Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Florida Keys Children's Shelter - Tavernier, Florida
CINS/FINS Program

December 18-19, 2024

Compliance Monitoring Services Provided by

FOREFRONT

CINS/FINS Rating Profile

Standard 1: Management Accountability

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

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

Standard 2: Intervention and Case Management

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

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

Standard 3: Shelter Care & Special Populations

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

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

Standard 4: Mental Health/Health Services

4.01 Healthcare Admission Screening	Satisfactory
4.02 Suicide Prevention	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: 89.29 %
Percent of indicators rated Limited: 10.71 %
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
Rondarrell George – Regional Monitor, Department of Juvenile Justice
Wendy Pierre-McNealy – Florida Network of Youth and Family Services
Taneshea Sargent – Lutheran Services Florida Southeast
Kristi Walsh – Children's Home Society Treasure Coast

Methodology

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

Persons Interviewed

X	Chief Executive Officer	X	Case Manager		Nurse – Full time
	Chief Financial Officer	X	Counselor Non-Licensed	X	Nurse – Part time
X	Chief Operating Officer		Advocate	3	# Case Managers
	Executive Director	X	Direct – Care Full time	1	# Program Supervisors
	Program Director		Direct – Part time		# Food Service Personnel
	Program Manager		Direct – Care On-Call	1	# Healthcare Staff
X	Program Coordinator		Intern		# Maintenance Personnel
	Clinical Director		Volunteer	1	# Other (listed by title): Training and Compliance Manager
	Counselor Licensed	X	Human Resources		

Documents Reviewed

	Accreditation Reports	X	Table of Organization		Visitation Logs
X	Affidavit of Good Moral Character	X	Fire Prevention Plan	X	Youth Handbook
X	CCC Reports	X	Grievance Process/Records	5	# Health Records
X	Logbooks		Key Control Log	6	# MH/SA Records
	Continuity of Operation Plan	X	Fire Drill Log	8	# Personnel /Volunteer Records
X	Contract Monitoring Reports	X	Medical and Mental Health Alerts	8	# Training Records
	Contract Scope of Services	X	Precautionary Observation Logs	8	# Youth Records (Closed)
X	Egress Plans	X	Program Schedules	5	# Youth Records (Open)
X	Fire Inspection Report	X	List of Supplemental Contracts		# Other: ___
	Exposure Control Plan	X	Vehicle Inspection Reports		

Observations During Review

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

Surveys

6	# of Youth	11	# of Direct Staff		# of Other

Comments

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

Monitoring Purpose

The purpose of this monitoring is to provide an annual quality improvement program review. This is to verify the agency adheres to all current CINS/FINS standards and contract compliance requirements for residential and/or community counseling services.

Narrative Summary

The Florida Keys Children's Shelter (FKCS) contracts with the Florida Network to operate the Child in Need of Services and Family in Need of Services (CINS/FINS) program in Monroe County, Florida. The program is located at the Tavernier's Jelsema Center, at the north-end of the county next to the Tavernier Government Center. Funding through CINS/FINS allows the agency to serve both male and female youth up to seventeen years old who are locked out, runaway, ungovernable and/or truant, homeless, abused, neglected, or at-risk. The agency provides services to special populations who meet the criteria for Staff Secure Shelter, Domestic Minor Sex Trafficking, and youth referred by the Juvenile Justice Court System for domestic violence, probation respite, and Family/Youth Respite Aftercare Services (FYRAC). FKCS is not contracted to provide Intensive Case Management (ICM) services or Stop Now and Plan (SNAP). In addition to the CINS/FINS Program, the agency operates the Poinciana Emergency Shelter (birth through 10 years) and Poinciana Group Home (11-17 years old) in Key West, for children who have been removed from their families/homes as a result of abuse or neglect. It also provides street outreach through Project Lighthouse where staff conducts outreach in areas where homeless youth congregate with the goal of getting these youth help and providing a safe shelter. The youth census during the Quality Improvement (QI) visit was eight youth. FKCS is currently accredited by the Council of Accreditation (COA) through July 31, 2028. The Council on Accreditation (COA) partners with human service organizations worldwide to improve service delivery outcomes by developing, applying, and promoting accreditation standards.

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

Standard 1: There are seven indicators for Standard 1.
Indicator 1.01 Background Screening of Employees/Volunteers was rated **Satisfactory**.
Indicator 1.02 Provision of an Abuse Free Environment was rated **Satisfactory with Exception**.
Indicator 1.03 Incident Reporting was rated **Satisfactory**.
Indicator 1.04 Training Requirements was rated **Satisfactory with Exception**.
Indicator 1.05 Analyzing and Reporting Information was rated **Satisfactory with Exception**.
Indicator 1.06 Client Transportation was rated **Limited.**
Indicator 1.07 Outreach Services was rated **Satisfactory.**

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

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

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.**
Indicator 4.04 Medical/Mental Health Alert Process was rated **Satisfactory.**
Indicator 4.05 Episodic/Emergency Care was rated **Satisfactory**.

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

Standard 1:
Indicator 1.06 - Limited
None of the ten single transport trips reviewed maintained check-in documentation of phone call/contact with supervisor upon destination arrival and departure by staff for single client transport.

Standard 2:
Indicator 2.01 - Limited
1) Out of five records reviewed, one screening was completed the following day after intake.
2) Out of the five records reviewed, four of the screening were completed beyond three business days after the referral was received.
3) Three community counseling records reviewed did not have documentation to support parent/guardians received information on available service options, and rights and responsibilities of youth and parents/guardians.
4) Seven of the ten records reviewed did not have documentation to show the following was available to the youth and parents/guardians: possible actions occurring through involvement with CINS/FINS services (cases staffing committee, CINS petition, CINS adjudication). Two community counseling records did not have documentation to support grievance procedures were made available to the parents/guardian.

Standard 3:
Indicator 3.06 - Limited
While staff observation was seen for each of the five dates/samples reviewed, the bed checks across all of the samples were not documented in the logbook in “real time” as required and consistent with the electronic monitoring system. The logbook entries noted the exact time checks were expected to be completed, either every 10 minutes or 15 minutes depending upon the time interval for the supervision, while video revealed many variances from one-six minutes compared to the written entry.

One of the bed checks was conducted more than 15 minutes apart on hallway 2, November 25th, between 00:08:50 and 00:28:52.

