Florida Network for Youth and Family Services
Compliance Monitoring Report for

ARNETTE HOUSE

2310 NE 24th Street
Ocala, FL 34470

October 23-24, 2024

Compliance Monitoring Services Provided by

EXECUTIVE SUMMARY

Forefront LLC conducted a Quality Improvement (QI) monitoring visit on behalf of the Florida Network of Youth and Family Services (FNYFS) for the Arnette House for the FY 2024-2025 at its program office located at 2310 NE 24th Street Ocala, FL 34470. Forefront LLC (Forefront) is an independent compliance monitoring firm that is contracted by FNYFS to perform onsite program reviews to assess the agency's adherence to fiscal, programmatic and overall contract requirements. Arnette 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 2024 through June 30, 2025.

The review was conducted by Andrea Haugabook, Consultant for Forefront LLC and LeAnn Gruentzel, Bradley Taylor, Nathaly Milla, Erick Scott, and Gina Dozier. Agency representatives from Arnette House present for the entrance interview were: Cheri Pettitt, Mark Shearon, Nicholas Benway, Pamela Washington, Jason Kasten, Shanda Hope, and Melissa Grzyb. The last onsite QI visit was conducted January 17-18, 2024.

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

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

2024-2025 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 10-23-24-2024

Agency Name: Arnette House	**Monitor Name: Andrea Haugabook, Lead Reviewer**
Contract Type : CINS/FINS	**Region/Office: 2310 NE 24th Street Ocala, FL 34470**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): October 23-24, 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:
I. Administrative and Fiscal							
DJJ Quality Improvement Peer Reviewer a. Provider shall demonstrate that a minimum of two (2) staff members have been trained to be certified as DJJ QI Peer reviewers. Provider shall participate in a minimum of one (1) on-site quality assurance review of a similar type of program in another judicial circuit during each 12-month period of the contract, if requested.	☐	☐	☒	☐	☐	The provider has three certified DJJ QI Peer reviewers: Mark Shearon, Pamela Washington, and Shand Hope.	
Additional Contracts a. Provider shall provide a listing of all current federal, state, or local government contracts, as well as other contracts entered into with for profit and not-for-profit organizations. Such a listing shall identify the awarding entity and contract start & end dates. **PTV**	☐	☐	☒	☐	☐	The provider receives funds from various sources including United Way, Federal Basic Center, Department of Children and Families, and Sexauer Foundation.	
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	☐	☐	☒	☐	☐	The agency provided a certificate of insurance produced by Brown and Brown of Florida, Inc. with the following insurers affording coverage: Philadelphia Indemnity Insurance Company and Associated Industries Insurance Company, Inc. The coverages are effective from 12/01/2023-12/01/2024 for the following coverages and limits. Commercial	

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Service Description: Comprehensive Onsite Compliance Monitoring						**Site Visit Date(s): October 23-24, 2024**	
	Explain Rating						
Major Programmatic Requirements	**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:**
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**						General Liability; $1,000,000 each occurrence, $1,000,000 damage to rented premises, $20,000 medical expense, $1,0001000 personal injury, $3,000,000 general aggregate and product aggregate; Automobile Liability with a combined single limit of $1,000,000; umbrella liability with a $1,000,000 limit per occurrence and $1,000,000 aggregate and worker's compensation and employee liability for each $1,000,000, $1,000,000 employee and $1,000,000 policy limit. The certificate lists The Florida Network of Youth and Families as a certificate holder	
External/Outside Contract Compliance a. Provider has corrective action item(s) cited by an external funding source (Fiscal or Non-Fiscal). **ON SITE**	☐	☐	☐	☐	☒	The agency reported that there are no corrective action items (fiscal or non-fiscal) cited by other external funders.	
Fiscal Practice a. Agency must have employee and fiscal policy/procedures manuals that are in compliance with GAAP and provide sound internal controls. Agency maintains fiscal files that are audit ready. **PTV**	☐	☐	☒	☐	☐	The agency has employee and fiscal policies and procedures that are in compliance with GAAP and provide sound internal controls. The agency	

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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:
						maintains fiscal files that are audit ready.	
b. Agency maintains a general ledger and the corresponding source documents. A general ledger must be set up to track the activity of the grant separately (standard account numbers / separate funds for each revenue source, etc.). **PTV**	☐	☐	☒	☐	☐	The agency's general ledger from July 1, 2024 to October 1, 2024 was reviewed. The general ledger is set up to track activities of this grant separately from other funding sources with the use of standard account numbers.	
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**	☐	☐	☒	☐	☐	Petty cash is maintained by the administrative assistant. It is kept in a locked box in the front office. The petty cash limit is $200. The petty cash is used to cover small, unexpected expenses that may not require a check. Receipts for funds received from petty cash are submitted to the administrative assistant. The administrative assistant reconciles all receipts and cash on had and submits requests to the finance department for reimbursement to the petty cash fund. Petty cash was verified while on-site and accurately reconciled.	
d. Financial records and reports are current. Includes bank statements reconciled within 6 weeks of receipt. Vendor invoices past 6 months. Invoices are submitted on a monthly basis with supporting documentation and	☐	☐	☒	☐	☐	The agency provided current financial reports for the most recent six months, June 2024- September 2024. June 2024- September 2024 bank statements	

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documentation provided contained 2 signatures. (Disbursements/invoices are approved & monitored by management). **ON SITE**						reviewed and included reconciliation reports. Bank statements are reconciled by the director of finance and reviewed by the CEO or Board Treasurer. Bank statements for the most recent six months all showed proof of reconciliation within days of the end of the previous month. Invoices are reconciled by the finance department, prepared for payment, and approved by the CEO. Invoices are paid timely.	
e. Agency maintains inventory in accordance with a written policy and FNYFS contractual requirements. If over $1,000 inventory has DJJ Property Inventory Number/Tag. In the event the provider has purchased computer equipment an Informational Resources Request (IRR) has been submitted to DJJ. **PTV/ON SITE**	☐	☐	☐	☐	☒	The agency does not have an inventory, (including computers) over $1000 requiring a DJJ property inventory number/ tag.	
f. Agency submits payroll taxes and deposits (and retirement deposits as applicable), Employee IRS Form W-2 and Independent Contractors IRS Form 1099 forms prior to federal requirements. **ON SITE**	☐	☐	☒	☐	☐	The agency provided their two most recent quarterly tax reports for period ending March 30, 2024 and June 30, 2024 with proof of corresponding payment. The agency's quarterly tax payment reports and payments are managed by a third party payroll company, ADP. Employee IRS W-2 and	

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						1099 forms are all produced and managed by ADP.	
g. Budget to actual reports prepared and reviewed by appropriate management. Variance from the budget are investigated and explained. **PTV/ON SITE**	☐	☐	☒	☐	☐	Interview with the director of finance indicates the budget is prepared in th finance department and approved by the director of finance and the CEO. The agency has quarterly finance meetings with the director of finance, CEO finance assistant, board chair, secretary, and vice-president. The agency's profit and loss, budget versus actual, and variances for fiscal year 24-25 are among financial matters discussed at the quarterly finance meetings.	
h. A Single Audit is performed as part of the annual audit if expenses are greater than $750,000. The agency must submit a Corrective Action Plan for findings cited in the management letter and single audit. An annual financial audit was completed within 120 days after the previous fiscal year/calendar year and that a copy was provided to the Network unless and extension has been requested and approved in writing. Copy of Audit is submitted to the FNYFS by December 31st. **Can obtain from FNYFS**	☐	☐	☒	☐	☐	The agency has financial statements and an independent auditor's report dated June 30, 2023, prepared by Purvis Gray certified public accountants. There are no findings stated within the audit report. A copy of the audit report has been submitted to the Florida Network of Youth and Family Services.	

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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:
i. Agency maintains confidentiality policy with written policies and procedures to ensure the security and privacy of all employee and client data. Personal information is not easily accessible. Agency maintains a backup system in case of accidental loss of financial information. Security procedures are in place to protect laptops. Obsolete documents are shredded and computer hard drives are wiped prior to discarding. **ON SITE**	☐	☐	☒	☐	☐	The agency has policies and procedures to ensure the security and privacy of all employees and client data is maintained. Personal information is not easily accessible, and the agency maintains a backup system in case of accidental loss of financial information. There are security procedures in place to protect laptops. Documents and computer hard drives are properly destroyed/ wiped prior to disposal.	
j. Agency provided evidence that every direct care staff employee, as of October 1, 2023, is being paid at least $19.00 per hour. This also includes funding for additional staff as approved by the Department. **ON SITE**	☐	☐	☒	☐	☐	The agency provided payroll checks for every employee confirming they earn at least $19.00 per hour.	

CONCLUSION

Arnette House has met the requirements for the CINS/FINS contract as a result of full compliance with twelve applicable indicators of the Administrative and Fiscal Contract Monitoring Tool. Two of the fourteen indicators were not applicable because the agency has no corrective action items cited by external funding sources and maintains no inventory of items valued over $1000 purchased with funds from the Florida Network of Youth and Family Services. Consequently, **the overall compliance rate for this contract monitoring visit is 100%.** There are no corrective actions cited. Overall, the provider is performing satisfactorily in meeting the fiscal and administrative terms of its contract. In addition, the majority of indicators reviewed were carried out in a manner which meets the standard described in the report findings.

SUMMARY OF RECOMMENDATIONS

Recommendation (1)
None

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

Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Arnette House - Ocala, FL
CINS/FINS Program

Date: October 23-24, 2024

Compliance Monitoring Services Provided by

FOREFRONT

CINS/FINS Rating Profile

Standard 1: Management Accountability

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

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

Standard 2: Intervention and Case Management

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

Percent of Indicators rated Satisfactory: 88.89 %
Percent of Indicators rated Limited: 11.11 %
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: 96.43 %
Percent of indicators rated Limited: 3.57 %
Percent of indicators rated Failed: 0 %

Rating Definitions

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

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

Reviewers

Members

Andrea Haugabook - Lead Reviewer Consultant-Forefront LLC/Florida Network of Youth and Family Services
LeAnn Gruntzel and Bradley Taylor – Regional Monitor, Department of Juvenile Justice
Erick Scott – Lutheran Services Florida
Gina Dozier – Capital City Youth Services
Nathaly Milla – Florida Keys Youth Shelter

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, 2024).

Persons Interviewed

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

Documents Reviewed

Accreditation Reports	X Table of Organization	X Visitation Logs
X Affidavit of Good Moral Character	Fire Prevention Plan	X Youth Handbook
X CCC Reports	X Grievance Process/Records	5 # Health Records
X Logbooks	Key Control Log	4 # MH/SA Records
Continuity of Operation Plan	X Fire Drill Log	4 # Personnel /Volunteer Records
X Contract Monitoring Reports	X Medical and Mental Health Alerts	7 # Training Records
Contract Scope of Services	X Precautionary Observation Logs	14 # Youth Records (Closed)
X Egress Plans	X Program Schedules	3 # Youth Records (Open)
X Fire Inspection Report	X List of Supplemental Contracts	# Other:
Exposure Control Plan	X Vehicle Inspection Reports	

Observations During Review

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

Surveys

9 # of Youth	2 # of Direct Staff	0 # of Other

Comments

A Quality Improvement Program Review was conducted for FY 2024-2025.

