Florida Network for Youth and Family Services
Compliance Monitoring Report for

Crosswinds Youth Services, Inc.

1407 Dixon Blvd.
Cocoa, FL 32922

October 30-31, 2024

Compliance Monitoring Services Provided by

FOREFRONT

EXECUTIVE SUMMARY

Forefront LLC conducted a Quality Improvement (QI) monitoring visit on behalf of the Florida Network of Youth and Family Services (FNYFS) for the Crosswinds Youth Services, Inc. for the FY 2024-2025 at its program office located at 1407 Dixon Blvd. Ocala, FL 32922. Forefront LLC (Forefront) is an independent compliance monitoring firm that is contracted by the FNYFS to perform onsite program reviews to assess the agency's adherence to fiscal, programmatic and overall contract requirements. Crosswinds Youth Services, Inc. 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 Shelly Gress, Jeannie Christiansen, Paulette Hinton, Belinda Ross (Peer Reviewers). Agency representatives from Crosswinds Youth Services, Inc. present for the entrance interview were: Mike Scully, Pierre Bandoo, Joan Johanesen, Cindi Lee, John Weiman, Donna Stokes, Tara Lawson, Cherish Lawson, Kathy Bailey, Violette Jean, Rikki Lea Krupezek, Karen Locke, John Pilley, Myra Peterson, Jennifer Erfurth, Jessica Picco, and Dawn Blustain. The last onsite QI visit was conducted October 11-12, 2023.

In general, the Reviewer found that Crosswinds Youth Services, Inc. is in compliance with specific contract requirements. **CROSSWINDS YOUTH SERVICES, INC. received an overall compliance rating of 100% for achieving full compliance with twelve 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 10-30-31-2024

Agency Name: Crosswinds Youth Services, Inc.	Monitor Name: Andrea Haugabook, Lead Reviewer
Contract Type : CINS/FINS	Region/Office: 1407 Dixon Boulevard Cocoa, FL 32922
Service Description: Comprehensive Onsite Compliance Monitoring	Site Visit Date(s): October 30-31, 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 agency has a total of three certified peer reviewers: Pierre Bandoo, Cindi Lee, and Jennifer Erfurth.	
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: the Florida Network of Youth and Family Services, other federal funds, United Way, fundraising, and family partnerships.	
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 proof of insurance produced by J.W. Edens and Company, Inc. The following insurers are listed as affording coverage: Wesco Insurance Company and Associated Industries Insurance Company. The coverages are all effective from 10/21/2024-10/21/2025 for the following coverages and limits. Commercial General Liability;	

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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**						$1,000,000 each occurrence, $300,000 damage to rented premises, $1,000,000 personal injury, $3,000,000 general aggregate and product aggregate; Automobile Liability with a combined single limit of $1,000,000; and worker's compensation and employee liability for each $100,000, $100,000 employee and $500,000 policy limit. The certificate of insurance lists the Florida Network of Youth and Family Servies 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 has no external corrective action plans from any other funding source.	
Fiscal Practice a. Agency must have employee and fiscal policy/procedures manuals that are in compliance with GAAP and provide sound internal controls. Agency maintains fiscal files that are audit ready. **PTV**	☐	☐	☒	☐	☐	The agency has employee and fiscal policies and procedures that are in compliance with GAAP and provide sound internal controls. Interview with the Director of Finance and the CEO reports that they meet daily to discuss the agency's financial position (i.e. census vs. expenses, budget	

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						variances, and cost containment strategies.) The agency's current fiscal files are audit ready.	
b. Agency maintains a general ledger and the corresponding source documents. A general ledger must be set up to track the activity of the grant separately (standard account numbers / separate funds for each revenue source, etc.). **PTV**	☐	☐	☒	☐	☐	The agency maintains a general ledger and corresponding source documents are uploaded to the financial system allowing the auditor immediate access to information pertaining to transactions. The general ledger is set up to track activity from the grant separately.	
c. Petty cash ledger system is balanced and all cash disbursements are compliant with financial policies and allowable under the contract. (Disbursements/invoices are approved & monitored by management.) –**ON SITE**	☐	☐	☒	☐	☐	The agency maintains a petty cash fund with a balance of $400.00, in cash and/ or receipts. At any time the total amount of cash and receipts in the box must total $400.00. The Chief Financial Officer is the designated custodian. Petty Cash purchases are those items that are normally less than $50.00 in cost and are items that are normally needed immediately. Staff will contact finance to arrange for a time to process the petty cash request. All receipts The petty cash is kept in a locked cabinet in the finance office and	

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						is reconciled by the staff account at least twice monthly.	
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 documentation provided contained 2 signatures. (Disbursements/invoices are approved & monitored by management). **ON SITE**	☐	☐	☒	☐	☐	The agency provided the most recent six months of bank statements and reconciliation reports for review. Interview with the CFO confirms reconciliation is done by the accountant before the 5th of the month then reviewed by the Director of Finance and reported to the CEO and Board. Interview with the CEO and Director of Finance (DOF) reported, the agency is laser focused on cost containment and monitoring expenses. The CFO reports to the board monthly. The agency's newly hired Director of Finance is a Certified Public Accountant and reports directly to the Board of Directors. The agency's entire management team attends board meetings regularly.	
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.	☐	☐	☐	☐	☒	The agency does not have an inventory, (including computers) over	

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In the event the provider has purchased computer equipment an Informational Resources Request (IRR) has been submitted to DJJ. **PTV/ON SITE**						$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 and proof of corresponding payment. A review of the tax reports and payments for quarters ending 03/31/2024 and 06/30/2024 was conducted and showed evidence they were prepared and managed by a third-party payroll company, Paycor. Employee IRS W-2 and 1099 forms are all produced and managed by Paycor.	
g. Budget to actual reports prepared and reviewed by appropriate management. Variance from the budget are investigated and explained. **PTV/ON SITE**	☐	☐	☒	☐	☐	The 2024-2025 year to date budget to actual report was reviewed. It is prepared by the Director of Finance and reviewed by the CEO. Variances are tracked daily and compared with the census. Daily discussion between the Director of Finance and the CEO examines and explains variances. Adjustments are made daily to account for variances. All variances are reported to the Board of Directors directly at monthly Board Meetings.	

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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**			☒			H & Co. LLP is the accounting firm hired to complete the agency's 2023 audit. The Director of Finance and CEO both reported there is constant communication with the audit team and exchange of information between the agency and the audit team to finalize the audit report. The most recent audit report for 2021 & 2022 was completed May 17, 2023 and provided for review. This report has been sent to the Florida Network of Youth and Family Services.	
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.	

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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 the most recent payroll journal to show proof of all direct care employees earning at least $19.00 per hour.	

CONCLUSION

Crosswinds Youth Services, Inc. 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 does not have any corrective actions items from external funders nor does it have any purchases (with FNYFS funds) greater than $1000, requiring inventory or IRR request. Consequently, **the overall compliance rate for this contract monitoring visit is 100%.** There are no corrective actions cited as a result of this contract monitoring visit. Overall, the provider is performing satisfactorily in meeting the fiscal and administrative terms of its contract. In addition, the majority of indicators reviewed were carried out in a manner which meets the standard described in the report findings.

SUMMARY OF RECOMMENDATIONS

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 Crosswinds Youth Services, Inc.
CINS/FINS Program

Date: October 30-31, 2024

Compliance Monitoring Services Provided by

FOREFRONT

CINS/FINS Rating Profile

Standard 1: Management Accountability

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

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

Standard 2: Intervention and Case Management

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

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

Standard 3: Shelter Care & Special Populations

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

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

Standard 4: Mental Health/Health Services

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

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

Overall Rating Summary

Percent of indicators rated Satisfactory: 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
Shelley Gress – Youth and Family Alternatives, Inc. (GWH)
Jean Christiansen-Goggin - Children's Home Society (Wavecrest)
Belinda Ross – CDS Family and Behavioral (Central)
Paulette Hilson – Orange County Youth and Family Services

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

Documents Reviewed

Accreditation Reports	Table of Organization	Visitation Logs
X Affidavit of Good Moral Character	Fire Prevention Plan	X Youth Handbook
X CCC Reports	X Grievance Process/Records	# Health Records
X Logbooks	Key Control Log	6 # MH/SA Records
Continuity of Operation Plan	X Fire Drill Log	7 # Personnel /Volunteer Records
X Contract Monitoring Reports	X Medical and Mental Health Alerts	7 # Training Records
Contract Scope of Services	X Precautionary Observation Logs	10 # Youth Records (Closed)
X Egress Plans	X Program Schedules	8 # Youth Records (Open)
X Fire Inspection Report	X List of Supplemental Contracts	# Other:
Exposure Control Plan	Vehicle Inspection Reports	

Observations During Review

Intake	X Posting of Abuse Hotline	X Staff Supervision of Youth
X Program Activities	Tool Inventory and Storage	X Facility and Grounds
Recreation	X Toxic Item Inventory & Storage	X First Aid Kit(s)
X Searches	Discharge	X Group
X Security Video Tapes	Treatment Team Meetings	X Meals
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

5 # of Youth	4 # of Direct Staff	# 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

Crosswinds Youth Services, Inc. is located at 1407 Dixon Blvd. Cocoa, Fl 32922. The program is currently accredited through the Council on Accreditation through 05/31/2027 and is licensed for 20 beds by the Department of Children and Families, through February 2025. Services provided by the program include Children In Need of Services/Families In Need of Services (CINS/FINS) shelter, Community Counseling, Domestic Violence Respite, Probation Respite, and Stop Now And Plan (SNAP). Program services are offered through groups, in homes, and the office. The program serves Circuit 18, covering all of Brevard County. The following is a list of new community partners: Eckerd Connects, Embrace Families CBC, Matthews Hope, and Merritt Island Rotary.

The agency is overseen by nine community-based volunteer board members. The day-to-day operations are run by the newly appointed CEO and CFO. The agency has restructured the agency's leadership and executive management team consisting of the COO, Compliance Director, HR team, and Program Administrator. The agency has a Registered Nurse on staff, two community counseling counselors, one part-time community counseling program assistant, one SNAP coordinator, one SNAP case manager, and the following shelter positions: one program administrator, two full-time counselors, two part-time counselors, two case managers, three youth specialist leads, fourteen part-time youth specialists, three part-time youth specialists, and one maintenance technician. There are seven vacancies: three full-time youth specialists, two part-time youth specialists, one youth specialist lead, and one part-time case manager.