CINS/FINS QUALITY IMPROVEMENT TOOL

Quality Improvement Indicators and Results: Please select the appropriate outcome for each indicator for each item within the indicator.		**Summary/Narrative Findings:** The narrative write-up is a thorough summary of each assigned QI indicator, explaining how finding(s) are determined.	**Deficiencies/Exceptions:** Please add additional detailed explanations for any items that have any deficiencies or exceptions.
Standard One – Management Accountability			
1.01: Background Screening of Employees, Contractors and Volunteers			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 1.01		**NO** If NO, explain here: Policy 1.12 was missing required procedures for re-taking the pre-employment suitability assessment for applicants who do not pass the initial assessment. The CEO updated the policy during the review. The provider has a policy and procedure, 1.12 -Background Screening and Post Hire Arrest, that was approved 11/1/24 by the CEO and COO.	
All positions providing direct services to youth has successfully passed pre-employment suitability assessment on the initial attempt.	**Compliance**	Since January 2019, Florida Keys Children Shelter (FKCS) has utilized a self-created pre-employment suitability questionnaire screening tool that is comprised of 11 open ended questions, I of which is a bonus question. The suitability questionnaire tool captures responses to 11 typical job related scenarios for direct-care positions and was used to evaluate the six new staff hired during the review period. The tool has a pass rate of 70%; all six staff hired met or exceeded the pass rate.	
For any applicant that did not pass the initial suitability assessment, there was evidence that the applicant retook the assessment and passed within five (5) business days of the initial attempt, not exceeding three (3) attempts within thirty (30) days.	**No eligible items for review**	All six applicable staff received passing scores.	
Agency has evidence for employees who have had a break in service for 18 months or more, and/or when the agency had a change or update in the suitability assessment tool used was different from the employee's original assessment, that a new suitability assessment and background screening was completed as required.	**No eligible items for review**	The program did not rehire any of the six new employees.	

Background screening completed prior to hire/start date (or exemption obtained prior to working with youth if rated ineligible) for new hires, volunteers/interns, and contractors. *(Employees who have had a break in service and are in good standing may be reemployed with the same agency without background screening if the break is less than 90 days.)*	**Compliance**	Background screenings for all six new hires were initiated prior to hire/start dates with eligibility documented on the DJJ background screening results. There were no exemptions required. The program did not utilize any interns/volunteers during the review period who met the criteria for background screenings.	
Five-year re-screening is completed every 5 years from the date of the last screening for all applicable employees and volunteers.	**Compliance**	The program had two staff who met the criteria for 5-year re-screening. Both staff were re-screened timely and had valid retained prints in the clearinghouse.	
Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?	**Compliance**	The provider emailed its Annual Affidavit of Compliance with Level 2 Screening Standards on December 18, 2023 prior to the January 31, 2024 deadline.	
Proof of E-Verify for all new employees obtained from the Department of Homeland Security	**Compliance**	The program provided E-Verify documentation from the Department of Homeland Security for all six new staff, verifying authorization to work.	
Additional Comments: **There are no additional comments for this indicator.**			
1.02: Provision of an Abuse Free Environment			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 1.02		**YES** If NO, explain here: The provider has the required policy and procedure, Service Delivery, which was approved on 11/1/2024 by the CEO and COO.	
Agency has a code of conduct of policy and there is evidence that staff are aware of agency's code of conduct.	**Compliance**	The program maintains a code of conduct procedures within the Service Delivery policy. The Rules of Conduct are provided to staff during orientation, which are signed and maintained in the personnel file. All eight staff personnel files reviewed included the signed Rules of Conduct.	
The agency has a process in place for reporting and documenting child abuse hotline calls.	**Compliance**	The program maintains a policy and practice where staff are required to report any alleged abuse to the Abuse Hotline. The Abuse Hotline number was observed throughout the facility, including in the youth common areas and near the dormitories. Four new staff training records reviewed demonstrate staff are trained in child abuse reporting.	
Youth were informed of the Abuse and Contact Number	**Compliance**	The program maintains a policy and practice where youth are oriented on locating and accessing the Abuse Hotline number, as outlined in the provided Residential Handbook (page 30).	

Grievance			
The program(s) have an accessible and responsive grievance process for youth to provide feedback and address complaints. Program director/ supervisor has access to and can manage grievances unless it is towards themselves.	**Compliance**	The program maintains a Grievance Process, 3.10, within the Policy and Procedure Manual, which requires all grievances to be resolved by program director and documented within 72 hours, and checked by management, or designated supervisor, at least daily (excluding weekends and holidays), and documented in program logbook.	
Shelter only: Grievances are maintained on file at minimum for 1 year.	**Compliance**	The program demonstrated retention of grievances beyond a year from the submission date.	
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 process is reviewed and provided to each youth during orientation, and accessible in the provided Residential Handbook (page 12). The grievance box and forms were observed in the facility, locked and near the dormitories.	
Shelter only: There is evidence that grievance boxes are checked by management or a designated supervisor at least daily (excluding weekends and holidays) and documented in the program logbook.	**Exception**	During the review, both the Residential Coordinator and the Counseling Services Coordinator were interviewed, and both confirmed the practice as outlined the program's policy. Residential Coordinator as well as the Education Specialist and Residential Specialist have keys to grievance box, which is routinely checked at least daily (excluding weekends and holidays) Monday through Friday. The Residential Coordinator enters the grievance checks into the logbook. In the logbook, grievance checks are highlighted in orange (indicated as "checked g box" or "check grievance box").	Of the 31 reviewed grievances during the review period, the program logbook did not include three documentation of grievance box checks for 6/13/24, 6/14/24, and 11/26/24.
Shelter only: Grievances are resolved within 72 hours of being submitted or there was documentation explaining the cause for the delay in providing a resolution.	**Exception**	All 31 reviewed grievances during the review period, were reviewed within 72 hours. Of the 31 grievances reviewed during the review period, six were not elevated to the next level as the youth indicated not agreeing with the initial review or left the section blank.	There was no additional documentation to reflect six grievances were resolved as they did not indicate agreement by the youth and were not forwarded to the COO for review as outlined in the policy and the Residential Handbook.
Additional Comments: **There are no additional comments for this indicator.**			

1.03: Incident Reporting			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 1.03		**YES** If NO, explain here: The provider has the required policy and procedure, Incident Reporting procedure, 1.13, within the Program Management policy, which was approved on 11/1/2024 by the CEO and COO.	
During the past 6 months, the program notified the Department's CCC (Central Communication Center) no later than two hours after any reportable incident occurred or within two hours of the program learning of the incident	**Compliance**	All six CCC reportable incidents reviewed during the review period, were reported within the required 2-hour timeframe.	
The program completes follow-up communication tasks/special instructions as required by the CCC	**Compliance**	The program maintains documentation of follow-up communication with the CCC unit, as required. All of the incidents reviewed were closed indicating no additional information or tasks were outstanding.	
Agency internal incidents are documented on incident reporting forms and all CCC reportable incidents were consistently reported to CCC as required.	**Compliance**	The program documents internal incidents on an incident report form titled DJJ Central Communication Center Incident Report.	
Incidents are documented in the program logs and on incident reporting forms	**Compliance**	The program logbook was reviewed for notation of the six incidents that were reported to CCC. All six CCC incidents and reporting to CCC were not noted in the logbook.	
All incident reports are reviewed and signed by program supervisors/ directors	**Compliance**	All six incident reports were reviewed and signed by the program supervisor.	
Additional Comments: **There are no additional comments for this indicator.**			
1.04: Training Requirements (*Staff receives training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions*)			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 1.04		**YES** If NO, explain here: The provider has the required policy and procedures, Staff Development 5.01, which was approved on 11/1/2024 by the CEO and COO.	

