



**Florida Network for Youth and Family Services
Compliance Monitoring Report for**

SMA Healthcare Beach House

**3875 Tiger Bay Road
Daytona Beach, FL 32124**

November 6-7, 2024

Compliance Monitoring Services Provided by



EXECUTIVE SUMMARY

Forefront LLC conducted a Quality Improvement (QI) monitoring visit on behalf of the Florida Network of Youth and Family Services (FNYFS) for the SMA Beach House for the FY 2024-2025 at its program office located at 3875 Tiger Bay Road Daytona Beach, 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. SMA Beach House is contracted with the Florida Network of Youth and Family Services (FNYFS) to provide direct services to Children/Families in Need of Services (CINS/FINS). The services to be provided are identified in Contract Section A - Descriptions and Specifications and Section B - Delivery and Performance and are funded with General Revenue Funds effective from July 2024 through June 30, 2025.

The compliance monitoring review was conducted by Marcia Tavares, Consultant for Forefront LLC. Agency representatives from SMA Beach House present for the entrance interview were: Pam Palmer, Director of Residential Adolescent Services; Kim Stone, Operation Supervisor Beach House; and Erica Summerall, Operation Supervisor RAP House; Nicole Nickerson, Senior Clinical Compliant Specialist; and Kim Croft, Clinical Compliance Manager. The last onsite QI visit was conducted on November 8, 2023.

In general, the Reviewer found that SMA Beach House is in compliance with specific contract requirements. SMA Beach House **received an overall compliance rating of 100% for achieving full compliance with 13 indicators** of the CINS/FINS Monitoring Tool. There were no recommendations or corrective actions as a result of the monitoring visit.

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

2024-2025 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL

Report Number: CM 11-06-2024-2025

Agency Name: SMA Beach House					Monitor Name: Marcia Tavares, Lead Reviewer		
Contract Type : CINS/FINS					Region/Office: 3875 Tiger Bay Road, Daytona Beach, FL		
Service Description: Comprehensive Onsite Compliance Monitoring					Site Visit Date(s): November 6-7, 2024		
Explain Rating							
Major Programmatic Requirements	Unacceptable	Conditionally Acceptable	Fully Met	Exceeded	Not Applicable	Ratings Based Upon: I = Interview O = Observation D = Documentation PTV = Submitted Prior To Visit (List Who and What)	Notes Explain Unacceptable or Conditionally Acceptable:
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.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	The program currently has four staff members certified as DJJ QI Peer reviewers: Pam Palmer, Jeffrey Honaker, Kim Stone, and Erica Summerall. To date, two of the staff, Ms. Palmer and Jeff Honaker, have participated in a QI review.	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	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	The agency provided a list of additional contracts for FY2024-2025. The list includes: the Name of the Contract, Contract Period, and Contract Amount. The program also maintains interagency agreements and Memorandums of Agreement (MOUs) with schools, mental health, and substance abuse providers. All of the agreements reviewed had current contract/agreement dates.	No recommendation or Corrective Action.
Limits of Coverage a. Provider shall provide and maintain during this contract, the following minimum kinds of insurance: Worker's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	General Liability through Alliance of Nonprofits for Insurance for limits of coverage \$1,000,000 each \$3,000,000	No recommendation or Corrective Action.

2024-2025 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL

Report Number: CM 11-06-2024-2025

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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					aggregate, and \$20,000 medical expense, effective 6/30/24-6/30/25. Automobile insurance through Alliance of Nonprofits for Insurance for combined limits of liability/property damage for \$1,000,000 each and aggregate. Policy effective for 6/30/24-6/30/25. Umbrella liability coverage through Alliance of Nonprofits for Insurance for limits of coverage \$1,000,000 each/aggregate effective 6/30/24-6/30/25. Workers Comp insurance through Accident Fund Insurance Company of America for limits of coverage \$1,000,000 each accident, each employee, and policy limit, effective 4/1/2024 – 4/1/2025. Professional Liability Insurance through Scottsdale Insurance Company for limits of coverage		

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\$1,000,000 each/ \$3,000,000 aggregate, effective 6/30/2024-6/30/2025. Florida Network is listed on the certificate as 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	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	The only external CAP the agency received is for its Department of Corrections facility.	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	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Documentation: Fiscal Policies and Procedures are contained in the Financial Services Policy and Procedures Manual. The manual is divided into eight sections with subsections in each one. The procedures reviewed appear to be consistent with GAAP and provide for sound internal controls.	No recommendation or Corrective Action.
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	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Documentation: Detailed General Ledger for the current year-to-date, as of 10/31/2024. Agency maintains a detailed general	No recommendation or Corrective Action.

2024-2025 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL

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(standard account numbers / separate funds for each revenue source, etc.). PTV						ledger that is structured to track all funding sources as well as activities for the CINS/FINS program.	
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	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Interview: No change in practice was reported by the agency since the last onsite program review in November 2023. Petty Cash fund does not exceed the established minimum of \$500. Requests for money greater than \$75 require a check request. Cash is stored in a secure locked location in the building. Petty cash is reconciled on a consistent basis, monthly and quarterly, by designated staff and reviewed by the Supervisor. Disbursements and invoices are approved by the Program Supervisor as required.	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.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Documentation: Reviewed Bank Statements and Bank Reconciliations for the period April – September 2024 for account held with Wells Fargo. Financial Statements are	No recommendation or Corrective Action.

2024-2025 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
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(Disbursements/invoices are approved & monitored by management). ON SITE						reported on a monthly basis and were found to be reconciled each month. Bank reconciliations are conducted timely each month for the activities and bank statements for the preceding month and are signed by both the preparer and approving authority. Invoices are approved by the director and submitted monthly with supporting documentation. The agency maintains individual vendor files.	
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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	N/A – The agency has not purchased any items with FNYFS monies since the last time on-site.	No recommendation or Corrective Action.
f. Agency submits payroll taxes and deposits (and retirement deposits as applicable), <u>Employee</u> IRS Form W-2 and <u>Independent Contractors</u> IRS Form 1099 forms prior to federal requirements. ON SITE	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Documentation: Agency Provided copies of Form 941 for the 2 nd and 3 rd quarters of 2024. Form 941 shows payroll taxes were paid for each quarter reflecting no balances due.	No recommendation or Corrective Action.

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	Unacceptable	Conditionally Acceptable	Fully Met	Exceeded	Not Applicable		
g. Budget to actual reports prepared and reviewed by appropriate management. Variance from the budget is investigated and explained. PTV/ON SITE	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Documentation: Agency provided a Budget to Actual statement, for the period July-September 2024. A review of the report shows program budget and variances with YTD Total Budget. Variances in budget are monitored on a regular basis and approved by management.	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 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	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Documentation: Financial audit conducted for year ending June 30, 2023, and 2022 was completed by James Moore, C.P.A. and Consultants. A separate Management Letter requiring a Corrective Action Plan was not issued by the auditor as there were no items required to be reported. A copy of the audit was submitted to the FNYFS	No recommendation or Corrective Action.

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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:
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	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Documentation: Procedures relating to confidentiality and data backup are found in the Health Information Management Manual last approved February 2023. The policies were reviewed and appear to provide for sound internal control. The agency has an IT department that maintains strict control over the security of all computers and laptops. All documents are shredded after seven years.	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	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Documentation: SMA Compensation Information-Direct Care Staff Wage Increase Salary List. The list shows all direct care staff with salaries at a minimum of \$19/hour since October 1, 2023.	No recommendation or Corrective Action.

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CONCLUSION

SMA Beach House has met the requirements for the CINS/FINS contract as a result of full compliance with 13 applicable indicators of the Administrative and Fiscal Contract Monitoring Tool. One of the 14 indicators was not applicable because the agency has not purchased any equipment with FNYFS monies since the last time on-site. Consequently, **the overall compliance rate for this contract monitoring visit is 100%**. There are no recommendations or corrective actions required as a result of the contract monitoring visit. Overall, the provider is performing satisfactorily in meeting the fiscal and administrative terms of its contract. In addition, all of the indicators reviewed were carried out in a manner which meets the standard described in the report's 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 SMA Healthcare, Inc. - Beach House
CINS/FINS Program

November 6-7, 2024

Compliance Monitoring Services Provided by



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	Satisfactory
1.07 Outreach Services	Satisfactory

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

Standard 2: Intervention and Case Management

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

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

Standard 3: Shelter Care & Special Populations

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

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

Standard 4: Mental Health/Health Services

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

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

Overall Rating Summary

Percent of indicators rated Satisfactory: 92.86 %
Percent of indicators rated Limited: 7.14 %
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
 Megan Thrasher – Regional Monitor, Department of Juvenile Justice
 Michele Maynard – Regional Monitor (In Training), Department of Juvenile Justice
 Shanda Hope – Arnette House
 Jarma Morgan – Family Resources
 Carline Pierre – Children's Home Society

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

<ul style="list-style-type: none"> Chief Executive Officer Chief Financial Officer Chief Operating Officer Executive Director X Program Director Program Manager Program Coordinator Clinical Director Counselor Licensed 	<ul style="list-style-type: none"> X Case Manager X Counselor Non-Licensed Advocate X Direct – Care Full time Direct – Part time Direct – Care On-Call Intern Volunteer X Human Resources 	<ul style="list-style-type: none"> Nurse – Full time X Nurse – Part time 2 # Case Managers 1 # Program Supervisors # Food Service Personnel 1 # Healthcare Staff # Maintenance Personnel # Other (listed by title): ____
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Documents Reviewed

<ul style="list-style-type: none"> Accreditation Reports X Affidavit of Good Moral Character X CCC Reports X Logbooks Continuity of Operation Plan X Contract Monitoring Reports Contract Scope of Services X Egress Plans X Fire Inspection Report Exposure Control Plan 	<ul style="list-style-type: none"> X Table of Organization X Fire Prevention Plan X Grievance Process/Records Key Control Log X Fire Drill Log X Medical and Mental Health Alerts X Precautionary Observation Logs X Program Schedules X List of Supplemental Contracts X Vehicle Inspection Reports 	<ul style="list-style-type: none"> Visitation Logs X Youth Handbook 5 # Health Records 6 # MH/SA Records 10 # Personnel /Volunteer Records 8 # Training Records 12 # Youth Records (Closed) 4 # Youth Records (Open) # Other: ____
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Observations During Review

<ul style="list-style-type: none"> Intake X Program Activities Recreation X Searches X Security Video Tapes Social Skill Modeling by Staff X Medication Administration 	<ul style="list-style-type: none"> X Posting of Abuse Hotline X Tool Inventory and Storage X Toxic Item Inventory & Storage Discharge Treatment Team Meetings X Youth Movement and Counts X Staff Interactions with Youth 	<ul style="list-style-type: none"> X Staff Supervision of Youth X Facility and Grounds X First Aid Kit(s) Group Meals X Signage that all youth welcome X Census Board
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Surveys

<ul style="list-style-type: none"> 5 # of Youth 	<ul style="list-style-type: none"> 4 # of Direct Staff 	<ul style="list-style-type: none"> # of Other
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November 6-7, 2024

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

SMA Healthcare Foundation is a non-profit human services organization that has provided behavioral healthcare services in Florida for more than 60 years. SMA Healthcare provides a full continuum of comprehensive services for individuals in need of mental health and substance abuse services including crisis intervention, short-term residential, and substance use treatment in-patient programs. Services are provided in the following counties: Flagler, Marion, Putnam, St. Johns, and Volusia County. BEACH House is a CINS/FINS shelter that provides short-term respite for youth ages 10-17 who are truant, ungovernable, or runaway, and/or homeless. The shelter is located at 3875 Tiger Bay Road, South Daytona Beach. The program also 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). Beach House is licensed for twenty beds but has a capacity to serve twelve youth. The program's license was renewed by the Department of Children and Families (DCF) and is valid until July 11, 2025. The census during the Quality Improvement (QI) visit was seven CINS/FINS and one DV youth. The agency is currently accredited with Commission on Accreditation of Rehabilitation Facilities (CARF) effective through April 30, 2026.

