Florida Network for Youth and Family Services
Compliance Monitoring Report for

Lutheran Services Florida Southeast - Lippman Youth Shelter

221 NW 43rd Court
Oakland Park, Florida 33309

November 13-14, 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 Lutheran Services Florida Southeast (LSF Southeast) for the FY 2024-2025. The agency has two program locations: 1) Lippman Youth Shelter located at 221 NW 43rd Court, Oakland Park, Florida, and 2) Administrative and Community Counseling office located at 2700 W. Cypress Creek Road, Suite D131, Fort Lauderdale Florida. Forefront LLC (Forefront) is an independent compliance monitoring firm that is contracted by the FNYFS to perform onsite program reviews to assess the agency's adherence to fiscal, programmatic and overall contract requirements. LSF Southeast 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 Marcia Tavares, Consultant for Forefront LLC. Agency representatives from LSF Southeast present for the entrance interview were Raymond Ballinger, Regional Director (via phone); Lisa Skirving, Shelter Director; and Ivonne Fusco, Senior Administrative Assistant. The last onsite QI visit was conducted on October 11, 2023.

In general, the Reviewer found that LSF Southeast is in compliance with specific contract requirements. **LSF Southeast received an overall compliance rating of 100% for achieving full compliance with all 12 applicable indicators** of the CINS/FINS Monitoring Tool. There were no recommendations or corrective actions because of the monitoring visit.

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

2024-2025 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 11-13-2024-2025

Agency Name: Lutheran Services Florida Southeast	**Monitor Name: Marcia Tavares, Lead Reviewer**
Contract Type: CINS/FINS	**Region/Office: 221 NW 43 Ct., Oakland Park, FL 33309**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): November 13-14, 2024**

Major Programmatic Requirements	Explain Rating: Unacceptable	Conditionally Acceptable	Fully Met	Exceeded	Not Applicable	Ratings Based Upon: I = Interview; O = Observation; D = Documentation; PTV = Submitted Prior To Visit; (List Who and What)	Notes: Explain Unacceptable or Conditionally Acceptable:
I. Administrative and Fiscal							
DJJ Quality Improvement Peer Reviewer a. Provider shall demonstrate that a minimum of two (2) staff members have been trained to be certified as DJJ QI Peer reviewers. Provider shall participate in a minimum of one (1) on-site quality assurance review of a similar type of program in another judicial circuit during each 12-month period of the contract, if requested.	☐	☐	☒	☐	☐	Documentation – Peer Reviewer Contact List 2024. The provider currently has five certified DJJ-QI Peer Reviewers: Raymond Ballinger; Diana Davila; Ivonne Fusco; Lisa Skirving; and Taneshea Sargent.	**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: Grant Listing – FY 2024-2025. A list of nine additional contracts were submitted for the LSF Southeast region including: Childcare Food Program, Department of Health and Human Services Basic Center and Street Outreach; Eckerd; Children's Network of SW Florida; and four contracts with ChildNet Inc. The list includes awarding entity, and contract start and end dates. The agency maintains multiple interagency agreements held with a variety of community partners to	**No recommendation or Corrective Action.**

2024-2025 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 11-13-2024-2025

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	Explain Rating						
Major Programmatic Requirements	**Unacceptable**	**Conditionally Acceptable**	**Fully Met**	**Exceeded**	**Not Applicable**	**Ratings Based Upon:** **I = Interview** **O = Observation** **D = Documentation** **PTV = Submitted Prior To Visit** **(List Who and What)**	**Notes** **Explain Unacceptable or Conditionally Acceptable:**
						provide a comprehensive referral process including mental health, substance abuse, truancy, safe place sites, employment services, educational, medical services, and support services.	
Limits of Coverage a. Provider shall provide and maintain during this contract, the following minimum kinds of insurance: Worker's Compensation and Employer's liability insurance as required by Chapter 440, F.S. with a minimum of $100,000 per accident, $100,000 per person and $500,000 policy aggregate. Commercial General Liability with a limit of $500,000 per occurrence, and $1,000,000 policy aggregate. Automobile Liability Insurance shall be required and shall provide bodily injury and property damage liability covering the operation of all vehicles used in conjunction with performance of this contract, with a minimum limit for bodily injury of $250,000 per person; with a minimum limit for bodily injury of $500,000 per accident; with a minimum limit for property damage of $100,000 per accident and with a minimum limit for medical payments or $5,000-$10,000 per person. Florida Network is listed as payee or co-payee. **PTV**	☐	☐	☐	☒	☐	Documentation: The provider has a policy with Markel Global Reinsurance Company for General Liability insurance with limits of coverage of $1,000,000 each/$3,000,000 aggregate and $10,000 each for medical expenses. Additional policies with this carrier include Professional Liability insurance with limits of coverage of $1,000,000 each/$3,000,000 Aggregate, and Abuse/Molestation insurance with limits of coverage of $1,000,000 each/$3,000,000 aggregate. The provider has a policy with Florida Insurance Trust for Automobile insurance that provides limits of coverage of $1,000,000 combined for	**No recommendation or Corrective Action.**

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	Explain Rating						
Major Programmatic Requirements	**Unacceptable**	**Conditionally Acceptable**	**Fully Met**	**Exceeded**	**Not Applicable**	**Ratings Based Upon:** **I = Interview** **O = Observation** **D = Documentation** **PTV = Submitted Prior To Visit** **(List Who and What)**	**Notes** **Explain Unacceptable or Conditionally Acceptable:**
						each accident. The provider has a policy with Century Surety Company for Excess/Umbrella Liability insurance which provides limits of coverage of $1,000,000 each/aggregate. Coverage for the above policies is in effect for the current FY 6/01/2024-6/01/2025. The certificate lists the Florida Network on the certificate of liability as a certificate holder.	
External/Outside Contract Compliance a. Provider has corrective action item(s) cited by an external funding source (Fiscal or Non-Fiscal). **ON SITE**	☐	☐	☐	☐	☒	Documentation/Interview: N/A – Regional Director indicated there are 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: The provider has existing policies which address general accounting practices which are maintained by the Chief Financial Officer for the agency. Fiscal policies and procedures are	**No recommendation or Corrective Action.**

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	Explain Rating						
Major Programmatic Requirements	**Unacceptable**	**Conditionally Acceptable**	**Fully Met**	**Exceeded**	**Not Applicable**	**Ratings Based Upon:** **I = Interview** **O = Observation** **D = Documentation** **PTV = Submitted Prior To Visit** **(List Who and What)**	**Notes** **Explain Unacceptable or Conditionally Acceptable:**
						contained in the agency's Financial Services Policy and Procedures Manual. The procedures appear to be consistent with GAAP and provide for limited internal controls. Provider provided 45 policies which include procedures for general ledger, cost accounting, payroll, petty cash, computer backup, and other relevant financial processes. The procedures are updated as necessary with revised policies showing a revision/approval date.	
b. Agency maintains a general ledger and the corresponding source documents. A general ledger must be set up to track the activity of the grant separately (standard account numbers / separate funds for each revenue source, etc.). **PTV**	☐	☐	☒	☐	☐	Documentation: Detailed General Ledger for July 1, 2024 – August 31, 2024. Provider maintains a detailed general ledger that includes breakdown of GL code, GL title, effective date, doc number, ID number, name of funding source, transaction description, fund code, year code, program code, location code, and debit and credit columns. Ledgers included current balances and differences.	**No recommendation or Corrective Action.**

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Major Programmatic Requirements	Explain Rating: Unacceptable	Conditionally Acceptable	Fully Met	Exceeded	Not Applicable	Ratings Based Upon: I = Interview; O = Observation; D = Documentation; PTV = Submitted Prior To Visit; (List Who and What)	Notes: Explain Unacceptable or Conditionally Acceptable:
c. Petty cash ledger system is balanced and all cash disbursements are compliant with financial policies and allowable under the contract. (Disbursements/invoices are approved & monitored by management.) –**ON SITE**	☐	☐	☒	☐	☐	Observation/Documentation: Reviewed Petty Cash 4.32 Policy and Procedure included in the Fiscal Manual. There are two separate funds, one for the community counseling program ($500) and the other for the shelter which does not exceed $1000. Petty cash is maintained by the Administrative Assistant (community counseling) and the Residential Director (Shelter) and is stored in secured cash boxes. Petty cash is reconciled at least monthly by the custodians, approved by management, and submitted to the corporate office for refund as needed. Disbursements and invoices are approved by the program director/ designee.	**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 provided contained 2 signatures.	☐	☐	☒	☐	☐	Reviewed Bank Statements and Bank Reconciliations for the months of April 2024-August 2024 for one account with Ameris Bank. Bank reconciliations	**No recommendation or Corrective Action.**

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	Explain Rating						
Major Programmatic Requirements	**Unacceptable**	**Conditionally Acceptable**	**Fully Met**	**Exceeded**	**Not Applicable**	**Ratings Based Upon:** **I = Interview** **O = Observation** **D = Documentation** **PTV = Submitted Prior To Visit** **(List Who and What)**	**Notes** **Explain Unacceptable or Conditionally Acceptable:**
(Disbursements/invoices are approved & monitored by management). **ON SITE**						are conducted each month for the activities and bank statements for the preceding month and are reviewed by two parties. Vendor payments are distributed through the corporate office in Tampa, Florida through check requisitions by the Broward office. Vendor files are maintained locally with copies of the invoices and check requisitions. Invoices are submitted on a monthly basis with supporting documentation.	
e. Agency maintains inventory in accordance with a written policy and FNYFS contractual requirements. If over $1,000 inventory has DJJ Property Inventory Number/Tag. In the event the provider has purchased computer equipment an Informational Resources Request (IRR) has been submitted to DJJ. **PTV/ON SITE**	☐	☐	☐	☐	☒	Documentation/Interview: N/A – The agency has not purchased any items with FNYFS funds since the last time on-site. Provider maintains an inventory for computer and periphery equipment purchased from 12/2002. Inventory was last updated on 10/2/24 and no additional items were purchased with FN funds within the last year.	**No recommendation or Corrective Action.**

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Major Programmatic Requirements	**Explain Rating**					**Ratings Based Upon:** **I = Interview** **O = Observation** **D = Documentation** **PTV = Submitted Prior To Visit** **(List Who and What)**	**Notes** **Explain Unacceptable or Conditionally Acceptable:**
	Unacceptable	**Conditionally Acceptable**	**Fully Met**	**Exceeded**	**Not Applicable**		
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: Deposit Recap First and Second Quarter 2024. ADP is contracted by LSF to process payroll. ADP is responsible for submitting information for W2s, Quarterly 941 reports, and payroll taxes. ADP Deposit Details for the first and second quarters of 2024 were reviewed. These reports demonstrate submission of payroll taxes and deposits biweekly through electronic funds transfer.	**No recommendation or Corrective Action.**
g. Budget to actual reports prepared and reviewed by appropriate management. Variance from the budget are investigated and explained. **PTV/ON SITE**	☐	☐	☒	☐	☐	Documentation: Agency provided a detailed CINS/ FINS Budget Report which included months including June through August 2024. The report tracks all budget categories by current period actual and current period contract separately. The provider has a monthly process for reviewing and explaining variances.	**No recommendation or Corrective Action.**
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	☐	☐	☒	☐	☐	Documentation: Financial audit was conducted for the fiscal year ending June 30, 2023 and 2022 by RSM US	**No recommendation or Corrective Action.**

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	Explain Rating						
Major Programmatic Requirements	**Unacceptable**	**Conditionally Acceptable**	**Fully Met**	**Exceeded**	**Not Applicable**	**Ratings Based Upon:** **I = Interview** **O = Observation** **D = Documentation** **PTV = Submitted Prior To Visit** **(List Who and What)**	**Notes** **Explain Unacceptable or Conditionally Acceptable:**
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**						LLP. A letter dated March 29, 2024, stated no corrective action was needed. A copy was submitted directly to the Florida Network of Youth and Family Services.	
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 reviewed included policy and procedures regarding the following: data back-up contained in the Agency's Policy and Procedure Section 2.10, on Information Management; Section 1, 1.09 Confidentiality of Client Information; Section 12, 12.01 Access to Case Records; 12.02 Case Record Keeping; and 4.66 Records Retention. Laptops are not furnished to case workers.	**No recommendation or Corrective Action.**
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 an Employee List Point-in-Time report providing evidence of staff members' hourly pay rate of a minimum of $19.The agency provided direct care staff pay increases effective as of October 1, 2023 to present.	**No recommendation or Corrective Action.**

CONCLUSION

Lutheran Services Florida Southeast has met the requirements for the CINS/FINS contract as a result of full compliance with 12 applicable indicators of the Administrative and Fiscal Contract Monitoring Tool. Two of the 14 indicators were not applicable because the provider, 1) does not have any corrective action item(s) cited by an external funding source, and 2) has not purchased any inventory with DJJ/Florida Network funds. Consequently, **the overall compliance rating for this contract monitoring visit is 100%.** There are no corrective actions cited or recommendations made as a result of the contract monitoring visit. Overall, the provider is performing satisfactorily in meeting the fiscal and administrative terms of its contract. In addition, the majority of indicators reviewed were carried out in a manner which meets the standard described in the report findings.