First Year Direct Care Staff			
All direct care staff have completed a new hire pre-service training provider orientation before they work independently. At a minimum, the orientation included the following: • Agency policies and procedures • Behavior Management (Shelter Only) • Building/Facility layout • File Documentation/development of paperwork requirements and confidentiality • CCC & Incident Reporting • Child Abuse Reporting • Client Intake & Screening • Client Orientation (direct care staff training on delivering new client orientation) • Fire Equipment Safety • Medical and Mental Health Alert System (Shelter) • Risk Management--Including but not limited to the following: - Disaster Preparedness and Emergency Response - First Aid/CPR - Universal Precautions • Video Camera Surveillance & Equipment • All other necessary information to orient a new hire to perform their job role and duties.	**Compliance**	Training records for four new hire staff were reviewed. All four training records documented the staff completed mandatory pre-service training required prior to working independently with youth as outlined in the program's policy.	
All staff completed the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days from date of hire.	**Compliance**	All four reviewed new hire training records documented the staff completed the required Civil Rights training within the 30-day required timeframe.	
All direct care CINS/FINS staff for shelter and community counseling services, including independent contractors (full-time, part-time, and on-call) and interns met the minimum requirement of 80 hours of training for the first full year of employment.	**Compliance**	All four reviewed new hire training records documented the staff completed well over the 80 hours requirement as outlined in the program's policy.	
All staff receives all mandatory training during the first 90 days of employment from date of hire.	**Compliance**	All four reviewed new hire training records documented the staff completed all required new hire trainings during the first 90 days to perform their duties as outlined in the program's policy.	
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**	All non-licensed new hire training records reviewed documented the staff completed Medication Management and PYXIS training by the program’s nurse prior to administering medication to youth.	

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 new hire training records reviewed included staff who utilize NETMIS.	
Staff Participating in Case Staffing & CINS Petitions (within the first year of employment BUT no later 7/1/24 for previous staff)			
Documentation of instructor-led FL Statute 984 CINS Petition Training by a local DJJ Attorney within 1 year of employment or no later than 7/1/24 if hired before 7/1/23. (*Policy went into effect 7/1/23).*	**No eligible items for review**	None of the new hire training records reviewed included staff who participate 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 has not hired any new non-licensed mental health clinical shelter staff person during the review period.	
In-Service Direct Care Staff			
In-service staff completes all of the required annual or 2-year mandatory refresher Florida Network, SkillPro, or other job-related trainings within the required timeframe.	**Exception**	Four in-service staff training files were reviewed. Three of the four reviewed files documented completion of all required in-service trainings.	One of the four in-service training records reviewed files did not document the completion of required training within the required timeframe. The staff completed the following courses late: Child Abuse: Recognition, Reporting, and Prevention and Human Trafficking. There was no completion record for Trauma Responsive Practices for the review period.
Community Counseling Direct Care staff completes 24 hours of mandatory refresher Florida Network, SkillPro, and job-related training annually.	**Compliance**	The reviewed file for Community Counseling staff reflected completion of 28 hours, more than the required 24 hours of training.	
Shelter Program Direct Care staff completes 40 hours of mandatory refresher Florida Network, SkillPro, and job-related training annually *(E.g. the program has a DCF child caring license).*	**Compliance**	The reviewed files for three Shelter Staff reflected completion of more than the required 40 training hours.	
Required Training Documentation			
The agency has a training plan that includes all of the required training topics including the pre-service and in-service.	**Compliance**	The program maintains a training plan outlining required training topics required for both new hire staff and in-service trainings.	

The agency has a designated staff member responsible to manage all employee's individual training files and completes routine tracking and reviews of staff files to ensure compliance.	**Compliance**	The Quality Compliance Manager (QCM) is the designated staff member responsible for managing all employees' individual training files and completes routine reviews of staff files to ensure compliance.	
The program maintains an individual training file or employee file AND a FLN Training Log (or similar document that includes all requirements) for each staff, which includes an annual employee training hours tracking form and related documentation, such as electronic record/transcript, training certificates, sign-in sheets, and agendas for each training attended.	**Compliance**	In accordance to the standards and the program's policy, each reviewed file consisted of a tracking log to document required and completed trainings for each staff.	
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:		The program documented completion of Naloxone/Overdose Prevention training, within the timeframes, for three applicable staff. One staff is within the timeframe to complete the training prior to 7/1/2025.	
Additional Comments: **There are no additional comments for this indicator.**			
1.05 - Analyzing and Reporting Information			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 1.05		**YES** If NO, explain here: The provider has the required policy and procedure, 1.19 Data Collection, Analysis and Reporting, which was approved on 11/1/2024 by the CEO and COO.	
Case record review reports demonstrate reviews are conducted quarterly, at a minimum. *(A summary report of case record reviews, identifying compliance with the CINS/FINS requirements, which is reviewed by management and communicated with staff on a quarterly basis at minimum.)*	**Exception**	Quarterly case record reviews are completed for each program at least once per quarter by the Quality Compliance Manager for the Residential files, and by the Community Counseling Coordinator for the Community Based Counseling Program using two different types of forms. File reviews are also routinely conducted by the shelter supervisor. The Quality Record Review form provides a numerical overall summary of the record review. It is not clear how many records were reviewed by the shelter supervisor or all parties involved as this information is not summarized.	Case record reviews are not summarized with clear indication of required corrective actions to communicate with management and staff.

The program conducts reviews of incidents, accidents, and grievances quarterly, at a minimum	**Compliance**	Florida Keys Children's Shelter conducts quarterly risk management reviews of all incident reports, grievances and accidents involving persons served or personnel for all program sites. The CEO or designee prepares a risk management report that compiles all of the information reviewed. The reports are disseminated to Leadership Team members on a quarterly basis for review prior to scheduled meetings. Quarterly risk reports for April-June 2024 and July-September 2024 were reviewed and observed to include a collection of data on major maintenance repairs, incidents, accidents, grievances, abuse calls, CCC calls, work related injuries, and fire/emergency drills.	
The program conducts an annual review of customer satisfaction data	**Compliance**	Assigned staff member(s) are responsible for entering the results on the Satisfaction Surveys into NetMIS data entry system. The results from the surveys are aggregated annually to produce a satisfaction survey summary report. The program provided reports for FY 2023-2024 (188 of 193 respondents indicated satisfaction) and year to date, FY2024-2025 (all 50 respondents indicated satisfaction).	
The program demonstrates a monthly review of the statewide End-of-Month ("EOM") report generated by the Florida Network Office. This includes monthly data, fiscal year to date data, benchmarks for residential and community counseling, screening data, report card measures, follow-up reporting measures.	**Compliance**	Florida Keys Children's Shelter collects and reviews several sources of information and/or areas to identify patterns and trends including outcome data. Outcomes data is generated by CEO and COO and included in the provider's monthly leadership report. EOM reports from the Florida Network is shared with the leadership team and is a standing agenda item on the meeting agenda. The outcome data incorporates all contract, NetMIS, and program benchmarks required by the Florida Network and DJJ. Documentation of meeting agenda and sign in sheets supports this practice.	
The program has a process in place to review and improve accuracy of data entry & collection	**Compliance**	Florida Keys Children's Shelter utilizes NETMIS and JJIS (Juvenile Justice Information System) to track data. All youth information is entered into the NETMIS and JJIS. FKCS cooperates with the Florida Network in their efforts to collect uniform and accurate client data and inconsistencies are monitored by the CEO and resolved immediately by program manager's. End of month (EOM) NetMIS data is reviewed on a monthly basis by the program managers who correspond mainly via email to communicate areas of performance met/ deficient.	

