Florida Network for Youth and Family Services
Compliance Monitoring Report for

Hillsborough County Children's Services Department

3110 Clay Mangum Lane
Tampa, Florida 33618

November 20-21, 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 Hillsborough County Children's Services Department (HCCS) for the FY 2024-2025 at its program office located at 3110 Clay Mangum Lane, Tampa, Florida 33618. 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. Hillsborough County Children's Services Department 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 compliance monitoring review was conducted by Keith Carr, Consultant for Forefront and assigned Peer Reviewers. Agency representatives from HCCS present for the entrance interview were Hillsborough County Government Children's Services Department included Patrick Minzie, Director; Sarah Grimmig, Residential Services Operations Manager; Kayrinah Hunter, Clinical Manager; Doris Gillette, Senior Program Coordinator; David Gray, Senior Training Specialist and additional Hillsborough County Children's Services Department staff members. The last onsite QI visit was conducted on December 13-14, 2023.

In general, the Reviewer found that the HCCS is in compliance with specific contract requirements. The Hillsborough County Children's Services Department **received an overall compliance rating of 100% for achieving full compliance on 13 applicable indicators** on the CINS/FINS Monitoring Tool. There were no recommendations or corrective actions as a result of the monitoring visit.

The following report presents the results of the in-depth evaluation of the provider's General Administrative performance, with all the 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 11-20-21-2024

Agency Name: Hillsborough County Children's Services Department	**Monitor Name: Keith Carr, Lead Reviewer**
Contract Type : CINS/FINS	**Region/Office: 3110 Clay Mangum Lane, Tampa, FL 33618**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): November 20-21-2024**

Major Programmatic Requirements	**Explain Rating**					**Ratings Based Upon:** **I = Interview** **O = Observation** **D = Documentation** **PTV = Submitted Prior To Visit** **(List Who and What)**	**Notes** **Explain Unacceptable or Conditionally Acceptable:**
	Unacceptable	**Conditionally Acceptable**	**Fully Met**	**Exceeded**	**Not Applicable**		
I. Administrative and Fiscal							
DJJ Quality Improvement Peer Reviewer a. Provider shall demonstrate that a minimum of two (2) staff members have been trained to be certified as DJJ QI Peer reviewers. The provider shall participate in a minimum of one (1) on-site quality assurance review of a similar type of program in another judicial circuit during each 12-month period of the contract, if requested.	☐	☐	☒	☐	☐	Interview: The agency exceeds the minimum of two required staff members who have been trained as Certified Quality Improvement (QI) Peer Reviewers. At the time of this onsite program review, the agency has six Certified QI Peer Reviewers; Linda Sessions, Jocie Fletcher, Doris Claude-Gillette, Kayrinah Hunter, Nasheika Martin, and Lisa Bragano.	**No recommendation or corrective action.**
Additional Contracts a. Provider shall provide a listing of all current federal, state, or local government contracts, as well as other contracts entered into with for profit and not-for-profit organizations. Such a listing shall identify the awarding entity and contract start & end dates. **PTV**	☐	☐	☒	☐	☐	Documentation: The provider reported additional funding/contracts for a broad array of services from other state and non-profit sources. Other services include FNYFS – Domestic Violence Respite Care; Children's Network of Hillsborough County – Foster Care and Related Services; National School Lunch Program – Breakfast and Lunch meals.	**No recommendation or corrective action.**

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Limits of Coverage a. Provider shall provide and maintain during this contract, the following minimum kinds of insurance: Worker's Compensation and Employer's liability insurance as required by Chapter 440, F.S. with a minimum of $100,000 per accident, $100,000 per person and $500,000 policy aggregate. Commercial General Liability with a limit of $500,000 per occurrence, and $1,000,000 policy aggregate. Automobile Liability Insurance shall be required and shall provide bodily injury and property damage liability covering the operation of all vehicles used in conjunction with performance of this contract, with a minimum limit for bodily injury of $250,000 per person; with a minimum limit for bodily injury of $500,000 per accident; with a minimum limit for property damage of $100,000 per accident and with a minimum limit for medical payments or $5,000-$10,000 per person. Florida Network is listed as payee or co-payee. **PTV**	☐	☐	☒	☐	☐	Documentation: Management Budget - Certificate of Self-Insurance. The Hillsborough County Government has elected to self-insure for General Liability, Automobile Liability, Workers' Compensation, and certain Property losses. This means that instead of purchasing commercial insurance policies, Hillsborough County has budgeted funding to pay claims and maintains sufficient reserves for future claims. General Liability coverage and Automobile Liability coverage are authorized under FS 768.28. Under this statute, the County's Tort liability sovereign immunity has been waived to the following extent: $200,000 per person and $300,000 per occurrence. Workers' Compensation coverage is authorized under FS 440.38(6) and Hillsborough County is a qualified self-insurer.	**No recommendation or corrective action.**

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						Damage and losses to County-owned vehicles, equipment, and uninsured property are paid from the self-insurance fund when properly reported and documented. Date of coverage: October 1, 2020, until canceled (continuous coverage). The Certificate of Self-Insurance letter was dated November 30, 2023.	
External/Outside Contract Compliance a. Provider has corrective action item(s) cited by an external funding source (Fiscal or Non-Fiscal). **ON SITE**	☐	☐	☒	☐	☐	Interview: During the Entrance Conference, the Agency reported no outstanding corrective action item(s) cited by an external funding source.	**No recommendation or corrective action.**
Fiscal Practice a. Agency must have employee and fiscal policy/procedures manuals that are in compliance with GAAP and provide sound internal controls. Agency maintains fiscal files that are audit ready. **PTV**	☐	☐	☒	☐	☐	Documentation: Hillsborough County Clerk of the Circuit Court, BOCC Accounting Department, dated July 2004. The agency confirmed this document is the most up-to-date policy manual. Fiscal Policies and Procedures are issued and maintained by the Accounting Department. The document contains terms, definitions, and 19 chapters.	**No recommendation or corrective action.**

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b. Agency maintains a general ledger and the corresponding source documents. A general ledger must be set up to track the activity of the grant separately (standard account numbers / separate funds for each revenue source, etc.). **PTV**	☐	☐	☒	☐	☐	Documentation: Detailed General Ledger (GL) for the current FY 2024-2025 from July 2024 – November 2024 was provided. The ledger includes financial activities for the CINS/FINS program (13316) separately. The ledger captures categories including Accounting Period; Ledger; Fund; Center; Account; Sub Account; Activity; Project; Future; Beginning Blace; Period Activity; and Ending Balance.	**No recommendation or corrective action.**
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**	☐	☐	☒	☐	☐	Documentation: The agency has a petty cash system and maintains a maximum of $250.00. The agency provided copies of Petty Cash Fund Reports for the last 6 months. A Petty Cash reconciliation was performed onsite and resulted in a balanced count of all onsite cash.	**No recommendation or corrective action.**
d. Financial records and reports are current. Includes bank statements reconciled within 6 weeks of receipt. Vendor invoices past 6 months. Invoices are submitted on a monthly basis with supporting documentation and	☐	☐	☒	☐	☐	Documentation: The agency provided financial document which included bank statements from April 2024 –	**No recommendation or corrective action.**

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documentation provided contained 2 signatures. (Disbursements/invoices are approved & monitored by management). **ON SITE**						September 2024 for agency's Wells Fargo bank account. All statements are reconciled monthly and reviewed by several staff across multiple departments.	
e. Agency maintains inventory in accordance with a written policy and FNYFS contractual requirements. If over $1,000 inventory has DJJ Property Inventory Number/Tag. In the event the provider has purchased computer equipment an Informational Resources Request (IRR) has been submitted to DJJ. **PTV/ON SITE**	☐	☐	☐	☐	☒	N/A – The agency reported it has not purchased any capital equipment items with FNYFS funds.	**No recommendation or corrective action.**
f. Agency submits payroll taxes and deposits (and retirement deposits as applicable), Employee IRS Form W-2 and Independent Contractors IRS Form 1099 forms prior to federal requirements. **ON SITE**	☐	☐	☒	☐	☐	Documentation: The agency provided copies of 941s for the second (April-June) and third (July-September) quarters of 2024 from EFTPS payroll taxes documents. Agency fourth quarter payroll taxes are scheduled to be submitted December 31, 2023. No balances were noted as due on the quarterly reports.	**No recommendation or corrective action.**

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g. Budget to actual reports prepared and reviewed by appropriate management. Variance from the budget are investigated and explained. **PTV/ON SITE**	☐	☐	☒	☐	☐	Documentation: A review of Budget versus Actuals Summary and Budget versus Actuals Detail documents for the aforementioned period was conducted. The agency provided copies of Budget versus Actuals Summary report. The report includes categories including Revenue and Expenditures; Fund; Fund Description; Character; Character Description; Current FY Budget; Commitments (Reqs); Obligations (Pos); Current FY Actuals; and Remaining Balance, as of July 2024 through November 2024. The agency also provided Budget versus Actuals – Detail Report. The categories included Revenue/Expenditure; Fund; Fund Description; Cost; Center Description; Character; Character Description; Current FY Budget; Commitments (Reqs); Obligations (Pos); Current FY Actuals; and Remaining Balance.	**No recommendation or corrective action.**

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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**	☐	☐	☒	☐	☐	Documentation: The agency provided the FNYFS a copy of the most recent electronic copy of the audit prepared by the County Finance Department and audited by RSM US LLP for the fiscal year ended September 30, 2023. The cover letter is dated June 28, 2024.	**No recommendation or corrective action.**
i. Agency maintains confidentiality policy with written policies and procedures to ensure the security and privacy of all employee and client data. Personal information is not easily accessible. Agency maintains a backup system in case of accidental loss of financial information. Security procedures are in place to protect laptops. Obsolete documents are shredded and computer hard drives are wiped prior to discarding. **ON SITE**	☐	☐	☒	☐	☐	Documentation: The agency reported no changes to the following policies and procedures: Information Management policy 1.20, effective 11/1/2019, and Storing/Disposition of Client Records, policy 4.37, effective 8/1/2018. All policies are related to the security and privacy of data and the maintenance of the backup system for data storage in case of accidental power loss.	**No recommendation or corrective action.**

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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**	☐	☐	☒	☐	☐	Documentation: The agency provided documentation of personnel action statements with information confirming the minimum salary compensation rates of direct care staff members. The documentation contains evidence that staff members are compensated at a minimum of $19 per hour.	**No recommendation or corrective action.**

CONCLUSION

The Hillsborough County Children's Services Department has met the requirements for the CINS/FINS contract as a result of full compliance with 13 applicable indicators of the Administrative and Fiscal Contract Monitoring Tool. One Administrative and Fiscal Contract Compliance Monitoring indicator is not applicable due to the agency not purchasing property with FNYFS funds. As a result, **the overall compliance rate for this contract monitoring visit is 100%.** There are no recommendations or corrective actions required as a result of the contract monitoring visit. Overall, the provider is

performing satisfactorily in meeting the fiscal and administrative terms of its contract. In addition, the majority of indicators reviewed were carried out in a manner which meets the standard described in the report findings.

SUMMARY OF CORRECTIVE ACTIONS or RECOMMENDATIONS

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 Hillsborough County Children's Services (Tampa)
CINS/FINS Program

Date: November 20-21, 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	Limited
1.07 Outreach Services	Satisfactory

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

Standard 2: Intervention and Case Management

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

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

Standard 3: Shelter Care & Special Populations

3.01 Shelter Environment	Satisfactory
3.02 Program Orientation	Satisfactory
3.03 Youth Room Assignment	Limited
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: 85.71 %
Percent of Indicators rated Limited: 14.29 %
Percent of Indicators rated Failed: 0 %

Standard 4: Mental Health/Health Services

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

Percent of Indicators rated Satisfactory: 60 %
Percent of Indicators rated Limited: 20 %
Percent of Indicators rated Failed: 20 %

Overall Rating Summary

Percent of indicators rated Satisfactory: 85.71 %
Percent of indicators rated Limited: 10.71 %
Percent of indicators rated Failed: 3.57 %

Rating Definitions

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

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

Reviewers

Members

Keith Carr- Lead Reviewer Consultant-Forefront LLC/Florida Network of Youth and Family Services
Amanda Nelson– Regional Monitor, Department of Juvenile Justice
Fern Ellenwood– Youth & Family Advocate Manager, Safe Child Coalition
Nicole Leslie – Vice President of Impact, Family Resources
Michele Almand - Quality Improvement Coordinator, Youth and Family Alternatives, Inc.

