavioral interventions are applied immediately, with certainty, and reflect the severity of the behavior c. BMS uses a wide variety of awards/incentives to encourage participation and completion of the program d. Appropriate consequences and sanctions are used by the program and consequences for behavior are logical and designed to promote skill-building for the youth e. Counseling, verbal intervention and de-escalation techniques are used prior to physical intervention (Only techniques approved by the Florida Network and DJJ are used if physical intervention is required) f. Only staff discipline youth. Group discipline is not imposed g. Room restriction is not used as part of the system or for youth who are physically and/or emotionally out of control h. Youth should never be denied basic rights such as meals, clothing, sleep, services, exercise, or correspondence privileges	**Compliance**	The program has a behavior management system in place that adheres to the guidelines in the indicator. The behavior management system is designed to foster accountability for one's behavior and compliance with the program's rules and expectations. The system in place is titled, "Journey to Success" (JTS). JTS is a point based system. Youth attain points for completing tasks and adhering to program expectations. The system relies on affirming and validating youth for positive behaviors and maintaining compliance with program rules and routines rather than being consequence based.	
Program's use of the BMS			
All staff are trained in the theory and practice of administering BMS rewards and consequences	**Compliance**	Training begins during the first week of employment through observation and review of policies and procedures.	

There is a protocol for providing feedback and evaluation of staff regarding their use of BMS rewards and consequences	**Compliance**	The YCS III (and Shelter Manager) provides feedback to staff regarding their use of rewards and consequences with youth. During their annual performance evaluation, youth care staff are evaluated on their appropriate use of the Behavior Management System.	
Supervisors are trained to monitor the use of rewards and consequences by their staff	**Compliance**	Evidence of training records shows that supervisors are trained to monitor the use of rewards and consequences by their staff.	
Additional Comments: **There are no additional comments for this indicator.**			
3.06 - Staffing and Youth Supervision			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 3.06		**YES** If NO, explain here: The agency has a policy called 3.06 Staffing and Youth Supervision. The policy was reviewed and approved by the Regional Director on August 1, 2024.	
The program maintains minimum staffing ratios as required by Florida Administrative Code and contract. • 1 staff to 6 youth during awake hours and community activities • 1 staff to 12 youth during the sleep period	**Compliance**	The schedule reflects that a minimum of two staff are scheduled. When there are callouts or staffing shortages that are unresolved, the youth are transported to Curry House for the current shift per the Residential Counselor.	
All shifts must always provide a minimum of two direct care staff present that have met the minimum training requirements	**Exception**	Evidence shows that all shifts provide a minimum of two direct care staff. Schedules were reviewed from March 2024 to August 2024.	Five of five youth care specialist files that were reviewed were either missing trainings or were past due.
Program staff included in staff-to-youth ratio includes only staff that are background screened and properly trained youth care workers, supervision staff, and treatment staff	**Compliance**	All staff scheduled to work as part of the staff to youth ratio have been background screened.	

The staff schedule is provided to staff or posted in a place visible to staff	**Compliance**	The staff schedule is posted in the Youth Care Staff office.	
There is a holdover or overtime rotation roster which includes the telephone numbers of staff who may be accessed when additional coverage is needed	**Compliance**	Youth Care Staff phone numbers are posted and available to other staff. If a YCS is unavailable or delayed for a scheduled shift, they are responsible for contacting another staff person to arrange for coverage. If they are unable to obtain coverage from a peer, they contact the supervisor/Shelter Manager who will arrange for/provide coverage to maintain the required staffing level.	
Staff observe youth at least every 15 minutes while they are in their sleeping room, either during the sleep period or at other times, such as during illness or room restriction	**Compliance**	The program's practice is to conduct bed checks every ten minutes when they are in their room during sleeping hours or at other times, such as illness.	
Additional Comments: **Bed checks times are more frequent than required.**			
3.07 - Video Surveillance System			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 3.07		**YES** If NO, explain here: The agency has a policy called 3.07 Video Surveillance System. The policy was reviewed and approved by the Regional Director on August 1, 2024.	
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 a fully functioning video surveillance system that records from 16 cameras. The cameras were observed placed overhead in reception area, the front hallway near the front entrance, the conference room, the YCS office (x2) where searches are conducted, the dining area, the kitchen, the day room (x3), the top of the stairs/landing area of second floor, and the stairwell leading upstairs inside the facility. There were no cameras in the bathrooms or bedrooms. Outside cameras were seen in the backyard (three covering differing space/angles) and on the front porch/entry area. Notice of video surveillance was clearly posted in the entrance of the building as well as throughout. The system can retain video for 30 days as evidenced by review of recorded activity from 8/17/24 (30 days prior to QI site visit). The counselor explained that the system has a battery backup power supply to enable the cameras to operate in the event of a power outage.	