There is documentation that findings are regularly reviewed by management and communicated to staff and stakeholders.	**Compliance**	Monthly risk management reports are presented for review and discussion during Leadership Team meetings. Management reviews all findings on a regular basis and communicates them to staff and stakeholders. Strengths and weaknesses are identified, improvements are implemented or modified and staff are informed and involved throughout the process. In addition, all risk management reports are submitted to the Governance board annually.	
There is evidence the program demonstrates that program performance is routinely reviewed with the Board of Directors. All final reports that include a Limited or Failed score is submitted electronically or by mail to the providers Executive Committee on the Board of Directors.	**Compliance**	Documentation of meeting agenda and sign in sheets supports the CEO presents program performance at Board of Director's meetings. The CEO provided minutes of board meetings held in June, September, and October 2024 support program performance data reports are shared with the Board of Directors.	
There is evidence that strengths and weaknesses are identified, improvements are implemented or modified, and staff are informed and involved throughout the process.	**Compliance**	Following external or internal reviews and receipt of written review findings, the Leadership Team meets and determines how the findings can best be integrated into the PQI process and what corrective actions may be required and/or advised. Areas of concern are discussed and reviewed during Leadership Team Management held at least monthly. Issues discussed and resolutions are included in the meeting minutes. Program supervisors and direct care staff are requested to provide input into the most conducive and time-effect manner changes can be facilitated. Feedback is provided to staff as to overall effectiveness of changes facilitated.	
Additional Comments: **There are no additional comments for this indicator.**			
1.06: Client Transportation			**Limited**
Provider has a written policy and procedure that meets the requirement for Indicator 1.06		**YES** If NO, explain here: The provider has the required policy and procedures, Transportation of Youth, 8.02, which was approved 11/1/2024 by the CEO and COO.	
Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	**Compliance**	All staff who transport youth and cleared by the agency automobile insurance company are approved by the program, as outlined in the policy.	

Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	**Compliance**	All approved staff who transport youth are covered by the program's insurance policy and maintains a valid driver's license.	
Agency's Transportation policy prohibit transporting a client without maintaining at least one other passenger in the vehicle during the trip and include exceptions in the event that a 3rd party is NOT present in the vehicle while transporting	**Compliance**	The program maintains procedures for single staff transporting youth where the Program Director must be aware of, or notified prior, to the practice of individual staff transporting a single client and consent is documented accordingly in the Logbook and/or Transportation Log.	
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 program maintains the procedure for single staff transporting youth where the client's evaluations, history, personality, recent behavior and length of stay in the program indicate no inappropriate behavior is likely to occur and the staff work performance and history, length of employment indicates no inappropriate behavior is likely to occur.	
The 3rd party is an approved volunteer, intern, agency staff, or other youth	**Compliance**	The 3rd party for all single transports were observed to be documented on the transportation log as an agency staff or other youth.	
The agency demonstrated evidence via logbook or other written verification that supervisor approval was obtained prior to all single youth transports.	**Compliance**	A random sample of 10 single transport events were reviewed. All were recorded on the transportation log and show supervisor's prior approval. All 10 single transports were recorded in the logbook.	
When transporting a single client in a vehicle, there was documentation of the following: a. the transporting employee completed check-in by phone at agreed-upon intervals with the senior program leader, or designee, upon departure and arrival. b. the employee check-ins were documented by the manager or designee receiving the call.	**Exception**	The program maintains the procedure for single staff transporting youth where the trip must be documented and include the destination, approximate mileage and anticipated time of arrival; the transporting staff shall check-in by phone at agreed upon intervals with the senior program leader, or designee, upon arrival and departure; staff check-ins must be documented by manager or designee receiving the call; and a driver with concerns regarding safety can call any agency personnel and maintain an open phone line to act as an audio witness in the vehicle.	None of the ten single transport trips reviewed maintained check-in documentation of phone call/contact with supervisor upon destination arrival and departure by staff for single client transport.
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**	All ten trips reviewed maintained documentation of notes, names/initials of driver, date and time, mileage, and other passengers in the vehicle logs.	
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 and procedures, Public Awareness/Outreach, 7.01, which was approved on 11/1/2024 by the CEO and COO.	
The program has a lead staff member designated to participate in local DJJ board, Circuit and Council meetings with evidence that includes minutes of the event or other verification of staff participation.	**Compliance**	The program's CEO is the designated staff who participates in DJJ Board, Circuit and Council meetings as documented by the minutes, which were provided for the meetings held on 2/5/24, 5/6/24, 8/26/24, and 11/4/24.	
The program maintains written agreements with other community partners which include services provided and a comprehensive referral process.	**Compliance**	The provider maintains over a dozen agreements with community partners and stakeholders to include Guidance Care Center, the Housing Authority of Key West, FL Keys Community College, Mariners Hospital, the Monroe County Sheriff's Office, Florida International University, Project Lighthouse, the Wesley House Family Services, and many more.	
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 program logged 21 Outreach activities in NetMIS, which included all required information such as the event's title, date, location, description, and target audience.	
The program has designated staff that conducts outreach which is defined in their job description.	**Compliance**	The program has two filled Outreach positions, TLP Community Outreach and the SOP Outreach Worker. Designated Community Counseling and Shelter Staff logs Outreach activities into NetMIS.	
Additional Comments: **There are no additional comments for this indicator.**			