Methodology

This review was conducted in accordance with FDJJ-2000 (Quality Assurance Policy and Procedures), and focused on the areas of (1) Management Accountability, (2) Intervention and Case Management, (3) Shelter Care/Health Services, and (4) Mental Health/Health Services, which are included in the Children/Families in Need of Services (CINS/FINS) Standards (Effective July 1, 2024).

Persons Interviewed

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

Documents Reviewed

	Accreditation Reports	X	Table of Organization		Visitation Logs
X	Affidavit of Good Moral Character		Fire Prevention Plan	X	Youth Handbook
X	CCC Reports	X	Grievance Process/Records	5	# Health Records
X	Logbooks		Key Control Log	5	# MH/SA Records
	Continuity of Operation Plan	X	Fire Drill Log		# Personnel /Volunteer Records
X	Contract Monitoring Reports	X	Medical and Mental Health Alerts	9	# Training Records
X	Contract Scope of Services	X	Precautionary Observation Logs	8	# Youth Records (Closed)
X	Egress Plans	X	Program Schedules	2	# Youth Records (Open)
X	Fire Inspection Report	X	List of Supplemental Contracts	45	# Other: Outreach Entries in Netmis,
X	Exposure Control Plan	X	Vehicle Inspection Reports		DJJ Board Meeting Docs

Observations During Review

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

Surveys

4	# of Youth	18	# 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

Hillsborough County Children Services Department (HCCS) is a Hillsborough County operated human services unit of the County which delivers services to children, young adults, and families. The HCCS agency provides services that includes Children in Need of Services/Families in Need of Services (CINS/FINS); Case Management & Case Staffing; Safe Place; and Residential Group Care services in Circuit 13. The CINS/FINS program focuses on providing services to runaway, ungovernable, truant, and homeless children and their families. Further, the program offers individual, group, and family counseling services to reunite families and prevent runaway behavior, as well as short-term residential respite and shelter stays. The HCCS agency provides Emergency Shelter care which is targeted for dependent, abused, or neglected children. The agency also provides training classes for parents to improve their parenting skills. The target population served by the agency includes community youth 10-17 years of age for Residential and youth 6-17 years of age for Community-Based Counselling. The agency also provides services to special populations who meet the criteria for Staff Secure Shelter Services, Domestic Violence, Civil Citation, Probation Respite, Intensive Case Management, Domestic Minor Sex Trafficking, and youth referred by the Juvenile Justice Court System.

HCCS is currently accredited by the Council of Accreditation (COA) effective through June 2025. The agency reported that it is currently licensed until July 31, 2025, CCA Runaway/Emergency Shelter for a capacity of 10 residents. DCF currently licenses the agency as a child care facility until August 31, 2025, CCA Runaway/Emergency Shelter (CINS/FINS) for a capacity of 31 residents.

The agency reported that service delivery provisions to clients continue to be dynamic for the needs of the community. Groups are offered in the shelter and in the community. Virtual visits are offered when preferred by families and in-home services are provided for intensive case management clients. Further, the agency continues to work with the Hillsborough County Collaborative to support wrap-around services with Family Functional Therapy opportunities in the home for clients. HCCS also works with other community partners to support the stabilization of youth and families to remain together. The agency reported staff vacancies which included Residential Services Coordinator (1), Youth Care Specialist – Tier 2 (Intake Specialist) (2), Youth Care Specialist – Tier 2 (2), Youth Care Specialist (Tier1) (4), Registered Nurse (2), Case Manager – Tier 2 (1), and Treatment Counselor (1).

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

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

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

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

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

Standard 1:

Indicator 1.06 Transportation - Limited None of the reviewed single client transport events contained documentation of the staff member checking in with senior staff at arrival and departure as required by policy. An interview with the residential manager confirmed staff members are not checking in during single client transports.

Standard 3:

Indicator 3.03 Youth Room Assignment - Limited Three youth files did not list the youth room assignment as required (section left blank). All six files were missing information regarding youth's history and observations, as the youth room assignment section was blank (i.e., no checkmarks for history of violence/aggression for DV youth, or checkmarks for mental health for applicable youth).

Standard 4:

Indicator 4.02 Suicide Prevention - Limited Review of practice pertaining to Constant Sight and Sound indicates program does not consistently maintain continuous, unobstructed sight and sound on all youth placed on this supervision status. Documentation in three of five files reviewed had evidence of inconsistent or missing documentation of placing youth on and stepping down or removing youth.

Indicator 4.03 Medications - Failed The agency has not had a licensed Registered Nurse (RN) perform duties of a licensed nursing profession in over two years. The agency has continued with recruiting and interviewing nursing candidates. At the time of the onsite program review the agency is currently in process of making an offer to a prospective candidate to fill the position. The agency did not provide evidence of meeting to review medication practice, medication errors, and observations of practice. The agency Registered Nurse position is vacant. At the time of this onsite review, the agency lacks the licensed oversight of ongoing daily practice of staff members assisting in the delivery of medication to residents and overall medication screening, distribution, inventory, and storage practices.

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		**NO** If NO, explain here: . The Pre-employment Assessment policy reflects ratings of previous tool, not the internal tool currently used. The agency has a policy called Employee Screenings and Pre-Employment Assessment and was last reviewed by the Director on October 1, 2024. The agency uses titles only for policies.	
All positions providing direct services to youth has successfully passed pre-employment suitability assessment on the initial attempt.	**Compliance**	The staff member roster was reviewed and indicated one employee was eligible for the completion of a pre-employment assessment. The employee successfully completed and passed the pre-employment assessment tool prior to offer of employment.	
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**	The staff member roster was reviewed and only one employee was applicable for a suitability assessment and passed the initial assessment, so a retake was not required.	
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 program reported that it has not had any staff member re-hired in less than eighteen months or had a break in service for eighteen months or more.	
Background screening completed prior to hire/start date (or exemption obtained prior to working with youth if rated ineligible) for new hires, volunteers/interns, and contractors. *(Employees who have had a break in service and are in good standing may be reemployed with the same agency without background screening if the break is less than 90 days.)*	**Compliance**	A review of the staff member roster found five staff applicable for new hire background screening. All five staff received an eligible background screening prior to their hire date.	

Five-year re-screening is completed every 5 years from the date of the last screening for all applicable employees and volunteers.	**Compliance**	The staff member roster was reviewed and indicated two staff were eligible for a five-year re-screening during the annual compliance review period. Two eligible staff members were properly screened no more than five years from the last date of screening. Both screens resulted in approved screenings.	
Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?	**Compliance**	The Annual Affidavit of Compliance with Level 2 Screening Standards was completed and emailed to the Background Screening Unit (BSU) on January 31, 2024.	
Proof of E-Verify for all new employees obtained from the Department of Homeland Security	**Compliance**	The staff member roster was reviewed and indicated five staff were applicable for E-Verify during the annual compliance review period. All staff member files contained proof of E-Verify 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 with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 1.02		**YES** If NO, explain here: Policies were reviewed and approved by Director on October 1, 2024. Relevant Policies are named Conflict of Interest and Ethical Conduct, Reporting Criminal Behavior, Child Abuse or Neglect, and Client Grievances.	
Agency has a code of conduct of policy and there is evidence that staff are aware of agency's code of conduct.	**Compliance**	The agency has a policy and employee code of conduct which prohibits the use of physical threats, intimidation, threats, and profanity. Agency documents confirm staff files reviewed contained evidence of staff acknowledgement of the Code of Conduct.	One staff member surveyed stated they have witnessed other staff members use profanity/threats/intimidation or humiliation towards youth. This behavior is a violation of the agency's Code of Conduct and work environment communication standards.
The agency has a process in place for reporting and documenting child abuse hotline calls.	**Exception**	Agency had seven abuse calls made in the past six months. Agency's policy requires staff complete a call/online report to the Florida Abuse Hotline or assist a youth who requests to make an abuse report for any allegations of abuse/neglect. Policy also states staff will complete an incident report and notify their supervisor.	Fourteen staff were surveyed. Three staff could not articulate the process for reporting child abuse/neglect.
Youth were informed of the Abuse and Contact Number	**Compliance**	A review of eight youth records reflects abuse reporting is reviewed with youth during orientation. Three surveyed youth confirmed they are aware they have unimpeded access to call the Florida Abuse Hotline.	
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**	A review of eight youth records confirmed grievance process is reviewed with youth during orientation. Supervisor reviews grievances on a daily basis.	
Shelter only: Grievances are maintained on file at minimum for 1 year.	**Compliance**	Program maintains all grievances in a grievance file for the period of one year.	
Shelter only: There are formal grievance procedures for youth, including grievance forms, and a locked box which are easily accessible to youth in a common area.	**Compliance**	Observations during facility tour confirmed the agency has locked grievance boxes located in the common room for both the girls and boys cottages. Youth have unimpeded access to submit a grievance. Three youth were surveyed and each youth was aware of the grievance process. Grievance protocol is also reviewed during youth program orientation phase process.	
Shelter only: There is evidence that grievance boxes are checked by management or a designated supervisor at least daily (excluding weekends and holidays) and documented in the program logbook.	**Exception**	Five months of logbooks were reviewed for daily documentation of grievance box checks.	The agency is not consistently documenting daily grievance box checks in the program logbook.
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**	A review of five grievances during the annual compliance review period reflected all grievances were addressed within twenty-four hours, which exceeds the seventy-two hour requirement.	
Additional Comments: **There are no additional comments for this indicator.**			
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 Central Communications Center (CCC) Reporting. The policy meets general requirements. The policy was reviewed and approved by Director on October 1, 2024.	
During the past 6 months, the program notified the Department's CCC (Central Communication Center) no later than two hours after any reportable incident occurred or within two hours of the program learning of the incident	**Exception**	A review of the Department's Central Communications Center (CCC) program incidents for the past six months reflected program had twelve incidents reported to the CCC.	One of the reviewed CCC incidents was reported to the CCC five minutes beyond the two hour reporting timeframe.
The program completes follow-up communication tasks/special instructions as required by the CCC	**Compliance**	The agency had two incidents where follow-up was required by the Department of Juvenile Justice (DJJ) Central Communications Center (CCC). One of the two of the incidents, staff members were retrained on medication due to a staff medication error incident. The remaining incident, the staff member resigned prior to completion of the CCC investigation.	

Agency internal incidents are documented on incident reporting forms and all CCC reportable incidents were consistently reported to CCC as required.	**Compliance**	Agency internal incident forms were documented and reviewed on incident report forms. A review of eleven incident forms had a corresponding incident report.	
Incidents are documented in the program logs and on incident reporting forms	**Compliance**	Agency internal incident forms were reviewed, and were documented on incident report form. A sample of five CCC incidents were reviewed and all were documented in the program logbook as required.	
All incident reports are reviewed and signed by program supervisors/ directors	**Exception**	Agency internal incident forms were reviewed and were documented on incident report forms. A sample of five CCC incidents were reviewed and four were reviewed and signed by program supervisor.	One CCC incident did not have an incident report signed/reviewed by a supervisor.
Additional Comments: **There are no additional comments for this indicator.**			
1.04: Training Requirements (*Staff receives training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions*)			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 1.04		**YES** If NO, explain here: The agency has a policy 1.04 Required Staff Training. The policy meets general requirements. This policy was effective on 8/1/19 and revised on 7/15/24. The policy was reviewed and signed by Director 10/1/22.	
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	**Compliance**	All six of six new hire training files reviewed completed the pre-service requirements as noted that were applicable at the time of their hire. The new requirements which went into effect on July 1, 2024 were not all completed. First year staff still have time remaining to complete certain training topics prior to the end of their first year. The reviewer requested a copy of the updated pre-service checklist for the record to determine the answer to this question. The agency has a very comprehensive training regime for CINS/FINS, as well as Hillsborough County employee requirements to complete. Hillsborough County Children's Services utilizes interns to assist with much of the program requirements that do not require 1:1 contact with youths except those at Master level. Interns complete the requirements the same as paid staff. It is noted too that this program has County resources available to help them meet training demands such as Fire Safety in person.	