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

Arnette House, Inc. is a not-for-profit corporation organized under the laws of the state of Florida on April 22, 1981. The Corporation serves adolescents between the ages of 10 and 17, in Marion and Lake counties, who are runaways or are experiencing a family crisis, until adequate disposition is made for the youth. The programs offered include: shelter services, community counseling services, and Stop Now and Plan (SNAP).

Since the last on-site QI review, the program reports the following updates, improvements, or changes: installation of new playground equipment, a new computer lab with Chromebook, a new fence installed by a local church group, new backboards for the basketball court provided by the Sexauer foundation, new soft rock floor on the basketball court and the day room. A tree fell on the vocational building due to the hurricane and the agency is in the process of completing building repairs. The agency has sold a vehicle since the last review.

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

Standard 1: There are seven indicators for Standard 1.
Indicator 1.01 Background Screening of Employees/Volunteers was rated **Satisfactory with Exception**.
Indicator 1.02 Provision of an Abuse Free Environment was rated **Satisfactory**.
Indicator 1.03 Incident Reporting was rated **Satisfactory with Exception**.
Indicator 1.04 Training Requirements was rated Satisfa**ctory with Exception**.
Indicator 1.05 Analyzing and Reporting Information was rated **Satisfactory with Exception**.
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 **Limited**.
Indicator 2.02 Needs Assessment was rated **Satisfactory with Exception.**
Indicator 2.03 Case/Service Plan was rated **Satisfactory**.
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**.
Indicator 2.08 Specialized Additional Program Services was rated **Satisfactory.**
Indicator 2.09 Stop Now and Plan (SNAP) was rated **Satisfactory.**

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

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

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

Standard 2:
Indicator 2.01 was rated limited due to ten of ten youth files review showed evidence of the suicide risk screening containing the wrong questions.

Ten files were reviewed; five residential and five community counseling. Out of the five residential files reviewed, Three residential files were missing the supplemental question. Question five from the risk screening section did not have the follow-up question in accordance with the Florida Network Standard. Five of the five community counseling files reviewed contained risk screening questions that were different from the questions in standard 2. The community counseling files reviewed were using a set of nine different questions in some files and a set of six different questions in other files. The entire sample of files (ten out of ten) did not contain the suicide risk screening questions as outlined in the Florida Network's policy and procedure or QI manual.

CINS/FINS QUALITY IMPROVEMENT TOOL

Quality Improvement Indicators and Results: Please select the appropriate outcome for each indicator for each item within the indicator.		**Summary/Narrative Findings:** The narrative write-up is a thorough summary of each assigned QI indicator, explaining how finding(s) are determined.	**Deficiencies/Exceptions:** Please add additional detailed explanations for any items that have any deficiencies or exceptions.
Standard One – Management Accountability			
1.01: Background Screening of Employees, Contractors and Volunteers			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 1.01		**YES** If NO, explain here: The agency has a policy number FLN 1.0, 5.03 Background Screening and FLN 5.04 Annual Affidavit of Compliance with Good Moral Character Standards. The policy was last reviewed by the CEO on 10/21/2024.	
All positions providing direct services to youth has successfully passed pre-employment suitability assessment on the initial attempt.	**Compliance**	Four of four files reviewed has successfully passed pre-employment suitability assessment on the initial attempt.	
For any applicant that did not pass the initial suitability assessment, there was evidence that the applicant retook the assessment and passed within five (5) business days of the initial attempt, not exceeding three (3) attempts within thirty (30) days.	**No eligible items for review**	Interview with the Director of Human Resources reported that that all applicants passed the suitability assessment on the initial attempt.	
Agency has evidence for employees who have had a break in service for 18 months or more, and/or when the agency had a change or update in the suitability assessment tool used was different from the employee's original assessment, that a new suitability assessment and background screening was completed as required.	**No eligible items for review**	Interview with the Director of Human Resources and review of the staff roster did not indicate the agency had employee who have had a break in service for 18 months or more.	
Background screening completed prior to hire/start date (or exemption obtained prior to working with youth if rated ineligible) for new hires, volunteers/interns, and contractors. *(Employees who have had a break in service and are in good standing may be reemployed with the same agency without background screening if the break is less than 90 days.)*	**Compliance**	Four of four employee files reviewed showed satisfactory evidence of completion of a background screening prior to hire/ start date.	
Five-year re-screening is completed every 5 years from the date of the last screening for all applicable employees and volunteers.	**No eligible items for review**	Interview with the Director of Human Resources and review of the staff roster did not indicate any employees due for a five-year rescreening during the last six months or back to the date of the last QI review.	

Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?	**Compliance**	An annual affidavit of compliance with level two screening standards (Form IG/BSU-006) was completed by the CEO on January 2, 2024. Email correspondence sent to the Department of Juvenile Justice (DJJ) Background Screening Unit (BSU), dated January 2, 2024 was observed with the annual affidavit attached.	
Proof of E-Verify for all new employees obtained from the Department of Homeland Security	**Compliance**	Four of four files reviewed contained proof of E-Verify.	
Additional Comments: **There are no additional comments for this indicator.**			
1.02: Provision of an Abuse Free Environment			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 1.02		**YES** If NO, explain here: The agency has a policy number FLN 1.02 Abuse Reporting and FLN 1.02 Grievance Youth and Families, both revised 01/24/24 and reviewed by the CEO.	
Agency has a code of conduct of policy and there is evidence that staff are aware of agency's code of conduct.	**Compliance**	The agency has a code of conduct that employees are made aware of during their new hire orientation period. This was documented in the employee files.	
The agency has a process in place for reporting and documenting child abuse hotline calls.	**Compliance**	The agency has a process in place for reporting and documenting child abuse hotline calls. Two examples of child abuse reports were observed.	
Youth were informed of the Abuse and Contact Number	**Compliance**	The Florida Abuse hotline number was observed posted within the program and five of five client files reflected that youth were given information as port of intake and orientation process.	
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.	**Compliance**	The program has an accessible and responsive grievance process to allow feedback and address complaints. The Shelter Supervisor is designated to oversee the grievance process in the shelter. The Community Counseling process is outlined in the initial paperwork provided to families. Clients are asked to first report any concerns to the assigned counselor. If the issue is not resolved, they may then request to speak to the counselor's supervisor. No grievances were reported for the review period.	

Shelter only: Grievances are maintained on file at minimum for 1 year.	**Compliance**	The shelter program has a policy that outlines that copies of grievances are kept for one year in a central grievance book in addition to the original being placed in the client file of the youth submitting the grievance once it has been resolved and signed by the youth and staff. The Shelter Supervisor reported there have been no written grievances received since the last review.	
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**	A locked grievance box and forms were observed in the day room of the shelter. Forms are located next to the box and are accessible to the youth.	
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.	**Compliance**	The Shelter Supervisor or designee checks the grievance box daily. An interview with the Shelter Supervisor and verification observed in the program's logbook confirmed this practice is consistently being completed appropriately.	
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.	**Compliance**	The program has a policy that outlines a four-step process for resolving grievances. Each step of the process is an escalation to a higher level and each is to be resolved within three business days. The Shelter Supervisor was interviewed and explained that no written grievances had been filed since the last review nor within the past year. She stated that concerns are generally resolved by the client talking with staff without further intervention needed.	
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, FLN 1.03, 5.01 Incident Reporting, last reviewed and approved by the CEO 10/21/2024.	
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	**Compliance**	For the six-month period prior to the on-site review, the program provided 13 incidents that were reported to the Central Communication Center (CCC). All 13 were reported to the CCC within two hours of the time the incident occurred or within two hours of the program learning of the occurrence of the incident.	
The program completes follow-up communication tasks/special instructions as required by the CCC	**Compliance**	All Incident reports reviewed showed follow-up correspondence with the CCC as requested or instructed.	

Agency internal incidents are documented on incident reporting forms and all CCC reportable incidents were consistently reported to CCC as required.	**Compliance**	There were 13 incidents reported on the agency's "Incident Report" form and reported to the CCC as required.	
Incidents are documented in the program logs and on incident reporting forms	**Exception**	The occurrence of incidents was observed to be documented in the logbook and highlighted in yellow per the program's color coding system. There were 13 CCC reported incidents provided in the Incident Reports binder given to reviewers. The dates of those reports ranged from 3/10/24 to 8/28/24. Although the agency did not have completed incident report forms for some incidents, the listing provided by DJJ did indicate that all incidents were reported within the required two-hour period. Additionally, some incidents were deemed closed as "information only" and no additional follow-up was requested.	There were eight incidents on the CCC report listing provided by the Department of Juvenile Justice (DJJ) that were not documented on the program's incident reporting forms provided by the agency. The dates of those reports ranged from 5/15/24 to 10/16/24, with six of them being after the last report date (8/28/24) observed in the documentation provided by the agency. One report noted on the DJJ provided list, initially appeared to be missing from the agency list. However, it was determined to have been a duplicate or listing a different case number. Agency staff stated that the case number on the report was the Ocala Police Department case number instead of CCC case number. It was reported that there was a period of time during the past 6 months when the DJJ computer system was not accessible and CCC Duty Officers and Officers manually generated case numbers such as "CCC 1081" before later providing updated case numbers such as "2024038XX" once the system was able to do so. This manual generation of case numbers led to a number of incident reports being duplicated in DJJ's CCC system. The Shelter Supervisor provided information that the program was still receiving correspondence from the department regarding some incidents from the past six months and, therefore, some incident reports had not been completely processed and routed internally for review to include signatures within the agency, and thus were not provided in the initial sample to the review team.
All incident reports are reviewed and signed by program supervisors/ directors	**Compliance**	There were seven Mental Health/ Substance Abuse (Baker Acts) reports, four complaints against staff/medical (medication errors) reports, one medical (client injury), and one program disruption (contraband) reports observed in the agency's Incident Report Binder.	

1.04: Training Requirements (*Staff receives training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions*)			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 1.04		**YES** If NO, explain here: The agency has a policy number FLN 1.04 Training, last reviewed by the CEO on 10/21/2024.	
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.	**Compliance**	Three first year employee training files were reviewed. All three were Direct Care Workers. All three employees had completed training on Agency Policies and Procedures, Behavior Management, Building/ facility Layout, File Documentation, Confidentiality, Client Intake and Screening, Client Orientation, Fire Safety Equipment, Medical and Mental Health Alert System, Risk Management, and job roles and responsibilities. Three of three files reviewed were for employees that were within the first 90 days of employment.	
All staff completed the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days from date of hire.	**Exception**	Two of the three employee files showed that the employee completed the Civil Rights and Federal Funding training within the first 30 days of employment.	Of the files reviewed, one employee completed the training outside the 30 day window. The employee file showed a hire date of 8/13/24 and the training was completed on 9/30/24.
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.	**Compliance**	Three first year employee training files were reviewed. All three were Direct Care Workers. All three employees had completed training on Agency Policies and Procedures, Behavior Management, Building/ facility Layout, File Documentation, Confidentiality, Client Intake and Screening, Client Orientation, Fire Safety Equipment, Medical and Mental Health Alert System, Risk Management, and job roles and responsibilities.	