The facility has undergone the following updates: Repaired/ updated the HVAC system, repaired water pipe leaks, replaced the exterior shelter door, repaired and updated the shelter shower infrastructure, repaired the eroded driveway, installed a new badge access control system facility-wide, installed exterior motion window detectors, expanded the security monitoring system inside the shelter, and installed a roof on the storage shed.

Funding updates reported include: Increased Florida Network program deliverable rates, enhanced service relationship with local CBC and updated Title IV-E Bed Rate. The agency has bought out all previous vehicle leases. The program had its 26th annual Great Brevard Duck Race in April 2024, 2024 Space Coast Derby Day in May 2024, Paint & Sip fundraiser in October 2024 and is planning a 50/50 cash raffle in the Spring of 2025 followed by the 27th annual Great Brevard Duck Race again in the Fall of 2025.

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

Standard 1: There are seven indicators for Standard 1.
Indicator 1.01 Background Screening of Employees/Volunteers was rated **Satisfactory**.
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 **Satisfactory with Exception**.
Indicator 1.05 Analyzing and Reporting Information was rated **Satisfactory**.
Indicator 1.06 Client Transportation was rated **Satisfactory.**
Indicator 1.07 Outreach Services was rated **Satisfactory.**

Standard 2: There are nine indicators for Standard 2.
Indicator 2.01 Screening and Intake was rated **Satisfactory**.
Indicator 2.02 Needs Assessment was rated **Satisfactory**.
Indicator 2.03 Case/Service Plan was rated **Satisfactory with Exception**.
Indicator 2.04 Case Management and Service Delivery was rated **Satisfactory**.
Indicator 2.05 Counseling Services was rated **Satisfactory with Exception**.
Indicator 2.06 Adjudication/Petition Process was rated **Satisfactory**.
Indicator 2.07 Youth Records was rated **Satisfactory**.
Indicator 2.08 Specialized Additional Program Services was rated **Satisfactory**.
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 with Exception.**
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 with Exception.**
Indicator 4.03 Medications was rated **Limited.**
Indicator 4.04 Medical/Mental Health Alert Process was rated **Satisfactory.**
Indicator 4.05 Episodic/Emergency Care was rated **Satisfactory with Exception**.

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

Standard 4: Indicator 4.03 Medications were rated limited due to;
a. Two non-nursing staff designated to assist with the self-administration of medication not having proof of annual recertification,
b. All sample files reviewed did not show evidence of the time of administration on the medication distribution log. The compliance administrator showed the reviewer a revised medication distribution log that will be implemented immediately,
c. The medication refrigerator did not have a thermometer upon initial inspection (a thermometer was later added by the compliance administrator) and the fridge did contain a medication filled in August 2024 for a discharged youth, and
d. The program's log book entries do not reflect the youth's medication administration in real-time.

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 FNS 1.01/ CYS 1.04 Background Screening approved by the COO on 6/24/2024.	
All positions providing direct services to youth has successfully passed pre-employment suitability assessment on the initial attempt.	**Compliance**	Seven of seven new hire files reviewed contained evidence the employee successfully passed the pre-employment suitability assessment on the initial attempt.	
For any applicant that did not pass the initial suitability assessment, there was evidence that the applicant retook the assessment and passed within five (5) business days of the initial attempt, not exceeding three (3) attempts within thirty (30) days.	**No eligible items for review**	All employee files reviewed 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**	The agency had no employees who have had a break in service for 18 months or more. The agency has used the Berke suitability assessment since 2019.	
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**	Seven of seven new hire files reviewed contained evidence the background screening was completed 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.	**Compliance**	One of one employee file reviewed showed evidence of a completed five year rescreening from the date of the last screening.	
Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?	**Compliance**	Annual Affidavit of Compliance with level 2 screening standards was emailed to BSU on January 25, 2024.	

Proof of E-Verify for all new employees obtained from the Department of Homeland Security	**Compliance**	Seven of seven new hire files reviewed contained proof of E-Verify obtained from the Department of Homeland Security.	
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, FNS 1.02 Abuse Free Environment, Abuse Report, Grievances signed by the COO July 2024.	
Agency has a code of conduct of policy and there is evidence that staff are aware of agency's code of conduct.	**Compliance**	Agency has a code of conduct policy that is given to the staff at orientation. Staff signs and acknowledgement of receipt of the code of conduct.	
The agency has a process in place for reporting and documenting child abuse hotline calls.	**Compliance**	The agency has a process in place for reporting and documenting child abuse hotline calls. There have been no calls to the child abuse hotline in the last six months.	
Youth were informed of the Abuse and Contact Number	**Compliance**	Three youth were interviewed at the shelter. All were aware of at least one poster in a common area with information for the abuse hotline and contact number. The reviewer observed posters in the dining area, halls outside youth quarters, and in the common area.	
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**	Grievances for the past six months were reviewed. All addressed the complaint and allowed the youth with the opportunity to provide feedback.	
Shelter only: Grievances are maintained on file at minimum for 1 year.	**Compliance**	Files are stored securely for at least one year in an area accessible to staff.	
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**	Three youth were interviewed at the shelter. They were all aware of the grievance forms and box. The box is located at the main desk where the youth have access in the common area.	
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**	Five randomly selected days were reviewed in the program's log book. All indicated the grievance box was checked daily, as documented in the log book.	
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**	Files for the past six months were reviewed. All were resolved within 72 hours of being submitted or there was documentation explaining the cause for the delay in providing a resolution.	

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 1.03 Incident reporting reviewed by COO July 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**	All reports from the past six months were reviewed and all were reported within the two hour period after the incident occurred or the program learned about the incident.	
The program completes follow-up communication tasks/special instructions as required by the CCC	**Compliance**	Information about follow-up actions and communication are noted on all the incident forms reviewed.	
Agency internal incidents are documented on incident reporting forms and all CCC reportable incidents were consistently reported to CCC as required.	**Compliance**	Incidents were documented properly on incident reporting forms. Reportable incidents were consistently reported to CCC as required.	
Incidents are documented in the program logs and on incident reporting forms	**Compliance**	Documentation for incidents in the log book coordinated with the information on the incident reporting forms.	
All incident reports are reviewed and signed by program supervisors/ directors	**Exception**	Thirty four files were reviewed for the six month period. The reports included: 8 Program Disruption, 3 Escape/Abscond, 5 Medical, 11 Mental Health and Substance Abuse, 0 Complaints against Staff, 8 Youth Behavior Incidents.	One signature was missing from three Crosswinds Incident reports on 8/21/2024, 7/8/2024, and 7/3/2024.
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 written policy for FNS 1.04- Training Requirements was signed by the COO August 2026.	

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 of three first year direct care staff files reviewed 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.	
All staff completed the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days from date of hire.	**Compliance**	Documentation of completed United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days of date of hire was included in the three employee files reviewed.	
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**	Documentation for staff training met the minimum requirement of 80 hours for the first full year of employment in all three files reviewed.	
All staff receives all mandatory training during the first 90 days of employment from date of hire.	**Exception**	Two of three new hire employees had all mandatory training courses completed within the 90 day period.	One of three new hires completed the following trainings (required during the first 90 days) late: Behavior Management, CPR, First Aid, CIN/ FINS Core, Crisis intervention, ACE, and Cultural Humility/ Cultural and Linguistic Diversity. These seven trainings were completed within a week after the 90 day period ended.

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**	Documentation for in-person training for medication distribution was found in each applicable employee file reviewed.	
Staff that are Utilizing NETMIS			
Any staff that is utilizing NETMIS has evidence of completing NetMIS Training in their training file.	**Compliance**	One of three employee files reviewed utilizes NETMIS. Evidence of NETMIS training was found in the employee training file reviewed.	
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).*	**No eligible items for review**	Three new hire employees are within the first year of employment and still have time to complete the CINS FINS Petition training by a DJJ attorney.	
Non-licensed Mental Health Clinical Shelter Staff (within first year of employment)			
Documentation of non-licensed mental health clinical staff person's training in Assessment of Suicide Risk form or written confirmation by a licensed mental health professional of training (includes date, signature and license number of the licensed mental health professional supervisor).	**Compliance**	Documentation of completed training for Assessment of Suicide Risk was included in the three employee training files.	
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**	Documentation for mandatory annual training, two-year refresher Florida Network, SkillPro, or other job-related trainings within the required time frame, was found in five of five employee training files reviewed.	
Community Counseling Direct Care staff completes 24 hours of mandatory refresher Florida Network, SkillPro, and job-related training annually.	**Compliance**	Documentation of 24 hours of annual refresher for Florida Network, SkillPro and job related training annually was found in the three applicable employee training files reviewed.	
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**	Documentation for program direct care staff completion of 40 hours of mandatory refresher for Florida Network, SkillPro and job related training was found in the two applicable employee training files reviewed.	
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**	A training plan was included in each employee training file reviewed.	
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**	Documentation of progress/tracking was completed by the quality improvement coordinator and routine tracking and reviews of each staff member's file is conducted to ensure compliance.	