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 Lutheran Services Florida - Southeast
CINS/FINS Program

November 13-14, 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	Limited
1.05 Analyzing and Reporting Information	Satisfactory
1.06 Client Transportation	Limited
1.07 Outreach Services	Satisfactory

Percent of indicators rated Satisfactory: 71.43 %
Percent of indicators rated Limited: 28.57 %
Percent of indicators rated Failed: 0 %

Standard 2: Intervention and Case Management

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

Percent of indicators rated Satisfactory: 66.67 %
Percent of indicators rated Limited: 33.33 %
Percent of indicators rated Failed: 0 %

Standard 3: Shelter Care & Special Populations

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

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

Standard 4: Mental Health/Health Services

4.01 Healthcare Admission Screening	Satisfactory
4.02 Suicide Prevention	Limited
4.03 Medications	Limited
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: 40 %
Percent of indicators rated Failed: 0 %

Overall Rating Summary

Percent of indicators rated Satisfactory: 71.43 %
Percent of indicators rated Limited: 28.57 %
Percent of indicators rated Failed: 0 %

Rating Definitions

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

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

Reviewers

Members

Marcia Tavares-Lead Reviewer Consultant-Forefront LLC/Florida Network of Youth and Family Services
Nathaly Milla – Florida Keys Children Shelter
Pamela Palmer – SMA Healthcare - Beach House
Latoya Robinson – Prevention Central

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

Documents Reviewed

	Accreditation Reports	X	Table of Organization		Visitation Logs
X	Affidavit of Good Moral Character	X	Fire Prevention Plan	X	Youth Handbook
X	CCC Reports	X	Grievance Process/Records	5	# Health Records
X	Logbooks		Key Control Log	5	# MH/SA Records
	Continuity of Operation Plan	X	Fire Drill Log	16	# Personnel /Volunteer Records
X	Contract Monitoring Reports	X	Medical and Mental Health Alerts	9	# Training Records
	Contract Scope of Services	X	Precautionary Observation Logs	7	# Youth Records (Closed)
X	Egress Plans	X	Program Schedules	7	# Youth Records (Open)
X	Fire Inspection Report	X	List of Supplemental Contracts		# Other: ___
X	Exposure Control Plan	X	Vehicle Inspection Reports		

Observations During Review

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

Surveys

13	# of Youth	3	# 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

Lutheran Services Florida (LSF) is a statewide, non-profit, human services agency with its headquarters located in Tampa, Florida. LSF Southeast (LSF SE) contracts with the Florida Network of Youth and Family Services (Florida Network) to operate Children In Need of Services/Families In Need of Services (CINS/FINS) residential and community counseling services to youth and families in Broward County. The program operates out of two locations: 1) Lippman Youth Shelter, located in the City of Oakland Park, Florida, and 2) its administrative office and community counseling program (also known as Broward Family Center), located at 2700 W. Cypress Creek Rd., Suite D131, Fort Lauderdale, Florida. Funding through CINS/FINS allows the agency to serve both male and female youth up to seventeen years old that are locked out, runaway, ungovernable, truant, homeless, abused, neglected, or at-risk. The agency provides services to special populations who meet the criteria for Staff Secure shelter, Domestic Minor Sex Trafficking (DMST), and youth referred by the Juvenile Justice Court System for domestic violence (DV) respite, probation (PR) respite, as well as DV and PR Family and Youth Respite Aftercare services (FYRAC). The census during the Quality Improvement (QI) visit was 12 CINS/FINS youth. Lippman is licensed to serve twenty (20) youth and the program's license was renewed by the Department of Children and Families (DCF) and is effective through June 28, 2025. In March of 2022, the agency was informed that the Council on Accreditation (COA) approved the accreditation of LSF through February 28, 2026. LSF SE programs were monitored during the visit for accreditation and met the standards set forth by COA.

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

Standard 1: There are seven indicators for Standard 1.
Indicator 1.01 Background Screening of Employees/Volunteers was rated **Satisfactory with Exception**.
Indicator 1.02 Provision of an Abuse Free Environment was rated **Satisfactory with Exception.**
Indicator 1.03 Incident Reporting was rated **Satisfactory with Exception.**
Indicator 1.04 Training Requirements was rated **Limited**.
Indicator 1.05 Analyzing and Reporting Information was rated **Satisfactory.**
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**.
Indicator 2.02 Needs Assessment was rated **Limited.**
Indicator 2.03 Case/Service Plan was rated **Satisfactory with Exception.**
Indicator 2.04 Case Management and Service Delivery was rated **Satisfactory with Exception.**
Indicator 2.05 Counseling Services was rated **Limited.**
Indicator 2.06 Adjudication/Petition Process was rated **Satisfactory.**
Indicator 2.07 Youth Records was rated **Limited.**
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.**
Indicator 3.03 Youth Room Assignment was rated **Satisfactory with Exception.**
Indicator 3.04 Log Books was rated **Satisfactory with Exception.**
Indicator 3.05 Behavior Management Strategies was rated **Satisfactory.**
Indicator 3.06 Staffing and Youth Supervision was rated **Limited.**
Indicator 3.07 Video Surveillance System was rated **Satisfactory with Exception.**

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

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

Standard 1:
Indicator 1.04 - Limited
1) One first year staff's pre-service training did not document training on client intake, video camera, disaster preparedness, and fire safety.
2) All four shelter staff training records did not include evidence of medication/mental health alert training during orientation and one of the staff's record did not document training on client intake, video camera, disaster preparedness, and fire safety. All four staff did not complete the MAB 16-hour in-person training. Two staff completed CPR/First Aid after the 90 day timeframe.
3) Three of four training records were missing annual/biannual trainings as follows:
One staff was missing all DJJ SkillPro trainings, Suicide Prevention, and Fire Safety and completed only 16.6 of the 40 hours; Rose is missing all DJJ SkillPro trainings, Suicide Prevention, MAB, and Fire Safety and completed only 18 of the 40 hours; Kimberly missed Information Security, PREA 1&2, Sexual Harassment, Fire Safety, and only 13.5 of the 40 hours.
4) Three of four in-service staff did not complete the required 40 annual training hours. One staff completed only 16.6 of the 40 hours; a second staff completed 18 of the 40 hours; and a third staff completed only 13.5 of the 40 hours.

Indicator 1.06 - Limited
1) Out of the ten single youth transportations reviewed, there were three single transports, which did not have supervisors approval. Seven "supervisors approvals" were done after transportation took place. The location to transport youth is not noted on logbook or van log.
2) The program does not have a specific protocol for documenting check-ins at specific times during single transport. None of the ten single transports reviewed included documentation of transporting staff checking in and the manager or designee receiving the call.
3) Destination locations are usually not explicit. Most logs for school transportation just mentioned school. However, there are no locations or school names where kids are being transported to or picked up from.

Standard 2:

Indicator 2.02 - Limited

The NIRVANA assessment for five youths was backdated. Staff members signed the assessments with a date prior to the generated or printed date. One of the youth's self-reports does not have a date.

Indicator 2.05 - Limited

1) Twelve random weeks were reviewed for group sessions held: November 3-9 , two 2 groups; November 10-15, 2 groups; October 20-26 - no groups; October 6-12, no group; September 15-21, 1 group; September 1-7, 1 group, Aug 18-24, no group; Aug 4-10, 1 group; July 21-27,1 group; July -19, 2 groups; June 21-29, no groups; June 2-8, no groups.
2) Not all house meeting groups conducted met the criteria for group sessions as duration was barely 15 minutes. A vast majority of group sign in sheets for house meetings did not include length of time.

Indicator 2.07- Limited

1) Files transferred from other agency facility were not stored in a locked container, which poses a risk to sensitive information. To ensure the safety of these files, staff must use locked boxes and clearly label them as confidential which was not observed during the review. The program was not able to furnish an opaque container marked “confidential” that staff uses to transport files offsite.
2) The file storage room door was unlocked and not observed to be secure during tour of the facility.

Standard 3:

Indicator 3.06 - Limited

Video surveillance captured a bed check at 2:40am and the next bed check was observed at 3:00am. In reviewing the logbook, staff falsely documented they completed a bed check at 2:51am and no bed check was completed at that time according to the video reviewed. CCC was called to report the observed falsification event.

Standard 4:

Indicator 4.02 - Limited

1) Out of the six files reviewed, two files, one residential and one counseling did not have review and signature from a supervisor.
2) Although program has assigned staff to monitor youth, reviewer found there were several missing observation logs. One record was missing sight and sound logs missing 9/10/24, 3:00PM until 5:30PM; 9/11/24, 7:00AM - 3:00PM; 9/12/24, 7AM - 5:00PM; 9/13/24, 7AM until 6PM; 9/15/24, no staff initials on logs from 11PM until 7AM; and 9/1/24, five missing logs from 7:00AM until 9/16/24 at 4:50 PM. A second record shows the suicide assessment (SA) was done by a counselor on 07/30/24 where recommendation to keep child on sight and sound was made. Clinical supervisor signed SA on 08/07/24. Client was taken out off sight and sound on 08/01/24 but there was not SA found, which indicated youth should be removed from sight and sound. No observation (sight and sound) logs were found after 08/01/24 leading up to the clinical review on 8/7/24.
3) From the three residential files reviewed, it was noted that the recommendation to change supervision level was not clearly documented.

Indicator 4.03 - Limited

1) There was no evidence found of any monthly or quarterly meeting documents, where managers or RN participated that could have been used to assess strategies to reduce medication errors.
2) Reviewer found evidence that not all medication was stored in a Pyxis ES medication Cabinet. The agency has a storage closet inside the medication room which was not only used to store youth's belongings but also extra medication that was not placed inside Pyxis.
3) For controlled substances from medication distribution logs reviewed, reviewer observed that shift to shift count did not happen on several occasions.
4) During medication pass on 11/14/2024 reviewer found that discrepancies with medication were not clear after each shift. MDL from two current clients did not match med count on Pyxis machine; discrepancy, which according to RN was created two shifts before review date.

CINS/FINS QUALITY IMPROVEMENT TOOL

Quality Improvement Indicators and Results: Please select the appropriate outcome for each indicator for each item within the indicator.		**Summary/Narrative Findings:** The narrative write-up is a thorough summary of each assigned QI indicator, explaining how finding(s) are determined.	**Deficiencies/Exceptions:** Please add additional detailed explanations for any items that have any deficiencies or exceptions.
Standard One – Management Accountability			
1.01: Background Screening of Employees, Contractors and Volunteers			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 1.01		**NO** If NO, explain here: The agency's policy and procedure 1.01 does not accurately reflect all requirements of the indicator. The procedure indicates an applicant can retake the suitability assessment more than three attempts within 30 days contrary to the requirement of up no more than three attempts in 30 days. The policy was also not updated to indicate employees with a break in service may be re-employed without additional background screening if the break is less than 90 days and not the previous 18 months requirement. The provider has a policy and procedure 1.01 Background Screening of Employees, Interns, and Volunteers, that was approved on September 9, 2024 by the Regional Director.	
All positions providing direct services to youth has successfully passed pre-employment suitability assessment on the initial attempt.	**Exception**	The agency uses the Predictive Index (PI) pre-employment assessment that was implemented July 2018. A total of 14 new staff were hired during the annual review. Two licensed staff were not required to take the suitability assessment. The tool was administered prior to offer of employment to eight of the applicable 12 direct care staff. All eight staff completing the assessment obtained passing scores of five or greater on a scale of 1-10.	An offer of employment was made to four staff who were hired prior to their completion of the pre-employment suitability assessment.
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.	**Exception**	Effective July 1, 2024, any applicant that did not pass the initial suitability assessment is required to retake the assessment. One of the new hires, date of hire 8/7/24, was an intern prior to hire and did not successfully pass the suitability assessment (scored a 4) on 7/25/24. Hire approval was granted by the program director based on the staff's performance as an intern; however, the staff did not retake the assessment to obtain a passing score.	The program approved hire for staff who did not obtain a passing score on the suitability assessment.
Agency has evidence for employees who have had a break in service for 18 months or more, and/or when the agency had a change or update in the suitability assessment tool used was different from the employee's original assessment, that a new suitability assessment and background screening was completed as required.	**No eligible items for review**	None of the new hires were prior employees.	