November 6-7, 2024

The overall findings for the program QI Review are summarized as follows:**Standard 1:** There are seven indicators for Standard 1.Indicator 1.01 Background Screening of Employees/Volunteers was rated **Satisfactory with Exception**.Indicator 1.02 Provision of an Abuse Free Environment was rated **Satisfactory**.Indicator 1.03 Incident Reporting was rated **Satisfactory with Exception**.Indicator 1.04 Training Requirements was rated **Limited**.Indicator 1.05 Analyzing and Reporting Information was rated **Satisfactory**.Indicator 1.06 Client Transportation was rated **Satisfactory with Exception**.Indicator 1.07 Outreach Services was rated **Satisfactory**.**Standard 2:** There are nine indicators for Standard 2.Indicator 2.01 Screening and Intake was rated **Satisfactory with Exception**.Indicator 2.02 Needs Assessment was rated **Satisfactory**.Indicator 2.03 Case/Service Plan was rated **Satisfactory with Exception**.Indicator 2.04 Case Management and Service Delivery was rated **Satisfactory**.Indicator 2.05 Counseling Services was rated **Satisfactory with Exception**.Indicator 2.06 Adjudication/Petition Process was rated **Satisfactory**.Indicator 2.07 Youth Records was rated **Satisfactory with Exception**.Indicator 2.08 Specialized Additional Program Services was rated **Satisfactory**.Indicator 2.09 Stop Now and Plan (SNAP) was rated **Not Applicable**.**Standard 3:** There are seven indicators for Standard 3.Indicator 3.01 Shelter Environment was rated **Satisfactory with Exception**.Indicator 3.02 Program Orientation was rated **Satisfactory**.Indicator 3.03 Youth Room Assignment was rated **Satisfactory with Exception**.Indicator 3.04 Log Books was rated **Limited**.Indicator 3.05 Behavior Management Strategies was rated **Satisfactory**.Indicator 3.06 Staffing and Youth Supervision was rated **Satisfactory**.Indicator 3.07 Video Surveillance System was rated **Satisfactory with Exception**.**Standard 4:** There are five indicators for Standard 4.Indicator 4.01 Healthcare Admission Screening was rated **Satisfactory**.Indicator 4.02 Suicide Prevention was rated **Satisfactory with Exception**.Indicator 4.03 Medications was rated **Satisfactory with Exception**.Indicator 4.04 Medical/Mental Health Alert Process was rated **Satisfactory**.Indicator 4.05 Episodic/Emergency Care was rated **Satisfactory**.

November 6-7, 2024

Summary of Deficiencies resulting in Limited or Failed Rating (If Applicable):**Standard 1:****Indicator 1.04 - Limited**

- 1) One file was missing the SMA Adolescent Campus On the Job Training Manual that covered six required in-person pre-service trainings.
- 2) Two new hires did not complete the required DOJ Civil Rights and Federal Funds training during the first 30 days of hire.
- 3) Four Pre-service training files were reviewed. Of the four files, one file was missing five required trainings with one additional training being completed outside the ninety day window of the hire date. One file was missing eight required trainings with one additional training being completed but outside the ninety day window of the hire date. One file was missing five trainings and three additional trainings were completed but outside the 90 day window of the hire date. The last file had three missing required trainings and four additional trainings that were completed but outside the ninety day window of the hire date.
- 4) None of the four files reviewed had indication a First Aid Refresher had been conducted within the past two years. One of the four in-service staff records had indication the Department of Juvenile Justice (DJJ) Skill Pro #316 Human Trafficking Intervention for Direct Care Staff was completed as required; however, this record was missing all other required DJJ Skill Pro trainings. Any trainings not completed within the required timeframe had no evidence or documentation as to why and when the staff members are scheduled to take the training.

Standard 3:**Indicator 3.04 - Limited**

- 1) On 5/5/24 and 6/16/24 reviewed observed entries with scribbled lines through the words. Also on 8/12/24, 8/23/24, 9/6/24, and 9/9/24, notes contained entries with multiple lines going through a word. On 8/22/24, 9/1/24, and 9/5/24, there were discoveries of staff writing over the error. Additionally, staff failed to initial and date their errors.
- 2) Documentation from the program director or designee were very brief and lacked any and all detail about staff's documentation in the logbook including events where errors are not noted correctly.
- 3) Staff are not indicating the dates reviewed or how many shifts they have read back to, in order to be cognizant of any unusual occurrences or problems since their last shift. For example, one staff entered her initials only on several dates: 8/18/24, 9/2/24, 9/3/24, 9/7/24, 9/8/24, 9/9/24, and 9/10/24.
- 4) Supervisor's review of logbook did not indicate the dates reviewed. Shelter counselors were not observed to document reviews of the logbook.

CINS/FINS QUALITY IMPROVEMENT TOOL		
Quality Improvement Indicators and Results: Please select the appropriate outcome for each indicator for each item within the indicator.	Summary/Narrative Findings: The narrative write-up is a thorough summary of each assigned QI indicator, explaining how finding(s) are determined.	Deficiencies/Exceptions: Please add additional detailed explanations for any items that have any deficiencies or exceptions.
Standard One – Management Accountability		
1.01: Background Screening of Employees, Contractors and Volunteers		Satisfactory with Exception
Provider has a written policy and procedure that meets the requirement for Indicator 1.01	YES	
	If NO, explain here: The provider has the required policy and procedures titled Background Screening of Employees/Volunteers that was last reviewed 10/28/2024 by the Director of Adolescent Services.	
All positions providing direct services to youth has successfully passed pre-employment suitability assessment on the initial attempt.	Compliance	The program uses the Impact pre-employment suitability tool that includes a video and reading assessment. The tool was administered prior to hiring six new direct care staff who were hired during the review period. Five of the six staff obtained passing scores greater than 70 on the assessment. One of the six new hires did not pass the reading assessment on the first attempt but successfully passed upon re-taking the assessment and prior to an offer of employment.
For any applicant that did not pass the initial suitability assessment, there was evidence that the applicant retook the assessment and passed within five (5) business days of the initial attempt, not exceeding three (3) attempts within thirty (30) days.	Compliance	One of the six staff scored 67 on the reading component of the assessment on the first attempt. A second attempt was initiated within three days at which time a passing score of 93 was obtained.
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. <i>(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.)</i>	Exception	Background screenings for five of the six applicable 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. One of the new hire's background screening was approved on 7/30/2024; however, the agency's hire date was 7/29/2024, prior to receipt of the background screening results.

Five-year re-screening is completed every 5 years from the date of the last screening for all applicable employees and volunteers.	Exception	The program had two eligible 5-year re-screenings for the review period. One of the two staff was successfully re-screened prior to the retained prints expiration date.	One staff's retained prints expired 8/13/24 and a re-screening was not done on time. The program submitted a re-screening request on 10/24/24 and eligibility status was received on 11/8/2024 during the QI review.
Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?	Compliance	The program emailed its Annual Affidavit of Compliance with Level 2 Screening Standards to the Background Screening Unit November 6, 2023 for 2024 prior to the January 31st deadline. An email from Human Resources was submitted on 11/6/23 in compliance with DJJ's policy allowing agencies to submit up to three months prior, but no later than January 31st.	
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 the six new hires.	
Additional Comments: There are no additional comments for this indicator.			
1.02: Provision of an Abuse Free Environment			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 1.02	YES		
	If NO, explain here:		
	The provider has the required policy titled Provision of an Abuse Free Environment that was revised 10/28/2024 by the Director of Adolescent Services.		
Agency has a code of conduct of policy and there is evidence that staff are aware of agency's code of conduct.	Compliance	The provider has a code of ethical conduct, that prohibits the use of physical abuse, profanity, threats or intimidations. This code is reviewed with staff upon hiring.	
The agency has a process in place for reporting and documenting child abuse hotline calls.	No eligible items for review	During this reporting period the program reported no abuse calls were made.	
Youth were informed of the Abuse and Contact Number	Compliance	Per the shelter supervisor, at intake each youth is informed of the abuse procedures and contact number. In addition, in each file there is a checklist indicating the youth was informed.	
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	Shelter supervisor reported the grievance procedures are explained at each intake. The youth have open access to the grievance box to file complaints. The key to the grievance box is in the possession of the program director and shelter supervisor only.	

Shelter only: Grievances are maintained on file at minimum for 1 year.	Compliance	Shelter supervisor informed writer grievances are kept on file for 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 grievance box was observed to be locked and is mounted on a wall in the multipurpose room in the shelter. 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	Grievance box checks were reviewed for randomly selected two-week periods during each of the past six months. The provider documented daily checks of the grievance box in the log book, at least five times per week. No missing checks were observed during the periods 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.	No eligible items for review	There were no client grievances reported for the review period.	
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 several policy's pertaining to incident reporting which are as follows: Occurrence reporting; Administrator on Call and Adverse Event/Incident Reporting; and Notification of Key Stakeholders Regarding Major Occurrences. Revisions were by completed by the Director of Adolescent Services and approved 10/28/2024.		
During the past 6 months, the program notified the Department's CCC (Central Communication Center) no later than two hours after any reportable incident occurred or within two hours of the program learning of the incident	Exception	A total of fifteen incident reports were reviewed that were reported to CCC. Twelve of the fifteen reportable incidents were reported within two hours of the program learning of the incident.	Three of the reported incidents were not in compliance with the two hour reporting time frame.
The program completes follow-up communication tasks/special instructions as required by the CCC	Compliance	All CCC incident reports reviewed indicated follow-up correspondent.	
Agency internal incidents are documented on incident reporting forms and all CCC reportable incidents were consistently reported to CCC as required.	Compliance	All incidents are recorded and documented in an electronic platform.	
Incidents are documented in the program logs and on incident reporting forms	Exception	Seven of the fifteen incidents reviewed were observed to be documented in the program log book.	Eight of the fifteen incidents reviewed were not noted in the log book. The dates of the incidents are as follows: 11/8/23; 11/9/23; 11/19/23; 11/21/23; 2/12/24; 2/28/24; 4/7/24; and 8/23/24.