All staff receives all mandatory training during the first 90 days of employment from date of hire.	**Compliance**	The three first year training files selected for review were all for new employees who were still within the first 90 days of employment.	
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**	The agency has a policy that aligns with the Quality Improvement indicator. The agency currently limits the staff that assists the youth with the self-administration of medication to the Registered Nurse and Supervisors. The three new employees whose files were reviewed do not assist with medication administration.	
Staff that are Utilizing NETMIS			
Any staff that is utilizing NETMIS has evidence of completing NetMIS Training in their training file.	**Compliance**	The agency has a policy that aligns with the Quality Improvement indicator. The training files for three first year employees were reviewed. These three employees do not utilize NetMIS,	
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).*	**Compliance**	The agency has a policy that complies with the requirements of the indicator. Three first year employee training files and four annual in-service training were reviewed. None of the applicable employees were in positions to participate in the Case Staffing and CINS Petition process.	

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**	No non-licensed mental health clinical staff training files were reviewed during this review.	
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.	**Compliance**	Four annual /in service training files were reviewed. All four employees had completed Child Abuse, Human Trafficking Information Security Awareness training in Skill Pro. Three of the four have completed PREA parts 1 & 2 and Sexual Harassment. Three of the four had completed Trauma informed Care and that training was not applicable for the fourth employee as it was an administrative staff member who did not have direct contact with youth. Similarly, one shelter direct care staff member had completed all applicable Florida Network in service trainings. Three of the four did not work in shelter and therefore did not require shelter specific trainings. All four employees were hired in 2023 and the trainings that are required every two years were not applicable at the time of review. As the agency calculated annual training by the calendar year, all four employees had time to complete additional in-service training if needed.	
Community Counseling Direct Care staff completes 24 hours of mandatory refresher Florida Network, SkillPro, and job-related training annually.	**Compliance**	Two Direct Care staff member files reviewed showed staff completed over the required 24 hours of mandatory refresher Florida Network, SkillPro, and annual job-related training as applicable.	
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).*	**Compliance**	Annual in-service training was reviewed for one Direct Care shelter staff member. The employee had 34 hours of training completed for the year at time of review. Interview with the Shelter Supervisor indicates, the annual in service training year runs on the calendar year (once the employee passes the new hire training period), therefore the employee has the balance of this calendar year to complete the required training hours.	

Required Training Documentation			
The agency has a training plan that includes all of the required training topics including the pre-service and in-service.	**Compliance**	The agency's training policy outlines all the required training topics including the pre-service and in-service topics for the various positions.	
The agency has a designated staff member responsible to manage all employee's individual training files and completes routine tracking and reviews of staff files to ensure compliance.	**Compliance**	The agency has a designated staff person that is responsible for managing all employee's individual training files and completes routine tracking and reviews of staff 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.	**Exception**	The program maintains an individual training record for each employee that is contained within a multi-sectioned classification folder. Various components (such as the orientation checklist, training hours log, and certificates) are placed in designated sections of the folder. The training log included the employee name, date of hire, position, name of training, delivery method, and there was a space titled "Training as of:"	There was one first-year/new hire training file that did not contain a training log in the file at the onset of the review. The file was in the process of being fully developed, it contained copies of various completed training certificates and the employee completed the training log forms prior to the completion of the review.
All Staff have completed the Naloxone Training as required within 90 days of hire or 1 year from the policy effective date 7/1/24:	**Compliance**	Two of three first year employee training files showed the employees had completed the Administration of Naloxone training. One first year employee is still within the first 90 days and has time to complete the training. Four of four files reviewed for annual training still have until 6/30/25 to obtain the training.	
Additional Comments: **There are no additional comments for this indicator.**			
1.05 - Analyzing and Reporting Information			**Satisfactory with Exception**
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 number, FLN1.05 Data Analyzing and FLN 1.05, 2.02,6.0 Data Entry & Collection which were last reviewed by the CEO on 10/21/2024.	
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 has a comprehensive Performance and Quality Improvement (PQI) process. This includes data collection and analysis on a regular basis. The Clinical Supervisor was interviewed regarding the case record review reports and explained that she reviews all files every two to three months. A checklist of quality items is completed for each file reviewed. A sample of the checklist was provided.	Checklists are completed for each case record and the form is placed in each individual file. However, there was no evidence that the information from the checklists was aggregated or presented to the larger PQI team. There were no record review reports observed. This was confirmed during an interview with the Clinical Supervisor.

The program conducts reviews of incidents, accidents, and grievances quarterly, at a minimum	**Compliance**	The program conducts reviews of incidents, accidents, and grievances routinely through its Performance and Quality Improvement (PQI) meetings which generally occur monthly. Reports of monthly numbers were on various meeting minutes and data reports reviewed.	
The program conducts an annual review of customer satisfaction data	**Compliance**	NetMIS data collection and Dashboard reports are used to conduct reviews of customer (client) satisfaction survey. Data is reviewed internally more frequently and an annual review is presented to the board at their Annual Meeting.	
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**	Sample End of Month reports from the Florida Network for the past 6 months were observed. This information is also presented in the "CEO Report" to the Board and was observed reflected in program's quality improvement minutes.	
The program has a process in place to review and improve accuracy of data entry & collection	**Compliance**	The COO reported during interview that NetMIS Dashboard reports are used to improve timeliness and accuracy of date entry and collection. Timeliness is also reflected on the Network "Report Card".	
There is documentation that findings are regularly reviewed by management and communicated to staff and stakeholders.	**Compliance**	Documentation of review and communication of performance data was reviewed in the form of PQI minutes, copies of data reports, the CEO report and narrative reports to the US Department of Health and Human Services.	
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.	**Exception**	Copies of "CEO Report" were observed. This Report is prepared on monthly basis and is presented to the Board each time they meet.	The agency had one "limited" rating on its previous QI review. The information was included In the CEO report that was presented at the Board of Directors Meetings following the review. There was no evidence that the final report was submitted electronically or by mail to the Executive Committee of the Board. The CEO was interviewed and agreed that the information was clearly presented in person and not documented in the specific manner detailed in this indicator.
There is evidence that strengths and weaknesses are identified, improvements are implemented or modified, and staff are informed and involved throughout the process.	**Compliance**	Evidence that strengths and weaknesses are identified, improvements are implemented or modified, and staff are informed and involved throughout the process was observed in the program/s quality improvement meeting minutes.	
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 number FLN 1.06 Client Transportation, last reviewed by the CEO on 10/21/2024.	
Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	**Compliance**	Reviewed documentation confirmed all agency drivers are approved by administrative personnel to drive client(s) in agency vehicles.	
Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	**Compliance**	Reviewed documentation confirmed all approved agency drivers had a valid driver's license and are covered under the agency insurance policy.	
Agency's Transportation policy prohibit transporting a client without maintaining at least one other passenger in the vehicle during the trip and include exceptions in the event that a 3rd party is NOT present in the vehicle while transporting	**Compliance**	The agency's transportation policy reflected the prohibiting of transporting a client without maintaining at least one other passenger in the vehicle during the trip however included exceptions in the event a third party is not present in the vehicle while transporting.	
In the event that a 3rd party cannot be obtained for transport, the agency's supervisor or managerial personnel consider the clients' history, evaluation, and recent behavior	**Compliance**	The agency's transportation policy reflected the agency supervisor or managerial personnel consider the clients' history, evaluation, and recent behavior if a third party cannot be obtained for transport.	
The 3rd party is an approved volunteer, intern, agency staff, or other youth	**Compliance**	The agency's transportation policy reflected the third party is an approved volunteer, intern, agency staff, or other youth.	
The agency demonstrated evidence via logbook or other written verification that supervisor approval was obtained prior to all single youth transports.	**Compliance**	The agency demonstrated evidence of one single transport during the past six months and prior approval of the supervisor was observed in the program's logbook.	
When transporting a single client in a vehicle, there was documentation of the following: a. the transporting employee completed check-in by phone at agreed-upon intervals with the senior program leader, or designee, upon departure and arrival. b. the employee check-ins were documented by the manager or designee receiving the call.	**Compliance**	There was one occurrence of single transport where the employee check-in by phone was documented in the program's logbook with verification by the supervisor.	

There is documentation of use of vehicle that notes name or initials of driver, date and time, mileage, number of passengers, purpose of travel and location.	**Compliance**	Reviewed transportation logs for the past six months and documentation confirmed the transportation logbook included all required elements of name or initials of driver, date and time, mileage, number of passengers, purpose of travel, and location.	
Additional Comments: **There are no additional comments for this indicator.**			
1.07 - Outreach Services			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 1.07		**YES** If NO, explain here: The agency has a policy number FLN 1.01 Outreach Services, last reviewed by the CEO on 10/21/2024.	
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 Community Outreach and Development Coordinator who is designated to do community outreach events. The Chief of Operations/ Shelter Program Manager is the lead staff member designated to participate in local DJJ board, Circuit and Council meetings. The Chief of Operations/ Shelter Program Manager also serves as the Chairperson for the local Circuit Advisory Board. The agency maintains two binders with agendas, meeting minutes, and completed NetMIS forms documenting all outreach activities.	
The program maintains written agreements with other community partners which include services provided and a comprehensive referral process.	**Compliance**	Evidence of written agreements with other community partners which included a comprehensive referral process was observed while on-site.	
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**	NetMIS documentation was reviewed and included the title, date, duration, zip code, location description, number of people reached, modality, target audience and topic for each outreach activity attended or facilitated.	
The program has designated staff that conducts outreach which is defined in their job description.	**Compliance**	The outreach activities are outlined in the job description of the Community Outreach Development Coordinator.	
Additional Comments: **There are no additional comments for this indicator.**			