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**	Background screenings for all 14 new hires and two interns were initiated prior to hire/start dates with eligibility documented on the DJJ background screening results. There were no exemptions required.	
Five-year re-screening is completed every 5 years from the date of the last screening for all applicable employees and volunteers.	**No eligible items for review**	The program did not have any eligible re-screenings and/or expired retained prints during the annual review.	
Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?	**Compliance**	The program emailed its Annual Affidavit of Compliance with Level 2 Screening Standards to the Background Screening Unit on January 16, 2024 prior to the January 31st deadline.	
Proof of E-Verify for all new employees obtained from the Department of Homeland Security	**Compliance**	Proof of employment authorization from the Department of Homeland Security was obtained through E-verify and maintained on file for all 14 new hires.	
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: The provider has the required policy 1.02, titled Provision of an Abuse Free Environment, that was approved on September 9, 2024 by the Regional Director.	
Agency has a code of conduct of policy and there is evidence that staff are aware of agency's code of conduct.	**Compliance**	The agency has a code of conduct that prohibits use of physical abuse, profanity, threats or intimidations. All new staff are required to sign the code of conduct form during the orientation process.	
The agency has a process in place for reporting and documenting child abuse hotline calls.	**Compliance**	Postings of the Abuse Hotline Number were observed to be located in binders posted on the wall in each bedroom, the youth lounge, and on wall in the counseling hallway. The agency has a process in place for reporting and documenting abuse hotline calls. Once an abuse call is made, staff completes a Child Abuse and Neglect form and documents the call on a log that is maintained by the program manager. A review of the log showed the agency reported four calls to the abuse hotline during the past six months. None of the four calls were institutional.	
Youth were informed of the Abuse and Contact Number	**Compliance**	Per the shelter supervisor, youth are informed of the abuse hotline during orientation. The abuse hotline number was observed to be included in the Resident handbook and posted on a wall in the dorm hallway.	

Grievance			
The program(s) have an accessible and responsive grievance process for youth to provide feedback and address complaints. Program director/ supervisor has access to and can manage grievances unless it is towards themselves.	**Compliance**	The program has an accessible and responsive grievance process for youth to provide feedback and address complaints. The residential program director and youth care supervisor have access to and manage grievances unless it is towards themselves. There were no reported grievances towards the program director or supervisor during the review period. There were 15 grievances submitted within the last six months.	
Shelter only: Grievances are maintained on file at minimum for 1 year.	**Compliance**	The shelter manager maintains records of grievances in a file for a minimum 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**	The program's grievance procedure is reviewed with youth during intake. The grievance box was observed to be locked and is mounted on a wall in the shelter at the entry to the youth dormitory. Grievance forms are accessible next to the grievance box.	
Shelter only: There is evidence that grievance boxes are checked by management or a designated supervisor at least daily (excluding weekends and holidays) and documented in the program logbook.	**Compliance**	Twelve random 1-week periods in the logbooks were reviewed from May to October 2024 for evidence of grievance box checks by management daily. A total of 60 days were reviewed. Grievance box checks were conducted by the program manager and supervisor and were observed to be documented in the logbook for all 60 days reviewed.	
Shelter only: Grievances are resolved within 72 hours of being submitted or there was documentation explaining the cause for the delay in providing a resolution.	**Exception**	Fifteen grievances reported were reviewed. Fourteen of the fifteen grievances were observed to be resolved within 72 hours.	One grievance filed 5/16/24 was not resolved until 5/21/24, greater than 72 hours required.
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 the required policy 1.03, titled Incident Reporting, that was approved on September 9, 2024 by the Regional Director.	
During the past 6 months, the program notified the Department's CCC (Central Communication Center) no later than two hours after any reportable incident occurred or within two hours of the program learning of the incident	**Compliance**	A total of nine DJJ Department CCC Reports for the last six months were reviewed. The program notified the CCC no later than two hours after any reportable incident occurred or within two hours of the program learning of the incident for all nine incidents.	
The program completes follow-up communication tasks/special instructions as required by the CCC	**Compliance**	The program completed follow-up communication tasks/special instructions as required by the CCC. All nine of the incidents reviewed were closed with no outstanding tasks to be completed.	
Agency internal incidents are documented on incident reporting forms and all CCC reportable incidents were consistently reported to CCC as required.	**Compliance**	The program manager maintains incident reporting forms and all CCC reportable incidents in a file. All nine incidents were documented on reporting forms and were consistently reported to CCC as required.	

Incidents are documented in the program logs and on incident reporting forms	**Exception**	Eight of the nine CCC reports reviewed were documented in the program logbook. Logbook documentation for six of the nine incidents included information on both the incident event and the CCC call.	One of the nine CCC calls reported on 6/9/2024 was not documented in the logbook. Three of the nine incidents documented the CCC call in the logbook but not the events of the incidents (1 contraband (7/8/24), and 2 baker-acts (9/10/24 & 10/14/24).
All incident reports are reviewed and signed by program supervisors/ directors	**Compliance**	For the nine CCC reportable incidents reviewed, all internal incident reports were reviewed and signed by the program manager. Reportable incidents by type are as follows: medical -1; mental health and substance abuse - 5; complaints against staff 1; and youth behavior Incident - 3.	
1.04: Training Requirements (*Staff receives training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions*)			**Limited**
Provider has a written policy and procedure that meets the requirement for Indicator 1.04		**YES** If NO, explain here: The agency has the required policy 1.04, titled Training Requirements, that was approved on September 9, 2024 by the Regional Director.	
First Year Direct Care Staff			
All direct care staff have completed a new hire pre-service training provider orientation before they work independently. At a minimum, the orientation included the following: • Agency policies and procedures • Behavior Management (Shelter Only) • Building/Facility layout • File Documentation/development of paperwork requirements and confidentiality • CCC & Incident Reporting • Child Abuse Reporting • Client Intake & Screening • Client Orientation (direct care staff training on delivering new client orientation) • Fire Equipment Safety • Medical and Mental Health Alert System (Shelter) • Risk Management--Including but not limited to the following: - Disaster Preparedness and Emergency Response - First Aid/CPR - Universal Precautions • Video Camera Surveillance & Equipment • All other necessary information to orient a new hire to perform their job role and duties.	**Exception**	A total of four first year direct care staff training records were reviewed. Three of the four direct care staff have completed the required new hire pre-service trainings provided at orientation before they worked independently with youth.	One first year staff's pre-service training did not document training on client intake, video camera, disaster preparedness, fire safety.

All staff completed the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days from date of hire.	**Compliance**	All four first year direct care staff completed the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days of hire.	
All direct care CINS/FINS staff for shelter and community counseling services, including independent contractors (full-time, part-time, and on-call) and interns met the minimum requirement of 80 hours of training for the first full year of employment.	**Compliance**	None of the four staff completed their first year of employment; however, all four has exceeded the 80-hour annual training requirement.	
All staff receives all mandatory training during the first 90 days of employment from date of hire.	**Exception**	None of the four new hire direct care staff training files reviewed indicated all mandatory trainings were completed within the required 90-day timeframe.	1) All four shelter staff training records did not include evidence of medication/mental health alert training during orientation and one of the staff's record did not document training on client intake, video camera, disaster preparedness, and fire safety. 2) All 4 staff did not complete the MAB 16-hour in-person training. 3) Two staff completed CPR/First Aid after the 90 day timeframe.
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**	Three applicable staff who assist with Medication Distribution have completed the required in-person training conducted by the registered nurse, prior to administering medication to shelter youth.	
Any staff that is utilizing NETMIS has evidence of completing NetMIS Training in their training file.	**Compliance**	One applicable staff completed the NetMIS training.	
Staff Participating in Case Staffing & CINS Petitions (within the first year of employment BUT no later 7/1/24 for previous staff)			
Documentation of instructor-led FL Statute 984 CINS Petition Training by a local DJJ Attorney within 1 year of employment or no later than 7/1/24 if hired before 7/1/23. (*Policy went into effect 7/1/23).*	**No eligible items for review**	None the four new hire direct care CINS/FINS staff training files reviewed, participates in CINS Case Staffing Petitions	
Non-licensed Mental Health Clinical Shelter Staff (within first year of employment)			
Documentation of non-licensed mental health clinical staff person's training in Assessment of Suicide Risk form or written confirmation by a licensed mental health professional of training (includes date, signature and license number of the licensed mental health professional supervisor).	**Compliance**	The program hired one new non-licensed mental health clinical shelter staff person during the review period. Documentation supported staff completed the required training in Assessment of Suicide Risk and written confirmation met the requirement.	

In-Service Direct Care Staff			
In-service staff completes all of the required annual or 2-year mandatory refresher Florida Network, SkillPro, or other job-related trainings within the required timeframe.	**Exception**	Four in-service staff training files were reviewed. One of the four in-service staff completed all but one required annual trainings with one month remaining to complete the Fire Safety training.	Three of four training records were missing annual/biannual trainings as follows: One staff was missing all DJJ SkillPro trainings, Suicide Prevention, and Fire Safety and completed only 16.6 of the 40 hours; the second staff is missing all DJJ SkillPro trainings, Suicide Prevention, MAB, and Fire Safety and completed only 18 of the 40 hours; and the third staff missed Information Security, PREA 1&2, Sexual Harassment, Fire Safety, and only 13.5 of the 40 hours
Community Counseling Direct Care staff completes 24 hours of mandatory refresher Florida Network, SkillPro, and job-related training annually.	**No eligible items for review**	All four in-service training records reviewed were for residential program staff.	
Shelter Program Direct Care staff completes 40 hours of mandatory refresher Florida Network, SkillPro, and job-related training annually *(E.g. the program has a DCF child caring license).*	**Exception**	None the four in-service training records reviewed showed staff completed the required 40 hours of training to date. One of the staff had one month to complete 6 hours. The remaining three staff	Three of four in-service staff did not complete the required 40 annual training hours. One staff completed only 16.6 of the 40 hours; a second staff completed 18 of the 40 hours; and a third staff completed only 13.5 of the 40 hours.
Required Training Documentation			
The agency has a training plan that includes all of the required training topics including the pre-service and in-service.	**Compliance**	A review of the agency's FY 24-25 training plan shows all required training topics for pre/in-service staff. A copy of the training plan is included in each training file reviewed.	
The agency has a designated staff member responsible to manage all employee's individual training files and completes routine tracking and reviews of staff files to ensure compliance.	**Compliance**	The program manager is responsible for maintaining their employee's individual training files and completes routine tracking and reviews of staff files to ensure compliance.	
The program maintains an individual training file or employee file AND a FLN Training Log (or similar document that includes all requirements) for each staff, which includes an annual employee training hours tracking form and related documentation, such as electronic record/transcript, training certificates, sign-in sheets, and agendas for each training attended.	**Compliance**	All training files reviewed were in a maintained, individual training file 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.	
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:		Training documentation supported six of the seven applicable staff completed the training. One of the seven staff is currently within the timeframe for completing the training.	
Additional Comments: **There are no additional comments for this indicator.**			

1.05 - Analyzing and Reporting Information			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 1.05		**YES** If NO, explain here: The agency has the required policy 1.05, titled Analyzing and Reporting Information, that was approved on September 9, 2024 by the Regional Director. In addition, there is a comprehensive agency-wide Performance Quality Improvement (PQI) plan that includes detailed procedures to collect, review, and reports various sources of information to identify patterns and trends.	
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**	Case record reviews are conducted at a minimum on a monthly basis by the Quality Assurance Support Coordinator (QASC) and the local program clinical staff and documented individually for each record reviewed using LSF's Quality Assurance File Review Tool. A quarterly file review report summarizes the findings relative to the Council on Accreditation, 65C, Florida Network, and Program requirements. A preliminary report with outcomes for 70% of the sample is generated by the QASC and upon completion of the remaining 30% sample, the local program will determine three focus areas based on scores to develop and implement an improvement plan. The outcome of the peer reviews are reported to staff at monthly staff meetings to address deficiencies identified. Staff meeting minutes and agenda for the review period support peer record reviews are conducted and communicated to staff. Quarterly reports indicate a total of 16 residential files were reviewed (January - July 2024) and 45 community counseling files were reviewed (May - September 2024).	
The program conducts reviews of incidents, accidents, and grievances quarterly, at a minimum	**Compliance**	Data regarding the number of incidents/accidents and grievances is entered into the agency's CQI Monthly CQI Program Metrics Report. The spreadsheet captures a variety of data for all the programs statewide, as well as regionally, and monitors the number of incidents, accidents, and grievances. Incidents/accidents are tracked on the companion report monthly by level of severity. A review of monthly staff meeting agendas showed evidence of discussion of incidents/accidents and grievances during the review period.	
The program conducts an annual review of customer satisfaction data	**Compliance**	The program collects customer satisfaction survey data monthly and enter the number completed each month by the program into the CQI Program Metrics. A review of the staff meeting agendas/minutes demonstrated there was communication and discussion of client satisfaction surveys during the review period.	