All staff completed the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days from date of hire.	**Compliance**	Six of six files showed compliance with the requirements of this indicator and no exceptions.	
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**	Six of six files showed compliance with the requirements of this indicator and no exceptions.	
All staff receives all mandatory training during the first 90 days of employment from date of hire.	**Compliance**	A review of the staff members files indicated six of six files showed compliance with the requirements of this indicator and no exceptions.	
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**	Only one new hire was required to take this training and did so within the allowed timeframe.	
Staff that are Utilizing NETMIS			
Any staff that is utilizing NETMIS has evidence of completing NetMIS Training in their training file.	**Compliance**	Three of six new hires were required to take Netmis training and did it within the allowed timeframe.	
Staff Participating in Case Staffing & CINS Petitions (within the first year of employment BUT no later 7/1/24 for previous staff)			
Documentation of instructor-led FL Statute 984 CINS Petition Training by a local DJJ Attorney within 1 year of employment or no later than 7/1/24 if hired before 7/1/23. (*Policy went into effect 7/1/23).*	**Compliance**	One of four required staff have taken this training. The other three are still within a year of hire. Two In-Service staff were also required to take this as an annual requirement and did so timely.	
Non-licensed Mental Health Clinical Shelter Staff (within first year of employment)			
Documentation of non-licensed mental health clinical staff person's training in Assessment of Suicide Risk form or written confirmation by a licensed mental health professional of training (includes date, signature and license number of the licensed mental health professional supervisor).	**No eligible items for review**	No unlicensed staff are completing Suicide Assessments. Only licensed staff are allowed to complete suicide assessments.	
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**	All three in-service files reviewed showed that all required SkillPro, Bridge and other required trainings required were completed timely.	
Community Counseling Direct Care staff completes 24 hours of mandatory refresher Florida Network, SkillPro, and job-related training annually.	**Compliance**	All three in-service files reviewed showed that all required trainings were completed within the annual employment anniversary date timeframe.	
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**	All three in-service files reviewed showed that all required trainings were completed and met the 40 hours of annual training within the timeframe.	
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**	All training files provided for this review were hired prior to July 1, 2024. The training plans for each of those files had all required trainings listed. A new training plan for the 24/25 fiscal year was requested to insure that the new training requirements are being met.	
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**	Clear evidence of the tracking system and reviews was seen in staff member training files. The agency has a dedicated staff member which oversees the training calendar and delivery of trainings on an annual basis.	
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 staff member has a training file and the Excel log which captures and tracks the training topic, hours and all related certificates and other documents which verify the completed training course(s).	
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:		Five of six new hire files were reviewed. Only one did not complete Naloxone training yet but was hired 5/20/24, so they have time to complete it and still meet this requirement.	
Additional Comments: **There are no additional comments for this indicator.**			
1.05 - Analyzing and Reporting Information			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 1.05		**YES** If NO, explain here: The agency has a policy called Quality Improvement. The policy meets all general requirements. The policy was reviewed and approved by Director on October 1, 2024.	
Case record review reports demonstrate reviews are conducted quarterly, at a minimum. *(A summary report of case record reviews, identifying compliance with the CINS/FINS requirements, which is reviewed by management and communicated with staff on a quarterly basis at minimum.)*	**Compliance**	Program completes quarterly case record reviews. A review of six months of quarterly case record reviews confirms this practice. Case record report addresses compliance with all CINS/FINS requirements and is reviewed during the monthly management and staff meetings.	
The program conducts reviews of incidents, accidents, and grievances quarterly, at a minimum	**Compliance**	The agency reviews all incidents, accidents, and grievances monthly during management meetings.	
The program conducts an annual review of customer satisfaction data	**Compliance**	A review of November 14, 2024 staff meeting minutes confirmed customer satisfaction data was discussed.	
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**	A review of all End-of-Month reports confirmed information is being reviewed by management and staff.	

The program has a process in place to review and improve accuracy of data entry & collection	**Compliance**	The program has monthly reviews for data collection and entry. The agency disseminates this information with staff during monthly meetings.	
There is documentation that findings are regularly reviewed by management and communicated to staff and stakeholders.	**Compliance**	A review of six months of monthly staff and management meeting minutes confirms quality improvement and data findings are being communicated to staff.	
There is evidence the program demonstrates that program performance is routinely reviewed with the Board of Directors. All final reports that include a Limited or Failed score is submitted electronically or by mail to the providers Executive Committee on the Board of Directors.	**Exception**	The agency reviews all Quality Improvement and Compliance Monitoring reports with Children Services Department leadership staff.	The agency does not have proof that it has provided a copy of the final report to the Board of Directors. An interview with agency director and a review of meeting note documentation confirmed director notifies a representative of the Board of Directors verbally when a final report includes any Limited or Failed scores.
There is evidence that strengths and weaknesses are identified, improvements are implemented or modified, and staff are informed and involved throughout the process.	**Compliance**	Agency staff share strengths and weaknesses with staff members and supervisors through email and monthly meetings. Coaching sessions are held with staff members when needed.	
Additional Comments: **There are no additional comments for this indicator.**			
1.06: Client Transportation			**Limited**
Provider has a written policy and procedure that meets the requirement for Indicator 1.06		**YES** If NO, explain here: The agency has a policy called Transporting Clients and Use of Vehicles for County Business. The policies were reviewed and approved by director on October 1, 2024.	
Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	**Compliance**	The agency has eighteen staff approved to transport clients. A review of the approved driver's list confirmed all eighteen staff were listed on the approved driver's list.	
Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	**Compliance**	A review of the agency's approved driver's list reflected eighteen staff are approved to transport clients. All eighteen staff had valid diver's licenses which were checked on November 7, 2024. All staff members are covered under the Hillsborough County Board of County Commissioner policy.	

Agency's Transportation policy prohibit transporting a client without maintaining at least one other passenger in the vehicle during the trip and include exceptions in the event that a 3rd party is NOT present in the vehicle while transporting	**Compliance**	The agency's policy supports Florida Network policy which requires a limitation on single transports. The agency policy includes provisions which require a third party participant in transportation events and exception when a third party is not present. The agency has a policy which does include a pre-approval request be made prior to the transport and regular check-ins during the transportation event.	
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**	Agency policy requires supervisory personnel consider the client's history, evaluation, and recent behavior when deciding to approve a single client transport.	
The 3rd party is an approved volunteer, intern, agency staff, or other youth	**Compliance**	Agency policy requires that all 3rd party present during transport be an approved volunteer, intern, agency employee, or other youth.	
The agency demonstrated evidence via logbook or other written verification that supervisor approval was obtained prior to all single youth transports.	**Exception**	A sample of 10 single client transport events over the last six months were reviewed. All ten reviewed transport events were approved by the supervisor prior to the youth being transported.	None of the reviewed single client transport events contained documentation of the staff member checking in with senior staff at arrival and departure as required by policy. An interview with the residential manager confirmed staff members are not checking in during single client transports.
There is documentation of use of vehicle that notes name or initials of driver, date and time, mileage, number of passengers, purpose of travel and location.	**Compliance**	A review of ten authorizations for off-campus activities forms and vehicle logs confirmed all transport events document the name of the driver, date and time of transport, mileage, number of passengers, and purpose and location of travel.	
Additional Comments: **There are no additional comments for this indicator.**			
1.07 - Outreach Services			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 1.07		**YES** If NO, explain here: The agency has a policy 1.07 Community Outreach and Partnerships. The policy meets general requirements. The policy was reviewed and approved by the , 5/23/24.	
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 operations manager typically attends all DJJ Circuit meetings and also serves on the board. All four meetings held in 2024 were attended by staff with the evidence of attendance provided.	

The program maintains written agreements with other community partners which include services provided and a comprehensive referral process.	**Compliance**	There are two Memorandums of Understanding (MOU). There is one for internship relationship and one for Project LINK. The referrals are given to providers/guardians only with a Release of Information signed by the guardian.	
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.	**Exception**	The agency enters all Outreach events entered into Netmis. The agency provided Netmis entries from January 2024 to November 2024 (present). A total of 45 events are documented.	A total of four out of 45 entries did not have the 'Location' and 11 out of the 45 did not have the 'Staff Present' data.
The program has designated staff that conducts outreach which is defined in their job description.	**Compliance**	The agency has an identified staff member assigned to perform Outreach Services. The Community Relations staff member is designated to do outreach on behalf of the agency. This position lists outreach duties in the position description.	
Additional Comments: **There are no additional comments for this indicator.**			
2.01 - Screening and Intake			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 2.01		**YES** If NO, explain here: The agency has a policy titled Screening and Eligibility which was last revised on 5.31.2024. The policy meets general requirements. The policy was reviewed and approved by the Children's Services Director.	
Shelter youth: Eligibility screening form is completed immediately for all shelter placement inquiries.	**Compliance**	A total of five randomly selected shelter files were reviewed to assess the agency's adherence to the requirements of this indicator. All five files reviewed followed requirements as evidenced by a completed eligibility screening immediately for all shelter placement inquiries.	
Community counseling: Eligibility screening form is completed within 3 business days of referral by a trained staff using the Florida Network screening form.	**Compliance**	A total of five randomly selected community counseling files were reviewed to assess the agency's adherence tot he requirements of this indicator. Four out of the five files reviewed followed requirements as evidenced by a completed eligibility screening within three business days of referral. One file had a referral on April 9th, but the screening was not completed until April 19th. There are notes to indicate that a call was made to the family on April 11th with a voice mail left. A second call was made four days later on April 15th with a voicemail left. The third call was made another 4 days later, on April 19th, which resulted in the screening being completed.	
There is evidence all referrals for service is screened for eligibility and is logged in NetMIS within 72 hours of screening completion.	**Compliance**	Review of NetMIS data entry timeframes confirmed that all screenings and referrals were logged in NetMIS within 72 hours of screening completion.	