The program maintains an individual training file or employee file AND a FLN Training Log (or similar document that includes all requirements) for each staff, which includes an annual employee training hours tracking form and related documentation, such as electronic record/transcript, training certificates, sign-in sheets, and agendas for each training attended.	**Compliance**	Each training file reviewed contained a FLN training log for each staff. Annual training hours are included on this form. Documentation such as transcripts, training certificates, sign in sheets and agendas were included in the employee files reviewed.	
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:		All staff hired since 07/01/2024 received Naloxone Training within 90 days of hire.	
Additional Comments: **There are no additional comments for this indicator.**			
1.05 - Analyzing and Reporting Information			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 1.05		**YES** If NO, explain here: The agency has a policy FNS 1.05/ CYS 1.27 Analyzing and Reporting Information, reviewed by COO April 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.)*	**Compliance**	The agency has monthly staff meetings with shelter staff and management staff. Monthly case record review reports demonstrate compliance with quarterly requirements. The shelter staff addresses all case record review reports monthly, along with other shelter issues during their meetings. The current PQI plan focuses on trends recognized through analysis of the data pulled monthly and evolves to address any issues.	
The program conducts reviews of incidents, accidents, and grievances quarterly, at a minimum	**Compliance**	Evidence of shelter staff discussing incidents, accidents, and grievances was present in monthly staff meeting minutes.	
The program conducts an annual review of customer satisfaction data	**Compliance**	The current PQI plan indicates the program will conducts an annual review of customer satisfaction data. The CEO reviews and analyzes all data on an ongoing basis.	
The program demonstrates a monthly review of the statewide End-of-Month ("EOM") report generated by the Florida Network Office. This includes monthly data, fiscal year to date data, benchmarks for residential and community counseling, screening data, report card measures, follow-up reporting measures.	**Compliance**	The program's CEO, Director of Finance and staff demonstrate monthly review of the statewide End-of-Month ("EOM") report generated by the Florida Network Office. The evaluates data daily and uses it to monitor fiscal variances and gauge cost containment. Additionally, a monthly review and evaluation of data is used to measure benchmarks for residential and community counseling, screening data, report card measures, follow-up reporting measures.	
The program has a process in place to review and improve accuracy of data entry & collection	**Compliance**	The program has a robust PQI plan in place to review and improve accuracy of data entry & collection. The CEO has adopted the responsibility of data analysis.	
There is documentation that findings are regularly reviewed by management and communicated to staff and stakeholders.	**Compliance**	There is documentation that findings are regularly reviewed by management and communicated to staff and stakeholders.	

There is evidence the program demonstrates that program performance is routinely reviewed with the Board of Directors. All final reports that include a Limited or Failed score is submitted electronically or by mail to the providers Executive Committee on the Board of Directors.	**Compliance**	Board of Director's meeting minutes demonstrate the program performance is routinely reviewed with the Board of Directors. Interview with the CEO reports all final reports are conveyed to the Board of Directors electronically.	
There is evidence that strengths and weaknesses are identified, improvements are implemented or modified, and staff are informed and involved throughout the process.	**Compliance**	Program data analysis reports, management team meetings, and shelter staff team meetings show evidence that strengths and weaknesses are identified, improvements are implemented or modified, and staff are informed and involved throughout the process.	
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 written policy procedure for indicator FNS 1.06 Client Transportation was reviewed by the COO April 2024.	
Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	**Compliance**	The written policy included information about agency drivers who are staff approved by administrative personnel to transport clients in agency vehicles.	
Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	**Compliance**	The policy states agency drivers must have a valid Florida driver's license and coverage under company insurance policy. The human resource department conducts annual license checks through the Florida Department of Motor Vehicles to ensure all agency drivers have valid driver's licenses and the agency's insurance policies show coverages for all approved agency drivers.	
Agency's Transportation policy prohibit transporting a client without maintaining at least one other passenger in the vehicle during the trip and include exceptions in the event that a 3rd party is NOT present in the vehicle while transporting	**Compliance**	The policy included requirements for maintaining at least one other passenger in a vehicle and 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 policy included procedures in the event a third party cannot be obtained for transport which states; in the event that a 3rd party cannot be obtained for transport, the agency's supervisor or managerial personnel considers the client's history, evaluation, and recent behavior. The compliance officer reported that the facility is looking into installing cameras in the agency vehicles in the future and tracking vehicles with a mobile phone app.	
The 3rd party is an approved volunteer, intern, agency staff, or other youth	**Compliance**	The policy defined who can be a third party for transportation.	
The agency demonstrated evidence via logbook or other written verification that supervisor approval was obtained prior to all single youth transports.	**Compliance**	All ten transports reviewed requiring prior approval by a supervisor were documented in the log book.	

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**	Ten of ten single transports were documented in the program's logbook as completing check-in by phone with the program supervisor. The employee check-ins were documented in the program's logbook by the manager or designee receiving the call.	
There is documentation of use of vehicle that notes name or initials of driver, date and time, mileage, number of passengers, purpose of travel and location.	**Compliance**	The program documents transportation on a log which includes: the name or initials of the driver, date, time, mileage, number of passengers, purpose of travel and location. Transportation logs were reviewed for six months, from April 2024 - October 2024, for each vehicle.	
Additional Comments: **There are no additional comments for this indicator.**			
1.07 - Outreach Services			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 1.07		**YES** If NO, explain here: The program has a policy FNS 1.07 Outreach Services reviewed January 2024 by the COO.	
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 CEO is the lead staff member designated to participate in local DJJ board, Circuit and Council meetings. The CEO serves as the secretary for the local Circuit Advisory Board and evidence of participation was observed.	
The program maintains written agreements with other community partners which include services provided and a comprehensive referral process.	**Compliance**	The program maintains written agreements with other community partners which include services provided and a comprehensive referral process. Each of the agreements are auto-renewing, however, interview with the COO reports the agency is working to re-sign each of the agreements under the signature authority of the newly appointed CEO.	
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 of each outreach event (including: the title, date, duration/hours, zip code, location description, estimated number of people reached, modality, target audience and topic) was reviewed for the past six months.	
The program has designated staff that conducts outreach which is defined in their job description.	**Compliance**	The program has several staff members (including leadership and management staff) that conduct and participate in outreach which is defined in their job description.	
Additional Comments: **There are no additional comments for this indicator.**			

2.01 - Screening and Intake			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 2.01		**YES** If NO, explain here: The agency has a policy FNS 2.01 Screening and Intake/CYS 2.02, last reviewed on 6/24/2024 by the COO.	
Shelter youth: Eligibility screening form is completed immediately for all shelter placement inquiries.	**Compliance**	Five closed residential files reviewed contained eligibility screening forms which were completed immediately.	
Community counseling: Eligibility screening form is completed within 3 business days of referral by a trained staff using the Florida Network screening form.	**Compliance**	Five community counseling files (4 open and 1 closed) were reviewed and contained completed Florida Network eligibility screening forms which were completed within three business days of referral by a trained staff.	
There is evidence all referrals for service is screened for eligibility and is logged in NetMIS within 72 hours of screening completion.	**Compliance**	Five closed residential files and five community counseling files (4 open and 1 closed) were reviewed and all files showed evidence all referrals for services were screened for eligibility and 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 youth files reviewed showed evidence youth and parents/guardians received the following in writing: a. Available service options b. 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 files reviewed showed evidence of youth and parents/guardians receiving information pertaining to: a. Possible actions occurring through involvement with CINS/FINS services (case staffing committee, CINS petition, CINS adjudication) b. Grievance procedures	
During intake, all youth were screened for suicidality and correctly assessed as required if needed.	**Compliance**	All files reviewed, five closed residential and five community counseling files (4 open and 1 closed) were screened for suicidality at intake. One applicable file was correctly assessed as required. Further assessment was not required in nine of ten files reviewed.	
Additional Comments: **There are no additional comments for this indicator.**			
2.02 - Needs Assessment			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.02		**YES** If NO, explain here: The agency has a policy FNS 2.02 Needs Assessment/CYS 2.03, last reviewed on 10/12/23 by the COO.	
Shelter Youth: NIRVANA is initiated within 72 hours of admission	**Compliance**	Five closed residential files reviewed contained proof of NIRVANA initiated within 72 hours.	

Non-Residential youth: NIRVANA is initiated at intake and completed within 2 to 3 face-to-face contacts after the initial intake **OR** updated, if most recent assessment is over 6 months old	**Compliance**	Five community counseling files (4 open and 1 closed) reviewed contained proof of NIRVANA 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**	Five closed residential files and five community counseling files (4 open and 1 closed) reviewed contained supervisor signatures on all completed NIRVANA assessments.	
(Shelter Only) NIRVANA Self-Assessment (NSR) is completed within 24 hours of youth being admitted into shelter. If unable to complete, there must be documentation in NetMIS and the youth's file explaining the barriers to completion.	**Compliance**	Five closed residential files reviewed contained NIRVANA Self-Assessments completed within 24 hours of youth being admitted into shelter.	
A NIRVANA Post-Assessment is completed at discharge for all youth who have a length of stay that is greater than 30 days.	**No eligible items for review**	There weren't any youth, in any file reviewed, who had a length of stay greater than 30 days at discharge; therefore, a Nirvana post-assessment was not needed.	
A NIRVANA Re-Assessment is completed every 90 days excluding files for youth receiving SNAP services.	**Compliance**	Two applicable community counseling youth files reviewed had a Nirvana re-assessment completed at the 30 day mark. No files were applicable for needing a NIRVANA Re-Assessment every 90 days.	
All files include the interview guide and/or printed NIRVANA.	**Compliance**	All files reviewed contained a printed NIRVANA.	
Additional Comments: **There are no additional comments for this indicator.**			
2.03 - Case/Service Plan			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 2.03		**YES** If NO, explain here: The agency has a policy, FNS 2.03 Case/Service Plan/CYS 2.04 last reviewed on 08/2024 by the COO.	
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**	Ten of ten files reviewed contained case/ service plans through NetMIS and based on information gathered during the initial screening, intake, and NIRVANA.	
Case/Service plan is developed within 7 working days of NIRVANA	**Exception**	Nine of ten youth case files reviewed contained evidence the case/ service plan was developed within seven working days of the NIRVANA.	One community counseling youth case file had a case plan that was developed within ten working days of Nirvana not the required seven working days.