A list of designated personnel who can access the video surveillance system is maintained (includes off-site capability per personnel)?	**Compliance**	At time of the QI review, the Shelter Manager, Counselor and the Regional Director had access to video surveillance.	
Supervisory review of video is conducted a minimum of once every 14 days and timeframes reviewed are noted in the logbook.	**Compliance**	The logbook was reviewed from March 2024 to September 2024. Evidence shows that camera reviews are conducted by a minimum of once every 14 days and the timeframes reviewed are noted in the logbook.	
The reviews assess the activities of the facility and include a review of random sample of overnight shifts	**Compliance**	Records of the camera reviews were noted from March 2024 to August 2024 which reflected that activities of the facility and reviews of random sample of overnight shifts were completed.	
Grant the requesting of video recordings to yield a result within 24-72 hours from program quality improvement visits and when an investigation is pursued after an allegation of an incident	**Compliance**	The Shelter Manager explained the process for providing both still photos and video footage by downloading and then sending as requested.	
Camera service order/requests will be made within 24 hours of discovery of camera malfunctioning or being inoperable. All efforts made to obtain repairs are documented and maintained	**Compliance**	The Regional Director explained the process for camera service order/requests. A ticket is placed with LSF IT and if it is not an internal issue a call is placed with Security Engineering for further assistance.	
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 agency has a policy called 4.01 Health Care Admission Screening. The policy was reviewed and approved by the Regional Director on August 1, 2024.	
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**	A sample of five randomly selected client files were reviewed to determine the agency's adherence to the requirements of the indicator. All files included evidence of the program screening for current medications, existing medical and mental health diagnosis, allergies, injuries and illnesses, physical distress, acute health symptoms requiring quarantine and scars, tattoos, or other skin markings.	One of five client files documented the staff asking if the youth was on medication. The youth responded positive for a prescribed medication. However, the medication was not listed in the youth's Health Admissions Screening chart.
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**	All five client files have evidence of each file possessing a screening for a broad range of major chronic medical conditions.	

When needed, the parent is involved with the coordination and scheduling of follow-up medical appointments	**Compliance**	All five client files have evidence of each file possessing a screening for a broad range of major chronic medical conditions.	
All medical referrals are documented on a daily log.	**Compliance**	All staff are trained to document any medical referrals for outside medical care in the program's daily log. Interviews were conducted with three direct care staff members. All three staff members interviewed were familiar with steps necessary to be completed when documenting medical referrals.	
The program has a thorough referral process and a mechanism for necessary follow-up medical care as required and/or needed	**Compliance**	An interview with the agency's Registered Nurse (RN) reported the agency has a referral process which is reviewed by the RN and all staff members are informed of any follow up medical care.	
Additional Comments: **There are no additional comments for this indicator.**			
4.02 - Suicide Prevention			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 4.02		**YES** If NO, explain here: The agency has a policy called 4.02 Suicide Prevention. The policy was reviewed and approved by the Regional Director on August 1, 2024.	
Suicide Risk Screening and Approval (*Residential and Community Counseling*)			
Suicide risk screening occurred during the initial intake and screening process. Suicide screening results reviewed and signed by the supervisor and documented in the youth's case file.	**Compliance**	A sample of five randomly selected suicide prevention client files were reviewed to determine the agency's adherence to the requirements of the indicator. All files included evidence of the program screening for suicide risk, signature of supervisor and were documented in the youth's file.	
The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	**Compliance**	The agency has not changed the policy since the policy was last approved and was initially approved by the Florida Network of Youth and Family Services.	
Supervision of Youth with Suicide Risk *(Shelter Only)*			
Youth are placed on the appropriate level of supervision based on the results of the suicide risk assessment.	**Compliance**	A review of all five client files was conducted to determine if all files properly screen youth for current suicide risk. Files reviewed onsite have evidence of proof documented indicating each has been screened with the five suicide risk screening questions.	