The program demonstrates a monthly review of the statewide End-of-Month ("EOM") report generated by the Florida Network Office. This includes monthly data, fiscal year to date data, benchmarks for residential and community counseling, screening data, report card measures, follow-up reporting measures.	**Compliance**	The provider has established program and contract outcomes and collects performance measures data monthly on the monthly CQI Program Metrics by program as well as the Florida Network's End-of Month (EOM) reports. Data collected includes benchmarks and performance measures such as: client satisfaction; client functioning; staff turnover; incidents/accidents; grievances; care days; data entry; service completion and status at discharge; 30 and 60-day follow-up; and exits. PQI, outcomes, and NetMIS data is reviewed and discussed at staff meetings and monthly management meetings and are documented in the meeting minutes.	
The program has a process in place to review and improve accuracy of data entry & collection	**Compliance**	Weekly NetMIS reviews are conducted to review data entry collection, benchmark data, and deficiencies. This information is sent via email to the Regional Director and Community Counseling Director, the latter oversees quality checks of youth records.	
There is documentation that findings are regularly reviewed by management and communicated to staff and stakeholders.	**Compliance**	Findings are regularly reported on a monthly basis and documented in the agency's monthly CQI Program Metrics where reports can be generated and shared with staff at monthly staff meetings. Documentation of supported findings is reviewed by management and communicated with staff during manager and staff meetings. The agency publishes an Annual Report to share program information with stakeholders.	
There is evidence the program demonstrates that program performance is routinely reviewed with the Board of Directors. All final reports that include a Limited or Failed score is submitted electronically or by mail to the providers Executive Committee on the Board of Directors.	**Compliance**	LSF's Quality Assurance Department is responsible for data collection, data processing, analysis, and reporting of performance quality and improvement to the Executive Leadership Team and the LSF Board of Directors. Metrics that impact the agency are reviewed via LSF's cross-functional continuous quality improvement workgroups, committees, and departmental meetings. Per the agency's PQI, the Board of Directors/Executive Leadership reviews performance targets, including QI performance, on a quarterly basis. Board meeting minutes for meeting held July 25, 2024 indicate the Board of Directors acknowledged receipt of the CINS/FINS monitoring report.	
There is evidence that strengths and weaknesses are identified, improvements are implemented or modified, and staff are informed and involved throughout the process.	**Compliance**	The agency has an Associate Vice President Quality Assurance and Compliance who leads the development, implementation, documentation, evaluation, and promotion of continuous improvement practices and systems. LSF SE also has a director of compliance who is responsible for oversight at the regional level. Processes are in place and established in the PQI plan to collect date and identify areas needing improvement. Should negative trends be observed, a corrective action will be implemented as a priority issue to be addressed and is monitored by the compliance staff as well as the program management team.	

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 the required policy 1.06, titled Client Transportation, that was approved on September 9, 2024 by the Regional Director.	
Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	**Compliance**	The agency maintains a list of authorized drivers and per the program manager, nineteen drivers are approved drivers to transport youth in agency vehicles.	
Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	**Compliance**	Documentation from the Florida Department of Motor Vehicles supported all nineteen staff have a valid drivers licenses. Per agency's policy, approved drivers are covered under the agency's automobile insurance policy.	
Agency's Transportation policy prohibit transporting a client without maintaining at least one other passenger in the vehicle during the trip and include exceptions in the event that a 3rd party is NOT present in the vehicle while transporting	**Compliance**	The agency has a transportation policy that requires staff to make arrangements to transport youth and ensure the staff member is never in a one to one situation with any youth. When another youth care staff is unavailable to assist with transportation the youth care staff may utilize interns, volunteer or may utilize other youth during transport. The agency does have in place a procedure if a 3rd party cannot be obtained for transport.	
In the event that a 3rd party cannot be obtained for transport, the agency's supervisor or managerial personnel consider the clients' history, evaluation, and recent behavior	**Compliance**	In the event of a single transport of youth, per the transportation policy, approval is required by the residential program manager who considers the client's history, evaluation, and recent behavior.	
The 3rd party is an approved volunteer, intern, agency staff, or other youth	**Compliance**	Transportation logs were reviewed for two agency vans for the review period May 2024 through the review date. With the exception of single transports, third party present in vehicles were typically agency staff or other youth.	
The agency demonstrated evidence via logbook or other written verification that supervisor approval was obtained prior to all single youth transports.	**Exception**	A total of 10 randomly selected single transports completed during the period were reviewed. One of the ten single youth transports documented supervisor's prior approval; however, seven additional supervisor's approvals were not observed to occur prior to the transports.	Out of the ten single youth transportations reviewed, there were three single transports, which did not have supervisors approval. Seven "supervisors approvals" were done after transportation took place. Location to transport youth is not noted on logbook or van log.
"When transporting a single client in a vehicle, there was documentation of the following: a. the transporting employee completed check-in by phone at agreed-upon intervals with the senior program leader, or designee, upon departure and arrival. b. the employee check-ins were documented by the manager or designee receiving the call."	**Exception**	The reviewer was unable to see in the program logbook where there was a call made to the shelter manager or senior program lead, or designee upon departure or arrival of single transport.	The program does not have a specific protocol for documenting check-ins at specific times during single transport. None of the ten single transports reviewed included documentation of transporting staff checking in or the manager or designee receiving the call.

There is documentation of use of vehicle that notes name or initials of driver, date and time, mileage, number of passengers, purpose of travel and location.	**Exception**	The program has a vehicle utilization tracking log that includes information to document transportation events. The logs include name or initials of driver, date and time, mileage, number of passengers, purpose of travel and location.	Destination locations are usually not explicit. Most logs for school transportation just mentioned school. However, the logs do not indicate the location or names of school where kids are being transported to or picked up from.
Additional Comments: **There are no additional comments for this indicator.**			
1.07 - Outreach Services			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 1.07		**YES** If NO, explain here: The agency has the required policy 1.07, titled Outreach Services, that was approved on September 9, 2024 by the Regional Director.	
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 Regional Director and shelter Program Manager are the designated lead staff to attend the local DJJ council advisory board (CAB) meetings. Staff provided meeting documentation to support attendance to all of the CAB meetings held.	
The program maintains written agreements with other community partners which include services provided and a comprehensive referral process.	**Compliance**	The agency maintains multiple interagency agreements that meet all contractual requirements. The agreements are held with a variety of community partners to provide a comprehensive referral process including mental health, substance abuse, truancy, safe place sites, employment services, educational, medical services, and support services.	
The program will maintain documentation of outreach activities and enter into NetMIS the title, date, duration (hours), zip code, location description, estimated number of people reached, modality, target audience and topic.	**Compliance**	Outreach activities are entered into NetMIS including the title, date, duration (hours), zip code, location description, estimated number of people reached, modality, target audience and topic. Outreach activities in the past six months have included attendance to symposiums, schools, community events, festivals, provider meetings, clubs, support groups, and local city/county events. It was observed DJJ Advisory meetings attended were not entered in NetMIS for outreach.	
The program has designated staff that conducts outreach which is defined in their job description.	**Compliance**	The program has a designated position, Outreach Specialist, that is responsible for the outreach program. In addition to the Outreach Specialist, the Regional Director, program managers, and counseling staff also conduct outreach. These individuals were listed as participating staff on the NetMIS outreach log for the review period.	
Additional Comments: **There are no additional comments for this indicator.**			

2.01 - Screening and Intake			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 2.01		**YES** If NO, explain here: The agency has the required policy 2.01, titled Screening and Intake, that was approved on September 9, 2024 by the Regional Director.	
Shelter youth: Eligibility screening form is completed immediately for all shelter placement inquiries.	**Compliance**	All five residential youth records contained screenings that had been completed prior to or immediately upon admission to shelter.	
Community counseling: Eligibility screening form is completed within 3 business days of referral by a trained staff using the Florida Network screening form.	**Compliance**	All five community counseling youth records contained screenings that had been completed within 3 business days of referral and prior to intake.	
There is evidence all referrals for service is screened for eligibility and is logged in NetMIS within 72 hours of screening completion.	**Compliance**	All twelve youth records contained evidence referrals for service is screened for eligibility and is 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 twelve records reviewed contained verification that the youth and parents/guardians were provided with information related to available service options and rights and responsibilities of youth and parents/guardians.	
The following is also available to the youth and parents/guardians: a. Possible actions occurring through involvement with CINS/FINS services (case staffing committee, CINS petition, CINS adjudication) b. Grievance procedures	**Compliance**	All twelve youth records contained documentation to support CINS/FINS brochure was discussed by way of a form that stated the brochure and handbook were reviewed. All ten records included documentation grievance procedures were provided/reviewed with youth and parents/guardians.	
During intake, all youth were screened for suicidality and correctly assessed as required if needed.	**Compliance**	A completed copy of the CINS/FINS intake was present in all ten youth records to support suicide screening was conducted at intake and the youth were referred for assessment of suicide risk, if needed.	
Additional Comments: **There are no additional comments for this indicator.**			
2.02 - Needs Assessment			**Limited**
Provider has a written policy and procedure that meets the requirement for Indicator 2.02		**YES** If NO, explain here: The agency has the required policy 2.02, titled Network Inventory of Risks, Victories, and Needs Assessment (NIRVANA), that was approved on September 9, 2024 by the Regional Director.	
Shelter Youth: NIRVANA is initiated within 72 hours of admission	**Compliance**	All five residential records reviewed had the NIRVANA Assessment initiated 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 records reviewed demonstrated NIRVANA Assessments were initiated at intake and completed within face-to-face contacts.	

Supervisor signatures is documented for all completed NIRVANA assessments and/or the chronological note and/or interview guide that is located in the youths' file.	**Exception**	Each file contains a printed NIRVANA that shows the date printed, beyond the intake date when the NIRVANA was completed. A case manager provided a note explaining the delayed printing of the NIRVANA assessment.	One of the youth's self-report does not have a date. The NIRVANA assessment for five youth were backdated. Staff members signed the assessments with a date prior to the generated or printed date. The program was informed to contact CCC regarding the backdating of the Nirvana assessments. The call was accepted by CCC.
(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**	The five residential records reviewed included NIRVANA Self-Assessment (NSR) that were completed within 24 hours of youth being admitted into shelter.	
A NIRVANA Post-Assessment is completed at discharge for all youth who have a length of stay that is greater than 30 days.	**Compliance**	There were two applicable closed community counseling records with length of stay greater than 30 days. Both records reviewed included a post NIRVANA Assessment. The supervisor is signing the NIRVANA over 20 days later but less than 30 days.	
A NIRVANA Re-Assessment is completed every 90 days excluding files for youth receiving SNAP services.	**No eligible items for review**	None of the youth records reviewed were active for over 90 days.	
All files include the interview guide and/or printed NIRVANA.	**Compliance**	All reviewed files from the youth records included a printed NIRVANA assessment.	
Additional Comments: **There are no additional comments for this indicator.**			
2.03 - Case/Service Plan			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 2.03		**YES** If NO, explain here: The agency has the required policy 2.05, titled Counseling Services, that was approved September 9, 2024 by the Regional Director.	
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 files case/service plans reviewed were documented on a local provider-approved form and are based on information gathered during the initial screening, intake, and NIRVANA	
Case/Service plan is developed within 7 working days of NIRVANA	**Exception**	Nine of the ten youth records had a service plan developed within seven working days.	One of the ten youth records lack both a service plan and the corresponding documentation.
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 nine case/service plans reviewed contained individualized and prioritized need(s) and goal(s) identified by the NIRVANA; service type, frequency, location; person(s) responsible for completing goals; and target date(s) for completion of goals. Seven of the nine case plans reviewed included actual goal completion dates.	Two of the nine records did not include actual completion dates for goals completed and one was missing the service plan initiation date.

Case/service plans are reviewed for progress/revised by counselor and parent (if available) every 30 days for the first three months and every 6 months after	**Compliance**	All five community counseling records reviewed demonstrated timely reviews for progress by the counselor during the required timeframes. None of the five residential youth were in shelter care for at least 30 days and therefore did not require 30-day reviews.	
Additional Comments: **There are no additional comments for this indicator.**			
2.04 - Case Management and Service Delivery			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 2.04		**YES** If NO, explain here: The agency has the required policy 2.04, titled Case Management and Service Delivery, that was approved September 9, 2024 by the Regional Director.	
Counselor/Case Manager is assigned	**Exception**	Eight of the nine files demonstrated a counselor/case manager was assigned to work with the youth/family from case assignment to termination.	The file for one youth did not include the primary case manager.
The Counselor/Case Manager completes the following as applicable: 1. Establishes referral needs and coordinates referrals to services based upon the on-going assessment of the youth's/family's problems and needs 2. Coordinates service plan implementation 3. Monitors youth's/family's progress in services 4. Provides support for families 5. Monitoring progress of court ordered youth in shelter 6. Makes referrals to the case staffing to address problems and needs of the youth/family 7. Accompanies youth and parent/guardian to court hearings and related appointments 8. Refers the youth/family for additional services when appropriate 9. Provides case monitoring and reviews court orders 10. Provides case termination notes 11. Provides follow-up after 30 days post discharge 12. Provides follow-up after 60 days post discharge	**Exception**	All nine records were observed to demonstrate identification of referral needs, coordination of service plans, provision of various types of support, and provision of case management and overall support and follow up. None of the nine records reviewed were court ordered or referred to the case staffing committee, thereby requiring any court related/adjudication services. Case termination notes were completed for five applicable closed cases. Thirty and 60-day follow ups were conducted for one of three applicable closed cases.	The 30-day and 60-day reviews for one youth was missing from the charts and a second youth's 60-day review was late.