Case plan/service plan includes: 1. Individualized and prioritized need(s) and goal(s) identified by the NIRVANA 2. Service type, frequency, location 3. Person(s) responsible 4. Target date(s) for completion and actual completion date(s) 5. Signature of youth, parent/guardian, counselor, and supervisor 6. Date the plan was initiated	**Compliance**	Five closed residential files and five community counseling files (four open and one closed) were reviewed. All files reviewed contained documentation of case plans including: individualized and prioritized need(s) and goal(s) identified by the NIRVANA, service type/ frequency/ location, person(s) responsible, target date(s) for completion and actual completion date(s), signature of youth/ counselor, and date the plan was initiated. Four of the five residential files reviewed and one community counseling file did not have a parent signature on the case plan. However, there was documentation in the file that parent was not available.	
Case/service plans are reviewed for progress/revised by counselor and parent (if available) every 30 days for the first three months and every 6 months after	**Compliance**	Four youth case files reviewed were applicable to have a case plan review every 30 days and each file was in compliance.	
Additional Comments: **There are no additional comments for this indicator.**			
2.04 - Case Management and Service Delivery			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.04		**YES** If NO, explain here: The agency has a policy, FNS 2.04 Case Management and Service Deliveries/CYS 2.05/CYS 2.06, last reviewed on 03/2024 by the COO.	
Counselor/Case Manager is assigned	**Compliance**	Five closed residential files and five community counseling files (four open and one closed) reviewed, all had a counselor/ case manager assigned.	
The Counselor/Case Manager completes the following as applicable: 1. Establishes referral needs and coordinates referrals to services based upon the on-going assessment of the youth's/family's problems and needs 2. Coordinates service plan implementation 3. Monitors youth's/family's progress in services 4. Provides support for families 5. Monitoring progress of court ordered youth in shelter 6. Makes referrals to the case staffing to address problems and needs of the youth/family 7. Accompanies youth and parent/guardian to court hearings and related appointments 8. Refers the youth/family for additional services when appropriate 9. Provides case monitoring and reviews court orders 10. Provides case termination notes 11. Provides follow-up after 30 days post discharge 12. Provides follow-up after 60 days post discharge	**Compliance**	The Counselor/Case Manager completed the following as applicable in each of the youth case files reviewed: 1. Established referral needs and coordinated referrals to services based upon the on-going assessment of the youth's/family's problems and needs 2. Coordinated service plan implementation 3. Monitored youth's/family's progress in services 4. Provided support for families 5. Monitored progress of court ordered youth in shelter 6. Made referrals to the case staffing to address problems and needs of the youth/family 7. Accompanied youth and parent/guardian to court hearings and related appointments 8. Referred the youth/family for additional services when appropriate 9. Provided case monitoring and reviews court orders 10. Provided case termination notes 11. Provided follow-up after 30 days post discharge 12. Provided follow-up after 60 days post discharge.	

The program maintains written agreements with other community partners that include services provided and a comprehensive referral process	**Compliance**	The agency has many written agreements with other community partners that include services provided and a comprehensive referral process. The agreements are self-renewing, however it is the agency's plan to re-sign each of the agreements with under the new CEO.	
Additional Comments: **There are no additional comments for this indicator.**			
2.05 - Counseling Services			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 2.05		**YES** If NO, explain here: The agency has a policy, FNS 2.05 Counseling Services/CYS 2.07, last reviewed on 02/16/24 by the COO.	
Shelter Program			
Shelter programs provides individual and family counseling	**Compliance**	Review of shelter schedule and interview with the staff confirm the shelter provides individual and family counseling.	
Group counseling sessions held a minimum of five days per week	**Exception**	Shelter group counseling documentation was reviewed for the past six months (April 2024 - October 2024). The documentation reviewed indicated the shelter was not consistent in holding group counseling sessions a minimum of five days per week.	The documentation reviewed indicated the shelter was not consistent in holding group counseling sessions a minimum of five days per week. A corrective action form was completed on 10/28/2024 by the program director to address the issue. The program has a plan in place to ensure groups will be conducted a minimum of five days per week and the program director will be monitoring the status per the internal plan developed.
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**	A review of the shelter group logs for the past six months, show groups are conducted by staff, youth, or guests and consist of: a clear leader, relevant topic, opportunity for youth to participate.	Eight groups were observed in the group binder that were less than 30 minutes long.
Documentation of groups must include date and time, a list of participants, length of time, and topic.	**Compliance**	Group logs observed in the binder included the 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**	Five of five community counseling files reviewed showed evidence that the program provides 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, and the local provider's counseling office. The program does not provide services 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**	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 in ten of ten youth case files reviewed.	
Maintain individual case files on all youth and adhere to all laws regarding confidentiality.	**Compliance**	Ten of ten youth files reviewed indicated the program maintains individual case files on all youth and adheres to all laws regarding confidentiality. Each case file was marked confidential.	
Case notes maintained for all counseling services provided and documents youth's progress.	**Compliance**	Case notes were maintained for all counseling services provided and documents youth's progress in each of the ten files reviewed.	
On-going internal process that ensures clinical reviews of case records and staff performance.	**Compliance**	The program has an on-going internal process that ensures clinical reviews of case records and staff performance.	
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 does not conduct intakes through virtual means.	
Additional Comments: **There are no additional comments for this indicator.**			
2.06 - Adjudication/Petition Process			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.06		**YES** If NO, explain here: The agency has a policy, FNS 2.06 Adjudication/Petition Process/CYS 2.10, last reviewed on 03/09/24 by the COO.	
Must include: a. DJJ rep. or CINS/FINS provider b. Local school district representative	**Compliance**	Three open community counseling files for case staffing were reviewed and showed evidence of DJJ representatives or CINS/ FINS provider and local school district representatives being included.	
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**	Evidence of law enforcement representative and a mental health representative in attendance at the case staffing was present in case files reviewed.	
The program has an established case staffing committee, and has regular communication with committee members	**Compliance**	The program has an established case staffing committee, and has regular communication with committee members.	
The program has an internal procedure for the case staffing process, including a schedule for committee meetings	**Compliance**	The program has an internal procedure for the case staffing process which includes a schedule for committee meetings.	

The youth and family are provided a new or revised plan for services	**Compliance**	Three of three youth case files reviewed contained evidence the youth and family are provided 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	**Compliance**	Three of three youth case files reviewed contained evidence the parent/ guardian was provided a written report within seven days of the case staffing meeting, outlining recommendations and reasons behind the recommendations.	
If applicable, the program works with the circuit court for judicial intervention for the youth/family	**Compliance**	Three of three youth case files reviewed showed evidence the program works with the circuit court for judicial intervention for the youth/family.	
Case Manager/Counselor completes a review summary prior to the court hearing	**Compliance**	Three of three youth case files reviewed contained a summary prepared by the case manager/ counselor prior to the court hearing.	
Additional Comments: **There are no additional comments for this indicator.**			
2.07 - Youth Records			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.07		**YES** If NO, explain here: The agency has a policy, FNS 2.07 Youth Records/CYS 2.07/CYS 2.09. last reviewed on 02/16/24 by the COO.	
All records are clearly marked 'confidential'.	**Compliance**	Ten of ten (residential and community counseling) files reviewed were marked "confidential."	
All records are kept in a secure room or locked in a file cabinet that is marked "confidential"	**Compliance**	During the shelter tour conducted by the compliance administrator, it was observed that records are kept in a locked room in file cabinets that are all marked "confidential" as well as there is a sign on the door that reads "confidential."	
When in transport, all records are locked in an opaque container marked "confidential"	**Compliance**	The program director of counseling services demonstrated that records are locked in a black case when in transport and is marked "confidential."	
All records are maintained in a neat and orderly manner	**Compliance**	All records reviewed (five closed residential and five community counseling, four open and one closed) are maintained in a neat and orderly manner.	

SHELTER FILES contain the following: Table of Contents that outlines documents in each section: •Screening •Informed Consent • Photograph of the youth • Shelter Intake Form • Suicide Assessment (if needed) • NIRVANA Self Report (NSR) • NIRVANA full Assessment • Plan of Service • Chronological Notes • Medication Inventory Form • Approved contact list • Copies of referrals made & Follow-Up (if needed) • Discharge summary once case is closed	**Compliance**	Five closed residential files were reviewed, there was a table of contents in each section of the youth records.	
COMMUNITY COUNSELING FILES contain the following: Table of Contents that outlines documents in each section: • Screening • Informed Consent • Community Counseling Intake Form • Suicide Assessment (if needed) • NIRVANA full Assessment • Plan of Service • Chronological case notes • Copies of referrals made & Follow-Up (if needed) • Discharge summary once the case is closed	**Compliance**	Five community counseling files (four open and one closed) were reviewed, there was a table of contents in each section of the youth records.	
All records kept electronically, are maintained securely and can be made immediately available upon request for audit purposes.	**Compliance**	All youth files are paper files, but log books are kept electronically which was made immediately available upon request.	
Records are retained for the duration of the time specified by the contract.	**Compliance**	The program director of counseling services reported that records are retained for the seven year required time span according to the Rule 64B4-9.001, F.A.C.	
Additional Comments: **There are no additional comments for this indicator.**			
2.08 - Specialized Additional Program Services			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.08		**YES** If NO, explain here: The agency has a policy, FNS 2.08/CYS 3.27, 3.31, 3.32 Specialized Additional Program Services, last reviewed by the COO.	
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 cases of staff secure youth in the past six months or back to the date of the last QI review.	

Staff Secure policy and procedure outlines the following: a. In-depth orientation on admission b. Assessment and service planning c. Enhanced supervision and security with emphasis on control and appropriate level of physical intervention d. Parental involvement e. Collaborative aftercare	**Compliance**	The agency has a Staff Secure policy and procedure which 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	
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 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 cases of staff secure youth in the past six months or back to the date of the last QI review.	
Agency provides a written report for any court proceedings regarding the youth's progress	**No eligible items for review**	The agency had no cases of staff secure youth in the past six months or back to the date of the last QI review.	
Domestic Minor Sex Trafficking (DMST)			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	**No eligible items for review**	The agency had no domestic minor sex trafficking cases in the past six months or back to the date of the last QI review.	
Agency has evidence that the FNYFS was contacted for approval prior to admission for all Domestic Minor Sex Trafficking (DMST) placements.	**No eligible items for review**	The agency had no domestic minor sex trafficking cases in the past six months or back to the date of the last QI review.	
There is evidence the youth was entered into NetMIS as a Special Populations youth at admission and a Human Trafficking Screening Tool (HTST) was completed.	**No eligible items for review**	The agency had no domestic minor sex trafficking cases in the past six months or back to the date of the last QI review.	
Services provided to these youth specifically designated services designed to serve DMST youth	**No eligible items for review**	The agency had no domestic minor sex trafficking cases in the past six months or back to the date of the last QI review.	
Did the placement of DMST youth require additional supervision for the safety of the youth or the program? If so, did the agency provide the appropriate level of supervision and safety measures?	**No eligible items for review**	The agency had no domestic minor sex trafficking cases in the past six months or back to the date of the last QI review.	