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**	A review of all five client files was conducted to determine if all files properly maintained fifteen minute or less sight and sound and behavior checks. Files reviewed onsite have evidence of proof of documentation indicating each has been screened with the five suicide risk screening questions.	Two of the file fives reviewed include suicide risk checks conducted by the agency that were not conducted within the ten minute requirement. One file had two or more checks beyond the 10 minute requirement. A second file contained evidence of two 10 minute checks completed late. One observation check was late by 26 minutes, a second observation check was late by five minutes.
Documentation includes the time of day, behavioral observations, any warning signs observed, and the observers' initials and was maintained in either an observation log or in the shelter daily log.	**Compliance**	All client files reviewed onsite contained evidence of documentation in the file indicating status of the youth's behavior, health and mental health. The entry is documented with the staff person's initials.	
Supervision level was not changed/reduced until a licensed professional or a non-licensed mental health professional under the supervision of a licensed professional completed a further assessment OR Baker Act by local law enforcement	**Compliance**	All five client files reviewed onsite contained evidence of documentation in the file indicating the supervision level was not changed unless authorized by the licensed professional overseeing the program's suicide risk practice.	
There was evidence that documentation was reviewed by supervisory staff each shift. If program uses an observation log, completed logs are maintained in the youth's file.	**Compliance**	All five client files reviewed onsite contained evidence of documentation in the file indicating the supervisor on shift reviewed and signed all ten minute observation checks conducted by direct care staff.	
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**	All Community Counseling staff are familiar with the suicide risk screening process. The agency conducts screening on all client files. At the time of this review, the agency did not have youth indicating positive for suicide across the Community Counseling census.	
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 agency has a comprehensive risk screening process for numerous presenting risk factors, including suicide. All Community Counseling staff are familiar with the suicide risk screening process.	
Information on resources available in the community for further assessment was provided to the parent/guardian and is documented in the youth's file and signed by the parent/guardian OR a written follow-up notification was sent by certified mail if the parent/guardian was not present during the screening and was notified by telephone.	**Compliance**	The agency has a process for providing and documenting in each client file all applicable youth and their families were provided with resources for addressing risks for further assessment and safety planning. At the time of this onsite program review, no files contained evidence of a client file needing risk screening on school property during school hours.	
If the parent/guardian cannot be contacted, all efforts to contact them are documented in the case file.	**No eligible items for review**	No files contained evidence of a parent not being able to be contacted when a risk is identified during the screening process.	

When the screening was completed during school hours on school property, the appropriate school authorities were notified.	**Not Applicable**	No files contained evidence of a client file needing risk screening on school property during school hours.	
Additional Comments: **There are no additional comments for this indicator.**			
4.03 - Medications			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 4.03		**YES** If NO, explain here: The agency has a policy called 4.03 Medications. The policy has The policy was reviewed and approved by the Regional Director on August 1, 2024.	
The agency has a Registered Nurse (RN) and/or a Licensed Practical Nurse (LPN) that is being supervised by RN and all of their credentials have been verified.	**Compliance**	The agency has a part-time Registered Nurse (RN) that is on duty a minimum of 20 hours per week. The RN is required to oversee the agency's medication distribution practice, training and remediation of all staff.	
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**	All training of new non-licensed staff members is required to be delivered by the RN. The agency requires all staff receive training that demonstrates their proficiency in assisting in the delivery of medications. The RN is responsible for review of practice of each non-licensed staff member and any necessary retraining or remediation following an error of new training requirement.	
The agency held at least quarterly staff meetings conducted by RN and/or Shelter Manager to review and assess: a. strategies implemented to reduce medication errors shelter wide b. analyze factors that contributed to medication errors c. allow staff the opportunity to practice and role-play solutions	**Compliance**	The agency conducts monthly meetings with staff members. The agency documents each meeting. The agency has evidence of the RN addressing general medication distribution and practice concerns in meetings.	
The agency has strategies implemented to ensure medications are provided within the 2-hour time frame.	**Compliance**	The agency has evidence of training and strategies in place to ensure medications are provided within the 2-hour time frame. Medication distribution is a training topic during the onboarding process. All staff members are required to receive this training.	
All non-licensed staff members are clearly identified and designated on the staff schedule and shift change report/shift responsibility form for assisting with the self-administration of medications on each shift	**Compliance**	The agency has a specific list of staff members that are trained by the RN and approved on the staff member schedule and shift change report/shift with the responsibility to assisting with the self-administration of medications on each work shift.	