The program maintains written agreements with other community partners that include services provided and a comprehensive referral process	**Compliance**	Provider has agreements with two Mental Health Services, three substance abuse centers, one truancy provider, two safe place agencies, one employment services, seven educational facilities, three medical treatment facilities, and seven support agencies.	
Additional Comments: **There are no additional comments for this indicator.**			
2.05 - Counseling Services			**Limited**
Provider has a written policy and procedure that meets the requirement for Indicator 2.05		**YES** If NO, explain here: The agency has the required policy 2.05, titled Counseling Services, that was approved September 9, 2024 by the Regional Director.	
Shelter Program			
Shelter programs provides individual and family counseling	**Compliance**	Residential youth received individual and family counseling as evident by the counseling notes in the five residential youth records.	
Group counseling sessions held a minimum of five days per week	**Exception**	It has been noted that all five residential youth records are missing group sessions.	Twelve random weeks were reviewed for group sessions held: November 3-9 , two 2 groups; November 10-15, 2 groups; October 20-26 - no groups; October 6-12, no group; September 15-21, 1 group; September 1-7, 1 group, Aug 18-24, no group; Aug 4-10, 1 group; July 21-27,1 group; July -19, 2 groups; June 21-29, no groups; June 2-8, no groups.
Groups are conducted by staff, youth, or guests and group counseling sessions consist of : 1. A clear leader or facilitator 2.Relevant topic - educational/informational or developmental 3. Opportunity for youth to participate 4. 30 minutes or longer	**Exception**	The clinical groups reviewed mostly met the established criteria, with only minor errors noted. The reviewed documentation for these groups included several key elements: a clear leader or facilitator, a relevant and educational or informational topic, and 30 minutes long. However, the provider also considers house meetings as groups but documentation lacks group criteria.	Several groups held are house meetings but these types of groups did not meet the criteria for group sessions as duration, when listed, was barely 15 minutes and not the 30 minutes required.
Documentation of groups must include date and time, a list of participants, length of time, and topic.	**Exception**	The group sign-in sheets reviewed included date and time of the group, names of all participating youth, and topic discussed.	A vast majority of group sign in sheets for house meetings did not include length of time.
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**	Counseling services tailored to the needs identified during the assessment process were established in all relevant records reviewed, in line with each youth's case/service plan. In the five community counseling files examined, it was clear that the youth received counseling services, as evidenced by the attached case note.	

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**	Nine out of ten files reviewed showed coordination among presenting problems, psychosocial assessments, case/service plans, case/service plan reviews, case management, and follow-up when applicable.	
Maintain individual case files on all youth and adhere to all laws regarding confidentiality.	**Compliance**	All ten youth records reviewed were maintained in individual case files with adherence to all laws regarding confidentiality.	
Case notes maintained for all counseling services provided and documents youth's progress.	**Compliance**	Case notes were maintained in all ten files indicating the youth's progress as well as case notes for all services provided.	
On-going internal process that ensures clinical reviews of case records and staff performance.	**Compliance**	All of the files reviewed received ongoing clinical reviews of case records and staff performance. Case reviews are conducted by the supervisor and the review form is maintained in each case file.	
When an intake is conducted through virtual means, consent is confirmed by the counselor, documented in the file, and reviewed with the supervisor during supervision/case review. There is written documentation provided in the youths file for reasons why virtual sessions are in the best interest of the youth and family.	**No eligible items for review**	The intakes were completed in person.	
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 the required policy 2.06, titled Adjudication/Petition Process, that was approved September 9, 2024 by the Regional Director.	
Must include: a. DJJ rep. or CINS/FINS provider b. Local school district representative	**Compliance**	Since the last onsite review, there's been no request for case staffing. If requested, at a minimum, the committee is comprised of a DJJ representative or CINS/FINS provider and a local school district representative.	
Other members may include: a. State Attorney's Office b. Others requested by youth/ family c. Substance abuse representative d. Law enforcement representative e. DCF representative f. Mental health representative	**Compliance**	The agency has established a case staffing committee in the event the youth/family is not in agreement with services or treatment; the youth/family will not participate in the services selected; or the program receives a written request from a parent/guardian or any other member of the committee.	
The program has an established case staffing committee, and has regular communication with committee members	**Compliance**	The case staffing meetings occur monthly and additional meetings may be held, if requested, including emergency case staffing. Members of the committee are notified via email when a case staffing is scheduled to be convened.	
The program has an internal procedure for the case staffing process, including a schedule for committee meetings	**No eligible items for review**	No case staffings were held since the last QI review.	

The youth and family are provided a new or revised plan for services	**No eligible items for review**	No case staffings were held since the last QI review.	
Written report is provided to the parent/guardian within 7 days of the case staffing meeting, outlining recommendations and reasons behind the recommendations	**No eligible items for review**	No case staffings were held since the last QI review.	
If applicable, the program works with the circuit court for judicial intervention for the youth/family	**No eligible items for review**	No case staffings were held since the last QI review.	
Case Manager/Counselor completes a review summary prior to the court hearing	**No eligible items for review**	No case staffings were held since the last QI review.	
Additional Comments: **There are no additional comments for this indicator.**			
2.07 - Youth Records			**Limited**
Provider has a written policy and procedure that meets the requirement for Indicator 2.07		**YES** If NO, explain here: The agency has the required policy 2.07, titled Youth Records that was approved September 9, 2024 by the Regional Director.	
All records are clearly marked 'confidential'.	**Compliance**	All files were marked confidential.	
All records are kept in a secure room or locked in a file cabinet that is marked "confidential"	**Exception**	The files are located in an accessible room; however the door to the file room was left unlocked at that time of the review.	The file storage room door was unlocked and not observed to be secure during tour of the facility.
When in transport, all records are locked in an opaque container marked "confidential"	**Exception**	An interview was conducted with the program manager and case manager. Observation of files transferred from the residential program to the administrative offices during the review revealed the lack of a secure locked container, which poses a risk to sensitive information.	Files transferred from other agency facility were not stored in a locked container, which poses a risk to sensitive information. To ensure the safety of these files, staff must use locked boxes and clearly label them as confidential which was not observed during the review. The program was not able to furnish an opaque container marked "confidential" that staff uses to transport files offsite.
All records are maintained in a neat and orderly manner	**Compliance**	All files were organized into clearly defined sections that were consistent across both residential and community counseling records. Each client case record includes the following components: a chronological sheet, youth demographic data, program information, correspondence, service and treatment plans, needs assessments, case management details, and any other materials relevant to the case.	

SHELTER FILES contain the following: Table of Contents that outlines documents in each section: •Screening •Informed Consent • Photograph of the youth • Shelter Intake Form • Suicide Assessment (if needed) • NIRVANA Self Report (NSR) • NIRVANA full Assessment • Plan of Service • Chronological Notes • Medication Inventory Form • Approved contact list • Copies of referrals made & Follow-Up (if needed) • Discharge summary once case is closed	**Compliance**	All five residential records reviewed included a Table of Contents sections which outlines the documents in each section. The items included in the Table of Contents included the following: screening, informed consent, photograph of the youth, the shelter intake form, suicide assessment (if applicable), NIRVANA self-report (NSR), NIRVANA full assessment, plan of service, chronological notes, medication inventory form, approved contact list , and copies of referrals made and follow ups as needed.	
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**	All five community counseling records reviewed included a Table of Contents which included the following: screening, informed consent, community counseling intake form, suicide assessment (if applicable), NIRVANA full assessment, plan of service/case plan, chronological case notes, and copies of referrals made and follow ups (if needed).	
All records kept electronically, are maintained securely and can be made immediately available upon request for audit purposes.	**Not Applicable**	Files are not maintained electronically.	
Records are retained for the duration of the time specified by the contract.	**Compliance**	Per the agency's policy, files are retained for the duration specified in the CINS/FINS 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 the required policy 2.09, titled Special Populations, that was approved September 9, 2024 by the Regional 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 has not served any youth who met the criteria for staff secure in the last 6 months or since the last onsite QI review.	
Staff Secure policy and procedure outlines the following: a. In-depth orientation on admission b. Assessment and service planning c. Enhanced supervision and security with emphasis on control and appropriate level of physical intervention d. Parental involvement e. Collaborative aftercare	**Compliance**	A review of the current staff secure policy and procedures indicate protocols are in place to provide the following as required: In-depth orientation on admission; assessment and service planning; enhanced supervision and security with emphasis on control and appropriate level of physical intervention; parental involvement; and collaborative aftercare.	
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**		
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**		
Agency provides a written report for any court proceedings regarding the youth's progress	**No eligible items for review**		
Domestic Minor Sex Trafficking (DMST)			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	**No eligible items for review**	The agency has not served any youth who met the criteria for Domestic Minor Sex Trafficking (DMST) in the last 6 months or since the last onsite QI review.	
Agency has evidence that the FNYFS was contacted for approval prior to admission for all Domestic Minor Sex Trafficking (DMST) placements.	**No eligible items for review**		
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**		
Services provided to these youth specifically designated services designed to serve DMST youth	**No eligible items for review**		
Did the placement of DMST youth require additional supervision for the safety of the youth or the program? If so, did the agency provide the appropriate level of supervision and safety measures?	**No eligible items for review**		
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**		

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**		
All other services provided to DMST youth are consistent with all other general CINS/FINS program requirements	**No eligible items for review**		
Domestic Violence			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	**Compliance**	A total of three residential DV youth records (one open and two closed) were reviewed.	
Youth admitted to DV Respite placement have evidence in the file of a pending DV charge	**Compliance**	All three records reviewed have face sheets in their files with documentation to show the three youth have pending DV charge and were referred to the shelter for DV respite.	
Data entry into NetMIS within (3) business days of intake and discharge	**Compliance**	The three youth records were reviewed in NetMIS and data entry was verified to be completed within three business days of intake and two applicable discharges.	
Youth length of stay in DV Respite placement does not exceed 21 days. If more than 21 days, documentation exists in youth file of transition to CINS/FINS or Probation Respite placement, if applicable.	**No eligible items for review**	None of the three youth placements exceeded 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**	All three DV youth records included case plans that were developed and included goals for reducing violence in the home, 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**	All three files reviewed demonstrated youth participated in services consistent with other general CINS/FINS population such as individual counseling, education services, groups, and recreation.	
Probation Respite			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	**No eligible items for review**	The agency has not served any youth who met the criteria for Probation Respite in the last 6 months or since the last onsite QI review.	
All probation respite referrals are submitted to the Florida Network.	**No eligible items for review**		
All Probation Respite Referral come from DJJ Probation and there is evidence that the youth is on Probation regardless of adjudication status.	**No eligible items for review**		
Data entry into NetMIS and JJIS within (3) business days of intake and discharge	**No eligible items for review**		
Length of stay is no more than fourteen (14) to thirty (30) days. Any placement beyond thirty (30) days contains evidence in the file that the JPO was contacted in writing to request the need of an extension no later than the 25th day the youth was admitted into the program.	**No eligible items for review**		
All case management and counseling needs have been considered and addressed	**No eligible items for review**		

All other services provided to Probation Respite youth are consistent with all other general CINS/FINS program requirements	**No eligible items for review**		
Intensive Case Management (ICM)			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	**Not Applicable**	Lutheran Services Florida Southeast is not contracted to provide ICM services.	
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.	**Not Applicable**		
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.	**Not Applicable**		
Assessments include a. NIRVANA at intake b. NIRVANA Re-Assessment every 90 days c. Post NIRVANA at discharge as aligned with timeframe requirements	**Not Applicable**		
Service/case plan demonstrates a strength-based, trauma-informed focus	**Not Applicable**		
For any virtual services provided, there is written documentation in the youths' file as to why virtual contact is in the best interest of the youth and family	**Not Applicable**		
Family and Youth Respite Aftercare Services (FYRAC)			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	**No eligible items for review**	The agency has not served any youth who met the criteria for Family and Youth Respite Aftercare Services (FYRAC) in the last 6 months or since the last onsite QI review.	