Youth and parents/guardians receive the following in writing: a. Available service options b. Rights and responsibilities of youth and parents/guardians	**Compliance**	All 10 files reviewed had evidence of youth and parent/guardian receiving available service options and rights and responsibilities of youth and parent/guardian.	
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 10 files reviewed had evidence of the youth and parent/guardians being provided this required information.	
During intake, all youth were screened for suicidality and correctly assessed as required if needed.	**Exception**	During intake, 10 youth files reviewed were screened for suicidality. Ten out of ten were asked all five suicide risk questions as required. Nine out of nine contained evidence correctly administered assessment.	One community counseling youth was screened for suicidality with a positive risk assessment, but was not correctly assessed. Youth was being seen virtually and a full suicide assessment was not completed. Staff interview resulted in staff stating they were not aware that the agency's CSSRS (Columbia-Suicide Severity Rating Scale) assessment tool was not a full assessment. However, other positive risk screenings did show full assessments.
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		**NO** If NO, explain here: The policy has outdated language: references 15-calendar days of prepopulating of NIRVANA for youth who transfer between programs but FN policy, which was updated on 7.1.2024, references 30-calendar days of prepopulating of NIRVANA for youth who transfer between programs. The agency has a policy titled "Needs Assessments. The policy was last revised on September 12, 2024. The policy was approved by the Children's Services Director.	
Shelter Youth: NIRVANA is initiated within 72 hours of admission	**Compliance**	All five shelter files reviewed had an initiated NIRVANA within 72 hours of admission.	
Non-Residential youth: NIRVANA is initiated at intake and completed within 2 to 3 face-to-face contacts after the initial intake **OR** updated, if most recent assessment is over 6 months old	**Compliance**	All five community counseling files reviewed had an initiated NIRVANA at intake and a completed assessment 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**	All 10 files reviewed had evidence of supervisor signature on completed NIRVANA assignments.	
(Shelter Only) NIRVANA Self-Assessment (NSR) is completed within 24 hours of youth being admitted into shelter. If unable to complete, there must be documentation in NetMIS and the youth's file explaining the barriers to completion.	**Compliance**	All five shelter files reviewed had a completed NIRVANA Self-Assessment (NSR) 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.	**Compliance**	All shelter files reviewed had a stay less than 30 days and therefore were not eligible for post-NIRVANA. However, three community counseling files reviewed were open for greater than 30 days and all three had a post-NIRVANA present in the file.	
A NIRVANA Re-Assessment is completed every 90 days excluding files for youth receiving SNAP services.	**No eligible items for review**	All files reviewed for both shelter and community counseling did not have a stay greater than 90 days and therefore did not need a re-assessment.	
All files include the interview guide and/or printed NIRVANA.	**Compliance**	All 10 files reviewed contained printed copies of a completed 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 uses titles only for policies. The agency has a policy titled Service Plans. The policy meets general requirements. The policy was last reviewed and approved by the Children's Services Director on September 12, 2024.	
The case/service plan is developed on a local provider-approved form or through NETMIS and is based on information gathered during the initial screening, intake, and NIRVANA.	**Compliance**	All 10 files reviewed, for both shelter and community counseling, contained service plans. All plans reviewed had information that was gathered during screening, intake and NIRVANA.	
Case/Service plan is developed within 7 working days of NIRVANA	**Compliance**	All files reviewed for both shelter and community counseling had service plans that were developed within seven working days of intake (shelter) and of the NIRVANA initiation (community counseling).	

Case plan/service plan includes: 1. Individualized and prioritized need(s) and goal(s) identified by the NIRVANA 2. Service type, frequency, location 3. Person(s) responsible 4. Target date(s) for completion and actual completion date(s) 5. Signature of youth, parent/guardian, counselor, and supervisor 6. Date the plan was initiated	**Exception**	All files (10/10) reviewed had case plans with individualized needs and goals. All plans had service type, frequency, location, persons responsible and target dates for completion. Signatures of youth and counselor were present on all files.	Two out of the 10 files were missing actual completion dates on service plans (1 shelter, 1 community counseling), Two out of 10 shelter files were also missing the parent/guardian signature on initial service plan, and one shelter service plan was missing a supervisor's signature. One community counseling file had an initial treatment plan (8.14.24) that was not signed by the youth or counselor until 3 months later, (11.17.24) after the date of discharge (discharge was 11.13.24). The 30-day review for this client was not signed by anyone, and the 60-day and 90-day reviews were all signed on 11.15.24, two days after discharge. There was a note in the file on 11.15.24 stating that all pending documentation was sent electronically to the mother to sign. Interview with counselor resulted in staff recalling that there were issues with getting the paperwork signed due to this being a virtual case.
Case/service plans are reviewed for progress/revised by counselor and parent (if available) every 30 days for the first three months and every 6 months after	**Exception**	None of the shelter files reviewed had a length of stay that was greater than 30 days and therefore did not require service plan reviews. Of the community counseling files reviewed, there were inconsistent 30 day reviews.	See above for issues noted with inconsistent case reviews in community counseling files, especially for virtual cases. No evidence of the Parent's signature documented in three case files.
Additional Comments: **There are no additional comments for this indicator.**			
2.04 - Case Management and Service Delivery			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.04		**YES** If NO, explain here: The agency has a policy titled Case Management and Service Delivery. The policy meets general requirements. The policy was reviewed and approved on September 12, 2024 by the Children's Services Director.	
Counselor/Case Manager is assigned	**Compliance**	All client files reviewed (10/10) had evidence that a case manager/counselor was assigned to work with the youth.	

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**	All files reviewed (10/10) had evidence that the counselor/case manager completed all requirements as applicable. One youth had a court hearing while at shelter, but staff members reported that shelter staff members do not transport to court, therefore the hearings are virtual accommodate this. Staff members assist resident with access to virtual court services since they do not transport youth the court. Staff members provide assistance to parents to help them with court-related issues as needed.	
The program maintains written agreements with other community partners that include services provided and a comprehensive referral process	**Compliance**	Staff members reported they refer to other community agencies as needed, but do not have any written agreements. There are two Memorandums of Understanding (MOU) with local agencies.	
Additional Comments: **There are no additional comments for this indicator.**			
2.05 - Counseling Services			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.05		**YES** If NO, explain here: The agency has a policy titled individual, Group, and Family Counseling. The policy meets genera requirements. The policy was last reviewed and approved September 12, 2024 by the Children's Services Director.	
Shelter Program			
Shelter programs provides individual and family counseling	**Compliance**	A total of five out of five shelter files reviewed contained case notes that demonstrated both individual and family counseling occurred for youth throughout their shelter stay.	
Group counseling sessions held a minimum of five days per week	**Compliance**	A review of the groups binder activities completed over the last 6 months was conducted. Groups are occurring a minimum of five days each week, often exceeding this with six or seven days of groups being offered.	

Groups are conducted by staff, youth, or guests and group counseling sessions consist of : 1. A clear leader or facilitator 2.Relevant topic - educational/informational or developmental 3. Opportunity for youth to participate 4. 30 minutes or longer	**Compliance**	All groups were conducted by staff and had a clear facilitator, relevant topic (educational/informational or developmental), opportunity for youth to participate, and were a minimum of 30 minutes.	
Documentation of groups must include date and time, a list of participants, length of time, and topic.	**Compliance**	All group documentation included a date, 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**	The agency's Community Counseling program provide services both in the office and virtually. When virtual services are provided, a justification reason why was documented (family requested). One case did state the reason why virtual services were requested was because they were "FYRAC". Interview with staff resulted in confirmation that all FYRAC cases are not automatically virtual, rather, most prefer this means for their convenience.	
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**	Reviewed interdisciplinary team notes, which meets every other week. These notes, along with case file review, demonstrated evidence that the program completes both a review of case files and documentation for ongoing case coordination.	
Maintain individual case files on all youth and adhere to all laws regarding confidentiality.	**Compliance**	All youth reviewed had individual case files, were assigned ID numbers based on NetMIS entry, and adhered to confidentiality requirements.	
Case notes maintained for all counseling services provided and documents youth's progress.	**Compliance**	All client file case notes were detailed and described ongoing support and engagement of both the youth and their parent/guardian.	
On-going internal process that ensures clinical reviews of case records and staff performance.	**Compliance**	All client files had evidence of clinical reviews as noted by supervisory signatures on documentation and interdisciplinary team notes.	
When an intake is conducted through virtual means, consent is confirmed by the counselor, documented in the file, and reviewed with the supervisor during supervision/case review. There is written documentation provided in the youths file for reasons why virtual sessions are in the best interest of the youth and family.	**Compliance**	All shelter intakes occurred in person. Community Counseling utilizes virtual means more often, and consent for this form of service is signed by the parent/guardian and reason why this is in the best interest of the youth and family is documented in the file.	
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 titled Case Staffing Adjudication/Petitions. The policy was The policy was which was last revised on September 12, 2024 and was approved by the Children's Services Director.	
Must include: a. DJJ rep. or CINS/FINS provider b. Local school district representative	**Compliance**	Staffings were held for both Hillsborough County youth and other local outside agency youth. All staffings had evidence of the DJJ representative, Hillsborough County CINS/FINS provider, and Hillsborough County school district representative being present.	
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**	Other local system agency members were present at various staffings, including youth and/or parent/guardian, law enforcement representative, and mental health representative.	
The program has an established case staffing committee, and has regular communication with committee members	**Compliance**	The agency clearly has established case staffing committee and regular communication with committee members as evidenced by email and letter reviews and case notes.	
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 included reviewing the committee meeting schedule and evidence of unscheduled staffings occurring soon after a request for one was made.	
The youth and family are provided a new or revised plan for services	**Compliance**	New and revised case plans were reviewed for two cases for youth and families who had case staffings during the review period.	

Written report is provided to the parent/guardian within 7 days of the case staffing meeting, outlining recommendations and reasons behind the recommendations	**Compliance**	Written reports were provided to every parent/guardian within seven days of the case staffing meetings that occurred during this review period.	
If applicable, the program works with the circuit court for judicial intervention for the youth/family	**No eligible items for review**	The agency had no cases which met adjudication or petition requirements during this review period.	
Case Manager/Counselor completes a review summary prior to the court hearing	**No eligible items for review**	The agency had no cases which met adjudication or petition requirements during this review period.	
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 titled Client Records and Confidentiality. The policy meets the general requirements. The policy was reviewed on April 12, 2024 and was approved by the Children's Services Director.	
All records are clearly marked 'confidential'.	**Compliance**	All ten files reviewed for both shelter and community counseling were clearly marked as confidential.	
All records are kept in a secure room or locked in a file cabinet that is marked "confidential"	**Compliance**	All client files, ten out of ten, are kept in a secure room.	
When in transport, all records are locked in an opaque container marked "confidential"	**Compliance**	Client files are rarely transported, but if needed they are transported in a locked box and marked "confidential".	
All records are maintained in a neat and orderly manner	**Compliance**	A total of ten out of ten client files reviewed were maintained in a neat and orderly manner.	
SHELTER FILES contain the following: Table of Contents that outlines documents in each section: •Screening •Informed Consent • Photograph of the youth • Shelter Intake Form • Suicide Assessment (if needed) • NIRVANA Self Report (NSR) • NIRVANA full Assessment • Plan of Service • Chronological Notes • Medication Inventory Form • Approved contact list • Copies of referrals made & Follow-Up (if needed) • Discharge summary once case is closed	**Compliance**	All shelter files contained a table of contents that outlines required documents in each section.	

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**	A total of five out of five community counseling files reviewed contained a table of contents that outlines required documents in each section.	
All records kept electronically, are maintained securely and can be made immediately available upon request for audit purposes.	**Compliance**	All electronic records (community counseling virtual cases) were securely maintained and were made available upon request for this review.	
Records are retained for the duration of the time specified by the contract.	**Compliance**	All client records are retained for the time frame specified by the contract.	
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 titled Specialized Population Services. The policy meets the general requirements. The policy was last reviewed and approved on September 12, 2024 by the Children's Services Director.	
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 which met staff secure requirements during the last 6 months.	
Staff Secure policy and procedure outlines the following: a. In-depth orientation on admission b. Assessment and service planning c. Enhanced supervision and security with emphasis on control and appropriate level of physical intervention d. Parental involvement e. Collaborative aftercare	**No eligible items for review**	The agency had no cases which met staff secure requirements during the last six months.	
Program only accept youth that meet legal requirements of F.S. 984 for being formally court ordered in to Staff Secure Services	**No eligible items for review**	The agency had no cases which met staff secure requirements during the last 6 months.	

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 which met staff secure requirements during the last 6 months.	
Agency provides a written report for any court proceedings regarding the youth's progress	**No eligible items for review**	The agency had no cases which met staff secure requirements during the last six months.	
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 cases which met Domestic Minor Sex Trafficking requirements during the last six months.	
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 cases which met Domestic Minor Sex Trafficking requirements during the last six months.	
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 cases which met Domestic Minor Sex Trafficking requirements during the last six months.	
Services provided to these youth specifically designated services designed to serve DMST youth	**No eligible items for review**	The agency had no cases which met Domestic Minor Sex Trafficking requirements during the last six months.	
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 cases which met Domestic Minor Sex Trafficking requirements during the last six months.	
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 cases which met Domestic Minor Sex Trafficking requirements during the last six months.	
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 cases which met Domestic Minor Sex Trafficking requirements during the last six months.	
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 cases which met Domestic Minor Sex Trafficking requirements during the last six months.	
Domestic Violence			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	**Yes**	The agency had 32 DV Respite cases in the last six months, 11 of which were civil citations. Two closed cases were reviewed for the agency's adherence to the requirements of this indicator.	