The agency has clear methods of communicating which youth are on medications with the times and dosage easily discernable by all staff on each shift.	**Compliance**	The agency has clear and distinct methods of communicating which youth are on medications with the times and dosage easily discernable by all staff on each shift. Each youth has a specific medication distribution sheet per each medication in the medication distribution binder that accounts for tracking distribution on a monthly basis.	
The delivery process of medications is consistent with the FNYFS Medication Management and Distribution Policy and the agency has an internal quality assurance process to include the following: a. to ensure appropriate medication management and distribution methods b. to track medication errors c. to identify systemic issues and implement mitigation strategies, as appropriate.	**Compliance**	A review of the agency's medication and distribution practice was conducted to assess its adherence to the requirement of the indicator. All medication verification, inventory, distribution, storage and delivery is overseen by the RN and 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**	A review of the agency's medication and distribution admission and intake practice for medication was conducted to assess its adherence to the requirement of the indicator. All medication verification, inventory, distribution, storage and delivery is overseen by the RN and is consistent with the FNYFS Medication Management and Distribution Policy. All youth and parent/guardian are interviewed about current status of medication. A review of four client files indicates the agency's RN reviewed these three files within three (3) business days. The agency also has a policy if the RN is not on premise at admission, the agency requires that a medication review be conducted by a certified Leadership position.	
Medication Storage			

a. All medications are stored in a Pyxis ES Medication Cabinet that is inaccessible to youth (when unaccompanied by authorized staff) b. Pyxis machine is stored in accordance with guidelines in FS 499.0121 and policy section in Medication Management c. Oral medications are stored separately from injectable epi-pen and topical medications d. Medications requiring refrigeration are stored in a secure refrigerator that is used only for this purpose, at temperature range 2-8 degrees C or 36-46 degrees F. (If the refrigerator is not secure, the room is secure and inaccessible to youth.) e. Narcotics and controlled medications are stored in the Pyxis ES Station f. Pyxis keys with the following labels are accessible to staff in the event they need to access medications if there is a Pyxis malfunction: a TOP COVER b BACK PANEL- LEFT TALL CABINET LOCK- LEFT, c BACK PANEL- RIGHT TALL CABINET LOCK- RIGHT	**Compliance**	A review of the agency's storage practice for medication was conducted to assess its adherence to the requirement of the indicator. All medication Pyxis storage, controlled/narcotic medication storage, epi-pen, refrigeration storage, Pyxis key storage is overseen by the RN and is consistent with the FNYFS Medication Management and Distribution Policy.	
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 agency's medication distribution admission practice for medication was conducted to assess its adherence to the requirement of the indicator. All medication verification, medication distribution log forms, and overall distribution by non-licensed staff members is overseen by the RN and is consistent with the FNYFS Medication Management and Distribution Policy.	