2.01 - Screening and Intake			Limited
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 numbered FLN 201 Title: Screening for CINS FINS Eligibility, which was revised on 01/24/24 by CEO.	
Shelter youth: Eligibility screening form is completed immediately for all shelter placement inquiries.	**Compliance**	Five of five shelter files reviewed contained eligibility screening forms which were completed immediately for all shelter placement inquiries.	
Community counseling: Eligibility screening form is completed within 3 business days of referral by a trained staff using the Florida Network screening form.	**Exception**	Four of five community counseling files reviewed contained evidence the eligibility screening form was completed within three business days of referral by a trained staff.	Out of the five files reviewed, there was one file, which did not have a date, time, or location on the screening page. Therefore, evidence to support eligibility screening was completed within three business days of referral was not supported.
There is evidence all referrals for service is screened for eligibility and is logged in NetMIS within 72 hours of screening completion.	**Compliance**	All ten files reviewed contained evidence all referrals for service eligibility were logged in NetMIS within 72 hours of screening completion.	
Youth and parents/guardians receive the following in writing: a. Available service options b. Rights and responsibilities of youth and parents/guardians	**Compliance**	All ten files reviewed contained evidence youth and parents were provided with information about available services options, rights and responsibilities of youth and parents/guardians.	
The following is also available to the youth and parents/guardians: a. Possible actions occurring through involvement with CINS/FINS services (case staffing committee, CINS petition, CINS adjudication) b. Grievance procedures	**Compliance**	All ten files reviewed contained supported evidence youth and parents/guardians were provided with 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.	**Exception**	Ten files were reviewed; five residential and five community counseling. All ten files contained evidence that the youth were screened for suicidality during intake. Questions on the Community Counseling risk screenings were as follows: 1. Have you wished you were dead within the past two months? 2. Have you felt that life was not worth living within the past two months? 3.Have you felt like killing yourself within the past two weeks? 4. Have you felt like killing yourself within the past two weeks? 5. Have you given up hope for your life within the past 2 months? 6. Have you ever attempted to harm or kill yourself within the past one month? 7. Do you hear voices or see things that other people do not see or hear? 8. Are you currently feeling like hurting or killing someone else? 9. Have you ever seriously considered or attempted to harm or kill others?	There were three different sets of questions being used across the sample of files. Per the FN QI Standard, section 2.01 following question #5, states "If yes, do you have a plan (specific method) to kill yourself?" This question is not present in the risk screening for the three residential files reviewed. Five of the five community counseling files reviewed, contained risk screening questions that were different than questions in standard 2. The community counseling files reviewed were using a set of nine different questions in some files and, in others, a set of six different questions. During the review, the screening form was revised by the clinical director to reflect the correct questions and shown to the reviewer, as evidence of the program's immediate action to implement the correct screening questions.
Additional Comments: **There are no additional comments for this indicator.**			
2.02 - Needs Assessment			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 2.02		**YES** If NO, explain here: Agency has a policy numbered FLN 202 Title: Titled Network Inventory of Risk, Victories and Needs Assessment (Nirvana) which was revised on 01/24/24 by CEO.	
Shelter Youth: NIRVANA is initiated within 72 hours of admission	**Exception**	Four of five files reviewed contained evidence of a NIRVANA being initiated within 72 hours of admission.	One of the five residential files reviewed showed evidence of the NIRVANA assessment being initiated outside of the 72-hour timeframe. The youth was admitted on 09/19/2024 and the NIRVANA was completed on 09/23/2024. There was no indication of an initiation date on the assessment or in the file, subsequent interview with the COO reported that 09/23/2024 was the date of initiation for the NIRVANA assessment.
Non-Residential youth: NIRVANA is initiated at intake and completed within 2 to 3 face-to-face contacts after the initial intake **OR** updated, if most recent assessment is over 6 months old	**Compliance**	All five non-residential files reviewed, contained evidence that all NIRVANAS were initiated at intake and completed within two to three face-to-face contacts after the initial intake.	

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**	Supervisor signatures were documented for all completed NIRVANA assessments and/ or the chronological note and/or interview guide located in all ten youth files reviewed.	
(Shelter Only) NIRVANA Self-Assessment (NSR) is completed within 24 hours of youth being admitted into shelter. If unable to complete, there must be documentation in NetMIS and the youth's file explaining the barriers to completion.	**Exception**	Four of five residential files reviewed contained evidence that Nirvana self-assessments were completed within 24 hours.	Out of five residential files reviewed, it was found that one Nirvana self-assessment was missing the date the assessment was completed. Therefore, there is no evidence self-assessment was completed within 24 hours.
A NIRVANA Post-Assessment is completed at discharge for all youth who have a length of stay that is greater than 30 days.	**Compliance**	Reviewer found evidence in the closed files reviewed, that post-assessment gets completed at discharge for all youth who have length of stay that is greater than 30 days.	
A NIRVANA Re-Assessment is completed every 90 days excluding files for youth receiving SNAP services.	**Compliance**	Nirvana re-assessments are completed every 90 days, where applicable.	
All files include the interview guide and/or printed NIRVANA.	**Compliance**	All files included the interview guide printed Nirvana.	
Additional Comments: **There are no additional comments for this indicator.**			
2.03 - Case/Service Plan			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.03		**YES** If NO, explain here: Agency has policy numbered FLN 2.03Title: Case/Service Plan, which was revised on 01/24/24 by CEO	
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**	Case/Service Plans were developed on a local provider approved form and all service plans were based on information gathered during the initial screening, intake and Nirvana.	
Case/Service plan is developed within 7 working days of NIRVANA	**Compliance**	All case/service plans were developed within 7working days of Nirvana.	

Case plan/service plan includes: 1. Individualized and prioritized need(s) and goal(s) identified by the NIRVANA 2. Service type, frequency, location 3. Person(s) responsible 4. Target date(s) for completion and actual completion date(s) 5. Signature of youth, parent/guardian, counselor, and supervisor 6. Date the plan was initiated	**Compliance**	Ten of ten files reviewed showed evidence of the case plan/ service plan including: individualized and prioritized needs and goals as identified by the Nirvana, service type, frequency, location, persons responsible, target dates for completion and actual completion dates, date plan was initiated, a signature of parent/ guardian, counselor, and supervisor. Nine of ten files reviewed contained a signature of the youth on the case plan/service plan. One of ten files reviewed did not have the signature of the youth on the case service plan, however documentation was noted in the case notes as to the reason and time-frame expected to obtain the youth's signature.	
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	**No eligible items for review**	None of the case/ service plans reviewed met the 30 day requirement for a review for progress/ revision by counselor and parent.	
Additional Comments: **There are no additional comments for this indicator.**			
2.04 - Case Management and Service Delivery			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 2.04		**YES** If NO, explain here: Agency has policy numbered FLN 2.04 Title: Case Management Services, which was revised on 01/24/24 by CEO.	
Counselor/Case Manager is assigned	**Compliance**	All ten files reviewed had Counselor/Case Manager assigned.	

The Counselor/Case Manager completes the following as applicable: 1. Establishes referral needs and coordinates referrals to services based upon the on-going assessment of the youth's/family's problems and needs 2. Coordinates service plan implementation 3. Monitors youth's/family's progress in services 4. Provides support for families 5. Monitoring progress of court ordered youth in shelter 6. Makes referrals to the case staffing to address problems and needs of the youth/family 7. Accompanies youth and parent/guardian to court hearings and related appointments 8. Refers the youth/family for additional services when appropriate 9. Provides case monitoring and reviews court orders 10. Provides case termination notes 11. Provides follow-up after 30 days post discharge 12. Provides follow-up after 60 days post discharge	**Exception**	Ten of ten files reviewed showed evidence that the Counselor/Case Manager completed the following as applicable: establishes referral needs and coordinates referrals to services based upon the on-going assessment of the youth's/family's problems and needs, coordinates service plan implementation, monitors youth's/family's progress in services, provides support for families, monitoring progress of court ordered youth in shelter, makes referrals to the case staffing to address problems and needs of the youth/family, accompanies youth and parent/guardian to court hearings and related appointments, where applicable, refers the youth/family for additional services when appropriate, provides case monitoring and reviews court orders, where applicable, and provides case termination notes, where applicable Seven of ten files reviewed contained: follow-up after 30 and 60 days post discharge.	Out of all ten files reviewed, three files did not have 30 days follow ups; two files from residential setting and one from community counseling. In addition there were two files which did not have 60-day follow ups; one from the residential setting and one from community counseling.
The program maintains written agreements with other community partners that include services provided and a comprehensive referral process	**Compliance**	The program maintains written agreements with other community partners that include services provided and a comprehensive referral process.	
Additional Comments: **There are no additional comments for this indicator.**			
2.05 - Counseling Services			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 2.05		**YES** If NO, explain here: Agency has policy numbered FLN 2.05 Title: Community Counseling Services, which was revised on 01/24/24 by CEO.	
Shelter Program			
Shelter programs provides individual and family counseling	**Compliance**	Shelter program provides individual and family counseling.	

Group counseling sessions held a minimum of five days per week	**Exception**	Group schedule was reviewed and group log documentation was reviewed from April 1st until October 13th to ensure group counseling session are held a minimum of five days per week.	Groups were not done from June 10th until August 11th. In addition, April 1st-7th was missing a group; 8th-14th was missing a group; May 27th - June 2nd was missing all five groups; June 3rd-9th was missing a group; July 1st-7th and 8th-14th was each missing a group; and the week of October 7th-13th was missing a group. In accordance with the documentation presented, the facility failed to complete more than forty groups from April 1st through October 13th.
Groups are conducted by staff, youth, or guests and group counseling sessions consist of : 1. A clear leader or facilitator 2.Relevant topic - educational/informational or developmental 3. Opportunity for youth to participate 4. 30 minutes or longer	**Exception**	Many groups observed between April 1st through October 13, 2024, were conducted by staff, youth, or guests. The group counseling sessions consisted of a clear leader or facilitator, documented a relevant topic - educational/ informational or developmental, included opportunities for youth to participate, and were at least 30 minutes in duration.	Groups for 4/4, 5/3,5/23,6/19,10/11 did not indicate timeframe of 30 minutes or longer, also did not have facilitator's name.
Documentation of groups must include date and time, a list of participants, length of time, and topic.	**Compliance**	The program's group log forms include a date, 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**	There was evidence community counseling program provided therapeutic community based services designed to provide the intervention necessary to stabilize the family. Services were provided at a community location, and local provider counseling office in person. Services are not provided virtually.	
Counseling Services			
There is evidence the program completes review of all case files for coordination between presenting problem(s), psychosocial assessment, case/service plan, case/service plan reviews, case management, and follow-up.	**Compliance**	From all ten files reviewed there was evidence screening and NIRVANA assessments were in coordination with service plans created for each youth in accordance to presenting problems.	
Maintain individual case files on all youth and adhere to all laws regarding confidentiality.	**Compliance**	All ten files reviewed adhere to all laws regarding confidentiality. All case files reviewed were marked confidential.	
Case notes maintained for all counseling services provided and documents youth's progress.	**Compliance**	All ten files reviewed maintained case notes from counseling services, which provided youth's progress.	

On-going internal process that ensures clinical reviews of case records and staff performance.	**Compliance**	The program has an internal process that ensures clinical reviews of case records and staff performance are conducted. There was evidence from all ten files reviewed that the clinical director reviewed and signed off on service plans and NIRVANA assessments. Feedback on reviews and staff performance is communicated to staff during the program's staff meetings.	
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.	**Not Applicable**	The program is not conducting intake through virtual means.	
Additional Comments: **There are no additional comments for this indicator.**			
2.06 - Adjudication/Petition Process			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 2.06		**YES** If NO, explain here: Agency has policy numbered FLN 2.056Title:CINS Adjudication Services, which was revised on 01/24/24 by CEO.	
Must include: a. DJJ rep. or CINS/FINS provider b. Local school district representative	**Compliance**	Files reviewed included CINS/FINS provider and local school district representative.	
Other members may include: a. State Attorney's Office b. Others requested by youth/ family c. Substance abuse representative d. Law enforcement representative e. DCF representative f. Mental health representative	**Compliance**	Files reviewed included law enforcement representative and mental health representation, Program Clinical Supervisor.	
The program has an established case staffing committee, and has regular communication with committee members	**Compliance**	The program has established case staffing committee, and has regular communication with committee members. The program's case managers showed evidence of email communication with committee members regarding case staffing.	
The program has an internal procedure for the case staffing process, including a schedule for committee meetings	**Compliance**	Interview with the case manager indicated the program has an internal procedure for the case staffing process, including schedule for committee meetings. Evidence of the committee meeting schedule was presented during review.	