Youth admitted to DV Respite placement have evidence in the file of a pending DV charge	**Compliance**	Both cases reviewed contained evidence in the file of a pending DV charge.	
Data entry into NetMIS within (3) business days of intake and discharge	**Compliance**	Both cases reviewed were entered into NetMIS within three business days of both intake and discharge.	
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**	Both cases reviewed had a length of stay that did not exceed 21 days.	
Case plan in file reflects goals for aggression management, family coping skills, or other intervention designed to reduce propensity for violence in the home	**Compliance**	Both cases reviewed had a case plan in the file that reflected goals for anger management and family coping skills.	
All other services provided to Domestic Violence Respite youth are consistent with all other general CINS/FINS program requirements	**Compliance**	Both cases reviewed clearly reflected program requirements for general CINS/FINS youth. This was evidenced in case notes, referrals provided, and follow up.	
Probation Respite			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	**Yes**	The agency had two probation respite cases in the last six months, both of which were closed prior to this review. One client file was reviewed to determine the agency's adherence to the requirements of this indicator.	
All probation respite referrals are submitted to the Florida Network.	**Compliance**	There was evidence within the file that the case reviewed was submitted and approved by the Florida Network.	
All Probation Respite Referral come from DJJ Probation and there is evidence that the youth is on Probation regardless of adjudication status.	**Compliance**	Case reviewed was referred from DJJ Probation and there was evidence that the youth was on probation in the file (JJIS Face Sheet).	
Data entry into NetMIS and JJIS within (3) business days of intake and discharge	**Compliance**	Case reviewed was entered into NetMIS within three business days of both intake and discharge.	
Length of stay is no more than fourteen (14) to thirty (30) days. Any placement beyond thirty (30) days contains evidence in the file that the JPO was contacted in writing to request the need of an extension no later than the 25th day the youth was admitted into the program.	**Compliance**	Youth case reviewed was in shelter for 35 days. There was evidence within the file that the JPO was contacted regarding an extension needed and this was approved.	
All case management and counseling needs have been considered and addressed	**Compliance**	Case reviewed had evidence via case notes that case management and counseling needs were considered and addressed.	

All other services provided to Probation Respite youth are consistent with all other general CINS/FINS program requirements	**Compliance**	Case reviewed clearly reflected program requirements for general CINS/FINS youth. This was evidenced in case notes, referrals provided, and follow up.	
Intensive Case Management (ICM)			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	**Yes**	The agency had a total of eight ICM cases in the last six months. Two files, both open, were reviewed to determine the agency's adherence to the requirements of this indicator.	
Youth receiving services were deemed chronically truant and/or runaway and require more intensive and lengthy services. The youth was determined to be eligible because they have gone through petition and/or case staffing and was in need of case management services.	**Compliance**	Both youth files reviewed were deemed eligible via chronic truancy, which was reported during truancy court.	
Services for youth and family include: a. Two (2) direct contacts per month b. Two (2) collateral contacts per week c. Direct and collateral contacts not obtained must have documentation to support attempts made to obtain them. All reasonable attempts (at minimum of three) must be made to reach all contacts (direct and collateral) and documented in the case file and NetMIS.	**Compliance**	Both youth files reviewed contained detailed information regarding direct and collateral contacts. This was evident in case notes and contact logs. All content met the guidelines required for this indicator.	
Assessments include a. NIRVANA at intake b. NIRVANA Re-Assessment every 90 days c. Post NIRVANA at discharge as aligned with timeframe requirements	**Compliance**	Both youth files reviewed were in compliance with NIRVANA. One file has been open for two years, and contained multiple NIRVANA re-assessments to meet the 90-day requirement. The other case reviewed has been open for almost seven months and contained two re-assessments as required. Neither of the cases reviewed had post-NIRVANAs due to still being open.	
Service/case plan demonstrates a strength-based, trauma-informed focus	**Compliance**	Both youth files reviewed had case plans that demonstrated a strength-based and trauma informed focus, as there was an emphasis placed on the presenting issues for each youth.	
For any virtual services provided, there is written documentation in the youths' file as to why virtual contact is in the best interest of the youth and family	**Compliance**	There is documented proof that all services provided were conducted in-person, with approval for virtual support if requested.	
Family and Youth Respite Aftercare Services (FYRAC)			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	**Yes**	The agency had two FYRAC cases in the last six months, both of which were DV related and still open. Both cases were reviewed.	

Youth is referred by DJJ for a domestic violence arrest on a household member, and/or the youth is on probation regardless of adjudication status and at risk of violating.	**Compliance**	Youth cases reviewed had evidence that they were referred by DJJ for a DV arrest on a household member. The JJIS Face Sheet was also present in the file.	
Agency has evidence that all FYRAC referrals have documented approval from the Florida Network office	**Compliance**	Youth cases reviewed had documentation in the file that the Florida Network office approved the referral.	
Intake and initial assessment sessions meets the following criteria: a. Services shall be documented through the signature of the youth and his/her parent/guardian as well as orientation to the program which is kept in the youths file. b. The initial assessment shall be face-to-face, in person or through virtual means, to include a gathering of all family history and demographic information, as well as the development of the service plan. c. For youth on probation, a copy of the youths Community Assessment Tool (CAT) to assist with development of the family service plan.	**Compliance**	Youth cases reviewed had documentation in the file that the both intake and initial assessment sessions met required criteria. This was evidenced by youth and parent signatures, documentation of virtual services (both cases), and NIRVANA.	
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.	**Compliance**	Both cases reviewed had 60 minute sessions, provided virtually, with evidence of case notes documenting the focus on strengthening the family unit.	
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.	**Compliance**	Both client file cases reviewed had evidence of documentation of sessions conducted with both youth and family that identified strengths and needs of each member to help improve family functioning.	
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**	Both client file cases reviewed received individual services, not group.	

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**	Both cases reviewed were still open and not yet eligible for follow-up services.	
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	**Compliance**	Both cases reviewed were still open and engaged in services. Neither case reviewed had yet reached 90 days of service so an extension is not needed or applicable.	
Any service that is offered virtually, is documented in the youth's file why it was in the youth and families best interest.	**Compliance**	Both cases reviewed had virtual services being offered and both cases had reasons why documented on the initial screening (reason was "FYRAC" for one case, and parent's work schedule for the other).	
All data entry in NetMIS is completed within 3 business days as required.	**Compliance**	Both cases had evidence of NetMIS data entry being completed within 3 business days as required.	
Additional Comments: **There are no additional comments for this indicator.**			
2.09- Stop Now and Plan (SNAP)			**Not Applicable**
Provider has a written policy and procedure that meets the requirement for Indicator 2.09		**NO** If NO, explain here: The agency does not participate in SNAP program service delivery.	
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	**Not Applicable**	The agency does not participate in SNAP program service delivery.	
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	**Not Applicable**	The agency does not participate in SNAP program service delivery.	
The NIRVANA was completed at initial intake, or within two sessions.	**Not Applicable**	The agency does not participate in SNAP program service delivery.	
There is evidence of the completed the Pre - Child Behavior Checklist (CBCL) by the caregiver and is located within the file.	**Not Applicable**	The agency does not participate in SNAP program service delivery.	
There is evidence of the completed Pre - TOPSE is completed by the caregiver and is located within the file.	**Not Applicable**	The agency does not participate in SNAP program service delivery.	

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.*)	**Not Applicable**	The agency does not participate in SNAP program service delivery.	
SNAP Clinical Groups Under 12 - Discharge			
There is evidence of the completed the Post - Child Behavior Checklist (CBCL) by the caregiver and is located within the file.	**Not Applicable**	The agency does not participate in SNAP program service delivery.	
There is evidence of the completed Post - TOPSE is completed by the caregiver and is located within the file.	**Not Applicable**	The agency does not participate in SNAP program service delivery.	
There is evidence of the completed SNAP Discharge Report located within the file for any discharged youth.	**Not Applicable**	The agency does not participate in SNAP program service delivery.	
There is evidence of the SNAP Boys/SNAP Girls Child Group Evaluation Form located in the file.	**Not Applicable**	The agency does not participate in SNAP program service delivery.	
There is evidence of the SNAP Boys/SNAP Girls Parent Group Evaluation Form located in the file.	**Not Applicable**	The agency does not participate in SNAP program service delivery.	
SNAP Clinical Groups for Youth 12-17			
Youth are screened to determine eligibility of services using the Florida Network Youth Screening Form.	**Not Applicable**	The agency does not participate in SNAP program service delivery.	
The file contains the completed Florida Network Community Counseling Intake Form and is located within the file.	**Not Applicable**	The agency does not participate in SNAP program service delivery.	
The Consent to Treatment and Participation in Research Form is completed, signed by the parent/guardian before receiving services, and located within the file.	**Not Applicable**	The agency does not participate in SNAP program service delivery.	
The NIRVANA was completed at initial intake, or within two sessions.	**Not Applicable**	The agency does not participate in SNAP program service delivery.	
There is evidence of the completed 'How I Think Questionnaire' (HIT) form located within the file or evidence of at least three (3) documented attempts in the youths' file to obtain this information.	**Not Applicable**	The agency does not participate in SNAP program service delivery.	
There is evidence of the completed Social Skills Improvement System (SSIS) Student form located within the file or evidence of at least three (3) documented attempts in the youths' file to obtain this information.	**Not Applicable**	The agency does not participate in SNAP program service delivery.	
There is evidence of the completed Social Skills Improvement System (SSIS) Teacher/Adult form located within the file or evidence of at least three (3) documented attempts in the youths' file to obtain this information.	**Not Applicable**	The agency does not participate in SNAP program service delivery.	
All closed files contained evidence in the file a NIRVANA was completed at discharge.	**Not Applicable**	The agency does not participate in SNAP program service delivery.	

SNAP for Schools & Communities			
The program demonstrated all of the required weekly attendance sheets that included youth names and/or identifying numbers completed with the teacher and trained SNAP Facilitator signatures. (*This must include a total of 13 attendance sheets for a full cycle*)	**Not Applicable**	The agency does not participate in SNAP program service delivery.	
The program maintained evidence of a completed 'Way to Go Goal' Sheet within the file.	**Not Applicable**	The agency does not participate in SNAP program service delivery.	
The program maintained evidence of both pre AND post Measure of Classroom Environment (MoCE) completed documents for the class reviewed.	**Not Applicable**	The agency does not participate in SNAP program service delivery.	
The program maintained evidence of completed pre and post evaluation documents for the class reviewed.	**Not Applicable**	The agency does not participate in SNAP program service delivery.	
There is evidence of the SNAP® for Schools & Communities Feedback Form completed by the supervisory adult responsible for the support of the youth receiving services and entered into NetMIS.	**Not Applicable**	The agency does not participate in SNAP program service delivery.	
There is evidence of one (1) Fidelity Adherence Checklist completed per classroom for the 13-week classroom sessions which is located in the file.	**Not Applicable**	The agency does not participate in SNAP program service delivery.	
Additional Comments: **There are no additional comments for this indicator.**			

3.01 - Shelter Environment		**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 3.01	**YES**	
	If NO, explain here:	
	The agency has a policy titled Residential. The policy meets general requirements. The policy was last approved and signed by the Program Director on May 31, 2024.	