Standard Two – Intervention and Case Management			
2.01 - Screening and Intake			**Limited**
Provider has a written policy and procedure that meets the requirement for Indicator 2.01		**YES** If NO, explain here: The provider has the required policy and procedure Screening and Intake -2.01, which was approved on 11/1/24 by the CEO and COO.	
Shelter youth: Eligibility screening form is completed immediately for all shelter placement inquiries.	**Exception**	Five residential youth records were reviewed for two open and three closed cases. Four of the five residential youth screenings reviewed were completed immediately on the day of intake.	Out of five records reviewed, one screening was completed the following day after intake.
Community counseling: Eligibility screening form is completed within 3 business days of referral by a trained staff using the Florida Network screening form.	**Exception**	Five community counseling youth records were reviewed for two open and three closed cases. One of the five screenings was completed within three business days after the referral was received.	Out of the five records reviewed, four of the screening were completed beyond three business days after the referral was received.
There is evidence all referrals for service is screened for eligibility and is logged in NetMIS within 72 hours of screening completion.	**Compliance**	All ten records had evidence that the screening for eligibility was entered into 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	**Exception**	Seven of the ten records reviewed (two community counseling and five residential) supported youth and parent/guardians received the available service options, rights and responsibilities of youth and parents/guardian in writing as evidenced by their signatures on the forms in the case files.	Three community counseling records reviewed did not have documentation to support parent/guardians received information on available service options, and rights and responsibilities of youth and parents/guardians.
The following is also available to the youth and parents/guardians: a. Possible actions occurring through involvement with CINS/FINS services (case staffing committee, CINS petition, CINS adjudication) b. Grievance procedures	**Exception**	Three of the ten records reviewed had documentation to show the following was available to the youth and parents/guardians: possible actions occurring through involvement with CINS/FINS services (cases staffing committee, CINS petition, CINS adjudication). These files were only community counseling. Eight out of the ten files had documentation to support the youth and parents/guardians received information on the grievance procedures. These were both three community counseling and five residential cases.	Seven of the ten records reviewed did not have documentation to show the following was available to the youth and parents/guardians: possible actions occurring through involvement with CINS/FINS services (cases staffing committee, CINS petition, CINS adjudication). Two community counseling records did not have documentation to support grievance procedures were made available to the parents/guardian.
During intake, all youth were screened for suicidality and correctly assessed as required if needed.	**Compliance**	Out of the ten records reviewed all files had documentation that all youth were screened and correctly assessed for suicidality.	
Additional Comments: **There are no additional comments for this indicator.**			

2.02 - Needs Assessment			Satisfactory with Exception
Provider has a written policy and procedure that meets the requirement for Indicator 2.02		**YES** If NO, explain here: The provider has the required policy and procedure, 2.02 Assessment, which was last approved on 11/1/24 by the CEO and COO.	
Shelter Youth: NIRVANA is initiated within 72 hours of admission	**Compliance**	The NIRVANA Assessments for the five residential records reviewed were all completed within 72 hours of admission and was placed in the case file.	
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**	The Nirvana Assessments were initiated at Intake and completed within 2 to 3 face contacts for all five community counseling records reviewed. The Nirvana Assessments were observed in the NETMIS system and one was observed in the case file.	
Supervisor signatures is documented for all completed NIRVANA assessments and/or the chronological note and/or interview guide that is located in the youths' file.	**Exception**	Nine of the ten records reviewed had documentation of the supervisor's signature and/or the chronological note and/or interview guide that is located in the youth's file.	One residential youth record did not have documentation of the supervisor's signature on the NIRVANA assessment.
(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 youth records showed documentation of the NIRVANA Self-Assessment (NSR) completed within 24 hours of the youth being admitted into the 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**	Seven applicable youth records provided documentation to verify the NIRVANA Post-Assessment was completed at discharge for all youth who had a length of stay greater than 30 days.	
A NIRVANA Re-Assessment is completed every 90 days excluding files for youth receiving SNAP services.	**Exception**	Nine of the files did not meet the requirements for the NIRVANA 90 day Re-Assessment.	The 90-day re-assessment was not completed for one applicable community counseling youth record.
All files include the interview guide and/or printed NIRVANA.	**Compliance**	All ten youth included the interview guide and/or 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 and procedure, 2.03 Service Plan, which was on 11/1/24 by CEO and COO.	
The case/service plan is developed on a local provider-approved form or through NETMIS and is based on information gathered during the initial screening, intake, and NIRVANA.	**Compliance**	All ten files showed documentation that the case/service plan is developed on a local provider-approved form or through NetMIS and is based on the information gathered during the initial screening, intake and NIRVANA.	
Case/Service plan is developed within 7 working days of NIRVANA	**Compliance**	All ten case plans reviewed were developed within 7 working days of the NIRVANA as indicated on the service plan date.	
Case plan/service plan includes: 1. Individualized and prioritized need(s) and goal(s) identified by the NIRVANA 2. Service type, frequency, location 3. Person(s) responsible 4. Target date(s) for completion and actual completion date(s) 5. Signature of youth, parent/guardian, counselor, and supervisor 6. Date the plan was initiated	**Exception**	All ten records were in compliance with the case/service plan that included individualized and prioritized need(s) and goal(s) identified by the NIRVANA and included persons responsible, service type, frequency, and location. All ten were in compliance with having target date(s) for completion and actual completion date(s) where applicable. Eight of the ten were in compliance with having the signature of the youth, parent/guardian, counselor and supervisor. All ten were in compliance with having the date the plan was initiated.	Two community counseling records did not include the parents signature on the case/plan.
Case/service plans are reviewed for progress/revised by counselor and parent (if available) every 30 days for the first three months and every 6 months after	**Exception**	Seven of the 10 files reviewed (four community counseling and three residential) demonstrated case/service plan reviews were conducted by counselor and parent (if available) every 30 days for the first three months. Two files were discharged prior to the 30 days and did not meet the requirements for the 30-day case/service plan review.	One community counseling record was not in compliance with completing the 30-day case/service plan review timely as it was completed eight days late.
Additional Comments: **There are no additional comments for this indicator.**			
2.04 - Case Management and Service Delivery			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 2.04		**YES** If NO, explain here: The provider has the required policies and procedures, 3.02 Exit Planning, Case Termination, Aftercare & Follow up, and 7.01 Prevention/Outreach & Community Partnership, which were approved on 11/1/24 by CEO and COO.	
Counselor/Case Manager is assigned	**Compliance**	All ten records reviewed documented the counselor/case manager assigned to the case.	

The Counselor/Case Manager completes the following as applicable: 1. Establishes referral needs and coordinates referrals to services based upon the on-going assessment of the youth's/family's problems and needs 2. Coordinates service plan implementation 3. Monitors youth's/family's progress in services 4. Provides support for families 5. Monitoring progress of court ordered youth in shelter 6. Makes referrals to the case staffing to address problems and needs of the youth/family 7. Accompanies youth and parent/guardian to court hearings and related appointments 8. Refers the youth/family for additional services when appropriate 9. Provides case monitoring and reviews court orders 10. Provides case termination notes 11. Provides follow-up after 30 days post discharge 12. Provides follow-up after 60 days post discharge	**Compliance**	The counselors established referrals and coordinated referrals based on the needs of the family, implemented and coordinated the service plans, provided support for the families, monitored the youth and family progress and documented it in the case notes, and provided case termination notes in the discharge summary and in the case notes for the clients that were terminated. None of the youth were court ordered and required court monitoring or referrals to the case staffing. Five applicable closed records provided 30 day follow up post discharge. Two applicable files provided follow ups after 60 days post discharge.	
The program maintains written agreements with other community partners that include services provided and a comprehensive referral process	**Compliance**	Florida Keys maintains written agreements with community partners that allows them to refer their youth for additional services. They have a written process that allows them to refer to the community partners.	
Additional Comments: **There are no additional comments for this indicator.**			
2.05 - Counseling Services			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 2.05		**YES** If NO, explain here: The provider has the required policies and procedures: 1.02 Program Description, Mission, Vision and Values; 3.01 Community Based Counseling; 3.09 Shelter Program Services; .05 CINS Petition Process; and 3.04 Case Staffing Committee. All of the policies were approved on 11/1/24 by CEO and COO.	
Shelter Program			
Shelter programs provides individual and family counseling	**Compliance**	Individual and family counseling was observed in the case file notes for applicable shelter youth.	