Youth is referred by DJJ for a domestic violence arrest on a household member, and/or the youth is on probation regardless of adjudication status and at risk of violating.	**No eligible items for review**		
Agency has evidence that all FYRAC referrals have documented approval from the Florida Network office	**No eligible items for review**		
Intake and initial assessment sessions meets the following criteria: a. Services shall be documented through the signature of the youth and his/her parent/guardian as well as orientation to the program which is kept in the youths file. b. The initial assessment shall be face-to-face, in person or through virtual means, to include a gathering of all family history and demographic information, as well as the development of the service plan. c. For youth on probation, a copy of the youths Community Assessment Tool (CAT) to assist with development of the family service plan.	**No eligible items for review**		
Life Management Sessions meets the following criteria: a. Sessions are face-to-face, sixty (60) minutes in length and focus on strengthening the family unit b. Services are highly supportive, individualized, and flexible and require a “whole family” approach to dealing with the problems affecting the youth and family.	**No eligible items for review**		
Individual Sessions: a. The program conducted sessions with the youth and family to focus on work to engage the parties and identify strengths and needs of each member that help to improve family functioning. b. Issues to be covered through each session include but are not limited to: Identifying emotional triggers; body cues; healthy coping strategies through individual, group and family counseling; understanding the cycle of violence and the physical and emotional symptoms of anger; developing safety plans; and educating families on the legal process and rights.	**No eligible items for review**		
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**		
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**		

Youth and family participate in services for thirteen (13) sessions or ninety (90) consecutive days of services, or there is evidence in the youth's file that an extension is granted by DJJ circuit Probation staff	**No eligible items for review**		
Any service that is offered virtually, is documented in the youth's file why it was in the youth and families best interest.	**No eligible items for review**		
All data entry in NetMIS is completed within 3 business days as required.	**No eligible items for review**		
Additional Comments: **There are no additional comments for this indicator.**			
2.09- Stop Now and Plan (SNAP)			**Not Applicable**
Provider has a written policy and procedure that meets the requirement for Indicator 2.09		**N/A** If NO, explain here: Lutheran Services Florida Southeast is not a SNAP provider.	
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**		
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 NIRVANA was completed at initial intake, or within two sessions	**Not Applicable**		
There is evidence of the completed the Pre - Child Behavior Checklist (CBCL) by the caregiver and is located within the file.	**Not Applicable**		
There is evidence of the completed Pre - TOPSE is completed by the caregiver and is located within the file.	**Not Applicable**		
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**		
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		
There is evidence of the completed Post - TOPSE is completed by the caregiver and is located within the file.	Not Applicable		
There is evidence of the completed SNAP Discharge Report located within the file for any discharged youth.	Not Applicable		
There is evidence of the SNAP Boys/SNAP Girls Child Group Evaluation Form located in the file.	Not Applicable		
There is evidence of the SNAP Boys/SNAP Girls Parent Group Evaluation Form located in the file.	Not Applicable		
SNAP Clinical Groups for Youth 12-17	Not Applicable		
Youth are screened to determine eligibility of services using the Florida Network Youth Screening Form.	Not Applicable		
The file contains the completed Florida Network Community Counseling Intake Form and is located within the file.	Not Applicable		
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 NIRVANA was completed at initial intake, or within two sessions.	Not Applicable		
There is evidence of the completed 'How I Think Questionnaire' (HIT) form located within the file or evidence	Not Applicable		
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		
There is evidence of the completed Social Skills Improvement System (SSIS) Teacher/Adult form located	Not Applicable		
All closed files contained evidence in the file a NIRVANA was completed at discharge.	Not Applicable		
SNAP for Schools & Communities	Not Applicable		
The program demonstrated all of the required weekly attendance sheets that included youth names and/or identifying numbers completed with the teacher and trained	Not Applicable		
The program maintained evidence of a completed 'Way to Go Goal' Sheet within the file.	Not Applicable		
The program maintained evidence of both pre AND post Measure of Classroom Environment (MoCE) completed documents for the class reviewed.	Not Applicable		
The program maintained evidence of completed pre and post evaluation documents for the class reviewed.	Not Applicable		

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**		
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**		
Additional Comments: **There are no additional comments for this indicator.**			
3.01 - Shelter Environment		**YES**	**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 3.01		If NO, explain here: The program has the required policy and procedure 3.01 Shelter Environment, which was approved on September 9, 2024 by the Regional Director.	
Facility Inspection: a. Furnishings are in good repair. b. The program is free of insect infestation. c. Bathrooms and shower areas are clean and functional, free of foul odors, leaks, dust, and mildew and in good working order. d. There is no graffiti on walls, doors, or windows. e. Lighting is adequate for tasks performed there. f. Exterior areas are free of debris; grounds are free of hazards. g. Dumpster and garbage can(s) are covered. h. All doors are secure, in and out access is limited to staff members and key control is in compliance. i. Detailed map and egress plans of the facility, general client rules, grievance forms, abuse hotline information, DJJ Incident Reporting Number and other related notices are posted. j. Interior areas (bedrooms, bathrooms, common areas) do not contain contraband and are free from hazardous unauthorized metal/foreign objects.	**Exception**	In touring the program with the Program Director, the furnishings were observed to be in good repair. The program has new flooring and new paint in the interior of the building. The program is free from infestations. The program had no graffiti anywhere in the facility. Lighting is adequate throughout the program. The exterior area and grounds is free from debris and hazards. The program dumpsters are covered. All doors are secured and in and out access is limited to staff members and is in key control compliance. The program posted egress plans in the lobby, the hallway in the office area, the exit door in the dinning room, in the youth's group room and there is one in each of the youth's rooms. The program rules, grievance forms, abuse hotline information and the DJJ Incident reporting number as well as DCF's Ombudsman hotline number is posted in the lobby, in youth areas. No contraband was observed during the tour.	The facility has six youth bathrooms; all had signs of mold in the showers. In rooms #8 and #7, the shared bathroom had a toilet seat that was too small for the toilet. In the group room bathroom used by youth, the faucet was loose on the sink, and moved when you turned it on.
Facility Inspection: a. All agency and staff vehicles are locked. b. Agency vehicles are equipped with major safety equipment including first aid kit, (all items in the first aid kit are current and do not have expired items; all expired items should be replaced regularly), fire extinguisher, flashlight, glass breaker and, seat belt cutter.	**Exception**	The program has three vehicles, a 2018 Toyota Sienna Caravan, a 2018 Ford van, and a 2024 Ford Equinox. One vehicle out of the three vehicles contained all required items.	The Ford 2018 van had a flashlight but the batteries were dead but had the other required items. The newer vehicle did not have a working flashlight and needed a new 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**	A review of the chemical inventory was conducted with the Lead Program Supervisor. Six months of inventory logs were also reviewed. The program's MSDS contained all chemicals on the inventory logs. The program completed weekly inventory logs that were signed and dated. The program also had chemicals inventoried perpetually and stored securely. The chemical inventory logs from April until November are all maintained for each chemical in real time.	
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 program has two washers and two dryers that were operational and were lint free. The program had the DCF Child Caring license displayed in the lobby and is effective through June 28, 2025. The youth's rooms were newly decorated with different themes and new bedding and decor. Two rooms, sponsored by the Kiwanis had new beds, bookshelves, and bean bag chairs. The youth have a safe place to lock up 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).	**Exception**	On 9/20/2024 the annual fire inspection was completed and the program is in compliance. The program conducted monthly fire drills on 1st shift: 5/26/24, 7/7/24, 8/16/24, 9/15/24, and 10/31/24. On 2nd shift the fires drills were completed on the following: 5/21/24, 6/23/24, 7/30/24, 9/28/24, and 10/29/24. On 3rd Shift the fire drills were completed on: 5/28/24, 6/10/24, 7/30/24, 8/19/24, 9/3/24, and 10/21/24. The program completed mock drills on the following dates: 1st Shift: 5/26/24,7/7/24, 9/15/24,and 10/31/24. 2nd Shift: 4/23/24, 6/10/24, and 10/29/24. 3rd Shift: 4/25/24, 7/30/24, 8/16/24, 9/3/24, and 10/21/24. Fire sprinklers and alarms were inspected on 2/15/24 with no violations. Fire extinguishers were inspected on 2/15/24. Fire extinguishers in the kitchen and throughout the program were inspected on August 2024. The overhead hood was inspected on September 2024. All extinguishers are easily accessed.	The program missed one fire drill for 1st shift in June and the 2nd shift for August. Mock drills were completed at minimum quarterly per shift except no mock drill was completed for 2nd shift in the 3rd quarter. Also the mock drills repeated the heat exhaustion drill within the same quarter.

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 program has a current satisfactory residential group care inspection report from the Department of Health on 9/18/24. The program has a satisfactory food inspection report from the Department of Health on 9/18/24. All food menus are current and posted with a licensed Dietician signing off. The reviewer found all cold food properly stored, marked and labeled. The refrigerators and freezer are clean and maintained at the required temperatures. The pantry was cleaned and all food was stored properly and labeled.	
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 program schedule was reviewed and the staff keep the youth engaged in meaningful, structured activities. The reviewer observed the youth playing board games, participating in Hi, Low and Goals group, and a clinical group on emotions. The youth were observed participating in recreational activity indoors and, in reviewing the logbook, recreational activities were documented consistently occurring one hour a day. In reviewing the logbook, youth are also able to participate in faith-based activities on a weekly basis. The program allows for the youth to complete homework and they have time to read as well. The program has the daily schedule posted in the youth group area. Three searches of youth returning from school were observed on 11/14/24 in the lobby prior to youth entering the program. The youth were wanded and their backpacks were searched according to policy and procedure. The youth's back packs were locked up after they was searched. The search occurred on camera. No contraband was discovered during the search.	
Additional Comments: **There are no additional comments for this indicator.**			
3.02 - Program Orientation			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 3.02		**YES** If NO, explain here: Provider has the required policy and procedure 3.02 Program Orientation, which was approved on September 9, 2024 by the Regional Director.	
Youth received a comprehensive orientation and handbook provided within 24 hours	**Compliance**	In all 5 files reviewed, 3 open and 2 closed, the youth received an orientation within 24 hours	

Orientation includes the following: a. Youth is given a list of contraband items b. Disciplinary action is explained c. Dress code explained d. Review of access to medical and mental health services e. Procedures for visitation, mail and telephone f. Grievance procedure g. Disaster preparedness instructions h. Physical layout of the facility i. Sleeping room assignment and introductions j. Suicide prevention- alerting staff of feelings or awareness of others having suicidal thoughts	**Compliance**	Orientation for all 5 youth included all of the requirements of the indicator. In reviewing the youth's files and the handbook, the youth signs that they receive the list of contraband items, disciplinary action explained, dress code, visitation and grievance procedures. The youth is provided a tour of the program. The disaster plan, the layout of the program, room assignments, and making staff aware of feelings or awareness of others who are having suicidal thoughts were included in the orientation.	
Documentation of each component of orientation, including orientation topics and dates of presentation, as well as signatures of the youth and staff involved is maintained in the individual youth record	**Compliance**	All 5 youth records contained documentation of each component of orientation, date of orientation, and youth, staff, and parent signatures.	
Additional Comments: **There are no additional comments for this indicator.**			
3.03 - Youth Room Assignment			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 3.03		**YES** If NO, explain here: Program has the required policy and procedure 3.03 Room Assignment which was approved by the Regional Director September 9, 2024.	
A process is in place that includes an initial classification of the youths, to include:			
a. Review of available information about the youth's history, status and exposure to trauma b. Initial collateral contacts, c. Initial interactions with and observations or the youth d. Separation of younger youth from older youth, e. Separation of violent youth from non-violent youth f. Identification of youth susceptible to victimization g. Presence of medical, mental or physical disabilities h. Suicide risk i. Sexual aggression and predatory behavior j. Acute health symptoms requiring quarantine or isolation	**Compliance**	Five files were reviewed, 2 closed and 3 open. All five youth records contained documentation of review of the youth's history, status, and exposure to trauma. The files contained initial collateral contacts, interactions with and observations of the youth. All youth files contained documentation that youth are separated based on age differences, tendency for violence, susceptible to victimizations, medical, mental or physical disabilities, suicide risk, sexual aggressions and predatory behaviors, and acute health symptoms.	
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	**Exception**	All youth records reviewed had required alerts entered on the youth's files for youth with special needs, mental health substance abuse, physical health or security and all but one included alerts for suicide.	One file did not have alerts for suicide risk but the chart contained a suicide risk assessment and documentation the youth was on sight and sound supervision.
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: Program has the required policy and procedure 3.04 Logbook which was approved by the Regional Director September 9, 2024.	
Log book entries that could impact the security and safety of the youth and/or program are highlighted	**Compliance**	The electronic logbook was reviewed for the following dates: May 5-11th, May 12th -18th; June 16th-22nd and 23rd-29th; July 14th-20th and 21st-27th; August 4th-10th and 11th -17th; September 1st-7th and 8th-14th; and October 13th-19th and 20th-26th. All entries reviewed that contained entries regarding safety and security issues were highlighted.	
All entries are brief, legibly written in ink and include: • Date and time of the incident, event or activity • Names of youth and staff involved • Brief statement providing pertinent information • Name and signature of person making the entry	**Compliance**	All entries in the electronic logbook contained the date, time of incidents, activities, and included the name of the staff and youth involved, along with a brief explanation. All signatures are completed electronically	
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**	All recorded errors are struck through with one line, initialed and dated in electronic logbook.	
The program director or designee reviews the facility logbook(s) every week and makes a note chronologically in the logbook indicating the dates reviewed and if any correction, recommendations and follow-up are required and sign/date the entry	**Compliance**	All 12 weeks reviewed in the logbook documented that the program director reviews the logbook, every week and documents any recommendation and follow up if required.	
All staff review the logbook of the previous two shifts and makes an entry signed and dated into the logbook indicating the dates reviewed	**Exception**	Staff are reviewing the logbook at the beginning of their shift but did not consistently review for the previous two shifts.	Staff did not document consistently that they are reviewing for two shifts prior to their shift for six of the 12 weeks reviewed.
At the beginning of their shift, oncoming supervisor and shelter counselor reviews the logbook of all shifts since their last log entry and makes a signed and dated entry and into log book indicating the dates reviewed.	**Exception**	In reviewing the electronic log book for the dates above the oncoming supervisor consistently signed at the beginning of their shift and the dates reviewed. However, this was not observed on a consistent basis for the shelter counselors.	The shelter counselors only reviewed the logbook at the beginning of their shift for six out of the 12 weeks reviewed.
Logbook entries include: a. Supervision and resident counts b. Visitation and home visits	**Compliance**	In all logbook reviews conducted the logbook contained supervision and resident counts as well as visitation and home visits.	
Additional Comments: **There are no additional comments for this indicator.**			