Facility Inspection: a. Furnishings are in good repair. b. The program is free of insect infestation. c. Bathrooms and shower areas are clean and functional, free of foul odors, leaks, dust, and mildew and in good working order. d. There is no graffiti on walls, doors, or windows. e. Lighting is adequate for tasks performed there. f. Exterior areas are free of debris; grounds are free of hazards. g. Dumpster and garbage can(s) are covered. h. All doors are secure, in and out access is limited to staff members and key control is in compliance. i. Detailed map and egress plans of the facility, general client rules, grievance forms, abuse hotline information, DJJ Incident Reporting Number and other related notices are posted. j. Interior areas (bedrooms, bathrooms, common areas) do not contain contraband and are free from hazardous unauthorized metal/foreign objects.	**Compliance**	A full physical plan inspection of the youth cottages did not identify any furnishings that are in disrepair. All appeared in good condition. There was no evidence of any insect infestation onsite. The bathroom and shower areas in each cottage was clean and functional. Eight bathrooms, four in each cottage, were inspected during the review. Each east and west wing of the cottages have two bathrooms per wing. Toilets, sinks and showers are all functional, free of mildew, leaks, and dust. There is no evidence of any graffiti on the walls, doors, or windows. The walls in both cottages had been freshly painted, per the Human Services Supervisor. There was adequate lighting throughout the facility the exterior areas of the facility were free of debris, and any hazards. The grounds were well kept. In and out access is limited to staff only, as each door was securely locked and required a key signed out by staff. There is a detailed map and egress plans of the facility in each cottage. The general client rules, abuse hotline information, DJJ incident reporting number, and other related notices are in a centralized place on the wall in each cottage. The grievance forms and locked boxes are located on a wall accessible to the youth in each cottage. The interior areas did not contain any contraband. There were no hazardous materials or foreign objects seen during this inspection of the youth cottages.	One bathroom in both the male and female's cottages, each had a foul odor.
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 agency vehicles were found to be secured and locked as required. All agency vehicles are equipped with safety items which include a fire extinguisher, glass break mechanism and seat belt cutter. A first aid kit is checked out to be utilized on each transportation event. No expired items were found in the first aid kit.	

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**	Monthly Chemical Inventory Sheets are located in both cottages and they contained a listing of the approved chemicals in use. MSDS book and the inventory sheets were securely stored. The inventory sheets reveal that the chemicals are documented on a perpetual basis at the time of use and inventoried as required.	
Facility Inspection: Washer/dryer are operational & general area/lint collectors are clean. Agency has a current DCF Child Care License which is displayed in the facility. Each youth has own individual bed with clean covered mattress, pillow, sufficient linens and blanket. Youth have a safe, lockable place to keep personal belongings, if requested.	**Compliance**	The review of both cottages revealed a laundry room with one operable washer and dryer. Each dryer had a lint collector which was free of lint. The DCF Child Care License has an effective date of August 1, 2024. The dorms have individual beds for the youth. Each mattress was fully covered with clean, sufficient linen, a pillow and a blanket/comforter. Each dorm also had a locked closet available for the youth to use for their personal items.	
Additional Facility Inspection Narrative (if applicable)			

Fire and Safety Health Hazards: a. Annual facility fire inspection was conducted, and the facility is in compliance with local fire marshal and fire safety code within jurisdiction. b. Agency completes a minimum of 1 fire drill on each shift monthly (within 2 minutes or less). c. Completes 1 mock emergency drill per shift per quarter. d. All annual fire safety equipment inspections are valid and up to date (extinguishers, sprinklers, alarm system and kitchen overhead hood, including fire extinguishers in all vehicles).	**Compliance**	The annual facility fire inspection was conducted on May 2, 2024 and there were no non-compliant findings. A review of fire drills completed in the last six months was conducted. 1st Shift Drills were compliant and completed within two minutes or less. 2nd Shift Drills were compliant and completed within two minutes or less. 3rd Shift Drills: N/A - agency only has two-twelve hour shifts. The agency provided documentation which revealed that fire drills are conducted each shift at least once a month. A mock emergency drill was conducted per the standards. All fire safety equipment was inspected by the Fire Marshall and passed on May 2, 2024. Each vehicle used for transporting youth had a fire extinguisher which is accessible. The buildings sprinkler system, alarm system, and extinguishers were inspected and are up-to-date per the documentation which was presented during the audit.	
Fire and Safety Health Hazards: a. Agency has a current Satisfactory Residential Group Care inspection report from the Department of Health. b. Agency has a current Satisfactory Food Service inspection report from the Department of Health and food menus are posted, current and signed by Licensed Dietician annually. c. All cold food is properly stored, marked and labeled and dry storage/pantry area is clean and food is properly stored. d. Refrigerators/Freezers are clean and maintained at required temperatures and all small and medium sized appliances are operable and clean for use as needed.	**Compliance**	The agency's current Satisfactory Residential Group Care Inspection report has an effective date of April 29, 2024. The latest satisfactory inspection was completed September 9, 2024. The kitchen food menus are posted, current, and signed by a Licensed Dietician annually. All cold and dry foods were stored in clean storage areas. Two refrigerators checked: 28F and 30F degrees. Two Freezers checked: one and eight degrees. Both kitchens were cleaned with operable appliances in each. The main dining room/cafeteria area was checked. The kitchen area had a large freezer with a temperature of 11F, and two refrigerators, one with a temperature of 37F, and the other had a temperature reading of 38F.	
Additional Fire and Safety Health Hazards Narrative (if applicable)			

Youth Engagement			
a. Youth are engaged in meaningful, structured activities (e.g., education, recreation, counseling services, life and social skill training) seven days a week during awake hours. Idle time is minimal. b. At least one hour of physical activity is provided daily. c. Youth are provided the opportunity to participate in a variety of faith-based activities. Non-punitive structured activities are offered to youth who do not choose to participate in faith-based activities. d. Daily programming includes opportunities for youth to complete homework and access a variety of age appropriate, program approved books for reading. Youth are allowed quiet time to read. e. Daily programming schedule is publicly posted and accessible to both staff and youth.	**Compliance**	The agency's daily activities calendar included a variety of activities. A review of the log books, as well as, this reviewer witnessing the youth interacting with staff revealed that the youth are engaged in meaningful, structured activities. The monthly calendar shows scheduled groups throughout the week, and a review of the log books revealed that the youth participated in the various shelter activities/groups. During the reviewer's assessments of the male dorms, staff were witnessed engaging the youth in a meaningful conversation about life after the shelter, and their future plans.	
Additional Comments: **There are no additional comments for this indicator.**			
3.02 - Program Orientation			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 3.02		**YES** If NO, explain here: The agency has a policy called Residential Client Orientation. The policy meets the general requirements. The policy was last reviewed and approved by the Program Director on April 12, 2024.	
Youth received a comprehensive orientation and handbook provided within 24 hours	**Compliance**	A total of six residential client files were reviewed. All youth files contained evidence of program being provided	
Orientation includes the following: a. Youth is given a list of contraband items b. Disciplinary action is explained c. Dress code explained d. Review of access to medical and mental health services e. Procedures for visitation, mail and telephone f. Grievance procedure g. Disaster preparedness instructions h. Physical layout of the facility i. Sleeping room assignment and introductions j. Suicide prevention- alerting staff of feelings or awareness of others having suicidal thoughts	**Compliance**	A total of six residential client files reviewed had evidence of completion of the orientation process. This process involves explaining all rules, schedules, activities, events and behavior requirements to each resident during new client 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	**Exception**	All six client files contained evidence of all sections of the orientation process being explained to each resident and each fille included all required signatures. Three of the six client files contained all required dates and signatures.	Two case files did not initial each line. The youth initialed first line of orientation checklist and then drew a line down for the rest of the lines. One case file did not have a date for youth signature on orientation checklist.
Additional Comments: **There are no additional comments for this indicator.**			
3.03 - Youth Room Assignment			**Limited**
Provider has a written policy and procedure that meets the requirement for Indicator 3.03		**YES** If NO, explain here: The agency has a policy called Residential Client Orientation. The policy meets the general requirements. The policy was last reviewed and approved by the Program Director on April 12, 2024.	
A process is in place that includes an initial classification of the youths, to include:			
a. Review of available information about the youth's history, status and exposure to trauma b. Initial collateral contacts, c. Initial interactions with and observations or the youth d. Separation of younger youth from older youth, e. Separation of violent youth from non-violent youth f. Identification of youth susceptible to victimization g. Presence of medical, mental or physical disabilities h. Suicide risk i. Sexual aggression and predatory behavior j. Acute health symptoms requiring quarantine or isolation	**Exception**	A review of six shelter files showed evidence which three files listed the room the youth room was assigned to as required. Interview with leadership explained that there was a previous form that detailed room assignment. This form was removed and staff members have not consistently utilized the designated section within the Residential Intake Form to demonstrate the information used in assigning rooms.	Three youth files did not list the youth room assignment as required (section left blank). All six files were missing information regarding youth's history and observations, as the youth room assignment section was blank (i.e., no checkmarks for history of violence/aggression for DV youth, or checkmarks for mental health for applicable youth).
An alert is immediately entered into the program's alert system when a youth is admitted with special needs and risks such as risk of suicide, mental health, substance abuse, physical health or security risk factors	**Compliance**	The agency has an alert system in place that allows staff members to know what alerts, if any, a youth has including any special needs.	
Additional Comments: **There are no additional comments for this indicator.**			

3.04 - Log Books			Satisfactory with Exception
Provider has a written policy and procedure that meets the requirement for Indicator 3.04		**YES** If NO, explain here: The agency has a policy titled Logbooks. The policy meets the general requirements. The policy was last reviewed and approved by the Program Director on May 31, 2024.	
Log book entries that could impact the security and safety of the youth and/or program are highlighted	**Compliance**	The agency does not utilize policy numbers, they only use titles for their policies. There is a policy titled Log Books, last approved and signed by the Program Director, October 1, 2024. The agency's electronic logbook platform (NoteActive) has a function which allows highlights in different colors. The hand-written log books displayed highlights of any safety and security issues.	
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**	Two logbooks and NoteActive documentation platform were reviewed. All entries were legibly written in ink and included all pertinent information per the standards.	
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**	The NoteActive documentation platform has a strike-through function that was used appropriately for any errors. There was no evidence of the use of whiteout in the paper logbooks.	
The program director or designee reviews the facility logbook(s) every week and makes a note chronologically in the logbook indicating the dates reviewed and if any correction, recommendations and follow-up are required and sign/date the entry	**Exception**	The Human Services Supervisors are signing in daily in the NoteActive documentation platform.	There are not any chronological notes from either logbook to indicate any type of follow-ups or recommendations for the staff.
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**	It is evident in NoteActive documentation platform that the direct care staff are reviewing the logs at the beginning of their shifts. The entries are electronically dated and signed.	
At the beginning of their shift, oncoming supervisor and shelter counselor reviews the logbook of all shifts since their last log entry and makes a signed and dated entry and into log book indicating the dates reviewed.	**Exception**	The NoteActive documentation platform shows that the oncoming supervisor reviews the previous shift entries of all shifts. The entry is electronically signed and dated.	There are no entries from the counselors per the policy. The residential manager states that the counselors were not logging in, per the policy, but has since been retrained to follow the logbooks policy to meet the written standards.

Logbook entries include: a. Supervision and resident counts b. Visitation and home visits	**Compliance**	It was evidenced during the review that resident's supervision, and counts are entered in the log books. A review of the log books and NoteActive documentation platform over the previous six months shows evidence that the agency's staff is documenting visitation and home visits as they occur.	
Additional Comments: **There are no additional comments for this indicator.**			
3.05 - Behavior Management Strategies			**Satisfactory with Exception**
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 titled Behavior Management System. The policy meets the general requirements. The policy was last reviewed and approved by the Program Director on October 1, 2024.	
The program has a detailed written description of the BMS and it is explained during program orientation	**Exception**	During an interview with the Human Services Supervisor, as well as, with the Residential Manager, the reviewer was informed by each of them that the Behavioral Management System is printed in the youth's handbook, and is explained to the youth during intake. There is a sentence in the client's handbook which mentions the Behavioral Management System, however there is not a detailed written description of the system.	The youth's handbook, which is given during intake does not give a detailed written description of the Behavioral management system. The rules and expectations are noted; however, there is not a detailed written description.