Length of Stay: a. Youth in program do not have length of stay in DMST placement that exceeds seven (7) days b. Agency has approval for stays and support beyond seven (7) days for DMST placements that are obtained on a case-by-case basis? (If applicable.)	**No eligible items for review**	The agency had no domestic minor sex trafficking cases in the past six months or back to the date of the last QI review.	
Agency has evidence that staff assigned to DMST youth under this provision are to enhance the regular services available through direct engagement in positive activities designed to encourage the youth to remain in shelter	**No eligible items for review**	The agency had no domestic minor sex trafficking cases in the past six months or back to the date of the last QI review.	
All other services provided to DMST youth are consistent with all other general CINS/FINS program requirements	**No eligible items for review**	The agency had no domestic minor sex trafficking cases in the past six months or back to the date of the last QI review.	
Domestic Violence			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	**Yes**	The agency has served domestic violence youth cases in the past six months. A sample of four domestic violence cases were reviewed.	
Youth admitted to DV Respite placement have evidence in the file of a pending DV charge	**Compliance**	Four of four youth admitted to DV respite placement have evidence of a pending DV charge in their file.	
Data entry into NetMIS within (3) business days of intake and discharge	**Compliance**	Four of four DV respite files reviewed contained evidence of data entry into NetMIS within 3 business days.	
Youth length of stay in DV Respite placement does not exceed 21 days. If more than 21 days, documentation exists in youth file of transition to CINS/FINS or Probation Respite placement, if applicable.	**Compliance**	All DV respite files reviewed did not exceed a 21 day stay.	
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**	Four of four DV respite files reviewed contained case plans with goals for aggression management, family coping skills, or other intervention designed to reduce propensity for violence in the home.	
All other services provided to Domestic Violence Respite youth are consistent with all other general CINS/FINS program requirements	**Compliance**	All files reviewed showed evidence that all other services provided to DV respite you are consistent with all other general CINS/ FINS program requirements.	
Probation Respite			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	**No eligible items for review**	The agency had no probation respite cases in the past six months or back to the date of the last review.	
All probation respite referrals are submitted to the Florida Network.	**No eligible items for review**	The agency had no probation respite cases in the past six months or back to the date of the last review.	
All Probation Respite Referral come from DJJ Probation and there is evidence that the youth is on Probation regardless of adjudication status.	**No eligible items for review**	The agency had no probation respite cases in the past six months or back to the date of the last review.	
Data entry into NetMIS and JJIS within (3) business days of intake and discharge	**No eligible items for review**	The agency had no probation respite cases in the past six months or back to the date of the last review.	

Length of stay is no more than fourteen (14) to thirty (30) days. Any placement beyond thirty (30) days contains evidence in the file that the JPO was contacted in writing to request the need of an extension no later than the 25th day the youth was admitted into the program.	**No eligible items for review**	The agency had no probation respite cases in the past six months or back to the date of the last review.	
All case management and counseling needs have been considered and addressed	**No eligible items for review**	The agency had no probation respite cases in the past six months or back to the date of the last review.	
All other services provided to Probation Respite youth are consistent with all other general CINS/FINS program requirements	**No eligible items for review**	The agency had no probation respite cases in the past six months or back to the date of the last review.	
Intensive Case Management (ICM)			
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 past six months or back to the date of the last QI review.	
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 past six months or back to the date of the last QI review.	
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 past six months or back to the date of the last QI review.	
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 past six months or back to the date of the last QI review.	
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 past six months or back to the date of the last QI review.	
For any virtual services provided, there is written documentation in the youths' file as to why virtual contact is in the best interest of the youth and family	**No eligible items for review**	The agency had no intensive case management cases in the past six months or back to the date of the last QI review.	
Family and Youth Respite Aftercare Services (FYRAC)			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	**No eligible items for review**	The agency had no family and youth respite aftercare cases in the past six months or back to the date of the last QI review.	

Youth is referred by DJJ for a domestic violence arrest on a household member, and/or the youth is on probation regardless of adjudication status and at risk of violating.	**No eligible items for review**	The agency had no family and youth respite aftercare cases in the past six months or back to the date of the last QI review.	
Agency has evidence that all FYRAC referrals have documented approval from the Florida Network office	**No eligible items for review**	The agency had no family and youth respite aftercare cases in the past six months or back to the date of the last QI review.	
Intake and initial assessment sessions meets the following criteria: a. Services shall be documented through the signature of the youth and his/her parent/guardian as well as orientation to the program which is kept in the youths file. b. The initial assessment shall be face-to-face, in person or through virtual means, to include a gathering of all family history and demographic information, as well as the development of the service plan. c. For youth on probation, a copy of the youths Community Assessment Tool (CAT) to assist with development of the family service plan.	**No eligible items for review**	The agency had no family and youth respite aftercare cases in the past six months or back to the date of the last QI review.	
Life Management Sessions meets the following criteria: a. Sessions are face-to-face, sixty (60) minutes in length and focus on strengthening the family unit b. Services are highly supportive, individualized, and flexible and require a “whole family” approach to dealing with the problems affecting the youth and family.	**No eligible items for review**	The agency had no family and youth respite aftercare cases in the past six months or back to the date of the last QI review.	
Individual Sessions: a. The program conducted sessions with the youth and family to focus on work to engage the parties and identify strengths and needs of each member that help to improve family functioning. b. Issues to be covered through each session include but are not limited to: Identifying emotional triggers; body cues; healthy coping strategies through individual, group and family counseling; understanding the cycle of violence and the physical and emotional symptoms of anger; developing safety plans; and educating families on the legal process and rights.	**No eligible items for review**	The agency had no family and youth respite aftercare cases in the past six months or back to the date of the last QI review.	
Group Sessions: a. Focus on the same issues as individual/family sessions with application to youth pulling on similar experiences with other group members with the overall goal of strengthening relationships and prevention of domestic violence. b. Shall be no more than eight (8) youth at one (1) time and shall be for a minimum of sixty (60) minutes per session	**No eligible items for review**	The agency had no family and youth respite aftercare cases in the past six months or back to the date of the last QI review.	
There is evidence of completed 30 and/or 60 day follow-ups and is documented in NetMIS following case discharge.	**No eligible items for review**	The agency had no family and youth respite aftercare cases in the past six months or back to the date of the last QI review.	

Youth and family participate in services for thirteen (13) sessions or ninety (90) consecutive days of services, or there is evidence in the youth's file that an extension is granted by DJJ circuit Probation staff	**No eligible items for review**	The agency had no family and youth respite aftercare cases in the past six months or back to the date of the last QI review.	
Any service that is offered virtually, is documented in the youth's file why it was in the youth and families best interest.	**No eligible items for review**	The agency had no family and youth respite aftercare cases in the past six months or back to the date of the last QI review.	
All data entry in NetMIS is completed within 3 business days as required.	**No eligible items for review**	The agency had no family and youth respite aftercare cases in the past six months or back to the date of the last QI review.	
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; FNS 2.09 SNAP/ CYS 6.01, 6.02, 6.04, 6.04, Stop Now And Plan Group Delivery, SNAP Program Delivery and Fidelity Adherence Monitoring, SNAP Discharge Requirements, SNAP in Schools.	
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**	Four of four (two open and two closed) youth files reviewed contained evidence youth are screened to determine eligibility of services with the required documents: a. Florida Network Youth Screening Form b. 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**	Four of four files (two open and two closed) reviewed contained each of the required documents: 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.	
The NIRVANA was completed at initial intake, or within two sessions.	**Compliance**	Evidence of a completed NIRVANA at initial intake or within two sessions was present in four of four files reviewed.	
There is evidence of the completed the Pre - Child Behavior Checklist (CBCL) by the caregiver and is located within the file.	**Compliance**	Evidence of a completed Pre - Child Behavior Checklist (CBCL) by the caregiver was observed in four of four files reviewed.	
There is evidence of the completed Pre - TOPSE is completed by the caregiver and is located within the file.	**Compliance**	Evidence of a completed Pre - TOPSE was present within four of four files reviewed.	

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**	Evidence of the following documents was observed within each of the four files reviewed: a. SNAP® Parent Goal Sheet b. Child Way To Go Goal Sheet.	
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**	Two of two closed files reviewed showed evidence of a completed Post - Child Behavior Checklist (CBCL) within the file.	
There is evidence of the completed Post - TOPSE is completed by the caregiver and is located within the file.	**Compliance**	There is evidence of the completed Post - TOPSE is completed by the caregiver and is located within the two closed files reviewed.	
There is evidence of the completed SNAP Discharge Report located within the file for any discharged youth.	**Compliance**	Evidence of a completed SNAP Discharge Report was observed in two of two files reviewed for discharged youth.	
There is evidence of the SNAP Boys/SNAP Girls Child Group Evaluation Form located in the file.	**Compliance**	There was evidence of the SNAP Boys/SNAP Girls Child Group Evaluation Forms observed in two of two closed files reviewed.	
There is evidence of the SNAP Boys/SNAP Girls Parent Group Evaluation Form located in the file.	**Compliance**	There was evidence of the SNAP Boys/SNAP Girls Parent Group Evaluation Form observed in two of two closed files reviewed.	
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 had no 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 had no 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 had no 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 had no 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 had no 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 had no 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 had no 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 had no 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**	All required weekly attendance sheets included youth names were completed with the teacher and trained SNAP Facilitator signatures for two of two completed SNAP in Schools sessions reviewed.	
The program maintained evidence of a completed 'Way to Go Goal' Sheet within the file.	**Compliance**	Evidence of a completed 'Way to Go Goal' Sheet was observed within the files for two of two completed SNAP in Schools sessions.	
The program maintained evidence of both pre AND post Measure of Classroom Environment (MoCE) completed documents for the class reviewed.	**Compliance**	The program maintained evidence in the files of both pre and post Measure of Classroom Environment (MoCE) completed documents for the class reviewed.	
The program maintained evidence of completed pre and post evaluation documents for the class reviewed.	**Compliance**	The program maintained evidence of completed pre and post evaluation documents for two of two classes 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**	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 was present in two of two SNAP in Schools sessions reviewed.	
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**	One (1) completed Fidelity Adherence Checklist per classroom for the 13-week classroom sessions was observed in each file 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, 3.06 Shelter Environment, last reviewed on April 2024 by COO.	