The youth and family are provided a new or revised plan for services	**Exception**	One of two case files reviewed contained a new plan for services. One of two contained a revised plan, where indicated.	One of two case files reviewed did not contain a new or revised plan for services.
Written report is provided to the parent/guardian within 7 days of the case staffing meeting, outlining recommendations and reasons behind the recommendations	**Exception**	One of two case files reviewed contained proof of parent/ guardian receiving a written report within seven days of the case staffing meeting.	For one of the case files reviewed, there was no evidence the parent/guardian was provided with a written report within seven days of the case staffing meeting. The case manager reported that a written report is usually mailed to the parent or guardian, however, there was no evidence of such mailing in the case file.
If applicable, the program works with the circuit court for judicial intervention for the youth/family	**Compliance**	Two of two case files reviewed showed evidence of the program working with the circuit court for judicial intervention for the youth/ family.	
Case Manager/Counselor completes a review summary prior to the court hearing	**Compliance**	Two of two case files reviewed contained a review summary prepared by the case manager prior to the court hearing.	
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 FLN 2.07 title: Youth records, which was reviewed by CEO on 01/24/24.	
All records are clearly marked 'confidential'.	**Compliance**	All records were clearly marked confidential.	
All records are kept in a secure room or locked in a file cabinet that is marked "confidential"	**Compliance**	All records were kept in a secure room and locked in a file cabinet that is marked confidential.	
When in transport, all records are locked in an opaque container marked "confidential"	**Compliance**	The reviewer met with the clinical director to ask about scenarios when staff needed to transport the files. The clinical director stated that each staff has access to a black locked container, which is marked confidential, to be utilized whenever files need to be transported out of the facility.	
All records are maintained in a neat and orderly manner	**Exception**	Files were contained in file jackets with separate partitions indexed for contents of each section.	One file reviewed contained a Nirvana assessment from another youth. Some assessments could not be found in accordance to the index in the file.

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**	All five shelter files reviewed contained screening, informed consent, photograph of the youth, shelter intake form, Suicide Assessment form, Nirvana self-report, NIRVANA full assessment, plan of service, chronological notes, medication inventory form, approved contact list, copies of referrals made and follow-ups whenever applicable and a discharge summary.	
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**	For all five community counseling files reviewed, there was evidence found that each file has a section for screening, informed consent, community counseling intake form, suicide assessment, NIRVANA full Assessment, plan of service, chronological case notes and copies of referrals made and follow ups when needed.	
All records kept electronically, are maintained securely and can be made immediately available upon request for audit purposes.	**Not Applicable**	The agency does not maintain electronic records.	
Records are retained for the duration of the time specified by the contract.	**Compliance**	In accordance to Intake coordinator records are retained for seven years after youth has left the program.	
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 several policies; FLN 2.09, 4.07 Specialized Additional Program Services, FLN 2.08, 4.07.01 Staff Secure Services, FLN 2.09, 4.07.04 Domestic Violence Respite Services, FLN 2.09, 4.07.05 Probation Respite Services The policies were last reviewed by the CEO on 10/21/2024.	
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**	The agency had no staff secure cases in the last six months or since the last onsite QI review was conducted.	
Staff Secure policy and procedure outlines the following: a. In-depth orientation on admission b. Assessment and service planning c. Enhanced supervision and security with emphasis on control and appropriate level of physical intervention d. Parental involvement e. Collaborative aftercare	**Compliance**	The agency has a policy FLN 2.08, 4.07.01 which outlines the following regarding staff secure services: 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; and e. Collaborative aftercare.	
Program only accept youth that meet legal requirements of F.S. 984 for being formally court ordered in to Staff Secure Services	**Compliance**	The agency's policy states that the program only accepts youth that meet legal requirements of F.S. 984 for being formally court ordered in to Staff Secure Services.	
Staff Assigned: a. One staff secure bed and assigned staff supervision to one staff secure youth at any given time b. Program assign specific staff during each shift to monitor location/ movement of staff secure youth c. Agency clearly documents the specific staff person assigned to the staff secure youth in the logbook or any other means on each shift	**No eligible items for review**	The agency had no staff secure cases in the last six months or since the last onsite QI review was conducted.	
Agency provides a written report for any court proceedings regarding the youth's progress	**No eligible items for review**	The agency had no staff secure cases in the last six months or since the last onsite QI review was conducted.	
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**	The agency had no Domestic Minor Sex Trafficking cases in the last six months or since the last onsite QI review was conducted.	

Agency has evidence that the FNYFS was contacted for approval prior to admission for all Domestic Minor Sex Trafficking (DMST) placements.	**No eligible items for review**	The agency had no Domestic Minor Sex Trafficking cases in the last six months or since the last onsite QI review was conducted.	
There is evidence the youth was entered into NetMIS as a Special Populations youth at admission and a Human Trafficking Screening Tool (HTST) was completed.	**No eligible items for review**	The agency had no Domestic Minor Sex Trafficking cases in the last six months or since the last onsite QI review was conducted.	
Services provided to these youth specifically designated services designed to serve DMST youth	**No eligible items for review**	The agency had no Domestic Minor Sex Trafficking cases in the last six months or since the last onsite QI review was conducted.	
Did the placement of DMST youth require additional supervision for the safety of the youth or the program? If so, did the agency provide the appropriate level of supervision and safety measures?	**No eligible items for review**	The agency had no Domestic Minor Sex Trafficking cases in the last six months or since the last onsite QI review was conducted.	
Length of Stay: a. Youth in program do not have length of stay in DMST placement that exceeds seven (7) days b. Agency has approval for stays and support beyond seven (7) days for DMST placements that are obtained on a case-by-case basis? (If applicable.)	**No eligible items for review**	The agency had no Domestic Minor Sex Trafficking cases in the last six months or since the last onsite QI review was conducted.	
Agency has evidence that staff assigned to DMST youth under this provision are to enhance the regular services available through direct engagement in positive activities designed to encourage the youth to remain in shelter	**No eligible items for review**	The agency had no Domestic Minor Sex Trafficking cases in the last six months or since the last onsite QI review was conducted.	
All other services provided to DMST youth are consistent with all other general CINS/FINS program requirements	**No eligible items for review**	The agency had no Domestic Minor Sex Trafficking cases in the last six months or since the last onsite QI review was conducted.	
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")	**Yes**	The agency had several Domestic Violence cases in the last six months. Two cases were randomly sampled for review.	
Youth admitted to DV Respite placement have evidence in the file of a pending DV charge	**Compliance**	Two of two Domestic Violence (DV) Respite files reviewed contained evidence of a pending DV charge.	
Data entry into NetMIS within (3) business days of intake and discharge	**Compliance**	Two of two Domestic Violence (DV) Respite files reviewed contained evidence of entry into NetMIS within three business days of intake.	
Youth length of stay in DV Respite placement does not exceed 21 days. If more than 21 days, documentation exists in youth file of transition to CINS/FINS or Probation Respite placement, if applicable.	**Compliance**	Two of two Domestic Violence (DV) Respite files reviewed did not exceed a 21 day length of placement.	

Case plan in file reflects goals for aggression management, family coping skills, or other intervention designed to reduce propensity for violence in the home	**Compliance**	Two of two Domestic Violence (DV) Respite files reviewed contained case plans which reflected goals for aggression management, family coping skills, or other intervention designed to reduce propensity for violence in the home.	
All other services provided to Domestic Violence Respite youth are consistent with all other general CINS/FINS program requirements	**Compliance**	Evidence that other services provided to Domestic Violence (DV) Respite youth are consistent with all other general CINS/ FINS program requirements was present in two of two files reviewed.	
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")	**Yes**	The agency had several Probation Respite cases in the last six months. Two cases were randomly sampled for review.	
All probation respite referrals are submitted to the Florida Network.	**Compliance**	Two of two Probation Respite cases reviewed submitted referrals to the Florida Network.	
All Probation Respite Referral come from DJJ Probation and there is evidence that the youth is on Probation regardless of adjudication status.	**Compliance**	Two of two Probation Respite cases reviewed contained referrals from DJJ Probation and contained evidence that the youth was on Probation regardless of adjudication status.	
Data entry into NetMIS and JJIS within (3) business days of intake and discharge	**Compliance**	Two of two Probation Respite cases reviewed showed evidence of data entry into NetMIS withing three business days.	
Length of stay is no more than fourteen (14) to thirty (30) days. Any placement beyond thirty (30) days contains evidence in the file that the JPO was contacted in writing to request the need of an extension no later than the 25th day the youth was admitted into the program.	**Compliance**	Each of the Probation Respite cases had a length of stay of less than 30 days and did not require and extension from the Juvenile Probation Officer.	
All case management and counseling needs have been considered and addressed	**Compliance**	All case management and counseling needs were considered in both Probation Respite cases reviewed.	
All other services provided to Probation Respite youth are consistent with all other general CINS/FINS program requirements	**Compliance**	Both Probation Respite cases reviewed were consistent with all other general CINS/FINS program requirements.	
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")	**No eligible items for review**	The agency had no Intensive Case Management cases in the last six months or since the last onsite QI review was conducted.	

Youth receiving services were deemed chronically truant and/or runaway and require more intensive and lengthy services. The youth was determined to be eligible because they have gone through petition and/or case staffing and was in need of case management services.	**No eligible items for review**	The agency had no Intensive Case Management cases in the last six months or since the last onsite QI review was conducted.	
Services for youth and family include: a. Two (2) direct contacts per month b. Two (2) collateral contacts per week c. Direct and collateral contacts not obtained must have documentation to support attempts made to obtain them. All reasonable attempts (at minimum of three) must be made to reach all contacts (direct and collateral) and documented in the case file and NetMIS.	**No eligible items for review**	The agency had no Intensive Case Management cases in the last six months or since the last onsite QI review was conducted.	
Assessments include a. NIRVANA at intake b. NIRVANA Re-Assessment every 90 days c. Post NIRVANA at discharge as aligned with timeframe requirements	**No eligible items for review**	The agency had no Intensive Case Management cases in the last six months or since the last onsite QI review was conducted.	
Service/case plan demonstrates a strength-based, trauma-informed focus	**No eligible items for review**	The agency had no Intensive Case Management cases in the last six months or since the last onsite QI review was conducted.	
For any virtual services provided, there is written documentation in the youths' file as to why virtual contact is in the best interest of the youth and family	**Compliance**	Interview with the Counselor/ Case Manager indicated there are no virtual services provided by the agency.	
Family and Youth Respite Aftercare Services (FYRAC)	**No eligible items for review**	The agency had no Family and Youth Respite Aftercare Services (FYRAC) cases in the last six months or since the last onsite QI	
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	**No eligible items for review**	The agency had no Family and Youth Respite Aftercare Services (FYRAC) cases in the last six months or since the last onsite QI review was conducted.	
Youth is referred by DJJ for a domestic violence arrest on a household member, and/or the youth is on probation regardless of adjudication status and at risk of violating.	**No eligible items for review**	The agency had no Family and Youth Respite Aftercare Services (FYRAC) cases in the last six months or since the last onsite QI review was conducted.	
Agency has evidence that all FYRAC referrals have documented approval from the Florida Network office	**No eligible items for review**	The agency had no Family and Youth Respite Aftercare Services (FYRAC) cases in the last six months or since the last onsite QI review was conducted.	