<p>All incident reports are reviewed and signed by program supervisors/ directors</p>	<p>Compliance</p>	<p>Fifteen CCC reports were reviewed. Eight were for Mental Health /Substance Abuse. Two were for Complaint Against Staff. Three were for Program Disruption and one was for Medical. No program signatures were observed due to the provider utilizing an electronic platform; however, the supervisor's review is noted.</p>	
<p>1.04: Training Requirements (Staff receives training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions)</p>			<p>Limited</p>
<p>Provider has a written policy and procedure that meets the requirement for Indicator 1.04</p>	<p>YES If NO, explain here: The provider has the required policy titled Provision of an Abuse Free Environment that was revised 10/28/2024 by the Director of Adolescent Services.</p>		
<p>First Year Direct Care Staff</p>			
<p>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:</p> <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> - 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. 	<p>Exception</p>	<p>A total of four training records were reviewed for staff who have completed more than 90 days of hire and within the first year of employment. The program conducts pre-service orientation training prior to staff working in the program. Three of the four new staff had evidence of completing pre-service training.</p>	<p>One file was missing the 'SMA Adolescent Campus On the Job Training Manual' that covered six required in-person pre-service trainings.</p>
<p>All staff completed the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days from date of hire.</p>	<p>Exception</p>	<p>Two of four new hires completed the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days from date of hire.</p>	<p>Two new hires did not complete the required DOJ Civil Rights and Federal Funds training during the first 30 days of hire.</p>

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.	No eligible items for review	All four training records reviewed are for staff who are still within the first year of employment and have time to complete the 80 hours required annually.	
All staff receives all mandatory training during the first 90 days of employment from date of hire.	Exception	None of the four new hires completed all mandatory training due during the first 90 days of employment.	Four Pre-service training files were reviewed. Of the four files, one file was missing five required trainings with one additional training being completed outside the ninety day window of the hire date. One file was missing eight required trainings with one additional training being completed but outside the ninety day window of the hire date. One file was missing five trainings and three additional trainings were completed but outside the 90 day window of the hire date. The last file had three missing required trainings and four additional trainings that were completed but outside the ninety day window of the hire date.
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	Training documentation from the registered nurse supported two of the four new hires who assist with medication distribution received in-person training.	
Staff that are Utilizing NETMIS			
Any staff that is utilizing NETMIS has evidence of completing NetMIS Training in their training file.	No eligible items for review	None of the four training records included staff who are required to use NetMIS.	
Staff Participating in Case Staffing & CINS Petitions (within the first year of employment BUT no later 7/1/24 for previous staff)			
Documentation of instructor-led FL Statute 984 CINS Petition Training by a local DJJ Attorney <u>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).</u>	No eligible items for review	The program did not hire any new staff during the review period who are responsible for participating in case staffing and CINS 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).	No eligible items for review	The program did not hire any new shelter counseling staff during the review period.	
In-Service Direct Care Staff			

<p>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.</p>	<p>Exception</p>	<p>Four in-service staff training records were reviewed for required annual and bi-annual training. All four records documented trainings that are required by the Florida Network of Youth and Family Services (FNYFS) in each of their training records as well as captured on the Florida Network (FLN) Training Log or a document similar to the FLN Training Log containing all required information. Three of the four records were observed to have completed all trainings required per policy and rule, with the exception of First Aid refresher. All four staff had documentation they had received training for the administration of Naloxone.</p>	<p>None of the four files reviewed had indication a First Aid Refresher had been conducted within the past two years. One of the four in-service staff records had indication the Department of Juvenile Justice (DJJ) Skill Pro #316 Human Trafficking Intervention for Direct Care Staff was completed as required; however, this record was missing all other required DJJ Skill Pro trainings. Any trainings not completed within the required timeframe had no evidence or documentation as to why and when the staff members are scheduled to take the training.</p>
<p>Community Counseling Direct Care staff completes 24 hours of mandatory refresher Florida Network, SkillPro, and job-related training annually.</p>	<p>Compliance</p>	<p>One of the four records reviewed is for a community counselor who completed 40 hours of training.</p>	
<p>Shelter Program Direct Care staff completes 40 hours of mandatory refresher Florida Network, SkillPro, and job-related training annually (<i>E.g. the program has a DCF child caring license</i>).</p>	<p>Compliance</p>	<p>Three of the four records reviewed are for direct care shelter staff who completed a minimum of 40 hours of training.</p>	
<p>Required Training Documentation</p>			
<p>The agency has a training plan that includes all of the required training topics including the pre-service and in-service.</p>	<p>Compliance</p>	<p>Each employee has a training plan that includes pre-and in-service training requirements. Human Resources completes all new hire training, including all 90-day training requirements. After 90-day training requirements have been met the staff member completes an additional 40 hours of training with the residential supervisor, including orientation before the employee is released to work in the shelter or with youth records. The program provides training across three different platforms including DJJ Skill Pro, Florida Network Bridge, and the agency's My Learning Pointe learning management system, as well as in-person classroom sessions.</p>	
<p>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.</p>	<p>Compliance</p>	<p>Each employee maintains their own training log and is responsible for recording all completed training with completion dates and uploading the certificate and log to the agency's shared drive. To ensure compliance, the program director reviews each employee's log on a regular basis and notifies the employee via email of pending, upcoming, or late trainings.</p>	

<p>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.</p>	<p>Compliance</p>	<p>The program provided training files for each employee selected for review. Each training file contained a Florida Network training log with all required information within, and several reports from additional training platforms used by the agency. Certificates of completion were attached for all trainings completed within the last 12 months or first 90 days of employment for each employee file reviewed.</p>	
<p>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:</p>	<p>Compliance</p>	<p>All eight training records reviewed, four first year and four in-service staff, demonstrated all staff completed the naloxone training as required.</p>	
<p>Additional Comments: There are no additional comments for this indicator.</p>			
<p>1.05 - Analyzing and Reporting Information</p>			<p>Satisfactory with Exception</p>
<p>Provider has a written policy and procedure that meets the requirement for Indicator 1.05</p>	<p>YES</p>		
	<p>If NO, explain here:</p>		
	<p>The provider has the required policies titled 1) Obtaining and Analyzing Client Feedback, and 2) Data Entry and Collection that were revised 10/28/2023 by the Director of Adolescent Services.</p>		
<p>Case record review reports demonstrate reviews are conducted quarterly, at a minimum. <i>(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.)</i></p>	<p>Exception</p>	<p>Case record reviews are conducted differently for each program, informally during treatment team meetings for residential records, and more formally using a file review form for community counseling records. In addition, the administrative assistant uses a checklist to review contents of all files at discharge.</p>	<p>A formal chart review process was not evident for the residential program that summarizes the outcome of the peer reviews and reporting to staff at staff meetings to address deficiencies identified.</p>
<p>The program conducts reviews of incidents, accidents, and grievances quarterly, at a minimum</p>	<p>Compliance</p>	<p>Incidents, accidents, and grievances are entered in real time into the provider's internal occurrence reporting data system called Resolver. Reviews by supervisors are required and documented in the system. A monthly report is generated to track the number of occurrences and a separate Incident Category Raw Data report lists more detail information including program, type of incident, and date/time. The provider also has a safety committee that conducts safety meetings regularly. Three safety committee meetings were held in May, July, and September and the agenda includes a discussion of safety issues identified, incident occurrence reporting, and safety drill and inspection updates.</p>	

<p>The program conducts an annual review of customer satisfaction data</p>	<p>Compliance</p>	<p>The program collects and enters client satisfaction data into an internal database. Monthly reports are sent to program directors who can view the scores and survey results collected. If the program score is highlighted yellow, the score fell below 4.00 and the text is red if the score was lower the following month. Any yellow scores with red font require the program to review the survey results and send a response as to why there is a downward trend. Survey results are discussed at program improvement committee meetings and staff meetings.</p>	
<p>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.</p>	<p>Compliance</p>	<p>The provider has a performance improvement committee that meets the third Monday each month. Performance measures for predetermined metrics are sent to the clinical data manager to enter into the program's report card. Findings are reported on a performance dashboard, reviewed by the committee, and communicated to program directors. End of month (EOM) Florida Network reports are reviewed by the program director and emailed to key staff. Scorecard information is shared with staff at monthly staff meetings.</p>	
<p>The program has a process in place to review and improve accuracy of data entry & collection</p>	<p>Compliance</p>	<p>The program director and shelter supervisor review data entry collection, benchmark data, and deficiencies upon receipt from the Florida Network. Data entry deficiencies identified are corrected and communicated via email with the Florida Network Director of Data and Research.</p>	
<p>There is documentation that findings are regularly reviewed by management and communicated to staff and stakeholders.</p>	<p>Compliance</p>	<p>There was documentation through monthly all staff meeting minutes that findings are communicated to staff and stakeholders.</p>	
<p>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.</p>	<p>Compliance</p>	<p>Findings are regularly reviewed by management and communicated to staff, stakeholders, and the board of directors through the Performance Improvement Committee process. Auditing and monitoring results throughout the year are compiled into a report by the compliance officer and presented to the SMA board of directors.</p>	
<p>There is evidence that strengths and weaknesses are identified, improvements are implemented or modified, and staff are informed and involved throughout the process.</p>	<p>Compliance</p>	<p>Monthly PIC meetings address program compliance and ensure corrective action is taken for any issues identified. The PIC documents strengths and weaknesses and monitors any improvements or corrective actions needed.</p>	
<p>Additional Comments: There are no additional comments for this indicator.</p>			

1.06: Client Transportation		Satisfactory with Exception	
Provider has a written policy and procedure that meets the requirement for Indicator 1.06		YES	
		If NO, explain here:	
		The provider has the required policies titled Vehicle Use; Driver Responsibility; and Transporting Clients, that were last revised 10/28/2024 by the Director of Adolescent Services.	
Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	Compliance	The provider maintains a list of drivers who were reviewed and approved by human resources (HR) to drive the agency vehicles.	
Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	Compliance	There is evidence from review of driver's license documentation that the approved drivers for the agency all have valid drivers' licenses and per agency policy, all approved drivers are covered under company's insurance policy. A copy of the current automobile policy was verified.	
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 3 rd party is NOT present in the vehicle while transporting	Compliance	The provider's transportation policy prohibits single transports but includes exceptions in the event that a third party is not present in the vehicle while transporting.	
In the event that a 3rd party cannot be obtained for transport, the agency's supervisor or managerial personnel consider the clients' history, evaluation, and recent behavior	Compliance	The provider's policy includes requirement for single transports to take into consideration the youth's history and recent behaviors prior to approval for transport.	
The 3 rd party is an approved volunteer, intern, agency staff, or other youth	Compliance	The provider's policy does require the third party to be an approved volunteer, intern, agency staff or another client.	
When transporting a single client in a vehicle, there was documentation of the following: a. the transporting employee completed check-in by phone at agreed-upon intervals with the senior program leader, or designee, upon departure and arrival. b. the employee check-ins were documented by the manager or designee receiving the call.	Compliance	One single transport was conducted during the review period. The single transport reviewed contained documentation of the event, authorization and check-in call.	
The agency demonstrated evidence via logbook or other written verification that supervisor approval was obtained prior to all single youth transports.	Exception	One single transport was reviewed. Staff documented the single transport in the green record book. Staff also logged the phone check-in the green record book. Staff did not log the transport in the vehicle log book.	Staff failed to log the August 25, 2024 single transport event in the vehicle log book.
There is documentation of use of vehicle that notes name or initials of driver, date and time, mileage, number of passengers, purpose of travel and location.	Compliance	The vehicle transportation log book reviewed included name of driver, date, time, mileage, number of passengers, location and reason for transport.	
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 provider has the required policy titled Vehicle Use; Driver Responsibility; and Transporting Clients. All three policies were last revised 10/28/2024 by the Director of Adolescent Services.		
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 Director of Adolescent Services is designated to participate in local DJJ board meetings. The outreach binder verified the designee attended the following meetings: 10/16/2024 - Flagler DJJ Council; 8/27/2024 - DJJ Circuit 7 Advisory Board; 9/18/2024 - Flagler Juvenile Justice Council; 5/10/2024 - Circuit 7 DJJ CAB Quarterly. On June 17, 2024, director was notified via email Volusia DJJ Council meeting would pause (June and July) and would restart after August.	
The program maintains written agreements with other community partners which include services provided and a comprehensive referral process.	Compliance	The provider maintained documentation of written agreements with community partners which included service provided to ensure a comprehensive referral process.	
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	The provider maintained a log book including documentation of outreach activities. The NetMIS outreach log includes all required information.	
The program has designated staff that conducts outreach which is defined in their job description.	Compliance	The director of adolescent residential services indicated she is the primary staff to conduct outreach.	
Additional Comments: There are no additional comments for this indicator.			
2.01 - Screening and Intake		Satisfactory with Exception	
Provider has a written policy and procedure that meets the requirement for Indicator 2.01	YES		
	If NO, explain here:		
	The provider has the required policy titled Screening, Eligibility, and Linkage to Services that was revised on October 28, 2024 by the Director of Adolescent Residential Services.		
Shelter youth: Eligibility screening form is completed immediately for all shelter placement inquiries.	Compliance	Eligibility screening was observed to be completed immediately for all five residential files reviewed.	
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 files reviewed demonstrated eligibility screening is completed within three business days of referral by a trained staff using the Florida Network screening form.	