Facility Inspection: a. Furnishings are in good repair. b. The program is free of insect infestation. c. Bathrooms and shower areas are clean and functional, free of foul odors, leaks, dust, and mildew and in good working order. d. There is no graffiti on walls, doors, or windows. e. Lighting is adequate for tasks performed there. f. Exterior areas are free of debris; grounds are free of hazards. g. Dumpster and garbage can(s) are covered. h. All doors are secure, in and out access is limited to staff members and key control is in compliance. i. Detailed map and egress plans of the facility, general client rules, grievance forms, abuse hotline information, DJJ Incident Reporting Number and other related notices are posted. j. Interior areas (bedrooms, bathrooms, common areas) do not contain contraband and are free from hazardous unauthorized metal/foreign objects.	**Compliance**	The program has a written policy and procedures that meet the requirement for standard 3.01. The shelter tour and observation confirmed: the furnishings are in good repair, and some were painted in bright colors with various themes to reflect positivity. The bathrooms, bedroom, and interior areas of the facility did not appear to contain any contraband and were free from hazardous unauthorized metal/foreign objects. Bathrooms included two toilets, two shower stalls, and double sinks. No graffiti present on doors, walls, and windows. Lighting was adequate and in good working condition. No evidence of hazards on the grounds during the tour of the facility. The dumpster and garbage cans were covered and free of clutter behind the dumpster. The facility maintained a locked cabinet in the staff office to secure the youth's valuables such as jewels, cash, etc. Maps and egress plans are located in all dorm rooms, entrances, and common areas. Client rules and grievance forms are available and posted in the common area that is accessible to the youth. The grievance box is secure and also accessible to the youth. All reporting hotline numbers were posted throughout the facility and present in the youth handbook.	
Facility Inspection: a. All agency and staff vehicles are locked. b. Agency vehicles are equipped with major safety equipment including first aid kit, (all items in the first aid kit are current and do not have expired items; all expired items should be replaced regularly), fire extinguisher, flashlight, glass breaker and, seat belt cutter.	**Compliance**	All staff and program vehicles were locked during the inspection. The program has two 2019 Honda Odyssey vans for youth transport. Each vehicle is equipped with first aid kit with all required items, fire extinguisher with valid inspection tag, flashlight, glass breaker, and seatbelt 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 listed for use in the facility were stored behind a locked secured cabinet. The program maintained a weekly perpetual inventory of chemicals used that is consistent and accurate after each use. Weekly inventory is reviewed and consistently signed by shift lead. MSDS list of chemicals present in the chemical room and all MSDS sheet present for all chemicals used.	

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**	Inspection of the facility revealed washers and dryers were operational and free of lint and debris in the areas around them. There was a display of the DCF Child Care License dated 2/18/2024 posted in the common area. All bedrooms revealed adequate sleeping space and ample storage for personal belongings. Individual beds had clean linens with pillows and blankets/throws to complement the theme of the room. The facility maintains a locked cabinet in the staff office to secure the youth's valuables such as jewels, cash, etc.	
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 current fire inspection was conducted by the Coco Fire Department on 1/19/24 and there were no violations. All fire safety equipment that includes sprinklers, alarm system, kitchen overhead hood, and extinguishers were inspected in November 2023. Fire extinguishers in place at designated locations with valid and updated tags. Fire drill conducted within the last six months: 1st Shift: 4/30/24; 5/29/24; 6/26/24; 7/31/24; 8/29/24; 9/18/24; 10/19/24; 2nd Shift: 4/12/24; 5/12/24;5/16/24; 6/24/24; 7/31/24; 8/7/24; 9/18/24; 9/25/24; 10/22/24; 3rd Shift: 4/30/24; 5/12/24; 5/ 6/7/24; 7/4/24; 8/17/14; 9/21/24; 10/2/24; 10/2/24. Mock emergency drills: 1st Shift: 4/30/24; 5/15/24;6/03/24;7/31/24; 8/29/24; 9/18/24;10/19/24; 2nd Shift: 4/12/24; 8/7/24; 9/25/24; 3rd Shift: 4/30/24;5/12/24; 6/7/24; 7/4/24; 8/17/24; 9/21/24;10/2/24. 2 vehicles are maintained with valid first aid kits, seatbelt cutter, window punch, and fire extinguisher.	
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**	Evidence of all current inspections were displayed in the kitchen and dining area. Health inspection certificate was completed 12/21/23. Four weeks cycle menu signed by licensed dietician displayed in the dining room and common area. Refrigerator and freezer foods were properly stored and labeled with current dates. Many pantry food items were also labeled and properly stored. There was open containers of stored cereal and pasta that were not labeled. It was brought to kitchen staff's attention who provided labels immediately. Two refrigerators were inspected and maintained temperature of 38 degrees. The freezer temperature was below zero degrees. The refrigerator and freezer were clean, and items were organized. The program also maintained a binder of recorded temperatures for both appliances.	
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**	Daily program activities are posted in the common areas of the facility. The program has a seven day a week detailed structured activity schedule that includes one hour of physical activity daily. Activity schedule for the weekend included off campus church or alternate. The program also offers on-site religious faith group as an option. The program's daily schedule includes study time, homework, and quiet reading. A library/quiet area is available for the youth to engage in reading and homework to minimize distraction.	
Additional Comments: **There are no additional comments for this indicator.**			
3.02 - Program Orientation			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 3.02		**YES** If NO, explain here: The program has a policy, CYS-3.12 Orientation, last reviewed April 2024 by the COO.	
Youth received a comprehensive orientation and handbook provided within 24 hours	**Compliance**	The program has written policies and procedures that addresses the orientation process that was reviewed by the COO.	
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	**Exception**	Five residential closed files were reviewed and all indicated that all youth received orientation during the intake process. There was evidence that all youth received an orientation handbook that included the program rules, contraband items, dress code, disciplinary action, access to medical and mental health, visitation, disaster protocol, and room assignments. All youth files had the appropriate alert color-coded stickers.	One youth file had no evidence that a room was assigned to the youth during the intake/orientation process.
Documentation of each component of orientation, including orientation topics and dates of presentation, as well as signatures of the youth and staff involved is maintained in the individual youth record	**Compliance**	All five youth files reviewed had evidence of documentation that orientation was completed and signed by youth and staff during the intake process.	
Additional Comments: **There are no additional comments for this indicator.**			

3.03 - Youth Room Assignment			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 3.03		**YES** If NO, explain here: The program has a policy, CYS-3.05 Classification, last reviewed April 2024 by the COO.	
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**	The program has written policies and procedures in place that include the initial classification of youth and room assignment which was last reviewed in March 2024. A review of the five youth files provided evidence of documentation that the requirements of the indicator were met.	
An alert is immediately entered into the program's alert system when a youth is admitted with special needs and risks such as risk of suicide, mental health, substance abuse, physical health or security risk factors	**Compliance**	All five youth files reviewed had appropriate color coded alert stickers in place that identifies with the information at intake.	
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 program has written policies and procedures that addresses the Logbook: YCS 3.28 reviewed August 2024.	
Log book entries that could impact the security and safety of the youth and/or program are highlighted	**Compliance**	The program uses an electronic logbook. All logbook entries that could impact the security and safety of the youth are highlighted. The logbook is color coded in the following highlights: Blue/Intakes information, Pink/Discharge information, Yellow/Medical information, Green/self-release information, Orange/Important Transitional program.	
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**	Logbook entries were reviewed from April 2024 - October 2024. Logbook entries includes date and time, youth and staff involved, brief statement, and initials of staff making entries.	
Recording errors are struck through with a single line. The staff person must initial and date the correction. The use of whiteout and erasures is prohibited.	**Compliance**	A review of various logbook entries revealed recording of errors were stuck through or late entries with initial and date.	

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**	Logbook review had evidence that the Compliance Administrator conducts weekly review of the logbook and provides comments, findings, or trends. Compliance Administrator provides staff with positive encouragements for a job well done.	
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**	Logbook revealed that all program staff at the start of their shift documented that they reviewed the logbook for the previous two shifts or since their last log entry. Each log entry had staff initials and date.	
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**	There was evidence that program supervisors and counselors reviewed the logbook for all shifts since their last log entry with the dates reviewed.	
Logbook entries include: a. Supervision and resident counts b. Visitation and home visits	**Compliance**	Each room check documented in the logbook reflects in real time and correlates with the video surveillance system. Youth movements and counts are also documented in the logbook.	
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, 3.05 Behavior Management, last reviewed March 2024 by the COO.	
The program has a detailed written description of the BMS and it is explained during program orientation	**Compliance**	The program has written a Behavior Management policy and procedure that was reviewed March 2024.	

Behavior Management Strategies must include:			
a. BMS is designed to teach youth new behaviors and help youth understand the natural consequences for their actions b. Behavioral interventions are applied immediately, with certainty, and reflect the severity of the behavior c. BMS uses a wide variety of awards/incentives to encourage participation and completion of the program d. Appropriate consequences and sanctions are used by the program and consequences for behavior are logical and designed to promote skill-building for the youth e. Counseling, verbal intervention and de-escalation techniques are used prior to physical intervention (Only techniques approved by the Florida Network and DJJ are used if physical intervention is required) f. Only staff discipline youth. Group discipline is not imposed g. Room restriction is not used as part of the system or for youth who are physically and/or emotionally out of control h. Youth should never be denied basic rights such as meals, clothing, sleep, services, exercise, or correspondence privileges	**Compliance**	The program utilized a Behavior Management System (BMS) that includes strategies for positive behaviors and logical consequences. At intake/orientation the youth is provided with a detailed program's handbook that outlines the BMS process. The handbook includes staff's introduction "who we are and what we do", dress code, clients rights, consequences and privileges. The program provides an array of intervention strategies to promote good behaviors such as life skills group to help the youth understand natural consequences and to develop good decision-making skills. A review of the logbook and youth files showed no evidence that youth disciplined other youth nor was room restriction used as a part of the BMS for out-of-control youth.	
Program's use of the BMS			
All staff are trained in the theory and practice of administering BMS rewards and consequences	**Compliance**	The program provided evidence of staff training during the staff's orientation process. Direct care staff are trained to achieve competency in a variety of techniques such as effective praise, teaching interaction, motivation system, and problem solving. Staff must complete 40 hour to training in the BMS model.	
There is a protocol for providing feedback and evaluation of staff regarding their use of BMS rewards and consequences	**Compliance**	Youth are given point cards that they can earn or loss points for appropriate and inappropriate behaviors. Card conferences are conducted daily with each youth to provide opportunities for youth and direct care staff to discuss ways to encourage positive behaviors and address consequences.	
Supervisors are trained to monitor the use of rewards and consequences by their staff	**Compliance**	Supervisors are provided an overview of the BMS model to ensure that staff is applying appropriate intervention strategies.	
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, CYS 3.19 Staff and Youth Supervision, last reviewed by the COO July 2024.	
The program maintains minimum staffing ratios as required by Florida Administrative Code and contract. • 1 staff to 6 youth during awake hours and community activities • 1 staff to 12 youth during the sleep period	**Compliance**	The program has written policies and procedures that address staff and youth supervision. Staff schedules were reviewed for the last 6 months (April 2024 - October 2024) which indicates the program met the required minimum staff ratio standard. A review of randomly selected days (10/02/2024, 10/05/2024, 10/14/2024, 10/20/2024, and 10/27/2024) of the video system confirmed that the program complies with the requirements of the indicator.	