Group counseling sessions held a minimum of five days per week	**Exception**	Group sessions were reviewed for the following dates: 7/1-7/6 and 7/21-7/25; 8/11-8/15 and 8/25-8/29; 9/8-9/12 and 9/22-26; 10/10-10/14 and 10/20/24; 11/3-11/8 and 11/17-11/21; and 12/1-12/6 and 12/8-12/12. Group sessions were observed to be documented at least five times a week from July 2024-December 2024, with the exception of August.	One week was observed having four groups during the week of 8/18-8/24 instead of five times.
Groups are conducted by staff, youth, or guests and group counseling sessions consist of : 1. A clear leader or facilitator 2.Relevant topic - educational/informational or developmental 3. Opportunity for youth to participate 4. 30 minutes or longer	**Compliance**	All 60 group documentation records reviewed were conducted by staff, youth, or guest, and group counseling sessions consisted of a clear leader or facilitator, relevant topic, opportunity for youth to participate and were held for 30 minutes or longer.	
Documentation of groups must include date and time, a list of participants, length of time, and topic.	**Compliance**	All 60 group documentation records included date, time, a list of participants, and length of time and topic.	
Community Counseling			
Community counseling programs provide therapeutic community-based services designed to provide the intervention necessary to stabilize the family. Services are provided in the youth's home, a community location, the local provider's counseling office or virtually if written documentation is provided in the youth's file for reasons why it is in the best interest of the youth and family.	**Compliance**	All five community counseling records reviewed provided documentation of the program offering 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, or the local provider's counseling office. One of five community counseling records provided written documentation to explain the reasons why virtual services were requested in the best interest of the youth and family due to needing translator services via telephone phone.	
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**	Out of the ten records reviewed, there is evidence the program completed the review of all files for coordination between presenting problem(s), psychosocial assessments, case/service plan, case/service plan reviews eight of the files were compliant.	
Maintain individual case files on all youth and adhere to all laws regarding confidentiality.	**Compliance**	All ten files were maintained in individual case files and adhered 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 youth records for all services provided and documented youth's progress.	

On-going internal process that ensures clinical reviews of case records and staff performance.	**Exception**	All five community counseling records reviewed documented an on-going internal process that ensures clinical reviews of case record and staff performance.	The five residential records reviewed did not document an on-going internal clinical review of the 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.	**Compliance**	One of the ten records reviewed documented a virtual intake was conducted and 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 youth's file because the parent needed translation service which was provided via telephone.	
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 and procedure, 3.04 Case Staffing, which was approved on 11/1/24 by CEO and COO.	
Must include: a. DJJ rep. or CINS/FINS provider b. Local school district representative	**Compliance**	The program has not held a case staffing since the last QI review. The counseling services coordinator was interviewed to assess practice for this indicator. Per the interview, a DJJ representative and/or CINS/FINS provider staff as well as a local school district representative participate in the case staffing process.	
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**	As requested by the youth/family, other members invited to the case staffing may also include state attorney's office, substance abuse representative, law enforcement representative, DCF representative, and/or mental health representative.	
The program has an established case staffing committee, and has regular communication with committee members	**Compliance**	The program has a case staffing committee and corresponds via email with committee members when there is a request for case staffing.	

The program has an internal procedure for the case staffing process, including a schedule for committee meetings	**Compliance**	The program has an internal process for case staffing which includes a schedule for meetings requested. It is decided in the supervision meeting with the counselor and supervisor whether a client will need to be assigned for case staffing. If a case is recommended for case staffing or requested by the parent/guardian, all parties are notified along with the case staffing team, and a meeting would be scheduled.	
The youth and family are provided a new or revised plan for services	**No eligible items for review**	The program has not held a case staffing since the last QI review.	
Written report is provided to the parent/guardian within 7 days of the case staffing meeting, outlining recommendations and reasons behind the recommendations	**No eligible items for review**	The program has not held a case staffing since the last QI review.	
If applicable, the program works with the circuit court for judicial intervention for the youth/family	**No eligible items for review**	The program has not held a case staffing since the last QI review.	
Case Manager/Counselor completes a review summary prior to the court hearing	**No eligible items for review**	The program has not held a case staffing since the last QI review.	
Additional Comments: **There are no additional comments for this indicator.**			
2.07 - Youth Records			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.07		**YES** If NO, explain here: The provider has the required policy and procedure, 1.16 Confidentially/HIPPA, and 1.26 Client Records, that were approved on 11/1/24 by CEO and COO.	
All records are clearly marked ‘confidential’.	**Compliance**	All ten records reviewed were clearly marked 'confidential'.	
All records are kept in a secure room or locked in a file cabinet that is marked “confidential”	**Compliance**	All records were observed to be kept in a secure room and locked in a file cabinet marked 'confidential'.	
When in transport, all records are locked in an opaque container marked “confidential”	**Compliance**	The program uses a locked opaque container that is marked confidential that is used to transport client records offsite.	
All records are maintained in a neat and orderly manner	**Compliance**	All the case files were observed to be well maintained, neat and in an orderly manner.	

SHELTER FILES contain the following: Table of Contents that outlines documents in each section: •Screening •Informed Consent • Photograph of the youth • Shelter Intake Form • Suicide Assessment (if needed) • NIRVANA Self Report (NSR) • NIRVANA full Assessment • Plan of Service • Chronological Notes • Medication Inventory Form • Approved contact list • Copies of referrals made & Follow-Up (if needed) • Discharge summary once case is closed	**Compliance**	All five shelter records reviewed contained a table of contents that outlines documents in each section such as screening, informed consent, photograph of the youth. shelter intake form, suicide assessment (if needed), NIRVANA self-assessment, NIRVANA full assessment, plan of service, chronological notes, medication inventory form, approved contact list, copies of referrals made & follow-up (if needed), and discharge summary once case is closed.	
COMMUNITY COUNSELING FILES contain the following: Table of Contents that outlines documents in each section: • Screening • Informed Consent • Community Counseling Intake Form • Suicide Assessment (if needed) • NIRVANA full Assessment • Plan of Service • Chronological case notes • Copies of referrals made & Follow-Up (if needed) • Discharge summary once the case is closed	**Compliance**	All five community counseling records reviewed contained the following table of contents that outlines documents in each section: screening, informed consent, community counseling intake form, suicide assessment (if needed), NIRVANA full assessment, plan of service, chronological case notes, copies of referrals made & follow-up (if needed), and discharge summary once the case is closed.	
All records kept electronically, are maintained securely and can be made immediately available upon request for audit purposes.	**Not Applicable**	The program does not maintain electronic youth records.	
Records are retained for the duration of the time specified by the contract.	**Compliance**	Per interview with the counseling coordinator records are retained for the specified time identified in the contract.	
Additional Comments: **There are no additional comments for this indicator.**			