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

There is evidence of completed 30 and/or 60 day follow-ups and is documented in NetMIS following case discharge.	**No eligible items for review**	The agency had no Family and Youth Respite Aftercare Services (FYRAC) cases in the last six months or since the last onsite QI review was conducted.	
Youth and family participate in services for thirteen (13) sessions or ninety (90) consecutive days of services, or there is evidence in the youth's file that an extension is granted by DJJ circuit Probation staff	**No eligible items for review**	The agency had no Family and Youth Respite Aftercare Services (FYRAC) cases in the last six months or since the last onsite QI review was conducted.	
Any service that is offered virtually, is documented in the youth's file why it was in the youth and families best interest.	**Compliance**	Interview with the Counselor/ Case Manager indicated there are no virtual services provided by the agency.	
All data entry in NetMIS is completed within 3 business days as required.	**No eligible items for review**	Interview with the Counselor/ Case Manager indicated there are no virtual services provided by the agency.	
Additional Comments: **There are no additional comments for this indicator.**			
2.09- Stop Now and Plan (SNAP)			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.09		**YES** If NO, explain here: The agency has several policies FLN 2.10, 4.12 SNAP Intake Requirements, FLN 2.10, 4.12 SNAP Group Delivery, FLN 2.10, 4.15 SNAP for Schools and Communities, FLN 2.10, 4.13 SNAP Fidelity Adherence Monitoring and FLN 2.10, 4.14 SNAP Discharge Requirements. All policies were reviewed by CEO on 01/24/24.	
SNAP Clinical Groups Under 12			
Youth are screened to determine eligibility of services with the required documents: a. Florida Network Youth Screening Form b. SNAP® Brief Intake Screening Checklist	**Compliance**	Three of three youth files reviewed were screened to determine eligibility of services with the: Florida Network Youth Screening Form and the SNAP Brief Intake Screening Checklist.	
All files contain **each** of the required documents below: a. SNAP Child Screening Interview Report b. Florida Network Community Counseling Intake Form c. Reinforcement Trap/Coercive Cycle Diagram d. Consent to Treatment and Participation in Research Form	**Compliance**	Each SNAP file reviewed contained the following required documents within: SNAP Child Screening Interview Report, Florida Network Community Counseling Intake Form, Reinforcement Trap/ Coercive Cycle Diagram, and Consent to Treatment and Participation in Research Form.	
The NIRVANA was completed at initial intake, or within two sessions.	**Compliance**	The Nirvana was completed at initial intake in three of three SNAP files reviewed.	

There is evidence of the completed the Pre - Child Behavior Checklist (CBCL) by the caregiver and is located within the file.	**Compliance**	Three of three files reviewed contained the completed Pre-Child Behavior Checklist.	
There is evidence of the completed Pre - TOPSE is completed by the caregiver and is located within the file.	**Compliance**	Three of three files reviewed contained a completed Pre-TOPSE.	
There is evidence of the following documents located within the file: a. SNAP® Parent Goal Sheet b. Child Way To Go Goal Sheet (*This may be in progress for open files but is required for all closed files.*)	**Compliance**	A SNAP Parent Goal Sheet and Child Way To Go Goal Sheet was present in each of the three files reviewed.	
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.	**Compliance**	Three of three files reviewed contained a completed Post- Child Behavior Checklist.	
There is evidence of the completed Post - TOPSE is completed by the caregiver and is located within the file.	**Compliance**	Three of three files reviewed contained a completed Post-TOPSE.	
There is evidence of the completed SNAP Discharge Report located within the file for any discharged youth.	**Compliance**	Three of three files reviewed contained a completed SNAP Discharge Report.	
There is evidence of the SNAP Boys/SNAP Girls Child Group Evaluation Form located in the file.	**Compliance**	All three SNAP files reviewed contained SNAP boys/girls Group Evaluation Forms.	
There is evidence of the SNAP Boys/SNAP Girls Parent Group Evaluation Form located in the file.	**Compliance**	All three SNAP files reviewed contained SNAP Parent Group Evaluation Forms.	
SNAP Clinical Groups for Youth 12-17			
Youth are screened to determine eligibility of services using the Florida Network Youth Screening Form.	**No eligible items for review**	The agency does not have any cases of SNAP Clinical Groups for Youth 12-17.	
The file contains the completed Florida Network Community Counseling Intake Form and is located within the file.	**No eligible items for review**	The agency does not have any cases of SNAP Clinical Groups for Youth 12-17.	

The Consent to Treatment and Participation in Research Form is completed, signed by the parent/guardian before receiving services, and located within the file.	**No eligible items for review**	The agency does not have any cases of SNAP Clinical Groups for Youth 12-17.	
The NIRVANA was completed at initial intake, or within two sessions.	**No eligible items for review**	The agency does not have any cases of SNAP Clinical Groups for Youth 12-17.	
There is evidence of the completed 'How I Think Questionnaire' (HIT) form located within the file or evidence of at least three (3) documented attempts in the youths' file to obtain this information.	**No eligible items for review**	The agency does not have any cases of SNAP Clinical Groups for Youth 12-17.	
There is evidence of the completed Social Skills Improvement System (SSIS) Student form located within the file or evidence of at least three (3) documented attempts in the youths' file to obtain this information.	**No eligible items for review**	The agency does not have any cases of SNAP Clinical Groups for Youth 12-17.	
There is evidence of the completed Social Skills Improvement System (SSIS) Teacher/Adult form located within the file or evidence of at least three (3) documented attempts in the youths' file to obtain this information.	**No eligible items for review**	The agency does not have any cases of SNAP Clinical Groups for Youth 12-17.	
All closed files contained evidence in the file a NIRVANA was completed at discharge.	**No eligible items for review**	The agency does not have any cases of SNAP Clinical Groups for Youth 12-17.	
SNAP for Schools & Communities			
The program demonstrated all of the required weekly attendance sheets that included youth names and/or identifying numbers completed with the teacher and trained SNAP Facilitator signatures. (*This must include a total of 13 attendance sheets for a full cycle*)	**Compliance**	Two of two SNAP for Schools and Communities sessions reviewed contained all of the required weekly attendance sheets that included youth names and both teacher and trained SNAP facilitator signatures.	
The program maintained evidence of a completed 'Way to Go Goal' Sheet within the file.	**Compliance**	A completed Way To Go Goal sheet was contained in both SNAP for Schools and Communities files reviewed.	
The program maintained evidence of both pre AND post Measure of Classroom Environment (MoCE) completed documents for the class reviewed.	**Compliance**	Completed pre and post Measure of Classroom Environment documents were contained in both SNAP for Schools and Communities files reviewed.	
The program maintained evidence of completed pre and post evaluation documents for the class reviewed.	**Compliance**	Completed pre and post evaluation documents were contained in both SNAP for Schools and Communities files reviewed.	

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.	**Compliance**	Each SNAP for Schools and Communities file reviewed showed evidence of SNAP for Schools and Communities Feedback Form which was completed by the facilitator and entered into NetMIS.	
There is evidence of one (1) Fidelity Adherence Checklist completed per classroom for the 13-week classroom sessions which is located in the file.	**Compliance**	A completed Fidelity Adherence Checklist was observed in both SNAP for Schools and Communities files reviewed.	
Additional Comments: **There are no additional comments for this indicator.**			
3.01 - Shelter Environment			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 3.01		**YES** If NO, explain here: The agency has a policy FLN 3.01 Program Orientation, reviewed by CEO on 01/24/24.	
Facility Inspection: a. Furnishings are in good repair. b. The program is free of insect infestation. c. Bathrooms and shower areas are clean and functional, free of foul odors, leaks, dust, and mildew and in good working order. d. There is no graffiti on walls, doors, or windows. e. Lighting is adequate for tasks performed there. f. Exterior areas are free of debris; grounds are free of hazards. g. Dumpster and garbage can(s) are covered. h. All doors are secure, in and out access is limited to staff members and key control is in compliance. i. Detailed map and egress plans of the facility, general client rules, grievance forms, abuse hotline information, DJJ Incident Reporting Number and other related notices are posted. j. Interior areas (bedrooms, bathrooms, common areas) do not contain contraband and are free from hazardous unauthorized metal/foreign objects.	**Compliance**	Physical observation of the facility showed: a. Furnishings are in good repair. Most furniture in the shelter was built by the agency's maintenance person. b. The program is free of insect infestation. c. All eight 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 prominently throughout the facility. j. Interior areas (bedrooms, bathrooms, common areas) do not contain contraband and are free from hazardous unauthorized metal/foreign objects.	

Facility Inspection: a. All agency and staff vehicles are locked. b. Agency vehicles are equipped with major safety equipment including first aid kit, (all items in the first aid kit are current and do not have expired items; all expired items should be replaced regularly), fire extinguisher, flashlight, glass breaker and, seat belt cutter.	**Compliance**	At the time of the on-site review, all agency and staff vehicles were locked. Inspection of all agency vehicles showed evidence they were equipped with all major safety equipment including first aid kit, extinguishers, flashlight, glass breaker and seat belt cutter.	
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 stored in one location in a locked closet in the hallway. All chemicals contained in the closet were listed, approved for use, inventoried weekly and perpetually, and stored securely and Material Safety Data Sheets (MSDS) are located in the supply closed and maintained on each item. Weekly and perpetual inventory logs were reviewed from 06/01/2024-10-23/2024.	
Facility Inspection: Washer/dryer are operational & general area/lint collectors are clean. Agency has a current DCF Child Care License which is displayed in the facility. Each youth has own individual bed with clean covered mattress, pillow, sufficient linens and blanket. Youth have a safe, lockable place to keep personal belongings, if requested.	**Compliance**	Washer and dryer are operational and general areas are clean. The agency does have a current DCF child care license which is displayed. The facility is licensed for 20 beds through November 14, 2024. Each youth has their own bed with clean covered mattress, pillows, and blankets. All youth have a place to lockup personal belongings.	
Additional Facility Inspection Narrative (if applicable)			