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 agency has a variety of positive incentives that they utilize. Observation during the review showed staff members having positive interactions with youth, and meaningful conversations to help keep the youth on task. Some of the incentives are, but not limited to off-campus outings. Examples include bowling and movies and on-campus canteen for youth to receive goodies for their positive behaviors, is operated on Saturdays. An option to participate in a Super Bowl party, which includes the opportunity to have a later bedtime is another incentive offered to the youth. An interview with the Human Services Supervisor concluded that the agency's staff members utilizes verbal de-escalation, and other appropriate interventions to help the youth gain an understanding of natural consequences for their actions. The staff members will re-direct a youth's behaviors immediately, reminding them of the consequences associated with their behaviors. A violation of the agency's rules are consistently and logically applied. Per the Human Services Supervisor, points are not taken away if a youth violates the rules; however, they will not earn their possible points for that day. The agency uses programs titled "COVE" and "Peace in Action", as well as, provides gift cards to the youth as incentives to encourage participation and completion of the program. The agency does not utilize any tactics, or forms of discipline that will deny the youth of any of their rights. The BMS program is aimed to make sure staff and youth respect each other and have positive interactions with others in the program. The positive interactions are one way of ensuring that the safety and protection of staff and youth are intact, and that there are no violations of the resident's rights.	
Program's use of the BMS			
All staff are trained in the theory and practice of administering BMS rewards and consequences	**Compliance**	All staff members are trained on the Behavioral Management System and how to utilize the system during their new hire orientation. During an interview with the Human Services Supervisor, it was stated that the Training Coordinator has selected two facilitators to start training new staff.	
There is a protocol for providing feedback and evaluation of staff regarding their use of BMS rewards and consequences	**Compliance**	Human Services Supervisor will have a meeting with the staff members when applicable to provide feedback to ensure that the BMS is used appropriately. Coaching and counseling is used when deemed necessary.	
Supervisors are trained to monitor the use of rewards and consequences by their staff	**Compliance**	The Human Services Supervisor monitors the use of the BMS to ensure that staff is utilizing the appropriate strategies.	
Additional Comments: **There are no additional comments for this indicator.**			

3.06 - Staffing and Youth Supervision			Satisfactory with Exception
Provider has a written policy and procedure that meets the requirement for Indicator 3.06		**YES** If NO, explain here: The agency has a policy titled Staffing and Client Supervision. The policy meets the general requirements. The policy was last reviewed and approved by the Program Director on May 31, 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**	An interview with the Human Services Supervisor, as well as, the Residential Manager, verified how the scheduling process ensures that the staff member to youth ratio stays in compliance. A review of the weekly staff member schedule was conducted. The cameras and the NoteActive documentation platform both showed that a minimum of two staff members were scheduled and worked each work shift to comply with the contract. The agency operates two work shifts, 1st and 2nd. The youth care workers work 3-12 hour shifts, and a 4-hour work shift on Wednesdays to ensure compliance.	
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 member schedule which is posted in each cottage, showed the rotation of at least two staff members per work shift. The schedule shows that a minimum of two staff members per shift are scheduled, and during camera reviews, two or more staff were present on each work shift. The shift leaders and supervisor are also available to cover work shifts whenever needed.	
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 program staff members had successfully completed all necessary trainings, and background screenings prior to working with the youth, as evidenced in the staff's employee's files. The agency had no new hires since the new standards became effective on July 1, 2024.	
The staff schedule is provided to staff or posted in a place visible to staff	**Compliance**	Staff member schedules are posted in the staff's office in each cottage and in the control room.	
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**	Both the Program Director and the Shelter Manager advised that they do not have any part-time or on-call staff member, therefore, they call every staff member on their staff list when coverage is needed.	

Staff observe youth at least every 15 minutes while they are in their sleeping room, either during the sleep period or at other times, such as during illness or room restriction	**Exception**	A review of randomly selected bed check dates and times indicated the following: - October 30th: 5am-7am-All bed checks were completed every 10 minutes. - November 1st: 4am-6am-All bed checks were completed every 10 minutes. - November 2nd: 2:15am-4:20am-All bed checks were completed every 10 minutes. - November 8th: 1:20am-4:00am-All bed checks were completed every 10 minutes. - November 10th: 12:01am-4:32am-All bed checks were completed every 10 minutes. - November 18th: 6:00am-7:20am-All bed checks were completed every 10 minutes. A review of the camera system was conducted for the above mentioned timeframes and all observed bed checks were conducted within ten minutes. The physical layout of the single bedrooms: one bed and one dresser, the double bedrooms have two-single beds, and two dressers, the beds are spaced out from each other, accordingly.	The positioning of a camera does not give a good view of a hallway in cottage E. Furthermore, the October 30th review at 0501 on the east hallway in cottage E does not show the staff member having direct visual contact of the youth and the same applies at 0511 on the west hallway. Reviewing the cameras does not show the opening space of doors of the bedrooms; therefore, it is undetermined whether or not the doors are open enough for staff to have a visual of the youth. The staff member is not viewed opening a few of the doors during the checks; however, it appears that he is positioning his ear towards the doors to listen for sound.
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 the required policy and procedure, Video Camera Surveillance, that was last approved and signed by the Program Director on October 1, 2024.	

Surveillance System			
The agency, at a minimum, shall demonstrate: a. A written notice that is conspicuously posted on the premises for the purpose of security b. System can capture and retain video photographic images which must be stored for a minimum of 30 days c. System can record date, time, and location; maintain resolution that enables facial recognition d. Back-up capabilities consist of cameras' ability to operate during a power outage e. Have cameras placed in interior (e.g. intake office, counseling office, cafeteria, day room) and exterior (e.g. entrance/exit, recreation area, parking lot) general locations of the shelter where youth and staff congregate and where visitors enter and exit; to include locations where youth searches are conducted. Cameras are never placed in bathrooms or sleeping quarters. f. All cameras are visible	**Compliance**	The agency has signs displayed throughout the facility which advises of 24-hour daily camera monitoring, and security officers are present on the facility 24-hours a day, as well. The agency has a camera system which retains the footage for up to thirty days. The operations manager stated that they have 27 cameras on-site. There are cameras positioned on each cottage, in the common areas of the cottages, the communications office, recreation area, parking lots, family counseling room, and other areas where youth and staff congregate, and where visitors enter and exit. The cameras are not hidden, or placed in any inconspicuous areas. There are no cameras in the dorms or bathrooms of the cottages. The agency's camera system can retain images up to 30 days. The images were clear, and had a good resolution. The date, time, and location of the images were recorded, and met the contractual requirements. The agency has an emergency generator that is used to keep the cameras operable during any power outages.	
A list of designated personnel who can access the video surveillance system is maintained (includes off-site capability per personnel)?	**Compliance**	The agency has designated personnel who can access the surveillance which includes the program director, the operations manager, the IT department, and the human services supervisors.	
Supervisory review of video is conducted a minimum of once every 14 days and timeframes reviewed are noted in the logbook.	**Compliance**	Camera reviews are conducted by the human services supervisor. June reviews were conducted 6/2-6/17; July's reviews were conducted 7/1-7/19; August's reviews were conducted 8/16-8/30; September reviews were conducted 9/10-9/24; October reviews were conducted 10/11-10/25; and November reviews were conducted 11/3-11/17. These camera reviews were documented in the NoteActive documentation platform at different times for each shift. There were a few notations of the cameras not available to review, some had an explanation of connectivity issues, others had no explanation. The reviewer interviewed the Residential Manager, asking her to explain the process for non-live views (recorded video within the last 30 days). The Residential Manager explained that the Tech Service department (IT) is notified to access the camera when recorded video is needed.	
The reviews assess the activities of the facility and include a review of random sample of overnight shifts	**Compliance**	During this review, there was evidence to show that the camera reviews were random from each shift, including overnights, and showed activities throughout the facility.	

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 operations manager stated that a work order ticket is submitted to the TSC (IT) department within the timeframe allowed. The operations manager is the point person for these reviews. The agency verifies that the source requesting the video is legitimate and then submits the necessary paperwork to process the requests for the recordings. The agency contacts the Tech Service dept (IT) to access the camera when recorded video is needed.	
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 my interview with the operations manager, it was advised that there has not been any issues with the camera service. The manager explained the process the agency follows when requests are made, stating that the Tech Service Center is notified immediately.	
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 titled Staffing and Client Supervision. The policy meets the general requirements. The policy was last reviewed and approved by the Program Director on May 31, 2024.	
Preliminary Healthcare Screening			
Screening includes : a. Current medications b. Existing (acute and chronic) medical conditions c. Allergies d. Recent injuries or illnesses e. Presence of pain or other physical distress f. Observation for evidence of illness, injury, physical distress, difficulty moving, etc. g. Observation for presence of scars, tattoos, or other skin markings h. Acute health symptoms requiring quarantine or isolation	**Compliance**	A total of five closed residential youth records were reviewed to determine the agency's adherence to the requirements of this indicator. All six records contained screening forms with evidence of being completed by staff members. The agency's health admission screening forms captured up-to-date information on each client's acute medical/mental health status. Staff screened youth for all applicable questions for acute past and present health and medical status as required. At the time of this onsite program review, the agency Registered Nurse position is still vacant. The agency does not have a licensed staff member reviewing the accuracy and completion of all completed residential health admission screening forms.	
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**	A review of the referral process was conducted. The referral process included a process that screens for medical conditions which may require medical attention during the resident's shelter stay. None of the five youth client files reviewed contained chronic medical conditions which required a referral for medical care.	

When needed, the parent is involved with the coordination and scheduling of follow-up medical appointments	**Compliance**	In the event of a medical emergency or appointment, the agency has procedures in place to contact parents or caregivers. The agency documents when parents and guardians are contacted for medical follow-up that requires outside medical appointments.	
All medical referrals are documented on a daily log.	**Compliance**	The agency requires documentation of all medical referrals be documented in the program logbook and Episodic Care log.	
The program has a thorough referral process and a mechanism for necessary follow-up medical care as required and/or needed	**Compliance**	The agency has a process for medical referrals, as well as follow up medical care. When a youth is admitted for offsite medical care and discharged, the agency obtains all medical care documentation for continued care of the youth for the remainder of their shelter stay.	
Additional Comments: **There are no additional comments for this indicator.**			
4.02 - Suicide Prevention			**Limited**
Provider has a written policy and procedure that meets the requirement for Indicator 4.02		**YES** If NO, explain here: The agency has a policy titled Suicide Prevention and Intervention. The policy meets the general requirements. The policy was last reviewed and approved by the Program Director on September 12, 2024.	
Suicide Risk Screening and Approval (*Residential and Community Counseling*)			
Suicide risk screening occurred during the initial intake and screening process. Suicide screening results reviewed and signed by the supervisor and documented in the youth's case file.	**Compliance**	A total of five residential youth records (2 open and 3 closed) were reviewed to determine the agency's adherence to the requirements of this indicator for suicide prevention. All five case files contained a suicide risk screening form completed during the Intake process. All client files have documented evidence indicating a positive on at least a minimum of one positive response for one of five questions on the suicide risk instrument.	
The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	**Compliance**	The agency uses an Assessment of Suicide, Homicide, Assault Risk form to screen all residents for risks. The tool and its contents have not changed since the last onsite program review.	

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**	All five youth files contained evidence of documentation that all youth were placed on sight and sound supervision. All youth client files contained evidence of completed assessment of suicide risk. Each of these forms were completed by a master's level counselor overseen by a mental health clinician.	
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 out of five youth were placed on elevated supervision. A review of the supervision logs found documented observation log checks conducted on each youth placed on elevated supervision by a staff member every 30 minutes or less while on supervision on all five of the client files. Youth on close watch supervision are not consistently under supervision.	Review of practice pertaining to constant sight and sound indicates program does not consistently maintain continuous, unobstructed sight and sound on all youth placed on this supervision status. Interview with residential group care Human Services Supervisor verified current practice that does not consistently maintain uninterrupted supervision he while youth is on constant supervision status.
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**	A review of the observation log detail for all five client files included date, time, client observations, warning signs, writer's initial and documentation of the review by the Shift Supervisor or Lead.	
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	**Exception**	A total of five youth files contained evidence of an assessment. The supervision level of each youth was not changed unless the staff were given permission by the Licensed Clinician.	Documentation in three of five files reviewed had evidence of inconsistent or missing documentation of placing youth on and stepping down or removing youth from constant supervision status.
There was evidence that documentation was reviewed by supervisory staff each shift. If program uses an observation log, completed logs are maintained in the youth's file.	**Compliance**	All five client files contained documented evidence that the Shift Supervisor or Lead reviewed the observation logs prior to the end of the work shift. Each log was found in the client case file as required.	
Youth with Suicide Risk *(Community Counseling Only)*			
Youth identified for suicide risk during intake was immediately assessed by a licensed professional or non-licensed professional (under the direct supervision of a licensed mental health professional) and the parents and supervisor were both notified of the results.	**No eligible items for review**	The agency did not have applicable items for review of this indicator.	
During the intake, if the appropriate staff is unavailable, youth identified for suicide risk was immediately referred by the provider and the parent/guardian is notified of the suicide risk findings disclosed and advised that an Assessment of Suicide Risk should be completed ASAP by a licensed professional.	**No eligible items for review**	The agency did not have applicable items for review of this indicator.	