There is evidence all referrals for service is screened for eligibility and is logged in NetMIS within 72 hours of screening completion.	Compliance	All five residential and five community counseling files reviewed demonstrated all 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 five residential and five community counseling files reviewed demonstrated youth and parents/guardians receive the available service options and rights and responsibilities of youth and parents/guardians in writing during intake.	
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	Exception	Grievance procedures are discussed with the youth and family during the intake. There is evidence staff provided information about the possible actions occurring through involvement with CINS/FINS to the five community counseling youth/family.	The program does not maintain documentation to support youth/family receive information on the possible actions occurring through involvement with CINS/FINS (case staffing etc.) for the five residential youth records reviewed.
During intake, all youth were screened for suicidality and correctly assessed as required if needed.	Compliance	All five residential and five community counseling files reviewed demonstrated during intake, all youth were screened for suicidality and assessed as required if needed.	
Additional Comments: There are no additional comments for this indicator.			
2.02 - Needs Assessment			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 2.02	YES		
	If NO, explain here:		
	The provider has the required policy titled Network Inventory of Risks, Victories and Needs Assessment-NIRVANA that was revised on October 28, 2024 by the Director of Adolescent Residential Services.		
Shelter Youth: NIRVANA is initiated within 72 hours of admission	Compliance	All five residential files reviewed demonstrated NIRVANA was 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 files reviewed demonstrated NIRVANA was initiated at intake and completed within two to three face-to-face contacts after the initial intake.	
Supervisor signatures is documented for all completed NIRVANA assessments and/or the chronological note and/or interview guide that is located in the youths' file.	Compliance	All ten files reviewed documented the supervisor's signature and dates for all completed NIRVANA assessments.	

(Shelter Only) NIRVANA Self-Assessment (NSR) is completed within 24 hours of youth being admitted into shelter. If unable to complete, there must be documentation in NetMIS and the youth's file explaining the barriers to completion.	Compliance	All five residential files reviewed demonstrated NIRVANA Self-Assessment was 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	Five residential and two community counseling files reviewed were not applicable as the length of stay did not exceed 30 days. Three community counseling files demonstrated post-NIRVANA assessments were completed at discharge.	
A NIRVANA Re-Assessment is completed every 90 days excluding files for youth receiving SNAP services.	No eligible items for review	None of the files reviewed were applicable for NIRVANA re-assessment because the length of stay did not exceed the 90 days requirement.	
All files include the interview guide and/or printed NIRVANA.	Compliance	All files reviewed included the NIRVANA interview guide or the printed NIRVANA.	
Additional Comments: There are no additional comments for this indicator.			
2.03 - Case/Service Plan			Satisfactory with Exception
Provider has a written policy and procedure that meets the requirement for Indicator 2.03	YES		
	If NO, explain here:		
	The provider has the required policy titled Assessment and Treatment Planning that was revised on October 28, 2024 by the Director of Adolescent Residential Services.		
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 ten files reviewed demonstrated the case/service plan is developed on a local provider-approved form and is 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 10 files reviewed demonstrated the case/service plan is developed within seven days of NIRVANA.	The case plan was developed more than seven days in one residential file reviewed.
Case plan/service plan includes: 1. Individualized and prioritized need(s) and goal(s) identified by the NIRVANA 2. Service type, frequency, location 3. Person(s) responsible 4. Target date(s) for completion and actual completion date(s) 5. Signature of youth, parent/guardian, counselor, and supervisor 6. Date the plan was initiated	Compliance	All ten files reviewed demonstrated individualized and prioritized need(s) and goal(s) identified by the NIRVANA, service type, frequency, location, person(s) responsible, target date(s) for completion, date the plan was initiated, and signature of youth, parent/guardian, and supervisor. All applicable files demonstrated actual completion date(s) of goals.	

<p>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</p>	<p>Compliance</p>	<p>Thirty day reviews were applicable to two community counseling files. The two files demonstrated case/service plans were reviewed for progress/revised by counselor and parent (if available) every 30 days for the first three months.</p>	
<p>Additional Comments: There are no additional comments for this indicator.</p>			
<p>2.04 - Case Management and Service Delivery</p>			<p>Satisfactory</p>
<p>Provider has a written policy and procedure that meets the requirement for Indicator 2.04</p>	<p>YES</p>		
	<p>If NO, explain here:</p>		
	<p>The provider has the required policy titled Case Management Services that was revised on October 28, 2024 by the Director of Adolescent Residential Services.</p>		
<p>Counselor/Case Manager is assigned</p>	<p>Compliance</p>	<p>Each of the ten files demonstrated a counselor/case manager was assigned to work with the youth/family from case assignment to termination.</p>	
<p>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</p>	<p>Compliance</p>	<p>All ten records reviewed demonstrated referral needs were identified and coordination of referrals to services based upon the on-going assessment of the youth's/family's problems and needs. It was also evident the case worker coordinated service plan implementation, monitored youth's/family's progress in services, provided support for families, referred the youth/family for additional services when appropriate, and provided case monitoring in all ten records. All five residential and five community counseling records reviewed were not applicable for monitoring of progress for court as none were reported to be court ordered during the review period. None of the files reviewed were applicable for making referrals to the case staffing. All six closed records included termination notes. Five applicable records, three closed residential and one closed community counseling files, demonstrated follow-ups after 30 days of exit and one closed residential and one closed community counseling file demonstrated follow-up after 60 days of exit.</p>	
<p>The program maintains written agreements with other community partners that include services provided and a comprehensive referral process</p>	<p>Compliance</p>	<p>All ten files reviewed included a document in the case file which listed agreed community partners and services provided to ensure a comprehensive referral process.</p>	
<p>Additional Comments: There are no additional comments for this indicator.</p>			

2.05 - Counseling Services		Satisfactory with Exception	
Provider has a written policy and procedure that meets the requirement for Indicator 2.05	YES		
	If NO, explain here:		
	The provider has the required policy titled Counseling Services that was revised on October 28, 2024 by the Director of Adolescent Residential Services.		
Shelter Program			
Shelter programs provides individual and family counseling	Compliance	Resident youth received individual 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	The five residential files reviewed demonstrated group counseling was provided to youth in care. Eleven random weeks were selected to review group sessions held. Eight of the 11 weeks verified groups were held five times per week.	The program did not provide documentation to support groups were held during the following dates: June 10-13, July 8-12 August 21-23.
Groups are conducted by staff, youth, or guests and group counseling sessions consist of : 1. A clear leader or facilitator 2.Relevant topic - educational/informational or developmental 3. Opportunity for youth to participate 4. 30 minutes or longer	Compliance	Per interview with Operation Supervisor, groups are conducted by approved individuals. All five residential files reviewed demonstrated groups were conducted by staff, consist of a clear leader or facilitator, relevant topic opportunity for youth participation, and a minimum of 30 minutes.	
Documentation of groups must include date and time, a list of participants, length of time, and topic.	Exception	Group participation is documented for each youth and maintained in the youth's file. Group documentation from June through October 2024 were collected for the periods selected from youth records and were reviewed. Group documentation included date and time, length of time for groups, and topic.	List of attendees is not documented for groups.
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	All five community counseling records demonstrated the community counseling program providing therapeutic community-based services designed to provide the intervention necessary to stabilize the family.	

Counseling Services			
There is evidence the program completes review of all case files for coordination between presenting problem(s), psychosocial assessment, case/service plan, case/service plan reviews, case management, and follow-up.	Compliance	Reflect all case files for coordination between presenting problem(s), psychosocial assessment, case/service plan, case/service plan reviews, case management, and follow-up. All ten files reviewed reflected coordination between presenting problem(s), psychosocial assessment, 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 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 ten files reviewed received ongoing clinical reviews of case records and staff performance.	
When an intake is conducted through virtual means, consent is confirmed by the counselor, documented in the file, and reviewed with the supervisor during supervision/case review. There is written documentation provided in the youths file for reasons why virtual sessions are in the best interest of the youth and family.	Exception	All ten files reviewed received ongoing clinical reviews of case records and staff performance. In addition peer record reviews are conducted monthly for a sample of case records and deficiencies are identified and addressed by management. Record reviews were evident for the past six months, June through October.	Three of the four community counseling files indicated virtual services were provided; however, no written documentation was provided to validate the reason for virtual services. Per the community counselor, transportation issues were the cause.
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 provider has the required policy titled Adjudication Services/Petition Process that was revised on October 28, 2024 by the Director of Adolescent Residential Services.		
Must include: a. DJJ rep. or CINS/FINS provider b. Local school district representative	Compliance	Per interview with Director of Adolescent Residential, there was one case staffing held during the review period. Director of Adolescent Residential was also interviewed and the agency's policy and procedure was reviewed to determine compliance. The case staffing 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	Per the program's policy and procedure, other members of the committee may include: State Attorney's Office; others requested by youth/ family; substance abuse representative; law enforcement representative; DCF representative; and mental health representative.	
The program has an established case staffing committee, and has regular communication with committee members	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 internal procedure for the case staffing process, including a schedule for committee meetings	Compliance	The case staffing meetings will 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 youth and family are provided a new or revised plan for services	Compliance	A revised case plan was provided to the youth/family at the conclusion of the case staffing.	
Written report is provided to the parent/guardian within 7 days of the case staffing meeting, outlining recommendations and reasons behind the recommendations	Compliance	The revised case plan was based on the recommendations of the committee and a written copy was given to the youth/family.	
If applicable, the program works with the circuit court for judicial intervention for the youth/family	Compliance	Documentation supported the program was involved in the judicial intervention with the circuit court.	
Case Manager/Counselor completes a review summary prior to the court hearing	Compliance	A pre-disposition report (PDR) was maintained in the youth's file documenting a review summary prior to the court hearing.	
Additional Comments: There are no additional comments for this indicator.			
2.07 - Youth Records			Satisfactory with Exception
Provider has a written policy and procedure that meets the requirement for Indicator 2.07	YES		
	If NO, explain here:		
	The provider has the required policy titled Youth Records that was revised on October 28, 2024 by the Director of Adolescent Residential Services.		
All records are clearly marked 'confidential'.	Exception	Nine of the 10 records reviewed was marked 'confidential'. □	One community counseling record packet was not marked confidential.