All shifts must always provide a minimum of two direct care staff present that have met the minimum training requirements	**Compliance**	A review of the staff schedule for the past six months (April 2024 - October 2024) showed a minimum of two direct care staff present for all shifts. The following dates reviewed in the programs logbook and video revealed at least two staff present on each shift that meets the required youth to staff ratio on each shift: 10/02/2024 (2am-4am), 10/05/2024 (4am - 6am), 10/14/2024 (1am - 3am), 10/20/2024 (3am - 6am), 10/27/2024 (3am - 4:30am).	
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 on the program list maintain eligible background screening and complete the required training in their work duties.	
The staff schedule is provided to staff or posted in a place visible to staff	**Compliance**	Facility tour revealed staff schedule was visible and posted in the staff office.	
There is a holdover or overtime rotation roster which includes the telephone numbers of staff who may be accessed when additional coverage is needed	**Compliance**	Overtime Staff list that includes their contact number is located in the staff office.	
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**	Camera system revealed that staff conducts bed checks at least every 15 minutes for the following dates: 10/2/24 (2am-4am); 10/5/24 (4am-6am); 10/14/24 (1am-3am); 10/20/24 (3am-6am); 10/27/24 (3am-4:30am). Logbook entries also revealed Compliance Administrator and/or CEO reviewed cameras weekly and provided feedback that included "good job" on bed checks.	
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, CYS 5.14 Video Surveillance, last reviewed by the COO September 2024.	

Surveillance System			
The agency, at a minimum, shall demonstrate: a. A written notice that is conspicuously posted on the premises for the purpose of security b. System can capture and retain video photographic images which must be stored for a minimum of 30 days c. System can record date, time, and location; maintain resolution that enables facial recognition d. Back-up capabilities consist of cameras' ability to operate during a power outage e. Have cameras placed in interior (e.g. intake office, counseling office, cafeteria, day room) and exterior (e.g. entrance/exit, recreation area, parking lot) general locations of the shelter where youth and staff congregate and where visitors enter and exit; to include locations where youth searches are conducted. Cameras are never placed in bathrooms or sleeping quarters. f. All cameras are visible	**Compliance**	The program has a written policy 5.14 Video Surveillance System that meets the requirements of the standard. Cameras are located in the common areas that are visible. Cameras are placed where youth congregate and where visitors enter and exit to include areas where youth searches are conducted. Cameras are not placed in any sleeping areas or in residents' and staff's restrooms. The program has a backup digital system of images that are stored for a minimum of 30 days and operates 24 hours a day 7 days a week with facial recognition, date, time, and location. A tour of the facility confirms that the video system is in operation and is accessible to the program director while they are off-site. Posting of video surveillance in operation is seen in various areas of the facility.	
A list of designated personnel who can access the video surveillance system is maintained (includes off-site capability per personnel)?	**Compliance**	The program has a list of designated personnel who are authorized to access the camera system on or off site.	
Supervisory review of video is conducted a minimum of once every 14 days and timeframes reviewed are noted in the logbook.	**Compliance**	The program Compliance Administrator and CEO conducts weekly reviews of the video footages. Documentation of the video reviewed includes date, time, and location are noted in the logbook. The program Compliance Administrator also provides regular feedback in the logbook such as "great job team" and other positive reinforcement to encourage staff support.	
The reviews assess the activities of the facility and include a review of random sample of overnight shifts	**Compliance**	The program's management staff conducts random samples of the facility to include various shifts. Evidence of the selected reviews are noted in the program logbook.	
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 provider has a process to grant third party request to review camera footage in the event of allegations of incidents or the overall program's quality improvement. Recording is available within 24-72 hours of request.	
Camera service order/requests will be made within 24 hours of discovery of camera malfunctioning or being inoperable. All efforts made to obtain repairs are documented and maintained	**Compliance**	During the program review period, all cameras viewed were operational and in good working order. The program did not provide any repair orders. In the event of camera malfunction or becoming inoperable, the program will make a service order/ request within 24 hours of discovery.	
Additional Comments: **There are no additional comments for this indicator.**			

4.01 - Healthcare Admission Screening			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 4.01		**YES** If NO, explain here: The agency has a policy, FNS 4.01 subsection CYS 3.17 Healthcare Admission Screening, last reviewed April 2024 by the COO.	
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**	Six of six closed residential youth files reviewed contained screenings which include: current medications, existing (acute and chronic) medical conditions, allergies, recent injuries or illnesses, presence of pain or other physical distress, observation for evidence of illness, injury, physical distress, difficulty moving, presence of scars, tattoos, or other skin markings, and acute health symptoms requiring quarantine or isolation. This screening was completed during the intake process for all 6 files reviewed.	
Referral and Follow-Up			
Youth with chronic medical conditions have a referral to ensure medical care (e.g. diabetes, pregnancy, seizure disorder, cardiac disorders, asthma, tuberculosis, hemophilia, head injuries, etc.)	**Compliance**	Six of six closed residential youth were screened for chronic medical conditions upon intake and none needed a referral to ensure medical care.	
When needed, the parent is involved with the coordination and scheduling of follow-up medical appointments	**No eligible items for review**	None of the youth files reviewed needed further parental involvement for scheduling and coordinating follow-up medical appointments.	
All medical referrals are documented on a daily log.	**Compliance**	The program maintains a daily log of any medical referrals. No medical referrals have been recorded in the past six months.	
The program has a thorough referral process and a mechanism for necessary follow-up medical care as required and/or needed	**Compliance**	The program has a thorough referral process and works with the parent/ guardian to coordinate necessary follow-up medical care as required and/or needed.	
Additional Comments: **There are no additional comments for this indicator.**			
4.02 - Suicide Prevention			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 4.02		**YES** If NO, explain here: The agency has a policy FNS 4.02/ CYC 4.12 Suicide Prevention, CYS 4.13 Non-Residential Suicide Risk Screening and Referral for Assessment, CYS 4.14 Suicide Prevention Plan - Identification, CYS 4.15 Suicide Prevention Plan -Risk Screening, CYS 4.16 Suicide Prevention Plan - Assessment, CYS 4.17 Suicide Prevention Plan - Suicide Precautions, CYS 4.18 Suicide Prevention Plan - Discontinuation/ Termination of Precautionary Observation, CYS 4.19 Clinical Staff Direct Supervision, last updated 2024.	

Suicide Risk Screening and Approval (*Residential and Community Counseling*)			
Suicide risk screening occurred during the initial intake and screening process. Suicide screening results reviewed and signed by the supervisor and documented in the youth's case file.	**Compliance**	Seven of seven closed youth files were reviewed, one community counseling and six residential. All files showed evidence that the suicide risk screening occurred during the initial intake and screening process. Suicide screening results were reviewed and signed by the supervisor and documented in each of the youth's case files.	
The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	**Compliance**	The program utilizes the suicide risk assessment that was created and 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**	Six closed residential files were reviewed. Of the six youth files reviewed, all youth were placed on the appropriate level of supervision based on the results of the suicide risk assessment.	
Staff person assigned to monitor youth maintained one-to-one supervision or constant supervision and documented his/her observations of the youth's behavior at 30 minute or less intervals	**Exception**	Five of five closed residential youth files reviewed showed evidence of staff maintaining one-to-one supervision or constant supervision for youth and documented his/her observations of the youth's behavior at 30 minute or less intervals.	One of six closed residential youth files reviewed did not have documentation of observation and signatures for a three hour period of time.
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**	The program uses a standalone form for their Precautionary observation: the form 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.	
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**	There was evidence found that 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 or Baker Act by local law enforcement. All six closed residential files reviewed maintained elevated supervision until a licensed mental health counselor completed an 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**	Six of six closed residential youth files reviewed contained evidence that documentation was reviewed by supervisory staff each shift. All completed logs are maintained in the youth's file.	
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.	**Exception**	One of one community counseling youth identified for suicide risk during intake was immediately assessed by a licensed professional and it was determined the youth was not at risk of self-harm or suicide at that time. Due to the assessment taking place immediately, there was no further referral needed.	One of one file reviewed did not contain evidence of efforts to notify the parent/ guardian.