2.08 - Specialized Additional Program Services			Satisfactory with Exception
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 and procedures 3.08 - Specialized Additional Program Services, that was approved on 11/1/24 by CEO and COO.	
Staff Secure			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? **(If no, select rating "No eligible items for review")**	**No eligible items for review**	FKCS has not served any youth who meet the criteria for Staff Secure services since the last QI review.	
Staff Secure policy and procedure outlines the following: a. In-depth orientation on admission b. Assessment and service planning c. Enhanced supervision and security with emphasis on control and appropriate level of physical intervention d. Parental involvement e. Collaborative aftercare	**No eligible items for review**	FKCS has not served any youth who meet the criteria for Staff Secure services since the last QI review.	
Program only accept youth that meet legal requirements of F.S. 984 for being formally court ordered in to Staff Secure Services	**No eligible items for review**	FKCS has not served any youth who meet the criteria for Staff Secure services since the last QI review.	
Staff Assigned: a. One staff secure bed and assigned staff supervision to one staff secure youth at any given time b. Program assign specific staff during each shift to monitor location/ movement of staff secure youth c. Agency clearly documents the specific staff person assigned to the staff secure youth in the logbook or any other means on each shift	**No eligible items for review**	FKCS has not served any youth who meet the criteria for Staff Secure services since the last QI review.	
Agency provides a written report for any court proceedings regarding the youth's progress	**No eligible items for review**	FKCS has not served any youth who meet the criteria for Staff Secure services since the last QI review.	
Domestic Minor Sex Trafficking (DMST)			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	**No eligible items for review**	FKCS has not served any youth who meet the criteria for Domestic Minor Sex Trafficking (DMST) services since the last QI review.	

Agency has evidence that the FNYFS was contacted for approval prior to admission for all Domestic Minor Sex Trafficking (DMST) placements.	**No eligible items for review**	FKCS has not served any youth who meet the criteria for Domestic Minor Sex Trafficking (DMST) services since the last QI review.	
There is evidence the youth was entered into NetMIS as a Special Populations youth at admission and a Human Trafficking Screening Tool (HTST) was completed.	**No eligible items for review**	FKCS has not served any youth who meet the criteria for Domestic Minor Sex Trafficking (DMST) services since the last QI review.	
Services provided to these youth specifically designated services designed to serve DMST youth	**No eligible items for review**	FKCS has not served any youth who meet the criteria for Domestic Minor Sex Trafficking (DMST) services since the last QI review.	
Did the placement of DMST youth require additional supervision for the safety of the youth or the program? If so, did the agency provide the appropriate level of supervision and safety measures?	**No eligible items for review**	FKCS has not served any youth who meet the criteria for Domestic Minor Sex Trafficking (DMST) services since the last QI review.	
Length of Stay: a. Youth in program do not have length of stay in DMST placement that exceeds seven (7) days b. Agency has approval for stays and support beyond seven (7) days for DMST placements that are obtained on a case-by-case basis? (If applicable.)	**No eligible items for review**	FKCS has not served any youth who meet the criteria for Domestic Minor Sex Trafficking (DMST) services since the last QI review.	
Agency has evidence that staff assigned to DMST youth under this provision are to enhance the regular services available through direct engagement in positive activities designed to encourage the youth to remain in shelter	**No eligible items for review**	FKCS has not served any youth who meet the criteria for Domestic Minor Sex Trafficking (DMST) services since the last QI review.	
All other services provided to DMST youth are consistent with all other general CINS/FINS program requirements	**No eligible items for review**	FKCS has not served any youth who meet the criteria for Domestic Minor Sex Trafficking (DMST) services since the last QI review.	
Domestic Violence			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating “No eligible items for review”)	**Yes**	A total of three DV youth records were reviewed for two closed and one open youth.	
Youth admitted to DV Respite placement have evidence in the file of a pending DV charge	**Compliance**	All three youth were referred to the shelter by the Juvenile Assessment Center, indicating the youth had a pending charge for domestic violence.	
Data entry into NetMIS within (3) business days of intake and discharge	**Compliance**	The data was entered into NETMIS within three days of intake for all three records and within three days of discharge in the two closed records as indicated in the NETMIS system.	

Youth length of stay in DV Respite placement does not exceed 21 days. If more than 21 days, documentation exists in youth file of transition to CINS/FINS or Probation Respite placement, if applicable.	**Compliance**	One of the three youth had a placement requiring more than 21 days. Documentation existed in the file and in NETMIS to show the youth was transitioned to CINS/FINS on the 21st day.	
Case plan in file reflects goals for aggression management, family coping skills, or other intervention designed to reduce propensity for violence in the home	**Exception**	The case plans for all three youth did not specifically list anger management as a goal; however, documentation shows two of the youth were receiving anger management services from the Guidance Care Center.	One of three youth records reviewed did not document referral for anger management services or goals for addressing aggression 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 services provided to domestic violence youth are consistent with all other CINS/FINS services as evidenced in the case files. The youth case files have the same case file forms and require the same services as other youth in the CIN/FINS program.	
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**	FKCS has not served any youth who meet the criteria for Probation Respite since the last QI review.	
All probation respite referrals are submitted to the Florida Network.	**No eligible items for review**	FKCS has not served any youth who meet the criteria for Probation Respite since the last QI 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**	FKCS has not served any youth who meet the criteria for Probation Respite since the last QI review.	
Data entry into NetMIS and JJIS within (3) business days of intake and discharge	**No eligible items for review**	FKCS has not served any youth who meet the criteria for Probation Respite since the last QI 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**	FKCS has not served any youth who meet the criteria for Probation Respite since the last QI review.	
All case management and counseling needs have been considered and addressed	**No eligible items for review**	FKCS has not served any youth who meet the criteria for Probation Respite since the last QI review.	
All other services provided to Probation Respite youth are consistent with all other general CINS/FINS program requirements	**No eligible items for review**	FKCS has not served any youth who meet the criteria for Probation Respite since the last QI 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**	FKCS is not contracted to provide ICM services.	
Youth receiving services were deemed chronically truant and/or runaway and require more intensive and lengthy services. The youth was determined to be eligible because they have gone through petition and/or case staffing and was in need of case management services.	**Not Applicable**	FKCS is not contracted to provide ICM services.	
Services for youth and family include: a. Two (2) direct contacts per month b. Two (2) collateral contacts per week c. Direct and collateral contacts not obtained must have documentation to support attempts made to obtain them. All reasonable attempts (at minimum of three) must be made to reach all contacts (direct and collateral) and documented in the case file and NetMIS.	**Not Applicable**	FKCS is not contracted to provide ICM services.	
Assessments include a. NIRVANA at intake b. NIRVANA Re-Assessment every 90 days c. Post NIRVANA at discharge as aligned with timeframe requirements	**Not Applicable**	FKCS is not contracted to provide ICM services.	
Service/case plan demonstrates a strength-based, trauma-informed focus	**Not Applicable**	FKCS is not contracted to provide ICM services.	
For any virtual services provided, there is written documentation in the youths' file as to why virtual contact is in the best interest of the youth and family	**Not Applicable**	FKCS is not contracted to provide ICM services.	
Family and Youth Respite Aftercare Services (FYRAC)			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	**No eligible items for review**	The program has not served any youth who met the criteria for FYRAC in the last six months or since the last onsite QI review.	
Youth is referred by DJJ for a domestic violence arrest on a household member, and/or the youth is on probation regardless of adjudication status and at risk of violating.	**No eligible items for review**	The program has not served any youth who met the criteria for FYRAC in the last six months or since the last onsite QI review.	