<p>All records are kept in a secure room or locked in a file cabinet that is marked "confidential"</p>	<p>Compliance</p>	<p>Per interview with the Operation's Supervisor and observation, all records are kept in an office in a secure locked cabinet that is marked with confidential.</p>	
<p>When in transport, all records are locked in an opaque container marked "confidential"</p>	<p>Compliance</p>	<p>Staff provided evidence showing they have locked opaque containers marked "confidential" to use for the transportation of records.</p>	
<p>All records are maintained in a neat and orderly manner</p>	<p>Compliance</p>	<p>All files were observed to be clearly divided into sections which were consistent in their organization among residential and community counseling files. Each client case record includes: chronological sheet and youth demographic data, program information, correspondence, service/treatment plans, needs information, case management information and other materials relevant to the case.</p>	
<p>SHELTER FILES contain the following: Table of Contents that outlines documents in each section: <ul style="list-style-type: none"> •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 </p>	<p>Compliance</p>	<p>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.</p>	
<p>COMMUNITY COUNSELING FILES contain the following: Table of Contents that outlines documents in each section: <ul style="list-style-type: none"> • 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 </p>	<p>Compliance</p>	<p>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).</p>	
<p>All records kept electronically, are maintained securely and can be made immediately available upon request for audit purposes.</p>	<p>Not Applicable</p>	<p>None of the files reviewed were maintained electronically.</p>	

Records are retained for the duration of the time specified by the contract.	Compliance	According to shelter staff and supervisor, all files are stamped confidential and secured with locks and keys. The community counselor confirmed that only three people have the key to the cabinets and the lock room. Files remain at the facility for one year before being transferred to another facility for seven years.	
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 provider has the required policy titled Special Populations Served that was revised on October 28 2024 by the Director of Adolescent Residential Services. Per the policies and procedures, Beach House does not have contracts to provide Domestic Minor Sex Trafficking (DMST), Staff Secure, Intensive Case Management (ICM), Physically Secure, or Family/Youth Respite Aftercare Services (FYRAC).		
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")	Not Applicable	Beach House does not have a contract to provide Staff Secure services	
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	Not Applicable		
Program only accept youth that meet legal requirements of F.S. 984 for being formally court ordered in to Staff Secure Services	Not Applicable		
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	Not Applicable		

Agency provides a written report for any court proceedings regarding the youth's progress	Not Applicable		
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")	Not Applicable	Beach House does not have a contract to provide Domestic Minor Sex Trafficking (DMST) services.	
Agency has evidence that the FNYFS was contacted for approval prior to admission for all Domestic Minor Sex Trafficking (DMST) placements.	Not Applicable		
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.	Not Applicable		
Services provided to these youth specifically designated services designed to serve DMST youth	Not Applicable		
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?	Not Applicable		
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.)	Not Applicable		
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	Not Applicable		
All other services provided to DMST youth are consistent with all other general CINS/FINS program requirements	Not Applicable		
Domestic Violence			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	Yes	A total of three closed residential DV youth records 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 discharge.	
Youth length of stay in DV Respite placement does not exceed 21 days. If more than 21 days, documentation exists in youth file of transition to CINS/FINS or Probation Respite placement, if applicable.	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	Beach House does not have a contract to provide ICM services.	

<p>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.</p>	<p>Not Applicable</p>		
<p>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.</p>	<p>Not Applicable</p>		
<p>Assessments include a. NIRVANA at intake b. NIRVANA Re-Assessment every 90 days c. Post NIRVANA at discharge as aligned with timeframe requirements</p>	<p>Not Applicable</p>		
<p>Service/case plan demonstrates a strength-based, trauma-informed focus</p>	<p>Not Applicable</p>		
<p>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</p>	<p>Not Applicable</p>		
<p>Family and Youth Respite Aftercare Services (FYRAC)</p>			
<p>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")</p>	<p>Not Applicable</p>	<p>Beach House does not have a contract to provide FYRAC services.</p>	
<p>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.</p>	<p>Not Applicable</p>		
<p>Agency has evidence that all FYRAC referrals have documented approval from the Florida Network office</p>	<p>Not Applicable</p>		

<p>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.</p>	<p>Not Applicable</p>		
<p>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.</p>	<p>Not Applicable</p>		
<p>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.</p>	<p>Not Applicable</p>		
<p>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</p>	<p>Not Applicable</p>		

There is evidence of completed 30 and/or 60 day follow-ups and is documented in NetMIS following case discharge.	Not Applicable		
Youth and family participate in services for thirteen (13) sessions or ninety (90) consecutive days of services, or there is evidence in the youth's file that an extension is granted by DJJ circuit Probation staff	Not Applicable		
Any service that is offered virtually, is documented in the youth's file why it was in the youth and families best interest.	Not Applicable		
All data entry in NetMIS is completed within 3 business days as required.	Not Applicable		
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:		
	Beach House does not have a contract to provide SNAP services.		
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			
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 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) 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 within the file or evidence of at least three (3) documented attempts in the youths' file to obtain this information.	Not Applicable		
All closed files contained evidence in the file a NIRVANA was completed at discharge.	Not Applicable		
SNAP for Schools & Communities			
The program demonstrated all of the required weekly attendance sheets that included youth names and/or identifying numbers completed with the teacher and trained SNAP Facilitator signatures. <i>(This must include a total of 13 attendance sheets for a full cycle)</i>	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		

<p>There is evidence of one (1) Fidelity Adherence Checklist completed per classroom for the 13-week classroom sessions which is located in the file.</p>	<p>Not Applicable</p>		
<p>Additional Comments: There are no additional comments for this indicator.</p>			
<p>3.01 - Shelter Environment</p>			<p>Satisfactory with Exception</p>
<p>Provider has a written policy and procedure that meets the requirement for Indicator 3.01</p>	<p>YES</p> <p>If NO, explain here:</p> <p>The provider has the required policy titled Shelter Environment that was revised on October 28, 2024 by the Director of Adolescent Residential Services.</p>		
<p>Facility Inspection:</p> <p>a. Furnishings are in good repair.</p> <p>b. The program is free of insect infestation.</p> <p>c. Bathrooms and shower areas are clean and functional, free of foul odors, leaks, dust, and mildew and in good working order.</p> <p>d. There is no graffiti on walls, doors, or windows.</p> <p>e. Lighting is adequate for tasks performed there.</p> <p>f. Exterior areas are free of debris; grounds are free of hazards.</p> <p>g. Dumpster and garbage can(s) are covered.</p> <p>h. All doors are secure, in and out access is limited to staff members and key control is in compliance.</p> <p>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.</p> <p>j. Interior areas (bedrooms, bathrooms, common areas) do not contain contraband and are free from hazardous unauthorized metal/foreign objects.</p>	<p>Exception</p>	<p>A tour was conducted with the Operation Supervisor. All furniture is in good repair. They are free of rips, tears, and graffiti. There was no visible sightings of any insect infestation. All window seals were inspected and found intact. There is a total of four (4) bathrooms. Two bathrooms are assigned to the girls and the other two (2) are for the boys. All bathrooms appear to be working in good condition. There is no unwanted graffiti on the walls, doors, or windows. All grounds are well kept. The dumpster and garbage cans are covered and the surroundings are clean as well. All rooms have to be accessed by a key. Detailed maps and egress is located by every door entry and in shadow bulletin boards. General client rules/violations are posted in the sleeping quarters hallway, common area, and cafe. Grievance forms and box is located by the common area room door. It can be easily accessed by any youth. The Abuse Hotline Information is in the living quarters of each hallway located in the shadow bulletin boards. The DJJ Incident Reporting number is located in the main unit behind staff desk. The facility was clean throughout with no observed contraband or hazardous objects.</p>	<p>Both of the boy's bathrooms were observed to have mold in the grouts of each shower.</p> <p>There is low lighting in the bedrooms. There has been a work order placed for lighting in the boys and girls bedrooms. It is unclear if it is the light fixture's frosted covering or there is a need for new/brighter light bulbs.</p>

<p>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.</p>	<p>Compliance</p>	<p>All vehicles were locked. There are a total of three (3) agency vehicles. They are: a white 2014, Ford Escape, vehicle #231; a white 2019 Chevy Trax, vehicle #291; and a red 2020 Chrysler Pacifica. All of the vehicles maintained the required safety equipment.</p>	
<p>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.</p>	<p>Compliance</p>	<p>All chemicals are listed and inventoried both perpetually and weekly. The MSDS Book is located with the chemicals in a hall closet. All chemicals have a matching MSDS page within the binder. The agency's weekly chemical sheets were reviewed for the past six months (May through October). Perpetual inventories document when chemicals were signed out and in on the same day. There were weeks when chemicals were signed out once or twice. For instance: RTU Sanitizer and US Chemicals were signed out and in on 5.17.24. The next sign out and in were for Comet and Array RTU Sanitizer on 5.21.24. A perpetual count was conducted on 5.7.24, 5.16.24, 5.24.24, 5.29.24, 6.5.24, 6.11.24, 6.18.24, 6.19.24, 6.25.24, 7.2.24, 7.10.24, 7.20.24, 7.23.24, 7.30.24, 8.6.24, 8.13.24, 8.20.24, 8.27.24, 9.03.24, 9.10.24, 9.17.24, 9.24.24, 10.1.24, 10.8.24, 10.15.24, and 10.22.24. In addition to perpetual inventories, evidence was provided to demonstrate the program conducts weekly chemical inventories.</p>	
<p>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.</p>	<p>Compliance</p>	<p>There is a total of two washers and two dryers within the facility. Each washer and dryer appear to be operating due to being in use during the time of review. It is apparent that lint filters are cleaned after each use. There is also a posted note on top of each dryer acting as a reminder. The DCF Child Care License is located in the lobby. It was issued on the 12th day of July, 2024 and is effective until 11th day of July 2025. Each youth bed that has been assigned to youth have been made with the proper linen. All youth are provided stand up lockers for their personal items and contrabands.</p>	
<p>Additional Facility Inspection Narrative (if applicable)</p>			

<p>Fire and Safety Health Hazards:</p> <p>a. Annual facility fire inspection was conducted, and the facility is in compliance with local fire marshal and fire safety code within jurisdiction.</p> <p>b. Agency completes a minimum of 1 fire drill on each shift monthly (within 2 minutes or less).</p> <p>c. Completes 1 mock emergency drill per shift per quarter.</p> <p>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).</p>	<p>Exception</p>	<p>The facilities Fire Inspection is currently pending.</p> <p>Fire drills were conducted during the review period as follows: 1st Shift: 5.16.24, 5.31.24, 6.18.24, 6.25.24, 7.9.24, 8.31.24, 9.17.24, and 10.15.24; 2nd Shift: 5.26.24, 6.18.24, 8.28.24, 9.20.24, 10.16.24; 3rd Shift: 5.30.24, 6.28.24, 7.10.24, 8.31.24, 9.26.24, and 10.15.24.</p> <p>Reviewer observed a semi-annual Restaurant System Inspection was performed on 01.16.24. Also, on 01.16.24, an Annual Fire Extinguisher inspection was performed. All unit results passed. On 07.24.24, a second semi-annual Restaurant System Inspection was conducted. There were no deficiencies found at the time of inspection. The annual fire inspections was conducted by Volusia Fire Rescue on June 5, 2023 and a re-inspection was satisfactorily completed December 13, 2023.</p> <p>All three (3) vehicles are equipped with a fire extinguisher. The alarm system received an annual inspect on 2.29.24.</p>	<p>During the review of Fire Drills it was discovered that there was no Fire Drill in July on 2nd shift.</p>
<p>Fire and Safety Health Hazards:</p> <p>a. Agency has a current Satisfactory Residential Group Care inspection report from the Department of Health.</p> <p>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.</p> <p>c. All cold food is properly stored, marked and labeled and dry storage/pantry area is clean and food is properly stored.</p> <p>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.</p>	<p>Compliance</p>	<p>A representative from the State of Florida Department of Health conducted a satisfactory group home inspection on 4.3.2024 and a satisfactory food service inspection on 7.19.2024. This inspection is posted inside of a shadow box bulletin board along with the entire month's menu. The program's food is delivered daily by a service company. Food is labeled with the date and stored properly on assigned shelves. The refrigerator is free of any spills or residue. The refrigerator showed adequate temperature of 35 degrees Fahrenheit. Since the food is delivered, there is no freezer on the premises to store frozen food.</p>	
<p>Additional Fire and Safety Health Hazards Narrative (if applicable)</p>			