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**	Youth was immediately assessed by the appropriate staff at the time of intake and there was no need for a referral.	
Information on resources available in the community for further assessment was provided to the parent/guardian and is documented in the youth's file and signed by the parent/guardian OR a written follow-up notification was sent by certified mail if the parent/guardian was not present during the screening and was notified by telephone.	**Compliance**	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.	
If the parent/guardian cannot be contacted, all efforts to contact them are documented in the case file.	**Compliance**	One of one screening reviewed showed evidence of youth completing a suicide assessment with a licensed mental health counselor and youth was determined not to be at risk of self-harm or suicide at the time of the assessment.	
When the screening was completed during school hours on school property, the appropriate school authorities were notified.	**No eligible items for review**	There were no screenings completed during school hours to review.	
Additional Comments: **There are no additional comments for this indicator.**			
4.03 - Medications			**Limited**
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 FNS 4.03/ CYS 4.06 Medication Verification at Admission and Consent, CYS 4.07 Medication Storage, Access Inventories and Disposal, and CYS 4.08 Medication Supervision and Monitoring, last review by the COO April 2024.	
The agency has a Registered Nurse (RN) and/or a Licensed Practical Nurse (LPN) that is being supervised by RN and all of their credentials have been verified.	**Compliance**	The agency has a Registered Nurse (RN) whose credentials have been verified.	
The agency has evidence of the following for all non-nursing shelter staff designated to assist with the self-administration of medication: a. Documentation of in-person self-administration of medication distribution training provided by a Registered Nurse b. Evidence demonstrating their competency to assist with self-administration of medication distribution c. Maintenance of their annual medication training re-certification	**Exception**	Evidence of documentation of in-person self-administration of medication distribution training provided by the registered nurse and evidence demonstrating their competency to assist with self-administration of medication distribution was present in the employee training files. Observation of maintenance of their annual medication training re-certification was also present for most staff on the program's medication distribution list.	Two staff on the medication distribution list have not had re-certification within the last year, one of who's last training was 2 years ago. One of the two staff had not distributed meds in over a year and is only used as a backup. The second staff member has distributed meds in the past six months and the re-certification training recently expired 10/26/2024. The compliance administrator did address this issue during the review by removing the two staff from the distribution list until training is completed.

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 meeting minutes from May 2024 - October 2024 were reviewed. The program had no medication errors. The RN would analyze factors contributing to errors, implement and role play strategies to reduce errors and allow staff to role play and practice solutions, upon the occurrence of an error.	
The agency has strategies implemented to ensure medications are provided within the 2-hour time frame.	**Compliance**	The agency has strategies in place to ensure medications are provided within the two hour time frame including notifying staff of all new medications, updating their medication board and having set medication administration times.	
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**	Evidence was observed confirming the agency clearly identifies all non-licensed staff members designated to assist with the self-administration of medications on each shift through an approved list of medication administrators that was hanging on the wall in the medication room. A review of staff schedules from April 2024 to October 2024 shows the designated non-licensed staff member responsible for assisting with the self-administration of medications on each shift.	
The agency has clear methods of communicating which youth are on medications with the times and dosage easily discernable by all staff on each shift.	**Compliance**	The agency has clear methods of communication which youth are on medications with the times and dosage easily discernable by all staff on each shift. It can be seen on the MAR of each youth for each medication.	
The delivery process of medications is consistent with the FNYFS Medication Management and Distribution Policy and the agency has an internal quality assurance process to include the following: a. to ensure appropriate medication management and distribution methods b. to track medication errors c. to identify systemic issues and implement mitigation strategies, as appropriate.	**Compliance**	A review of the agency's delivery process of medications confirms it 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. The program pulls all data, and discusses it at staff meetings, leadership meetings and board meetings to preemptively prevent medication errors.	

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**	Upon admission, the youth and parent/guardian (if available) are 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. Interviews with multiple staff including the RN, shift lead, and compliance administrator stated that the RN is pulled for the intake process when she is available to conduct assessments and gather information regarding the medication. This was seen on-site as an intake came in on day two.	
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	**Exception**	The program is compliant with all the following aspects of medication storage: a. All medications are stored in a Pyxis ES Medication Cabinet that is inaccessible to youth (when unaccompanied by authorized staff). The pyxis is located in a room that remains locked at all times, and the youth only enter with staff presence to take their meds and leave the room. 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. The program has two separate lock boxes to keep the types of medication separate, as well as storage containers to go in the refrigerator that keep the medications separated as needed. d. Narcotics and controlled medications are stored in the Pyxis ES Station. All medications are uploaded into the pyxis timely, if they are not in the pyxis they are in locked boxes that are only accessible by the staff. e. 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. The keys were located on hooks attached to the back of a filing cabinet within easy reach but out of plain view.	There was not a thermometer in the medication fridge, therefore the temperature was not able to be determined. The compliance administrator placed a thermometer in the medication fridge prior to the close of the review.

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 is compliant with each measure pertaining to medication distribution listed below: a. Agency maintains a minimum of 2 site-specific System Managers for the Pyxis ES Station - the program has 4 site administrators, the RN, the compliance coordinator, the shelter manager and an administrator as back up. b. Only designated staff delineated in User Permissions have access to secured medications, with limited access to controlled substances (narcotics). The only staff that have access to distribute medications are on the approved medication administration list. c. A Medication Distribution Log shall be used for distribution of medication by non-licensed and licensed staff. The log was seen hanging in the medication room, and the only staff that have passed medications in the last 6 months per Pyxis report reviews were staff listed on the approved log. d. Agency verifies medication using one of three methods listed in the FNYFS Policies & Procedures Manual. Most of the medications are verified by the RN when on site, however the staff have documents to show when the non-licensed staff verify the medication on the medication intake forms. 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. The nurse has a later shift specifically to administer night time medication. She is responsible for all medication passes while on site per interviews with the RN, compliance administrator and a shift lead. f. Agency does not accept youth currently prescribed injectable medications, except for epi-pens. Per interviews with the RN, compliance coordinator and the shift lead, the only injectable medication allowed are epi-pens. h. Non-licensed staff have received training in the use of epinephrine auto-injectors provided by a registered nurse. The staff training document for medication pass show that epi-pens are trained and discussed during that training. Observation of the self-administration of medication to youth, took place while on-site during the QI review.	
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	**Exception**	The medication distribution log documentation includes: evidence of youth initials that the dosage was given and evidence of staff initials that the dosage was given.	Medication distribution log documentation does not include the time of medication administration. The compliance administrator created and implemented a new MAR form for the youth that includes the time while on site. The program's logbook showed evidence of entries documenting medication distribution for all youth, collectively, at the same time but did not document individually in real-time.

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.	**Exception**	Medication Distribution Logs and logbook entries were reviewed from May 2024 to October 2024 to ensure staff provide youth with medications within one hour of scheduled time of delivery as ordered by the medication.	Due to the time of medication administration not being documented on the form, it is difficult to determine that medication is being administered within the required timeframe. Logbook entries document all youth receiving med passes at the same time. One of the youth reviewed for medication did not have staff or youth signatures noted on one of their AM medications, however the other AM medications for that same youth were administered that day. The youth care worker passing meds that day was interviewed, and they believe that the papers got stuck together and they forgot to sign that shift. It is believed that the medication was passed appropriately as the pill counts are accurate showing that a pill was administered.
During the review period, there were no instances where youth missed their medication due to failure to open the pyxis machine.	**Compliance**	During the review period, there were no instances where youth missed their medication due to failure to open the pyxis machine.	
<u>If applicable:</u> Any staff member deemed responsible for a medication error, there was evidence that the staff member received refresher training from an RN and demonstrated competency prior to being assigned future medication administration responsibilities. There is evidence that any staff member deemed responsible for 3 errors within a 1-year time frame, had their certification suspended and was not recertified until the completion of the full **in-person** medication administration training, demonstrating competency and re-certification from an RN.	**Not Applicable**	The program had no occurrences of 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**	A review of Medication Distribution logs and inventory logs for controlled substances shows a perpetual inventory with running balances is maintained as well as a shift-to shift count verified by a witness and documented. The youth's MAR form includes the shift to shift count, and the controlled medications reviewed had all counts completed shift to shift. Over-the-counter medications that are accessed regularly and inventoried weekly. The RN completes the weekly OTC inventory each Monday as reviewed in all of the medication forms reviewed. Syringes and sharps (needles, scissors, etc.) are secured, and counted and documented weekly. The sharps inventory is kept in the medication room and is up to date and accurate to what was available at the time of the audit.	
There are monthly reviews of the Pyxis reports to monitor medication management practice.	**Compliance**	Observation of the past six months of monthly reviews of the Pyxis reports indicate the program monitors medication management practice. The last 6 months reviewed, and show evidence of being pulled on the first of every month. The medication reports are documented to be discussed in the monthly leadership meetings as well as the monthly board meetings.	
Medication discrepancies are cleared after each shift.	**Compliance**	Verification of medication discrepancies being cleared after each shift was observed in the documentation reviewed. The program pulls a separate report on discrepancies, which showed all discrepancies were cleared by each shift within the last 6 months.	
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 FNS 4.04/ CYS 4.11 Medical and Mental Health Alert Processes last reviewed by the COO April 2024.	
Youth with a medical, mental health, or food allergy was appropriately placed on the program's alert system	**Compliance**	Four of four closed youth files reviewed with a medical, mental health, or food allergy was appropriately placed on the program's alert system as noted in their intake notes and on the color code in the youth's file.	
Alert system includes precautions concerning prescribed medications, medical/mental health conditions	**Compliance**	The program'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**	Evidence was present in staff training files of 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**	The program has 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. Indications of alerts were present on youth files, in staff observation areas, in medication room, and in the kitchen.	
Additional Comments: **There are no additional comments for this indicator.**			
4.05 - Episodic/Emergency Care			**Satisfactory with Exception**
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 FNS 4.05/ CYS 4.09 Episodic/ Emergency Care, last reviewed by the COO April 2024.	
Off Site Emergency Care			
a. If off-site emergency medical or dental care was provided, an incident report was submitted for the medical or dental care b. Upon youth return, there is a verification receipt of medical clearance via discharge instructions with follow-up is present in file c. Youth's parent/guardian was notified d. A daily log is maintained for emergency care provided	**Exception**	The agency maintains records: If off-site emergency medical or dental care was provided, an incident report was submitted for the medical or dental care. Upon youth return, there is a verification receipt of medical clearance via discharge instructions with follow-up is present in file. The logbook reflects emergency care provided and confirms parent/ guardian notification in four of five files reviewed.	One of five files reviewed had a record that emergency care was provided, however, there was no documentation in the logbook or client file that showed the parent was notified or addressed any needed follow up.
All staff are trained on emergency medical procedures	**Compliance**	Employee training files reviewed contained evidence of staff being trained on emergency medical procedures.	
The program has a Knife-for-life and wire cutters accessible to staff in a secure location(s)	**Compliance**	The program has a Knife-for-life and wire cutters accessible to staff in the following secure location(s): the staff control room, staff area near intake room, and kitchen. Each vehicle is equipped with first aid kits and seatbelt cutters. Narcan is kept in the administration office temporarily until the program designates a secure location in the shelter.	
Additional Comments: **There are no additional comments for this indicator.**			