The medication distribution log documentation includes: a. the time of medication administration b. evidence of youth initials that the dosage was given c. evidence of staff initials that the dosage was given	**Compliance**	A review of the agency's medication distribution documentation practice was conducted to assess its adherence to the requirement of the indicator. All medication documentation reviewed onsite in a total of four client files includes documented evidence of time or medication distribution, initials of both parties and when given. This process is overseen by the RN and is consistent with the FNYFS Medication Management and Distribution Policy.	
There is evidence that staff provide youth with medications within one hour of the scheduled time of delivery as ordered by the medication. Documentation is provided for instances this does not occur within the required timeframe.	**Compliance**	A review of the agency's medication distribution practice was conducted to assess its adherence to the requirement of the indicator. All medication documentation reviewed on onsite in a total of four client files includes documented evidence of time the youth was given the medication and did not exceed one hour before or one hour after the scheduled time the medication was ordered to be given.	
During the review period, there were no instances where youth missed their medication due to failure to open the pyxis machine.	**Compliance**	All medication documentation reviewed onsite in a total of four client files includes documented evidence of time the youth was given the medication. Across this sample, there were no instances where youth missed their medication due to failure to open the pyxis machine.	
If applicable: Any staff member deemed responsible for a medication error, there was evidence that the staff member received refresher training from an RN and demonstrated competency prior to being assigned future medication administration responsibilities. There is evidence that any staff member deemed responsible for 3 errors within a 1-year time frame, had their certification suspended and was not recertified until the completion of the full **in-person** medication administration training, demonstrating competency and re-certification from an RN.	**Compliance**	Two of the three staff members cited in recent CCCs in last 6 months are no longer with the agency. One of three was retrained by the RN and visually monitored on practice by RN until practice is corrected. Staff acknowledged their mistake. The RN does all training on medications, Narcan and bi-monthly in-service trainings at staff meetings.	
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**	A review of the agency's medication inventory clearance practice was conducted to assess its adherence to the requirement of the indicator. All over the counter (OTC) counts include: Acetaminophen, and Acetaminophen Jr. Ibuprofen, chewable Pepto Bismol, triple antibiotic, Benadryl. Sharps: razors, scissors, nail clippers, finger clippers, toe clippers, manicure file, tweezers. This process is overseen by the RN and is consistent with the FNYFS Medication Management and Distribution Policy.	
There are monthly reviews of the Pyxis reports to monitor medication management practice.	**Compliance**	A review of the agency's medication reporting practice was conducted to assess its adherence to the requirement of the indicator. Monthly Pyxis reports captures removals, refills, control counts, and loading.	
Medication discrepancies are cleared after each shift.	**Exception**	A review of the agency's medication discrepancy clearance practice was conducted to assess its adherence to the requirement of the indicator.	One discrepancy was not cleared in March 2024 based on a miscount.
Additional Comments: **There are no additional comments for this indicator.**			
4.04 - Medical/Mental Health Alert Process			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 4.04		**YES** If NO, explain here: The agency has a policy called 4.04 Medical / Mental Health Alert Process. The policy was reviewed and approved by the Regional Director on August 1, 2024.	
Youth with a medical, mental health, or food allergy was appropriately placed on the program's alert system	**Compliance**	A total of five client files were reviewed to assess each client receiving a full assessment of any applicable alerts. A total of four client files have evidence of the correct medical or mental health alert and were properly placed on the agency's alert system.	One of five client files was missing an appropriate dot on the file indicating medication or medical condition.
Alert system includes precautions concerning prescribed medications, medical/mental health conditions	**Compliance**	The agency's current medical and mental health alert system includes all necessary precautions for a broad range of 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**	The agency has training emergency care for medical and mental health topics which are required to be completed by all staff when onboarding and on an annual and every year basis. The agency requires specified emergency training topics to be completed on an annual basis.	

A medical and mental health alert system is in place that ensures information concerning a youth's medical condition, allergies, common side effects of prescribed medications, foods and medications that are contraindicated, or other pertinent mental health treatment information, is communicated to all staff	**Compliance**	The agency has a comprehensive medical and mental health alert system for youth taken into care in the residential group care program. All clients are screened for acute or current and past medical health and mental health conditions. Once a medical or mental health issue is reported, the agency has a system where all staff members are informed of the documented alert.	
Additional Comments: **There are no additional comments for this indicator.**			
4.05 - Episodic/Emergency Care			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 4.05		**YES** If NO, explain here: The agency has a policy called 4.05 Episodic / Emergency Care. The policy was reviewed and approved by the Regional Director on August 1, 2024.	
Off Site Emergency Care			
a. If off-site emergency medical or dental care was provided, an incident report was submitted for the medical or dental care b. Upon youth return, there is a verification receipt of medical clearance via discharge instructions with follow-up is present in file c. Youth's parent/guardian was notified d. A daily log is maintained for emergency care provided	**Compliance**	The agency had evidence of one client being provided offsite medical care in the last six months. The agency also provided proof that this client's incident was documented, parent/guardian contact was attempted, and a daily log was maintained for emergency care.	
All staff are trained on emergency medical procedures	**Compliance**	All staff members are trained on multiple emergency training, emergency drills, first aid, CPR, universal precautions and other safety training.	
The program has a Knife-for-life and wire cutters accessible to staff in a secure location(s)	**Compliance**	The agency has a knife for life, wire cutters and other equipment that is limited access to only staff members.	
Additional Comments: **There are no additional comments for this indicator.**			