Youth Engagement		
<p>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.</p> <p>b. At least one hour of physical activity is provided daily.</p> <p>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.</p> <p>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.</p> <p>e. Daily programming schedule is publicly posted and accessible to both staff and youth.</p>	Compliance	<p>The facility's coordinator creates the program's schedule for upcoming events. The weekly schedule is visibly posted throughout the facility such as the hallways and common area. The daily schedule displays meaningful and structured activities. Beach House Weekly Schedule is visibly posted in the hallways of the sleeping quarters and the common area showing youth recreational time twice during the day, at 12:46pm - 2:03pm and 3:30pm - 4:20pm. New Start, a non-denominational organization comes twice a week with Tuesdays assigned for girls and Thursdays for the boys. One of the counselors does religious services on Fridays with the youth. Youth do have access to the Quiet Room and have ample time to do homework with access to age appropriate activities along with age appropriate reading material.</p>
Additional Comments: There are no additional comments for this indicator.		
3.02 - Program Orientation		Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 3.02	YES	
	If NO, explain here:	
	The provider has the required policy titled Program Orientation that was revised on October 28,2024 by the Director of Adolescent Residential Services.	
Youth received a comprehensive orientation and handbook provided within 24 hours	Compliance	All five files reviewed have a checklist indicating the youth received a comprehensive orientation within 24 hours.
<p>Orientation includes the following:</p> <p>a. Youth is given a list of contraband items</p> <p>b. Disciplinary action is explained</p> <p>c. Dress code explained</p> <p>d. Review of access to medical and mental health services</p> <p>e. Procedures for visitation, mail and telephone</p> <p>f. Grievance procedure</p> <p>g. Disaster preparedness instructions</p> <p>h. Physical layout of the facility</p> <p>i. Sleeping room assignment and introductions</p> <p>j. Suicide prevention- alerting staff of feelings or awareness of others having suicidal thoughts</p>	Compliance	All five files have a checklist with the staff and youth's signature indicating the youth received a comprehensive orientation explaining the disciplinary action, program rules, grievance procedure and emergency procedures, the contraband policy, suicide prevention, tour, room assignment and how to contact the abuse hotline were explained.
Documentation of each component of orientation, including orientation topics and dates of presentation, as well as signatures of the youth and staff involved is maintained in the individual youth record	Compliance	All five files had a checklist that included each component of the orientation that was reviewed by staff. Both staff and client signed the checklist indicating the comprehensive orientation was completed.
Additional Comments: There are no additional comments for this indicator.		

3.03 - Youth Room Assignment		Satisfactory with Exception	
Provider has a written policy and procedure that meets the requirement for Indicator 3.03	YES		
	If NO, explain here:		
	The provider has the required policy titled Room Assignment that was revised on October 28, 2024 by the Director of Adolescent Residential Services.		
A process is in place that includes an initial classification of the youths, to include:			
<ul style="list-style-type: none"> a. Review of available information about the youth's history, status and exposure to trauma b. Initial collateral contacts, c. Initial interactions with and observations or the youth d. Separation of younger youth from older youth, e. Separation of violent youth from non-violent youth f. Identification of youth susceptible to victimization g. Presence of medical, mental or physical disabilities h. Suicide risk i. Sexual aggression and predatory behavior j. Acute health symptoms requiring quarantine or isolation 	Exception	Five total files were reviewed. Three files were closed and two files were open. Three of the files reviewed show documentation of staff gathering information of the youth's history and exposure to trauma, age, and gender, history of violence, disability, physical size and gang affiliation. All three files also show documentation of the youth's sexual behavior, sexual orientation, suicide risk and if isolation is necessary.	Two of the five files reviewed did not document room assignment and one of the two files did not have documentation that the youth was screened for level of aggression.
An alert is immediately entered into the program's alert system when a youth is admitted with special needs and risks such as risk of suicide, mental health, substance abuse, physical health or security risk factors	Compliance	The program has an alert system in place with a variety of protocols to identify and document alerts. Each file reviewed was labeled with a sticker on the front of the record representing the relevant alert. A comparison of the information within the record to the alert system confirmed the alerts were correct for all five youth.	
Additional Comments: There are no additional comments for this indicator.			
3.04 - Log Books		Limited	
Provider has a written policy and procedure that meets the requirement for Indicator 3.04	YES		
	If NO, explain here:		
	The provider has the required policy titled Log Books that was reviewed October 28, 2024 by the Director of Adolescent Residential Services.		

<p>Log book entries that could impact the security and safety of the youth and/or program are highlighted</p>	<p>Compliance</p>	<p>Logbook entries were reviewed during the periods as follows: May 5th-18th, June 9th-22nd, July 14th-27th, August 11th-24th, September 1st-14th, and October 20-31st. The program uses highlighted colors for entries that could impact the safety and security of youth with the following references: Yellow- Medication administration, Drills, Absconds, and Safety Concerns Green- Shift Review Pink- Log/Camera Review Blue- Maintenance Issues Orange- Supplies Needed</p>	
<p>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</p>	<p>Compliance</p>	<p>All entries include the date and time of the event/transitions. Names of youth and staff involved were observed for relevant events. All entries are very brief. All entries consisted of initials and employee ID number.</p>	
<p>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.</p>	<p>Exception</p>	<p>During the observation of logbook entries for the periods reviewed, staff failed to document recording errors correctly on nine of the 84 days reviewed.</p>	<p>On 5/5/24 and 6/16/24 reviewed observed entries with scribbled lines through the words. Also on 8/12/24, 8/23/24, 9/6/24, and 9/9/24, notes contained entries with multiple lines going through a word. On 8/22/24, 9/1/24, and 9/5/24, there were discoveries of staff writing over the error. Additionally, staff failed to initial and date their errors.</p>
<p>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</p>	<p>Exception</p>	<p>During the observation of logbook entries for the periods reviewed, the program director/designee completes daily entries; however, the entries lacked any notes in chronological order such as corrections, recommendations and follow-ups, or the dates that were reviewed.</p>	<p>Documentation from the program director or designee were very brief and lacked any and all detail about staff's documentation in the logbook including events where errors are not noted correctly.</p>

<p>All staff review the logbook of the previous two shifts and makes an entry signed and dated into the logbook indicating the dates reviewed</p>	<p>Exception</p>	<p>During the observation of logbook entries for the periods reviewed, on 8/15/24 and 9/12/24 it was observed that staff are not completing individual entries nor are they entering any exit entries. One staff documented in the logbook correctly. Staff that perform the shift review states at the end of the entry that "all matters discussed", and there is no notation of any matters within the logbook. However, it was discovered that staff are also completing shift exchange forms for each shift and that is where the matters discussed are documented.</p>	<p>Staff are not indicating the dates reviewed or how many shifts they have read back to, in order to be cognizant of any unusual occurrences or problems since their last shift. For example, one staff entered her initials only on several dates: 8/18/24, 9/2/24, 9/3/24, 9/7/24, 9/8/24, 9/9/24, and 9/10/24.</p>
<p>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.</p>	<p>Exception</p>	<p>There is documentation throughout the logbook from oncoming supervisor. However, the entries lack any and all unusual occurrences and/or problems, and are lacking any indications of date(s) reviewed. During the selected weeks, there were no entries/exit documentations from the counselor.</p>	<p>Supervisor's review of logbook did not indicate the dates reviewed. Shelter counselors were not observed to document reviews of the logbook.</p>
<p>Logbook entries include: a. Supervision and resident counts b. Visitation and home visits</p>	<p>Compliance</p>	<p>Resident counts are notated with each transition documentation in the logbook.</p>	
<p>Additional Comments: There are no additional comments for this indicator.</p>			
<p>3.05 - Behavior Management Strategies</p>			<p>Satisfactory</p>
<p>Provider has a written policy and procedure that meets the requirement for Indicator 3.05</p>	<p>YES</p>		
	<p>If NO, explain here: The provider has the required policy titled Behavior Management Strategies that was reviewed October 28, 2024 by the Director of Adolescent Residential Services.</p>		
<p>The program has a detailed written description of the BMS and it is explained during program orientation</p>	<p>Compliance</p>	<p>There is a very descriptive Behavior Management System in the SMA Healthcare Client Rights and CINS/FINS and Beach House Handbook.</p>	

Behavior Management Strategies must include:			
<p>a. BMS is designed to teach youth new behaviors and help youth understand the natural consequences for their actions</p> <p>b. Behavioral interventions are applied immediately, with certainty, and reflect the severity of the behavior</p> <p>c. BMS uses a wide variety of awards/incentives to encourage participation and completion of the program</p> <p>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</p> <p>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)</p> <p>f. Only staff discipline youth. Group discipline is not imposed</p> <p>g. Room restriction is not used as part of the system or for youth who are physically and/or emotionally out of control</p> <p>h. Youth should never be denied basic rights such as meals, clothing, sleep, services, exercise, or correspondence privileges</p>	<p>Compliance</p>	<p>Beach House has implemented rules and expectations for the youth to encourage youth to create self-discipline and structure in order to be successful. Beach House Behavior Management System is applied immediately and appropriately fits the severity of the violation. The SMA Healthcare: Client Rights and CINS/FINS and Beach House Handbook clearly states the requirements and incentives for each category: Orientation Level allows youth access to puzzles, books, and magazines, all recreation equipment, and one 5-minute phone call per day to an approved relative during phone time. VIP Level allows youth the same rewards as orientation privileges, plus participation in privileged time, use of playing cards, 2nd in line for snack time, ability to choose game/activity from privilege shelf during privilege time, vote on movie for movie of the night, and attend all outings if VIP Day 3 or higher. Super VIP Level includes all VIP privileges (phone and pass time increases), 10-minute phone calls to someone on your approved phone list during phone time, 1st in line for snack, attend all outings, option of attending Life Skills outings out of shelter, when offered, privilege snack (one snack from SVIP cabinet and one snack from VIP cabinet). Youth receive a reminder when they experience a minor violation. When a youth experiences two of the same minor violations it is equivalent to one minor infraction. Each minor infraction is a deduction of a point loss. Three of the same minor infractions are equivalent to a major violation. The disciplinary measures that have been set forth do not deny the youth any of their basic rights. Discipline is not applied to a group. Only trained staff are allowed to impose discipline to a youth. Staff are trained through Managing Aggressive Behavior training to use de-escalation techniques prior to approved forms of physical intervention. Youth are offered the opportunity to have time in the Quiet Room to gather their thoughts and recollect themselves before joining their counterparts; however, room restriction is not used as part of the system.</p>	
Program's use of the BMS			
<p>All staff are trained in the theory and practice of administering BMS rewards and consequences</p>	<p>Compliance</p>	<p>All staff are trained in person, prior to working independently with the youth. This training is conducted no later than 90-days after their start date. Three (3) staff members training files were reviewed to validate practice.</p>	