Information on resources available in the community for further assessment was provided to the parent/guardian and is documented in the youth's file and signed by the parent/guardian OR a written follow-up notification was sent by certified mail if the parent/guardian was not present during the screening and was notified by telephone.	**No eligible items for review**	The agency did not have applicable items for review of this indicator.	
If the parent/guardian cannot be contacted, all efforts to contact them are documented in the case file.	**No eligible items for review**	The agency did not have applicable items for review of this indicator.	
When the screening was completed during school hours on school property, the appropriate school authorities were notified.	**No eligible items for review**	The agency did not have applicable items for review of this indicator.	
Additional Comments: **There are no additional comments for this indicator.**			
4.03 - Medications			**Failed**
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 titled Medication Administration. The policy meets the general requirements. The policy was last reviewed and approved by the Program Director on September 12, 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.	**Exception**	At the time of this review, the agency's Registered Nurse position is vacant.	The agency has not had a licensed Registered Nurse (RN) perform duties of a licensed nursing profession in over two years. The agency has continued with recruiting and interviewing nursing candidates. At the time of the onsite program review, the agency is currently in process of making an offer to a prospective candidate to fill the position.
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**	The agency made arrangements for a local area Registered Nurse to provide medication distribution training to all non-licensed residential direct care staff members. The agency requires all staff members to receive training from a Registered Nurse and are required to demonstrate their ability to assist in the delivery of medication to residents. The agency requires all staff members to demonstrate their competency regarding the ability to assist in the delivery of medications to residents.	The agency did not provide evidence of their annual medication training and re-certification by an RN.

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	**Exception**	The agency does not have a RN. The agency was not able to provide evidence of documented quarterly meetings minutes with proof that meeting were conducted by a RN and or Shelter Manager.	The agency did not provide evidence of meeting minutes conducted by RN and or Shelter Manager to review medication practice, factors contributing to medication errors, and observations of practice.
The agency has strategies implemented to ensure medications are provided within the 2-hour time frame.	**Compliance**	The agency's current medication practice involves each youth's medication regimen being listed to be delivered within the two hour window on a medication distribution log. The agency utilizes notifications to alert staff that medications be delivered within two hour time frame of one hour before the prescribed time to distribute medications or no later than one of the prescribe medication distribution time.	
All non-licensed staff members are clearly identified and designated on the staff schedule and shift change report/shift responsibility form for assisting with the self-administration of medications on each shift	**Compliance**	The agency identifies staff members to be assigned to assist in the delivery of medication to residents that require medication. The staff member is designated to perform these duties on each work shift schedule.	
The agency has clear methods of communicating which youth are on medications with the times and dosage easily discernable by all staff on each shift.	**Compliance**	The agency utilizes an intake screening form which initially identifies youth currently on medication. The agency creates a medication distribution form for each youth required to take medication during their shelter stay.	
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.	**Exception**	At the time of this onsite program review, the agency has a medication distribution process to receive each resident's medication and separately inventory all medications. The agency also tracks errors and reports all medication errors to the DJJ CCC as required.	The agency Registered Nurse position is vacant. At the time of this onsite review, the agency lacks the licensed oversight of ongoing daily practice of staff members assisting in the delivery of medication to residents and overall medication screening, distribution, inventory, and storage practices.

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**	At the time of this onsite program review, the agency's RN position is vacant. The agency's current medication documents for each youth's prescription medication instruction were reviewed by the shelter manager, in the leadership position. The agency's shift leaders review the medication form to ensure that medication is provided according to the prescribed medication instructions. All shift supervisors review all youth medication forms for accuracy and completeness as required. The agency Registered Nurse position has been vacant beyond two years. At the time of this onsite review, the agency lacks the licensed oversight of the agency's medication practice as part of the Medical and Mental Health Assessment and Screening process.	
Medication Storage			
a. All medications are stored in a Pyxis ES Medication Cabinet that is inaccessible to youth (when unaccompanied by authorized staff) b. Pyxis machine is stored in accordance with guidelines in FS 499.0121 and policy section in Medication Management c. Oral medications are stored separately from injectable epi-pen and topical medications d. Medications requiring refrigeration are stored in a secure refrigerator that is used only for this purpose, at temperature range 2-8 degrees C or 36-46 degrees F. (If the refrigerator is not secure, the room is secure and inaccessible to youth.) e. Narcotics and controlled medications are stored in the Pyxis ES Station f. Pyxis keys with the following labels are accessible to staff in the event they need to access medications if there is a Pyxis malfunction: a TOP COVER b BACK PANEL- LEFT TALL CABINET LOCK- LEFT, c BACK PANEL- RIGHT TALL CABINET LOCK- RIGHT	**Compliance**	A review of all current medication storage practices were conducted. All agency medication received from residents that require medication are stored in a Pyxis medication cabinet which is housed in a locked medical building. The medication cabinet is secured and locked at all times as required. All oral, topical and liquid medications for each client are stored separately as required. When an epi-pen is present it is also stored separately from all other medications. The agency has a refrigerator that is specifically for the storage of medication requiring refrigeration. All controlled medications are stored separately in the medication cabinet as required. In the event of an emergency, the agency has all medication cabinet keys stored securely in the medical building in order to access medications locked in the cabinet.	

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	**Exception**	The agency maintains the minimum of two medication systems managers for the operation of the medication cabinet as required. Only staff members trained to assist in the delivery of medications were trained by a local area Registered Nurse. Only staff assigned to provide medication to residents have access to secured prescribed medications and controlled medications. The agency staff members utilize a medication log to document all youth provided medication during their shelter stay. The agency verifies all medication received by youth and parents/guardians using an verification process consistent with FNYFS policy. The agency does not accept youth that are prescribed insulin and other injectables. The agency staff members are trained on the use of auto-injectors and does accept youth that are prescribed to use injectable epi-pens.	The agency has not had a licensed Registered Nurse (RN) perform duties of a licensed nursing profession in over two years. The agency has not had a Registered Nurse to oversee their daily medication distribution practice in more than two years.
The medication distribution log documentation includes: a. the time of medication administration b. evidence of youth initials that the dosage was given c. evidence of staff initials that the dosage was given	**Compliance**	A review of the medication distribution log (MDL) was conducted to ensure the form meets all general requirements. The agency's MDL has all required areas for documentation including time of distribution and initials of both youth and staff member assisting in the delivery of medications.	

There is evidence that staff provide youth with medications within one hour of the scheduled time of delivery as ordered by the medication. Documentation is provided for instances this does not occur within the required timeframe.	**Compliance**	The agency provides all youth with medications no more than one hour before and one hour after the scheduled time for assisting the youth with medication.	
During the review period, there were no instances where youth missed their medication due to failure to open the pyxis machine.	**Compliance**	No youth missed their medication distribution sessions due to a failure to open the medication cabinet not functioning properly.	
If applicable: Any staff member deemed responsible for a medication error, there was evidence that the staff member received refresher training from an RN and demonstrated competency prior to being assigned future medication administration responsibilities. There is evidence that any staff member deemed responsible for 3 errors within a 1-year time frame, had their certification suspended and was not recertified until the completion of the full **in-person** medication administration training, demonstrating competency and re-certification from an RN.	**Compliance**	The agency reported no applicable items for review for this indicator. There is no staff person that has committed three errors withing a one year period. All staff that have committed less than three have received remedial training as required.	
Medication Inventory			
a. For controlled substances, a perpetual inventory with running balances is maintained as well as a shift-to shift count verified by a witness and documented b. Over-the-counter medications that are accessed regularly and inventoried weekly c. Syringes and sharps (needles, scissors, etc.) are secured, and counted and documented weekly	**Compliance**	The agency maintains a perpetual inventory of all medications with shift to shift inventories that are documented with a witness as required. All other medication inventory sessions are inventoried and documented on a weekly. All sharps are documented on a weekly basis.	
There are monthly reviews of the Pyxis reports to monitor medication management practice.	**Exception**	A review of the agency's monthly Pyxis reports to monitor their internal practice was conducted.	The agency does not have consistent monthly reviews for the last six months of Pyxis reports by licensed staff or lead staff members overseeing medication distribution.
Medication discrepancies are cleared after each shift.	**Compliance**	A review of the agency's internal practice of clearing discrepancies was conducted. All discrepancies are cleared as required.	
Additional Comments: **There are no additional comments for this indicator.**			

4.04 - Medical/Mental Health Alert Process			Satisfactory with Exception
Provider has a written policy and procedure that meets the requirement for Indicator 4.04		**YES** If NO, explain here: The agency has a policy titled Medical, Mental Health, Substance Abuse Screening, and Alerts. The policy meets the general requirements. The policy was last reviewed and approved by the Program Director on September 12, 2024.	
Youth with a medical, mental health, or food allergy was appropriately placed on the program's alert system	**Exception**	Four out of five client files reviewed the appropriate medical or mental health alerts in the file.	One of five client files reviewed is missing a alert to indicate the youth is positive for suicide risk (red dot).
Alert system includes precautions concerning prescribed medications, medical/mental health conditions	**Compliance**	The agency's alert system contains alerts for youth on prescribed or controlled medication, mental health and a various past and present medical conditions.	
Staff are provided sufficient training, information and instructions to recognize/respond to the need for emergency care for medical/mental health problems	**Compliance**	Staff members are provided training on the agency's medical and mental health alert system. All staff members are trained to identify youth with a broad array of medical and mental health issues during the initial new staff member orientation training.	
A medical and mental health alert system is in place that ensures information concerning a youth's medical condition, allergies, common side effects of prescribed medications, foods and medications that are contraindicated, or other pertinent mental health treatment information, is communicated to all staff	**Compliance**	The agency's medical alert system includes youth alerts which include youth on prescribed medications, allergies, mental health issues and other alerts. Each alert corresponds with a color code that represents the alert. The agency's alerts are communicated to each staff member through documentation in the file and the general alert board.	
Additional Comments: **There are no additional comments for this indicator.**			

4.05 - Episodic/Emergency Care			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 4.05		**YES** If NO, explain here: The agency has a policy titled Medical, Mental Health, Substance Abuse and Screening Alerts. The policy meets the general requirements. The policy was last reviewed and approved by the Program Director on September 12, 2024.	
Off Site Emergency Care			
a. If off-site emergency medical or dental care was provided, an incident report was submitted for the medical or dental care b. Upon youth return, there is a verification receipt of medical clearance via discharge instructions with follow-up is present in file c. Youth's parent/guardian was notified d. A daily log is maintained for emergency care provided	**Compliance**	A total of three residential youth records were reviewed to determine the agency's adherence to the requirements of this indicator. Each of the three cases contained evidence of contacting the parent/guardian and a daily log was maintained for emergency care received by the client. The discharge information from the receipt of offsite medical care was obtained in each case.	
All staff are trained on emergency medical procedures	**Compliance**	A review of training received by all direct care staff members involved staff members receiving emergency medical training.	
The program has a Knife-for-life and wire cutters accessible to staff in a secure location(s)	**Compliance**	The agency has emergency response safety equipment which includes a knife for life and wire cutters in the boys and girls cottage facilities.	
Additional Comments: **There are no additional comments for this indicator.**			