3.05 - Behavior Management Strategies			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 3.05		**YES** If NO, explain here: The program has the required policy and procedure 3.05 Behavior Management which was approved on September 9, 2024 by the Regional Director.	
The program has a detailed written description of the BMS and it is explained during program orientation	**Compliance**	All five records reviewed contained documentation the BMS was explained to the youth during orientation according to their policy and procedure.	
Behavior Management Strategies must include:			
a. BMS is designed to teach youth new behaviors and help youth understand the natural consequences for their actions b. Behavioral interventions are applied immediately, with certainty, and reflect the severity of the behavior c. BMS uses a wide variety of awards/incentives to encourage participation and completion of the program d. Appropriate consequences and sanctions are used by the program and consequences for behavior are logical and designed to promote skill-building for the youth e. Counseling, verbal intervention and de-escalation techniques are used prior to physical intervention (Only techniques approved by the Florida Network and DJJ are used if physical intervention is required) f. Only staff discipline youth. Group discipline is not imposed g. Room restriction is not used as part of the system or for youth who are physically and/or emotionally out of control h. Youth should never be denied basic rights such as meals, clothing, sleep, services, exercise, or correspondence privileges	**Compliance**	The program created a BMS that uses several behavioral interventions with youth that include counseling, verbal interventions, and a token economy to reward positive behaviors and reduce or eliminate negative behaviors. The program's practice is to apply immediate consequences to match the severity of the behavior. In reviewing the log book, it was noted when a youth was acting out and the consequence applied, such as losing points or contacting parents. The program has multiple incentives such as choosing items from the prize cabinets based on points earned, an extra phone call, daily free outing, special outing per week and a later bed time. In reviewing the five youth records, documentation supported that staff explained the BMS on admission along with the consequences. The program does not use room restriction or group discipline and does not deny youth basic needs as punishment.	
Program's use of the BMS			
All staff are trained in the theory and practice of administering BMS rewards and consequences	**Compliance**	The program trains all staff on the practice of the Behavior Management System as part of their orientation training. This was evident in the four new hire training records reviewed.	
There is a protocol for providing feedback and evaluation of staff regarding their use of BMS rewards and consequences	**Compliance**	The program has a process in place for providing feedback and evaluation of staff regarding their implementation of the BMS. Supervisors observe staff and provide feedback in staff meetings regarding their use of the BMS.	
Supervisors are trained to monitor the use of rewards and consequences by their staff	**Compliance**	Supervisors are trained annually on the BMS and are trained to monitor the use of rewards and consequences by their staff.	
Additional Comments: **There are no additional comments for this indicator.**			

3.06 - Staffing and Youth Supervision			Limited
Provider has a written policy and procedure that meets the requirement for Indicator 3.06		**YES** If NO, explain here: The program has the required policy and procedure 3.06 Staffing and Youth Supervision which was approved on September 9, 2024 by the Regional Director.	
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**	A review of staff schedules and logbook entries for the review period documented the required staffing ratios were met for the awake hours one staff to six youth and during sleeping hours, at least two staff on the overnight shift.	
All shifts must always provide a minimum of two direct care staff present that have met the minimum training requirements	**Compliance**	Schedules provided by Program Director show all shifts have a minimum of two direct care staff on each shift.	
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 new staff hired were background screened and property trained youth care workers. A review of eligible re-screened staff indicate continued eligible screening results for the applicable staff. Three applicable shelter new hires completed the required pre-service training prior to working independently with youth.	
The staff schedule is provided to staff or posted in a place visible to staff	**Compliance**	Staff schedule is available to all staff and is posted in the staff office.	
There is a holdover or overtime rotation roster which includes the telephone numbers of staff who may be accessed when additional coverage is needed	**Compliance**	The staff schedules have the name of the administrator on call who provides coverage for that shift by finding coverage or covering the shift. The Program Director provided the staff roster with telephone numbers to contact for coverage.	
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**	Bed Check Dates/Times Selected • October 16th, 2am-4am • October 20th , 4am-6am • October 25th, 1am-3am • November 4th, 3am-5am • November 7th 12am-2am For all dates reviewed, all bed checks were completed according to the logbook except for one bed check, on October 25th at 2:51am.	Video surveillance captured a bed check at 2:40am and the next bed check was observed at 3:00am. In reviewing the logbook, staff falsely documented they completed a bed check at 2:51am and no bed check was completed at that time according to the video reviewed. CCC was called to report the observed falsification event.
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 provider has the required policy and procedure for 3.07 Video Surveillance which was approved on September 9, 2024 by the Regional Director.	
Surveillance System			
The agency, at a minimum, shall demonstrate: a. A written notice that is conspicuously posted on the premises for the purpose of security b. System can capture and retain video photographic images which must be stored for a minimum of 30 days c. System can record date, time, and location; maintain resolution that enables facial recognition d. Back-up capabilities consist of cameras' ability to operate during a power outage e. Have cameras placed in interior (e.g. intake office, counseling office, cafeteria, day room) and exterior (e.g. entrance/exit, recreation area, parking lot) general locations of the shelter where youth and staff congregate and where visitors enter and exit; to include locations where youth searches are conducted. Cameras are never placed in bathrooms or sleeping quarters. f. All cameras are visible	**Compliance**	The program has a written notice posted in the lobby of the facility. Cameras are located throughout the interior and exterior of the shelter where youth and staff are congregating and where visitors enter and exit the program. All cameras are visible and no cameras are located in bathrooms or sleeping areas. The video surveillance system can capture and retain video images for a minimum of 30 days. The video surveillance system records the date, time and has excellent resolution enabling facial recognition. Back up capabilities for the video system is a temporary battery back-up in the event of power failure.	
A list of designated personnel who can access the video surveillance system is maintained (includes off-site capability per personnel)?	**Compliance**	Only the Program Director and Lead Operations Supervisor along with their IT department can access the video surveillance system.	
Supervisory review of video is conducted a minimum of once every 14 days and timeframes reviewed are noted in the logbook.	**Compliance**	The camera review log and logbook was reviewed for the following dates: May 5-11th, May 12th -18th, June 16th-22nd & 23rd-29th, July 14th-20th & 21st-27th, August 4th-10th & 11th -17th, September 1st-7th & 8th-14th, and October 13th-19th & 20th-26th. In reviewing the camera review log and logbook, the supervisor conducted camera review at least once every 14 days for the dates listed above. The camera review logs contain a summary of activities reviewed.	
The reviews assess the activities of the facility and include a review of random sample of overnight shifts	**Compliance**	Reviews of the camera included various daily activities of the facility as well as a random sample of overnight shifts.	
Grant the requesting of video recordings to yield a result within 24-72 hours from program quality improvement visits and when an investigation is pursued after an allegation of an incident	**Compliance**	The program has a process for third party review of video recordings for quality improvement visitors and when incidents occur. The program provides a copy within 72 hours of the request.	
Camera service order/requests will be made within 24 hours of discovery of camera malfunctioning or being inoperable. All efforts made to obtain repairs are documented and maintained	**No eligible items for review**	The program has had no camera issues in the past six months.	
Additional Comments: **There are no additional comments for this indicator.**			

4.01 - Healthcare Admission Screening			Satisfactory with Exception
Provider has a written policy and procedure that meets the requirement for Indicator 4.01		**YES** If NO, explain here: The program has the required policy and procedure, 4.01 Healthcare Admission Screening, which was approved on September 9, 2024 by the Regional Director.	
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**	All five files reviewed had a screening form, which included questions for current medications; existing medical conditions; allergies; recent injuries or illnesses; presence of pain or other physical distress; observation for evidence of illness; injury, physical distress, difficulty moving, etc.; observation for presence of scars, tattoos, or other skin markings and acute health symptoms requiring quarantine or isolation.	
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.)	**Exception**	The program has a policy and procedures that involve parents being involved whenever there is a follow up for medical appointments. Referrals are documented in client's file. A total of five files reviewed indicate two of the five youth had a pre-existing medical condition that did not require a referral. One youth indicated vision problems during the health screening.	In one of the files, client indicated to have problems with his/her vision; however, no follow up or referral was noted.
When needed, the parent is involved with the coordination and scheduling of follow-up medical appointments	**No eligible items for review**	Agency has a process to involve parents with the coordination and scheduling of follow-up medical appointments. There were no eligible medical referrals applicable to the sample records reviewed.	
All medical referrals are documented on a daily log.	**No eligible items for review**	There were no eligible medical referrals applicable to the sample records reviewed.	
The program has a thorough referral process and a mechanism for necessary follow-up medical care as required and/or needed	**Compliance**	The program does a nurse and policy and procedures in place for referral of youth for medical care and notification of parent/guardian and mechanism for necessary follow up as required and/or needed.	
Additional Comments: **There are no additional comments for this indicator.**			

4.02 - Suicide Prevention			Limited
Provider has a written policy and procedure that meets the requirement for Indicator 4.02		**YES** If NO, explain here: The program has the required policy and procedure, 4.02 Suicide Assessment, which was approved on September 9, 2024 by the Regional Director.	
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.	**Exception**	Three residential files and three community counseling files were reviewed and all youth received a suicide risk screening during the intake process. Four of the records included suicide screenings that were signed by the supervisor and documented in the youth's case file.	Out of the six files reviewed, two files, one residential and one counseling did not have review and signature from a supervisor.
The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	**Compliance**	The program's suicide risk assessment has been approved by the Florida Network of youth and Family services.	
Supervision of Youth with Suicide Risk *(Shelter Only)*			
Youth are placed on the appropriate level of supervision based on the results of the suicide risk assessment.	**Compliance**	Three residential files reviewed demonstrated the youth placed on sight-and-sound supervision based on the results of the suicide risk assessment.	
Staff person assigned to monitor youth maintained one-to-one supervision or constant supervision and documented his/her observations of the youth's behavior at 30 minute or less intervals	**Exception**	One of the three records documented the direct care staff assigned to monitor the youth documented the youth's behavior every thirty minutes or less.	Although program has assigned staff to monitor youth, reviewer found there were several missing observation logs. One record was missing sight and sound logs 9/10/24, 3:00PM until 5:30PM; 9/11/24, 7:00AM -3:00PM; 9/12/24, 7AM - 5:00PM; 9/13/24, 7AM until 6PM; 9/15/24, no staff initials on logs from 11PM until 7AM; and 9/1/24, five missing logs from 7:00AM until 9/16/24 at 4:50 PM. A second record shows the suicide assessment (SA) was done by a counselor on 07/30/24 where recommendation to keep child on sight and sound was made. Clinical supervisor signed SA on 08/07/24. Client was taken out off sight and sound on 08/01/24 but there was not SA found, which indicated youth should be removed from sight and sound. No observation (sight and sound) logs were found after 08/01/24 leading up to the clinical review on 8/7/24.
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**	Agency's documentation includes the time of the day, behavioral observations, any warning signs observed, and the observer's initials	