There is a protocol for providing feedback and evaluation of staff regarding their use of BMS rewards and consequences	Compliance	Supervisors implement protocols for providing feedback and evaluation when issues arise. The supervisor also conducts investigations when youth report any unfairness to the deduction of their points. Feedback and evaluations of staff's use of the BMS is discussed at staff meetings.	
Supervisors are trained to monitor the use of rewards and consequences by their staff	Compliance	Supervisors receive the same training of the Behavior Management System as their staff. The monitoring is to ensure that staff are being fair and consistent with youth.	
Additional Comments: There are no additional comments for this indicator.			
3.06 - Staffing and Youth Supervision			Satisfactory with Exception
Provider has a written policy and procedure that meets the requirement for Indicator 3.06	YES		
	If NO, explain here:		
	The provider has the required policy titled Staffing and Supervision that was reviewed October 28, 2024 by the Director of Adolescent Residential Services.		
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 the monthly schedules from May 1st, 2024 through October 31st, 2024, displays the required staffing ratio was met for the awake hours one (1) staff to six (6) youth. During sleeping hours, there was one (1) staff to six (6) youth ration maintained as well.	
All shifts must always provide a minimum of two direct care staff present that have met the minimum training requirements	Compliance	Schedules reviewed 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	Exception	All new staff hired were background screened. A review of eligible re-screened staff indicate continued eligible screening results for the applicable staff.	One of the four first year training records reviewed revealed a staff (hire date 5/20/24) who is utilized in the staff: youth ratio who was missing documentation for pre-service training during the review.
The staff schedule is provided to staff or posted in a place visible to staff	Compliance	The staff schedule for Beach House and RAP are visibly posted together in the staff area behind staff desk.	

<p>There is a holdover or overtime rotation roster which includes the telephone numbers of staff who may be accessed when additional coverage is needed</p>	<p>Compliance</p>	<p>There is a Holdover schedule visibly posted by the month next to the staff schedule. The schedule consist of holdover coverage for each shift with the exception of 2nd and 3rd shift on Sundays, Tuesdays, and Wednesdays. The supervisor is the back up staff as needed.</p>	
<p>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</p>	<p>Compliance</p>	<p>Bed Check Dates/Times reviewed: October 12th, 12am-2am October 16th, 2am-4am October 20th , 4am-6am October 25th, 1am-3am November 4th, 3am-5am All camera footage was reviewed and it is consistent with staff's documentation of bed checks. Staff completed all bed checks and documented them in a timely manner.</p>	
<p>Additional Comments: There are no additional comments for this indicator.</p>			
<p>3.07 - Video Surveillance System</p>			<p>Satisfactory with Exception</p>
<p>Provider has a written policy and procedure that meets the requirement for Indicator 3.07</p>	<p>YES If NO, explain here: The provider has the required policy titled Video Surveillance that was reviewed October 28, 2024 by the Director of Adolescent Residential Services.</p>		
<p>Surveillance System</p>			
<p>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</p>	<p>Compliance</p>	<p>Notice of Video Surveillance is posted on the entrance door as staff and visitors enter into the facility. The camera system can maintain 30-days of video footage and records the camera date, time, and location, as well as maintains resolution that enables facial recognition. The camera recording is not visible during a power outage; however it does still record. Once the camera footage is back up staff are able to review previous footage. The cameras are visibly placed throughout the facility and there are none placed within the sleeping quarters.</p>	

<p>A list of designated personnel who can access the video surveillance system is maintained (includes off-site capability per personnel)?</p>	<p>Compliance</p>	<p>Operation supervisor, program director, operations manager, and registered nurses have access to reviewing the camera footage. Only operation supervisors, program director, and operations manager have access to footage when off-sites only with the agencies laptops.</p>	
<p>Supervisory review of video is conducted a minimum of once every 14 days and timeframes reviewed are noted in the logbook.</p>	<p>Compliance</p>	<p>A total of six 14-day periods were reviewed as follows: May 5th-18th, June 9th-22nd, July 14th-27th, August 11th-24th, September 1st-14th, and October 20-31st. Upon review of the program logbook, the reviewer observed only one logbook entry that indicated camera review was conducted on May 8th by a supervisor. However, reviewer was informed that the operations supervisor maintains a separate log to document video reviews. A review of this documentation was provided after the exit meeting and reviewer observed a log which validated supervisory reviews of videos are conducted weekly for the periods reviewed.</p>	
<p>The reviews assess the activities of the facility and include a review of random sample of overnight shifts</p>	<p>Compliance</p>	<p>The weeks that were reviewed for supervisory review of videos included observations of a variety of program activities as well as random overnight shifts.</p>	
<p>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</p>	<p>Compliance</p>	<p>IT personnel are contacted immediately by assigned staff requesting footage for a particular incident. The requested information is placed on a Zip Drive, forwarded to staff, who in turn forward the footage to the Third Party.</p>	
<p>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</p>	<p>Exception</p>	<p>It was discovered 2.12.24 that there was no camera surveillance because the camera server malfunctioned. Emails support follow-up on 2/13/24 and 2/21/24 at which time it was indicated a new server will be ordered and installed. This issue was resolved two months later on 4.16.24. On 10.12.24, there was no video footage due to camera malfunction. Email documentation was provided that the operation supervisor was in contact with the surveillance company immediately after the outage for October.</p>	<p>Rectifications for camera malfunctions are not resolved in a timely manner despite prompt service order requests.</p>
<p>Additional Comments: There are no additional comments for this indicator.</p>			
<p>4.01 - Healthcare Admission Screening</p>			<p>Satisfactory</p>
<p>Provider has a written policy and procedure that meets the requirement for Indicator 4.01</p>	<p>YES</p>		
	<p>If NO, explain here:</p>		
	<p>The provider has the required policy titled Healthcare Admission Screenings that was reviewed October 28, 2024 by the Director of Adolescent Residential Services.</p>		

Preliminary Healthcare Screening		
Screening includes : a. Current medications b. Existing (acute and chronic) medical conditions c. Allergies d. Recent injuries or illnesses e. Presence of pain or other physical distress f. Observation for evidence of illness, injury, physical distress, difficulty moving, etc. g. Observation for presence of scars, tattoos, or other skin markings h. Acute health symptoms requiring quarantine or isolation	Compliance	Five youth records were reviewed, two open and three closed, for healthcare screening. Each of the five youth records included primary healthcare screenings containing current medications, existing medical conditions, allergies, recent injuries or illnesses, the presence of pain or physical distress, an observation for evidence of illness, injury, pain, or physical distress, or difficulty moving, the presence of scars, tattoos, or other skin markings, and acute health symptoms requiring isolation/quarantine.
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.)	No eligible items for review	Five youth records were reviewed, two open and three closed, for chronic conditions. Of the reviewed records, none were applicable as having a chronic condition requiring additional referrals.
When needed, the parent is involved with the coordination and scheduling of follow-up medical appointments	No eligible items for review	There were no applicable records requiring referral coordination for chronic conditions.
All medical referrals are documented on a daily log.	No eligible items for review	There were no applicable records requiring medical referral follow-up for documentation in the facility logbook.
The program has a thorough referral process and a mechanism for necessary follow-up medical care as required and/or needed	Compliance	The program has procedures which include a thorough referral process and mechanisms for follow-up medical care for youth admitted with chronic medical conditions.
Additional Comments: There are no additional comments for this indicator.		
4.02 - Suicide Prevention		Satisfactory with Exception
Provider has a written policy and procedure that meets the requirement for Indicator 4.02	YES	
	If NO, explain here:	
	The provider has the required policy titled Suicide Prevention that was reviewed October 28, 2024 by the Director of Adolescent Residential Services.	

Suicide Risk Screening and Approval (Residential and Community Counseling)			
Suicide risk screening occurred during the initial intake and screening process. Suicide screening results reviewed and signed by the supervisor and documented in the youth's case file.	Compliance	Three residential files and three community counseling files were reviewed and all youth received a suicide risk screening during the intake process, which was signed by a supervisor and documented in in the youth's files.	
The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	Compliance	The program's 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	The three files reviewed shows all three youth were placed on the appropriate level of supervision based on the results of the suicide risk assessment.	
Staff person assigned to monitor youth maintained one-to-one supervision or constant supervision and documented his/her observations of the youth's behavior at 30 minute or less intervals	Compliance	All three files reviewed contained observation logs that documented constant supervision of the youth's behavior at the minimum of thirty minute intervals.	
Documentation includes the time of day, behavioral observations, any warning signs observed, and the observers' initials and was maintained in either an observation log or in the shelter daily log.	Compliance	All three files reviewed contained observation log documentation that included behavioral observations, warning signs and observer's initials. Observation logs were utilized in all three youth's files.	
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	Three residential and three community youth records were reviewed. In all three residential records, one open and two closed, the Assessment of Suicide Risk was completed by a non-licensed professional under the direct supervision of a licensed professional. The previous Clinical Director separated from the program as of November 10, 2023; the program is currently in the screening process for a new Clinical Director.	The Assessment of Suicide Risk was not signed off/reviewed within twenty-four hours by a licensed professional. However, it is noted the youth all remained on Precautionary Observation until discharge because the program's clinical director's position is vacant.
There was evidence that documentation was reviewed by supervisory staff each shift. If program uses an observation log, completed logs are maintained in the youth's file.	Compliance	All three youth's files reviewed contained completed observation logs and all were reviewed by a supervisor each shift as evidenced by their signature on the logs.	
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.	Not Applicable	Community counseling suicide risk youth are referred to a qualified provider for assessment of suicide risk.	