Fire and Safety Health Hazards: a. Annual facility fire inspection was conducted, and the facility is in compliance with local fire marshal and fire safety code within jurisdiction. b. Agency completes a minimum of 1 fire drill on each shift monthly (within 2 minutes or less). c. Completes 1 mock emergency drill per shift per quarter. d. All annual fire safety equipment inspections are valid and up to date (extinguishers, sprinklers, alarm system and kitchen overhead hood, including fire extinguishers in all vehicles).	**Compliance**	The Annual facility fire inspection was conducted, September 19, 2024 and the facility is in compliance with local fire marshal and fire safety code within jurisdiction. Fire drills logs reviewed from April through September 2024, showed that drills were completed on each shift monthly (within 2 minutes or less). Mock emergency drills reviewed between April and September showed drills being completed once per shift per quarter. All annual fire safety equipment inspections, throughout the facility, are valid and up to date (extinguishers, sprinklers, alarm system and kitchen overhead hood, including fire extinguishers in all vehicles) as of February 16, 2024.	
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**	Agency has a current Satisfactory Residential Group Care inspection report from the Department of Health dated August 22, 2024. Agency has a current Satisfactory Food Service inspection report from the Department of Health with an expiration date of May 31, 2025. Food menus are posted, current and signed by Licensed Dietician annually. All cold food is properly stored, marked and labeled and dry storage/pantry area is clean and food is properly stored. Refrigerator was at 32 degrees and freezer at -4.2 degrees, when inspected. Refrigerators/Freezers are clean and maintained at required temperatures and all small and medium sized appliances are operable and clean for use as needed.	
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**	A review of the activity schedule, interview with program staff and observation of youth all indicate; youth are engaged in meaningful, structured activities. 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. At least one hour of physical activity is provided daily. Youth were observed outside participating in recreation during the on-site review. Additionally, daily programming includes opportunities for youth to complete homework. Youth are allowed quiet time to read. The facility has a library with a variety of age appropriate, program approved books and comfortable seating for reading and playing games. Daily programming schedule is publicly posted and accessible to both staff and youth.	
Additional Comments: **There are no additional comments for this indicator.**			
3.02 - Program Orientation			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 3.02		**YES** If NO, explain here: The agency has a policy number FLN 3.02 Program Orientation, last reviewed by the CEO on 10/21/2024.	
Youth received a comprehensive orientation and handbook provided within 24 hours	**Compliance**	Each youth admitted for services received a comprehensive orientation and handbook provided within 24 hours.	
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**	Five of five youth files reviewed contained evidence the program conducts orientation which includes the following elements: youth are given a list of contraband items, disciplinary action is explained, dress code explained, review of access to medical and mental health services, procedures for visitation, mail and telephone, grievance procedure, disaster preparedness instructions, physical layout of the facility, sleeping room assignment and introductions, and suicide prevention.	

Documentation of each component of orientation, including orientation topics and dates of presentation, as well as signatures of the youth and staff involved are maintained in the individual youth record.	**Compliance**	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 all five of the individual youth records reviewed.	
Additional Comments: **There are no additional comments for this indicator.**			
3.03 - Youth Room Assignment			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 3.03		**YES** If NO, explain here: The agency has a policy number FLN 3.03 Youth Room Assignments, last reviewed by the CEO on 10/21/2024.	
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	**Compliance**	During the initial intake the program reviews information about the youth's: history, status and exposure to trauma, initial collateral contacts, initial interactions with and observations of the youth, separation of younger youth from older youth, separation of violent youth from non-violent youth, identification of youth susceptible to victimization, presence of medical, mental or physical disabilities, suicide risk, sexual aggression and predatory behavior, acute health symptoms requiring quarantine or isolation. Evidence of these components were present in all five youth files reviewed.	
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's practice is to immediately enter an alert in the 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. Alerts are indicated on the shift report sheets, the youth files, the census board, the alert board in the med room and in the kitchen, as applicable for each youth.	
Additional Comments: **There are no additional comments for this indicator.**			

3.04 - Log Books			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 3.04		**YES** If NO, explain here: The agency has a policy number FLN 3.04 Logbooks, last reviewed by the CEO on 10/21/2024.	
Log book entries that could impact the security and safety of the youth and/or program are highlighted	**Compliance**	The program uses manual logbooks. A review of logbook entries from March 2024 to September 2024 showed evidence that all logbook entries that impact the security and safety of the youth were highlighted for security and safety.	
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 reviewed from March 2024 to present, are written legibly and in ink. Entries include the date and time of the incident, event or activity, names of youth and staff involved, a brief statement providing pertinent information and the name and signature of person making the entry.	
Recording errors are struck through with a single line. The staff person must initial and date the correction. The use of whiteout and erasures is prohibited.	**Compliance**	There were no errors observed.	
The program director or designee reviews the facility logbook(s) every week and makes a note chronologically in the logbook indicating the dates reviewed and if any correction, recommendations and follow-up are required and sign/date the entry	**Compliance**	Observations of the program director reviewing the facility logbook every week with an indication of the date reviewed with any corrections, recommendations, or follow-ups that were needed were seen chronologically in the logbook, signed and dated by the supervisor.	
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**	The staff reviewed the logbook of the previous two shifts and made entries in the logbook indicating the dates reviewed	
At the beginning of their shift, oncoming supervisor and shelter counselor reviews the logbook of all shifts since their last log entry and makes a signed and dated entry and into log book indicating the dates reviewed.	**Compliance**	Over the past six months (March 2024 to present), there is evidence that the shift supervisors indicated they reviewed the logbook of all shifts since the last log entry plus signed and dated the last review of the log book.	

Logbook entries include: a. Supervision and resident counts b. Visitation and home visits	**Compliance**	The program's logbook entries included supervision and resident counts, plus visitation and home visits.	
Additional Comments: **There are no additional comments for this indicator.**			
3.05 - Behavior Management Strategies			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 3.05		**YES** If NO, explain here: The agency has a policy number FLN 3.06 Behavior Management, Behavior Intervention and Behavior Plan, last reviewed by the CEO on 10/21/2024.	
The program has a detailed written description of the BMS and it is explained during program orientation	**Compliance**	The program does have a detailed written description of (BMS) Behavior Management Strategies and it is explained during the intake	
Behavior Management Strategies must include:			
a. BMS is designed to teach youth new behaviors and help youth understand the natural consequences for their actions b. Behavioral interventions are applied immediately, with certainty, and reflect the severity of the behavior c. BMS uses a wide variety of awards/incentives to encourage participation and completion of the program d. Appropriate consequences and sanctions are used by the program and consequences for behavior are logical and designed to promote skill-building for the youth e. Counseling, verbal intervention and de-escalation techniques are used prior to physical intervention (Only techniques approved by the Florida Network and DJJ are used if physical intervention is required) f. Only staff discipline youth. Group discipline is not imposed g. Room restriction is not used as part of the system or for youth who are physically and/or emotionally out of control h. Youth should never be denied basic rights such as meals, clothing, sleep, services, exercise, or correspondence privileges	**Compliance**	The Behavior Management Strategies teaches new behaviors and help youth understand consequences. Appropriate consequences and sanctions are used by the program. Counseling, verbal interventions, and de-escalation techniques approved by the Florida network and DJJ are used prior to physical intervention. Room restrictions are not used as a part of the system for youth who are physically out of control. The program uses natural consequences and reinforces positive behavior through a comprehensive point-based behavior plan system. Youth use points earned to shop in the shelter's point store which includes a variety of fun items, toiletries, games, snacks, candies, etc.	
Program's use of the BMS			
All staff are trained in the theory and practice of administering BMS rewards and consequences	**Compliance**	All staff are trained in the theory and practice of administering BMS rewards and consequences	

There is a protocol for providing feedback and evaluation of staff regarding their use of BMS rewards and consequences	**Compliance**	The shelter manager provides feedback and evaluation of staff regarding their use of BMS rewards and consequences.	
Supervisors are trained to monitor the use of rewards and consequences by their staff	**Compliance**	The shelter manger trains supervisors 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**
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 number FLN 3.06 Youth Staffing and Supervision, last reviewed by the CEO on 10/21/2024.	
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**	Confirmation the program maintains a minimum staffing ratio as required, one staff to six youth during awake hours and community activities, and one staff to twelve youths during sleeping period was observed in the staff schedules reviewed from March 2024 to present, on video reviews (10/15/24, 09/28/2024, and 10/03/2024 and in the program's logbook for the same dates.	
All shifts must always provide a minimum of two direct care staff present that have met the minimum training requirements	**Compliance**	All shifts did have a minimum of two direct staff that have met the minimum training requirements.	
Program staff included in staff-to-youth ratio includes only staff that are background screened and properly trained youth care workers, supervision staff, and treatment staff	**Compliance**	All staff working with youth have been properly background screened. Staff to youth ratio includes only staff that are properly trained youth care workers, supervision staff, and treatment staff.	
The staff schedule is provided to staff or posted in a place visible to staff	**Compliance**	The staff schedule is provided to staff and posted in the staff's observation area.	

There is a holdover or overtime rotation roster which includes the telephone numbers of staff who may be accessed when additional coverage is needed	**Compliance**	The program maintains a holdover and overtime rotation roster that includes the telephone numbers of staff that may be accessed when coverage is needed.	
Staff observe youth at least every 15 minutes while they are in their sleeping room, either during the sleep period or at other times, such as during illness or room restriction	**Compliance**	Review of bed check documentation from March 2024 to present verified staff are observing youth every 15 minutes while they are sleeping, either during the sleep period or at all other appropriate times.	
Additional Comments: **There are no additional comments for this indicator.**			
3.07 - Video Surveillance System			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 3.07		**YES** If NO, explain here: The agency has a policy number FLN 3.07 Video Surveillance System, last reviewed by the CEO on 10/21/2024.	
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 agency has a written notice conspicuously posted on the premise, the education building, for the purpose of security. The video system has 27 cameras and records date, time, location. The system maintains resolution while enabling facial recognition and can capture and retain video photographic images for a minimum of thirty days. Cameras have backup capabilities to operate during a power outage. All cameras are visible and are placed in the required interior and exterior areas, as well as general locations where youth and staff congregate, and where visitors enter and exit which include where youth searches are conducted. None of the cameras are located in bathrooms or sleeping quarters.	
A list of designated personnel who can access the video surveillance system is maintained (includes off-site capability per personnel)?	**Compliance**	The agency provided a list of designated personnel who can access the video surveillance system, for review.	

Supervisory review of video is conducted a minimum of once every 14 days and timeframes reviewed are noted in the logbook.	**Compliance**	Supervisory review documentation, for the past six months (March 2024 to present), verified the supervisor conducted video reviews at least once every fourteen days and notated such reviews in the program's logbook.	
The reviews assess the activities of the facility and include a review of random sample of overnight shifts	**Compliance**	A review of the video camera on October 15, 2024 from 12am to 1am, September 28, 2024 from 2am to 3am, and October 3, 2024 from 5am to 6am, was conducted to assess the activities of the facility over the overnight shifts.	
Grant the requesting of video recordings to yield a result within 24-72 hours from program quality improvement visits and when an investigation is pursued after an allegation of an incident	**Compliance**	The agency has a policy in place to grant any request for video recordings within twenty-four to seventy-two hours from program quality improvement visits and when an investigation is pursued after an allegation of an incident.	
Camera service order/requests will be made within 24 hours of discovery of camera malfunctioning or being inoperable. All efforts made to obtain repairs are documented and maintained	**Compliance**	Chief operating officer reported if any of the cameras were malfunctioning or inoperable a service order is requested within twenty-four hours with documentation of the request and repairs being maintained by the agency. There have been no occurrences of camera malfunctioning or being inoperable in the past six months or back to the date of the last review.	
Additional Comments: **There are no additional comments for this indicator.**			
4.01 - Healthcare Admission Screening			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 4.01		**YES** If NO, explain here: FLN 4.01 Health screening on Admission on 10/21/2024 by CEO.	
Preliminary Healthcare Screening			
Screening includes : a. Current medications b. Existing (acute and chronic) medical conditions c. Allergies d. Recent injuries or illnesses e. Presence of pain or other physical distress f. Observation for evidence of illness, injury, physical distress, difficulty moving, etc. g. Observation for presence of scars, tattoos, or other skin markings h. Acute health symptoms requiring quarantine or isolation	**Compliance**	Five youth records were reviewed. All files had a completed healthcare screening form to include all of the required elements.	