Supervision level was not changed/reduced until a licensed professional or a non-licensed mental health professional under the supervision of a licensed professional completed a further assessment OR Baker Act by local law enforcement	**Exception**	One of the three records included a follow up suicide assessment that was completed by the non-licensed staff on 5/26/24. However, there is no clear communication about discontinuing the supervision level in that record or the other two records that did not include a follow up assessment.	From the three residential files reviewed, it was noted that the recommendation to change supervision level was not clearly documented.
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**	There was evidence that documentation was reviewed by supervisory staff each shift. Agency uses observation logs, which are maintained in the youth's file.	
Youth with Suicide Risk *(Community Counseling Only)*			
Youth identified for suicide risk during intake was immediately assessed by a licensed professional or non-licensed professional (under the direct supervision of a licensed mental health professional) and the parents and supervisor were both notified of the results.	**Compliance**	Each of the three community counseling files reviewed demonstrated the youth was immediately assessed by a non-licensed professional under the direct supervision of a licensed mental health professional and the parents and supervisor were both notified of the results.	
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.	**Not Applicable**	The appropriate staff was available to complete the assessment of suicide risk.	
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	**Compliance**	There is evidence agency provides further resources to parents/guardians that is documented in the youth's file, which is signed by parent/guardian.	
If the parent/guardian cannot be contacted, all efforts to contact them are documented in the case file.	**Not Applicable**	The parent/guardian for all three youth were notified.	
When the screening was completed during school hours on school property, the appropriate school authorities were notified.	**Not Applicable**	All three suicide screenings were completed at the youth's home.	
Additional Comments: **There are no additional comments for this indicator.**			

4.03 - Medications			Limited
Provider has a written policy and procedure that meets the requirement for Indicator 4.03		**YES** If NO, explain here: The program has the required policy and procedure, 4.03 Medications, which was approved on September 9, 2024 by the Regional Director.	
The agency has a Registered Nurse (RN) and/or a Licensed Practical Nurse (LPN) that is being supervised by RN and all of their credentials have been verified.	**Compliance**	The agency has a registered nurse (RN) and all his credentials were verified.	
The agency has evidence of the following for all non-nursing shelter staff designated to assist with the self-administration of medication: a. Documentation of in-person self-administration of medication distribution training provided by a Registered Nurse b. Evidence demonstrating their competency to assist with self-administration of medication distribution c. Maintenance of their annual medication training re-certification	**Compliance**	The agency has evidence medication administration training was provided by registered nurse to all employees approved to administer medication. All staff approved by the RN to administer medication receive annual medication training.	
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**	Reviewer interviewed the nurse and shelter manager and was not able to ascertain quarterly meetings are held by either to address medication error reduction strategies or conduct medication training opportunities for staff.	There was no evidence found of any monthly or quarterly meeting documents, where managers or RN participated that could have been used to assess strategies to reduce medication errors.
The agency has strategies implemented to ensure medications are provided within the 2-hour time frame.	**Compliance**	To ensure medications are provided within the 2-hours time frame, a two hour time frame is allotted to ensure medication is being distributed in a timely matter, one hour before and one hour after the set time of the original time of dosage. The nurse maintains a white board in the medication room to communicate youth on medication and the medication times.	
All non-licensed staff members are clearly identified and designated on the staff schedule and shift change report/shift responsibility form for assisting with the self-administration of medications on each shift	**Compliance**	In accordance to the agency's staff schedules provided, staff members are clearly identified and designated on the schedule and shift change report/shift responsibility form for assisting with the self-administration of medications on each shift.	
The agency has clear methods of communicating which youth are on medications with the times and dosage easily discernable by all staff on each shift.	**Compliance**	The agency has clear methods of communicating which youth are on medications with the times and dosage easily discernable by all staff on each shift. Youth prescribed medication are documented on the white board in the medical room. The name of the medication, the dose, and the time of dose is included in the information on the white board.	

The delivery process of medications is consistent with the FNYFS Medication Management and Distribution Policy and the agency has an internal quality assurance process to include the following: a. to ensure appropriate medication management and distribution methods b. to track medication errors c. to identify systemic issues and implement mitigation strategies, as appropriate.	**Compliance**	The shelter has a delivery process of medications which is consistent with the FNYFS Medication Management and Distribution Policy. Furthermore, incidents are tracked on the agency's monthly CQI metrics and monitored by the program's compliance director.	
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**	RN interviewed youth and parent/guardian about youth's current medication as part of the Medical and Mental Health Assessment screening process. In accordance with files reviewed in the event the RN was not present at the moment of intake, the RN was able to review files withing 72 hours. The shelter manager reviews and signs all intake documentation including medication forms by the next business day.	
Medication Storage			
a. All medications are stored in a Pyxis ES Medication Cabinet that is inaccessible to youth (when unaccompanied by authorized staff) b. Pyxis machine is stored in accordance with guidelines in FS 499.0121 and policy section in Medication Management c. Oral medications are stored separately from injectable epi-pen and topical medications d. Medications requiring refrigeration are stored in a secure refrigerator that is used only for this purpose, at temperature range 2-8 degrees C or 36-46 degrees F. (If the refrigerator is not secure, the room is secure and inaccessible to youth.) e. Narcotics and controlled medications are stored in the Pyxis ES Station f. Pyxis keys with the following labels are accessible to staff in the event they need to access medications if there is a Pyxis malfunction: a TOP COVER b BACK PANEL- LEFT TALL CABINET LOCK- LEFT, c BACK PANEL- RIGHT TALL CABINET LOCK- RIGHT	**Exception**	Observations and an informal interview with the program's part-time registered nurse validated the program stores most of its medication in the Pyxis Med-Station 4000 Medication Cabinet which is inaccessible to youth. The Pyxis machine is stored in the locked medical office and in accordance with Florida Statute 499.0121. All oral medications including narcotics, controlled and over the counter medications are stored in the Pyxis cabinet and stored separately from topical medication. Medications requiring refrigeration is maintained in a refrigerator designed for medication only. Counts are conducted and documented as required. The agency has pyxis keys labeled and accessible to staff in the event they need to access medication if there is a pyxis malfunction.	Reviewer found evidence that not all medication was stored in a Pyxis ES medication Cabinet. The agency has a storage closet inside the medication room which was not only used to store youth's belongings but also extra medication that was not placed inside Pyxis.

Medication Distribution			
a. Agency maintains a minimum of 2 site-specific System Managers for the Pyxis ES Station b. Only designated staff delineated in User Permissions have access to secured medications, with limited access to controlled substances (narcotics) c. A Medication Distribution Log shall be used for distribution of medication by non-licensed and licensed staff d. Agency verifies medication using one of three methods listed in the FNYFS Policies & Procedures Manual e. When nurse is on duty, medication processes are ALWAYS conducted by the nurse or when the nurse is not onsite, then the designated staff who has been trained by a licensed Registered Nurse provides the medication. f. Agency does not accept youth currently prescribed injectable medications, except for epi-pens h. Non-licensed staff have received training in the use of epinephrine auto-injectors provided by a registered nurse	**Compliance**	Agency maintains a minimum of 2 site-specific system managers for the Pyxis ES station. Only staff trained by the RN to administered medication has access to secure medications with limited access to controlled substances (narcotics). Agency keeps a medication distribution log that is use for distribution of medication by non-licensed and licensed staff. Agency verifies medication using one of the three methods listed in the FNYFS policies and procedures manual. Medication processes are always conducted by the nurse when he is on duty. Furthermore, when RN is not on duty staff trained by RN is designated to administrate medication. Shelter does not accept youth currently prescribed injectable medication, except for epi-pens. Staff trained by RN to administered medication has also received training on epinephrine auto-injectors.	
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**	The program utilizes the standard Department Medication Distribution Log (MDL) to document administration of all medication, and the log clearly indicates the time of medication administration, evidence of youth initials that the dosage was given, and evidence of staff initials that the dosage was given.	
There is evidence that staff provide youth with medications within one hour of the scheduled time of delivery as ordered by the medication. Documentation is provided for instances this does not occur within the required timeframe.	**Compliance**	Agency has different methods to provide youth with medication within one hour of the scheduled time of delivery as ordered by medication. Shelter has a method to report any instances when medication is not provided withing the required timeframe.	
During the review period, there were no instances where youth missed their medication due to failure to open the pyxis machine.	**Compliance**	During medication administration, on 11/14/2024, shift 7:00AM-3:00 PM, no youth missed their medication due to failure to open the pyxis machine.	
If applicable: Any staff member deemed responsible for a medication error, there was evidence that the staff member received refresher training from an RN and demonstrated competency prior to being assigned future medication administration responsibilities. There is evidence that any staff member deemed responsible for 3 errors within a 1-year time frame, had their certification suspended and was not recertified until the completion of the full **in-person** medication administration training, demonstrating competency and re-certification from an RN.	**Not Applicable**	There were no medication errors during this review period.	

Medication Inventory			
a. For controlled substances, a perpetual inventory with running balances is maintained as well as a shift-to shift count verified by a witness and documented b. Over-the-counter medications that are accessed regularly and inventoried weekly c. Syringes and sharps (needles, scissors, etc.) are secured, and counted and documented weekly	**Exception**	Over the counter medications that are accessed regularly are inventoried weekly. Syringes and sharps were secured, and counted and documented weekly.	For controlled substances from medication distribution logs reviewed, reviewer observed that shift to shift count did not happen on several occasions.
There are monthly reviews of the Pyxis reports to monitor medication management practice.	**Compliance**	RN provided monthly reviews of the Pyxis reports to monitor medication management practice.	
Medication discrepancies are cleared after each shift.	**Exception**	Any medication discrepancies are to be cleared after each shift; however, an informal interview with the RN indicated the Pyxis Med-Station communicates discrepancies with red error messages.	During medication pass on 11/14/2024 reviewer found that discrepancies with medication were not clear after each shift. MDL from two current clients did not match med count on Pyxis machine; discrepancy, which according to RN was created two shifts before review date.
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 program has the required policy and procedure, 4.04 Medical/Mental Health Alert Process, which was approved on September 9, 2024 by the Regional Director.	
Youth with a medical, mental health, or food allergy was appropriately placed on the program's alert system	**Exception**	Files reviewed; three closed and two open.	Reviewer found that two clients were not appropriately placed on the program's alert system for sight and sound in two of the three closed files reviewed;
Alert system includes precautions concerning prescribed medications, medical/mental health conditions	**Compliance**	Agency has an alert system which includes precaution concerning prescribed medications, medical/mental health conditions.	
Staff are provided sufficient training, information and instructions to recognize/respond to the need for emergency care for medical/mental health problems	**Compliance**	Agency provides sufficient training information and instructions to recognize/respond to the need for emergency care for medical/mental health problems.	
A medical and mental health alert system is in place that ensures information concerning a youth's medical condition, allergies, common side effects of prescribed medications, foods and medications that are contraindicated, or other pertinent mental health treatment information, is communicated to all staff	**Compliance**	Residential facility has a medical and mental alert system in place to ensure 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.	
Additional Comments: **There are no additional comments for this indicator.**			

4.05 - Episodic/Emergency Care			Satisfactory with Exception
Provider has a written policy and procedure that meets the requirement for Indicator 4.05		**YES** If NO, explain here: The program has the required policy and procedure, 4.05 Episodic/Emergency Care, which was approved on September 9, 2024 by the Regional Director.	
Off Site Emergency Care			
a. If off-site emergency medical or dental care was provided, an incident report was submitted for the medical or dental care b. Upon youth return, there is a verification receipt of medical clearance via discharge instructions with follow-up is present in file c. Youth's parent/guardian was notified d. A daily log is maintained for emergency care provided	**Exception**	Three closed records for youth applicable for off-site emergency care were reviewed. The program maintains an electronic log which is to be utilized to document the transport of each youth for off-site medical care. Each of the three reviewed records included hospital discharge instructions with recommendations for follow up care.	Two exceptions were found from the two files reviewed. Once exception was due to no communication to parent/legal guardian after a reportable medical emergency for one of the clients. The second exception was that reviewer did not find medical clearance via discharge instructions with follow-up inside youth's file.
All staff are trained on emergency medical procedures	**Compliance**	Agency provided training documentation for four new staff which showed all staff were trained on emergency medical procedures.	
The program has a Knife-for-life and wire cutters accessible to staff in a secure location(s)	**Compliance**	Observations confirmed the program maintains two first aid kids within the shelter building, one located in the common area and the other located within the dining area. Additionally, the program maintains first-aid kits within each of the transportation vans. The kits are inventoried weekly.	
Additional Comments: **There are no additional comments for this indicator.**			