<p>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.</p>	<p>Compliance</p>	<p>Three files were reviewed and all three youth were reviewed/identified for suicide risk during intake. All three youth were immediately referred and the parent/guardian was notified of the suicide risk findings and advised that an Assessment of Suicide Risk should be completed as soon as possible by a licensed professional.</p>	
<p>Information on resources available in the community for further assessment was provided to the parent/guardian and is documented in the youth's file and signed by the parent/guardian OR a written follow-up notification was sent by certified mail if the parent/guardian was not present during the screening and was notified by telephone.</p>	<p>Compliance</p>	<p>All three youth's files reviewed contained documentation of information that was provided to the parent/guardian of community resources available based on the outcome of the assessment. All three parents/guardians were notified via telephone.</p>	
<p>If the parent/guardian cannot be contacted, all efforts to contact them are documented in the case file.</p>	<p>Not Applicable</p>	<p>Parents were notified for all three records reviewed.</p>	
<p>When the screening was completed during school hours on school property, the appropriate school authorities were notified.</p>	<p>Not Applicable</p>	<p>No applicable youth files as screenings were done at youth's home.</p>	
<p>Additional Comments: There are no additional comments for this indicator.</p>			
<p>4.03 - Medications</p>			<p>Satisfactory with Exception</p>
<p>Provider has a written policy and procedure that meets the requirement for Indicator 4.03</p>	<p>YES</p>		
	<p>If NO, explain here:</p>		
	<p>The program has the required policy titled Medications that was updated October 28, 2024 by the Director of Adolescent Residential Services.</p>		
<p>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.</p>	<p>Compliance</p>	<p>The program has two registered nurses with verified credentials.</p>	
<p>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</p>	<p>Exception</p>	<p>A review of documentation and an interview with the nurses on staff indicated registered nursing staff provide in-person self-administration of medication distribution training including evidence of demonstrating their competency to assist with self-administration of medication distribution. At the time of the review the requirement for annual re-certification was effective December 2023. All new staff and one in-service staff had valid annual medications training. Registered nursing staff are on site each weekday ready to give assistance if needed or answer any questions as well as attend each shift change to brief oncoming staff of all youth with medications. Registered nursing staff also review video to ensure proper administration techniques by staff.</p>	<p>Six of the ten staff listed on the authorized medication list had not completed the annual recertification medication training prior to the QI review. The agency conducted the re-certification training for the six staff immediately following the QI review.</p>

<p>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</p>	<p>Compliance</p>	<p>A review of documentation and interview with the nurses on staff indicated the agency held at least quarterly staff meetings, and in fact held them more than required on a monthly basis. Each meeting was conducted by a registered nurse and/or shelter manager to review and assess strategies implemented to reduce medication errors shelter wide, analyze factors that contributed to medication errors, and allow staff the opportunity to practice and role-play solutions.</p>	
<p>The agency has strategies implemented to ensure medications are provided within the 2-hour time frame.</p>	<p>Compliance</p>	<p>A review of documentation, video, and an interview with nursing staff indicated the agency has strategies implemented to ensure medications are provided within the two-hour time frame to include shift briefing meetings, monthly staff meetings, verification of the medication administration record of each youth, and via video review of best medication distribution practices.</p>	
<p>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</p>	<p>Compliance</p>	<p>A review of staff schedules demonstrated all non-licensed staff members are clearly identified and designated on the schedule and shift change report/responsibility form for assisting with the self-administration of medications on each shift.</p>	
<p>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.</p>	<p>Compliance</p>	<p>Documentation review and an interview with nursing staff indicated the agency has clear methods of communicating which youth are on medication as well as the time and dosage required that is easily discernable by all staff on each shift.</p>	

<p>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:</p> <ul style="list-style-type: none"> 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. 	<p>Compliance</p>	<p>Documentation review and an interview with nursing staff indicated the delivery process of medications is consistent with the Florida Network of Youth and Family Services (FNYFS) Medication Management and Distribution Policy and the agency has an internal quality assurance process to include ensuring appropriate medication management and distribution methods, tracking medication errors, and identifying systemic issues and implementing mitigation strategies, as appropriate.</p>	
<p>Admission/Intake of Youth</p>			
<ul style="list-style-type: none"> 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. <i>*If the agency does not have a RN, there was a medication review conducted by a certified Leadership position.</i> 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. 	<p>Compliance</p>	<p>Documentation review and an interview with nursing staff indicated teach youth and their parent/guardian were interviewed upon admission by the Registered Nurse (RN), when on-site, about each youth's current medications as part of the Medical and Mental health Assessment screening process and/or an interview was conducted by the registered nurse within three business days if the RN was not on the premise at admission. Upon intake and admission there is evidence that the on-shift certifies supervised or higher level staff did review all medication forms by the next business day.</p>	

Medication Storage			
<p>a. All medications are stored in a Pyxis ES Medication Cabinet that is inaccessible to youth (when unaccompanied by authorized staff)</p> <p>b. Pyxis machine is stored in accordance with guidelines in FS 499.0121 and policy section in Medication Management</p> <p>c. Oral medications are stored separately from injectable epi-pen and topical medications</p> <p>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.)</p> <p>e. Narcotics and controlled medications are stored in the Pyxis ES Station</p> <p>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</p>	<p>Compliance</p>	<p>All youth medication is contained in the program's Pyxis ES Medication Cabinet, which is inaccessible to youth. The Pyxis cabinet is orderly and stored in the medical/chart room in the administration building according to guidelines in Florida Statutes and the medication management policy. The space is secured with a residential key and user permissions restrict access to any medication in the cabinet. The secured room is a suitable space for cleaning, maintenance, and operation of the unit. The room also has a secured, functioning refrigerator for medications requiring it and a disposal container for the outdated, damaged, deteriorated, misbranded, or adulterated medications. The room is clean and free of any kind of infestation. All oral medications are kept separate from injectable epi-pens and topical medications. Documented shift-to-shift count, and a perpetual inventory of controlled medications are required when youth are prescribed them; however, no youth were prescribed controlled medications at the time of the annual compliance review. Documentation reflects discrepancies are cleared after each shift, and sharps, and syringes are secured and counted weekly. Non-controlled and over-the-counter medications are inventoried weekly in addition to the documented perpetual count. The agency has an internal quality assurance process to ensure appropriate medication management and distribution methods. The nursing staff complete monthly reports detailing any discrepancies or drawer failures. There were no instances of a failure to distribute medications due to the Pyxis cabinet malfunction error or refusal of access. There has been no instances of a youth missing a dose of medication. Properly labeled Pyxis keys were observed to be accessible to staff in the event of a Pyxis malfunction.</p>	

Medication Distribution			
<p>a. Agency maintains a minimum of 2 site-specific System Managers for the Pyxis ES Station</p> <p>b. Only designated staff delineated in User Permissions have access to secured medications, with limited access to controlled substances (narcotics)</p> <p>c. A Medication Distribution Log shall be used for distribution of medication by non-licensed and licensed staff</p> <p>d. Agency verifies medication using one of three methods listed in the FNYFS Policies & Procedures Manual</p> <p>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.</p> <p>f. Agency does not accept youth currently prescribed injectable medications, except for epi-pens</p> <p>h. Non-licensed staff have received training in the use of epinephrine auto-injectors provided by a registered nurse</p>	<p>Compliance</p>	<p>The agency's two registered nurses are in the Pyxis system managers. Only designated staff delineated in under permissions have access to controlled substances. A medication distribution log is utilized for all medication distribution by licensed or non-licensed staff. The program verifies medications using one of the three methods listed in the Florida Network of Youth and Family Services (FNYFS) Policies and Procedures Manual. When the nursing staff are on duty, medication is consistent with the FNYFS medication management and distribution policy. The nursing staff verifies medication using the approved methods listed in the FNYFS Operations Manual. The program does not accept youth requiring prescribed injectable medications, except for epi-pens. All non-licensed staff have received training from the program nurses on the use of epi-pens, with refreshers completed each time a new youth is admitted to the program with one.</p>	
<p>The medication distribution log documentation includes:</p> <p>a. the time of medication administration</p> <p>b. evidence of youth initials that the dosage was given</p> <p>c. evidence of staff initials that the dosage was given</p>	<p>Compliance</p>	<p>All youth medication distribution records included youth and staff initials and the time of administration.</p>	
<p>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.</p>	<p>Compliance</p>	<p>Three youth medication records were reviewed. Each administration record reflected doses were given within one hour of the scheduled delivery time.</p>	
<p>During the review period, there were no instances where youth missed their medication due to failure to open the pyxis machine.</p>	<p>Compliance</p>	<p>There were no instances of a failure to distribute medication due to the Pyxis cabinet malfunction or refusal of access; however, there was an instance of malfunction where staff had to open the cabinet manually.</p>	

<p>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.</p>	<p>No eligible items for review</p>	<p>There was no evidence of staff needing refresher training due to a medication error.</p>	
<p>Medication Inventory</p>			
<p>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</p>	<p>Compliance</p>	<p>The program had no youth on controlled medications or narcotics at the time of the annual compliance review; however, the Pyxis medication cabinet has a secure drawer specifically designated for these medications should any youth be admitted with them. Documented shift-to-shift counts, and a perpetual inventory of controlled medications are required when youth are prescribed them. Non-controlled and over-the-counter medication are inventoried weekly in addition to the documented perpetual count. Documentation reflects sharps and syringes are secured and counted weekly when added to the medical office supplies.</p>	
<p>There are monthly reviews of the Pyxis reports to monitor medication management practice.</p>	<p>Compliance</p>	<p>The nursing staff completes monthly reports detailing any discrepancies or drawer failures.</p>	
<p>Medication discrepancies are cleared after each shift.</p>	<p>Compliance</p>	<p>Documentation reflects discrepancies are cleared after each shift.</p>	
<p>Additional Comments: There are no additional comments for this indicator.</p>			
<p>4.04 - Medical/Mental Health Alert Process</p>			<p>Satisfactory</p>
<p>Provider has a written policy and procedure that meets the requirement for Indicator 4.04</p>	<p>YES</p>		
	<p>If NO, explain here:</p>		
	<p>The program has the required policy titled Medical and Mental Health Alert that was updated October 28, 2024 by the Director of Adolescent Residential Services.</p>		
<p>Youth with a medical, mental health, or food allergy was appropriately placed on the program's alert system</p>	<p>Compliance</p>	<p>Five youth files were reviewed and four of the applicable youth with either medical, mental health or food allergy were appropriately placed on the program's alert system.</p>	

Alert system includes precautions concerning prescribed medications, medical/mental health conditions	Compliance	The alert system includes precautions concerning prescribed medications and mental and medical health conditions. An alert board in the staff area provides information and instructions for staff on how to respond to the need for emergency medical and/or mental health care.	
Staff are provided sufficient training, information and instructions to recognize/respond to the need for emergency care for medical/mental health problems	Compliance	Staff are provided training, information and instructions to recognize/respond to the need for emergency care for medical/mental health problems. Nursing staff was interviewed and stated they attend shift briefings to offer information and training regarding specific youth's conditions/treatments.	
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	Detailed alert documentation is available to staff containing pertinent information on youth medical conditions, allergies, common side effects of prescribed medications, food and medications contraindicated, and other important mental health treatment specifics. Nursing staff was interviewed and stated they are available to staff to answer questions and give information regarding medication side effects and any contraindications.	
Additional Comments: There are no additional comments for this indicator.			
4.05 - Episodic/Emergency Care			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 4.05	YES		
	If NO, explain here:		
	The program has the required policy titled Episodic/Emergency Care dated 10/28/2024 and signed by the Director of Adolescent Services.		
Off Site Emergency Care			
<p>a. If off-site emergency medical or dental care was provided, an incident report was submitted for the medical or dental care</p> <p>b. Upon youth return, there is a verification receipt of medical clearance via discharge instructions with follow-up is present in file</p> <p>c. Youth's parent/guardian was notified</p> <p>d. A daily log is maintained for emergency care provided</p>	Compliance	There was one incident of off-site emergency care having occurred since the last compliance review. An internal incident report was completed for the incident and the incident was documented in the Department of Juvenile Justice Central Communications Center records. Documentation was provided upon the youth's return regarding discharge instructions and medical clearance. The youth's parent or guardian was notified and the daily log recorded the incident.	
All staff are trained on emergency medical procedures	Compliance	Eight staff training records, four in-service and four pre-service, were reviewed. All of the selected staff have been trained on emergency medical procedures.	
The program has a Knife-for-life and wire cutters accessible to staff in a secure location(s)	Compliance	The Knife-for Life and wire cutters are secured in the Beach House Medical Room.	
Additional Comments: There are no additional comments for this indicator.			