Referral and Follow-Up			
Youth with chronic medical conditions have a referral to ensure medical care (e.g. diabetes, pregnancy, seizure disorder, cardiac disorders, asthma, tuberculosis, hemophilia, head injuries, etc.)	**Compliance**	Five youth records were reviewed. No records indicated any youth having chronic medical conditions.	
When needed, the parent is involved with the coordination and scheduling of follow-up medical appointments	**Compliance**	For one applicable record, there is documentation showing the parent was involved with medical appointments.	
All medical referrals are documented on a daily log.	**Compliance**	A review of the logbook indicated medical referrals were notated.	
The program has a thorough referral process and a mechanism for necessary follow-up medical care as required and/or needed	**Compliance**	The nurse conducts weekly reviews of the youth records to ensure medical care is completed as required and/or needed.	
Additional Comments: **There are no additional comments for this indicator.**			
4.02 - Suicide Prevention			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 4.02		**YES** If NO, explain here: FLN 4.02 Risk in Shelter/Community Counseling Programs on 10/21/2024 by CEO.	
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**	Three youth records reviewed. Each record has a suicide risk screening document completed at time of intake, that is reviewed and signed by the supervisor.	
The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	**Compliance**	The program's suicide risk assessment has been 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**	Three youth records were reviewed. All youth were placed on the appropriate level of supervision.	

Staff person assigned to monitor youth maintained one-to-one supervision or constant supervision and documented his/her observations of the youth's behavior at 30 minute or less intervals	**Compliance**	Three youth records were reviewed. Each record showed staff conducted checks every ten-minutes on the observation logs along with the youth behavior and staff initials.	
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**	Three youth records were reviewed. Each record showed staff conducted checks every ten minutes on the observation logs along with the youth's behavior and staff 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**	Three youth records were reviewed. Each record showed the 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.	
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**	For the three youth records reviewed, there is a supervisor signature for each shift. Completed observation logs were maintained in the youth file for each of the youth records reviewed.	

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**	No community counseling youth identified for suicide risk during the past six months or back to the date of the last review.	
During the intake, if the appropriate staff is unavailable, youth identified for suicide risk was immediately referred by the provider and the parent/guardian is notified of the suicide risk findings disclosed and advised that an Assessment of Suicide Risk should be completed ASAP by a licensed professional.	**No eligible items for review**	No community counseling youth identified for suicide risk during the past six months or back to the date of the last review.	
Information on resources available in the community for further assessment was provided to the parent/guardian and is documented in the youth's file and signed by the parent/guardian OR a written follow-up notification was sent by certified mail if the parent/guardian was not present during the screening and was notified by telephone.	**No eligible items for review**	No community counseling youth identified for suicide risk during the past six months or back to the date of the last review.	
If the parent/guardian cannot be contacted, all efforts to contact them are documented in the case file.	**No eligible items for review**	No community counseling youth identified for suicide risk during the past six months or back to the date of the last review.	
When the screening was completed during school hours on school property, the appropriate school authorities were notified.	**No eligible items for review**	No community counseling youth identified for suicide risk during the past six months or back to the date of the last review.	
Additional Comments: **There are no additional comments for this indicator.**			

4.03 - Medications			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 4.03		**YES** If NO, explain here: The agency has a policy FLN 4.03 Medication Distribution for Non-Healthcare Staff, last reviewed on 10-21-2024 by CEO.	
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 Registered Nurse (RN) with verified credentials.	
The agency has evidence of the following for all non-nursing shelter staff designated to assist with the self-administration of medication: a. Documentation of in-person self-administration of medication distribution training provided by a Registered Nurse b. Evidence demonstrating their competency to assist with self-administration of medication distribution c. Maintenance of their annual medication training re-certification	**Compliance**	The supervisors are in compliance with training/rule/policy and authorized to distribute medications in the absence of the Registered Nurse (RN). Documentation of in-person training and evidence of demonstrating competency to assist with self-administration of medication distribution was observed in the training records. All medication trainings were current for annual recertification. During the review, the RN was on site and conducted the distribution of medication. Medication distribution was observed to the youth in shelter during the on-site review.	
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**	Staff meetings were reviewed for the following dates: 10/24/24, 9/26/24, 9/5/2024, 8/15/2024, 7/11/2024, 6/18/2024, 5/8/2024, 4/4/2024, 3/7/2024, 2/8/2024, 1/25/2024. Meetings are conducted on a monthly basis by the RN or shelter manager and address: strategies to reduce medication errors, analyze factors that contributed to medication errors and allow staff the opportunity to practice and role-play solutions, when appropriate.	
The agency has strategies implemented to ensure medications are provided within the 2-hour time frame.	**Compliance**	The agency utilizes Alexa timers to ensure medications are distributed with the 2-hour timeframe.	
All non-licensed staff members are clearly identified and designated on the staff schedule and shift change report/shift responsibility form for assisting with the self-administration of medications on each shift	**Compliance**	All non-licensed staff members designated to assist with the self-administration of medications are clearly identified on the shelter's daily shift reports prepared by the supervisors.	

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 ensures alerts are added to daily shift reports. If there is an unusual time for medications, the agency developed a sign system to place on doors and in staff locations to ensure and remind staff since it deviates from the normal morning and night routine.	
The delivery process of medications is consistent with the FNYFS Medication Management and Distribution Policy and the agency has an internal quality assurance process to include the following: a. to ensure appropriate medication management and distribution methods b. to track medication errors c. to identify systemic issues and implement mitigation strategies, as appropriate.	**Compliance**	The delivery process of medications is consistent with the FNYFS Medication Management and Distribution Policy and the agency has an internal quality assurance process to ensure appropriate medication management and distribution methods, to track medication errors, and to identify systemic issues and implement mitigation strategies, as appropriate.	
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**	Three of three reviewed youth files showed each medication was reviewed by the Registered Nurse (RN). The intake papers are also signed by the supervisor, ensuring medications forms are reviewed.	

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**	Observations confirmed all medications are stored in a Pyxis ES Medication Cabinet inaccessible to youth, the Pyxis machine is stored in accordance with guidelines in FS 499.0121 and policy section in Medication Management, oral medications are stored separately from injectable epi-pen and topical medications, medications requiring refrigeration are stored in a secure refrigerator inaccessible to youth used only for this purpose, at temperature range two to eight degrees Celsius or thirty-six to forty-six degrees Fahrenheit, narcotics and controlled medications are stored in the Pyxis ES Station, and the 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.	
Medication Distribution			

a. Agency maintains a minimum of 2 site-specific System Managers for the Pyxis ES Station b. Only designated staff delineated in User Permissions have access to secured medications, with limited access to controlled substances (narcotics) c. A Medication Distribution Log shall be used for distribution of medication by non-licensed and licensed staff d. Agency verifies medication using one of three methods listed in the FNYFS Policies & Procedures Manual e. When nurse is on duty, medication processes are ALWAYS conducted by the nurse or when the nurse is not onsite, then the designated staff who has been trained by a licensed Registered Nurse provides the medication. f. Agency does not accept youth currently prescribed injectable medications, except for epi-pens h. Non-licensed staff have received training in the use of epinephrine auto-injectors provided by a registered nurse	**Compliance**	The agency maintains a minimum of two site-specific System Managers for the Pyxis ES Station, only designated staff delineated in User Permissions have access to secured medications, with limited access to controlled substances (narcotics), and a Medication Distribution Log shall be used for distribution of medication by non-licensed and licensed staff. The agency verifies medication using one of three methods listed in the FNYFS Policies & Procedures Manual and does not accept youth currently prescribed injectable medications, except for epi-pens. 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. All non-licensed staff have received training in the use of epinephrine auto-injectors provided by a registered nurse.	
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**	Medication distribution was observed for three youth. Each youth identity was verified, along with medication and dosage, and verification that the youth and Registered Nurse initialed the Medication Administration Record (MAR).	
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**	Medication distribution was observed for three youth. Each youth identity was verified, along with medication and dosage, and verification that the youth and Registered Nurse initialed the Medication Administration Record (MAR).	
During the review period, there were no instances where youth missed their medication due to failure to open the pyxis machine.	**Compliance**	During the past six months, 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**	There was evidence of a medication error during the previous six months. The agency RN provided retraining and reviewed employee's medication distribution practices. The employee was approved for future medication administration responsibilities. The RN will review any and all medication errors.	
Medication Inventory			
a. For controlled substances, a perpetual inventory with running balances is maintained as well as a shift-to shift count verified by a witness and documented b. Over-the-counter medications that are accessed regularly and inventoried weekly c. Syringes and sharps (needles, scissors, etc.) are secured, and counted and documented weekly	**Compliance**	The agency maintained a perpetual inventory for all controlled substances with running balances as well as a shift-to shift count verified by a witness and documented. Over-the-counter medications that are accessed regularly and inventoried weekly. On-site review and count of all meds were accurate. The program does not utilize syringes and sharps on-site.	

There are monthly reviews of the Pyxis reports to monitor medication management practice.	**Compliance**	The program conducts monthly reviews of the Pyxis reports to monitor medication management practice.	
Medication discrepancies are cleared after each shift.	**Compliance**	Medication discrepancies are cleared after each shift.	
Additional Comments: **There are no additional comments for this indicator.**			
4.04 - Medical/Mental Health Alert Process			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 4.04		**YES** If NO, explain here: The agency has a policy, FLN 4.04 Medical, Mental Health And Substance Abuse Screening And Alert, last review on 10/21/24 by CEO.	
Youth with a medical, mental health, or food allergy was appropriately placed on the program's alert system	**Compliance**	Three youth records were reviewed. All youth records indicated each youth was appropriately placed on the program's alert system. This was verified by shift reports and logbook entries.	
Alert system includes precautions concerning prescribed medications, medical/mental health conditions	**Compliance**	The agency's alert system includes precautions concerning prescribed medications, medical/mental health conditions	
Staff are provided sufficient training, information and instructions to recognize/respond to the need for emergency care for medical/mental health problems	**Compliance**	Training files reviewed showed documentation that staff are provided sufficient training, information and instructions to recognize/respond to the need for emergency care for medical/mental health problems.	
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**	All alerts are reviewed daily by each shift with all staff. Alerts are prominently posted in staff central pod, medication room and kitchen areas, as well as noted on the printed shift change sheet for review by all staff on each shift.	
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 number, FLN 4.05 Episodic/Emergency Care, last reviewed on 10/21/2024 by CEO.	
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**	Two youth records were reviewed. Both records documented an incident report, verification of receipt of medical clearance, notification to the parent/guardian, and an entry was completed in the logbook.	
All staff are trained on emergency medical procedures	**Compliance**	Evidence that all staff are trained on emergency medical procedures was present in the staff training records.	
The program has a Knife-for-life and wire cutters accessible to staff in a secure location(s)	**Compliance**	First aid kits are located in the agency's two vehicles, the shelter building, kitchen, school and administration building. One knife for life kit located in the central staff pod between each wing of the shelter.	
Additional Comments: **There are no additional comments for this indicator.**			