Agency has evidence that all FYRAC referrals have documented approval from the Florida Network office	**No eligible items for review**	The program has not served any youth who met the criteria for FYRAC in the last six months or since the last onsite QI review.	
Intake and initial assessment sessions meets the following criteria: a. Services shall be documented through the signature of the youth and his/her parent/guardian as well as orientation to the program which is kept in the youths file. b. The initial assessment shall be face-to-face, in person or through virtual means, to include a gathering of all family history and demographic information, as well as the development of the service plan. c. For youth on probation, a copy of the youths Community Assessment Tool (CAT) to assist with development of the family service plan.	**No eligible items for review**	The program has not served any youth who met the criteria for FYRAC in the last six months or since the last onsite QI review.	
Life Management Sessions meets the following criteria: a. Sessions are face-to-face, sixty (60) minutes in length and focus on strengthening the family unit b. Services are highly supportive, individualized, and flexible and require a “whole family” approach to dealing with the problems affecting the youth and family.	**No eligible items for review**	The program has not served any youth who met the criteria for FYRAC in the last six months or since the last onsite QI review.	

Individual Sessions: a. The program conducted sessions with the youth and family to focus on work to engage the parties and identify strengths and needs of each member that help to improve family functioning. b. Issues to be covered through each session include but are not limited to: Identifying emotional triggers; body cues; healthy coping strategies through individual, group and family counseling; understanding the cycle of violence and the physical and emotional symptoms of anger; developing safety plans; and educating families on the legal process and rights.	**No eligible items for review**	The program has not served any youth who met the criteria for FYRAC in the last six months or since the last onsite QI review.	
Group Sessions: a. Focus on the same issues as individual/family sessions with application to youth pulling on similar experiences with other group members with the overall goal of strengthening relationships and prevention of domestic violence. b. Shall be no more than eight (8) youth at one (1) time and shall be for a minimum of sixty (60) minutes per session	**No eligible items for review**	The program has not served any youth who met the criteria for FYRAC in the last six months or since the last onsite QI review.	
There is evidence of completed 30 and/or 60 day follow-ups and is documented in NetMIS following case discharge.	**No eligible items for review**	The program has not served any youth who met the criteria for FYRAC in the last six months or since the last onsite QI review.	
Youth and family participate in services for thirteen (13) sessions or ninety (90) consecutive days of services, or there is evidence in the youth's file that an extension is granted by DJJ circuit Probation staff	**No eligible items for review**	The program has not served any youth who met the criteria for FYRAC in the last six months or since the last onsite QI review.	
Any service that is offered virtually, is documented in the youth's file why it was in the youth and families best interest.	**No eligible items for review**	The program has not served any youth who met the criteria for FYRAC in the last six months or since the last onsite QI review.	
All data entry in NetMIS is completed within 3 business days as required.	**No eligible items for review**	The program has not served any youth who met the criteria for FYRAC in the last six months or since the last onsite QI review.	
Additional Comments: **There are no additional comments for this indicator.**			

2.09- Stop Now and Plan (SNAP)			Not Applicable
Provider has a written policy and procedure that meets the requirement for Indicator 2.09		**N/A** If NO, explain here: FKCS is not contracted 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**	FKCS is not contracted to provide SNAP services	
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**	FKCS is not contracted to provide SNAP services	
The NIRVANA was completed at initial intake, or within two sessions.	**Not Applicable**	FKCS is not contracted to provide SNAP services	
There is evidence of the completed the Pre - Child Behavior Checklist (CBCL) by the caregiver and is located within the file.	**Not Applicable**	FKCS is not contracted to provide SNAP services	
There is evidence of the completed Pre - TOPSE is completed by the caregiver and is located within the file.	**Not Applicable**	FKCS is not contracted to provide SNAP services	
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**	FKCS is not contracted to provide SNAP services	
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**	FKCS is not contracted to provide SNAP services.	
There is evidence of the completed Post - TOPSE is completed by the caregiver and is located within the file.	**Not Applicable**	FKCS is not contracted to provide SNAP services.	
There is evidence of the completed SNAP Discharge Report located within the file for any discharged youth.	**Not Applicable**	FKCS is not contracted to provide SNAP services.	

There is evidence of the SNAP Boys/SNAP Girls Child Group Evaluation Form located in the file.	**Not Applicable**	FKCS is not contracted to provide SNAP services.	
There is evidence of the SNAP Boys/SNAP Girls Parent Group Evaluation Form located in the file.	**Not Applicable**	FKCS is not contracted to provide SNAP services.	
SNAP Clinical Groups for Youth 12-17			
Youth are screened to determine eligibility of services using the Florida Network Youth Screening Form.	**Not Applicable**	FKCS is not contracted to provide SNAP services.	
The file contains the completed Florida Network Community Counseling Intake Form and is located within the file.	**Not Applicable**	FKCS is not contracted to provide SNAP services.	
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**	FKCS is not contracted to provide SNAP services.	
The NIRVANA was completed at initial intake, or within two sessions.	**Not Applicable**	FKCS is not contracted to provide SNAP services.	
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**	FKCS is not contracted to provide SNAP services.	
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**	FKCS is not contracted to provide SNAP services.	
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**	FKCS is not contracted to provide SNAP services.	
All closed files contained evidence in the file a NIRVANA was completed at discharge.	**Not Applicable**	FKCS is not contracted to provide SNAP services.	
SNAP for Schools & Communities			
The program demonstrated all of the required weekly attendance sheets that included youth names and/or identifying numbers completed with the teacher and trained SNAP Facilitator signatures. (*This must include a total of 13 attendance sheets for a full cycle*)	**Not Applicable**	FKCS is not contracted to provide SNAP services.	

The program maintained evidence of a completed 'Way to Go Goal' Sheet within the file.	**Not Applicable**	FKCS is not contracted to provide SNAP services.	
The program maintained evidence of both pre AND post Measure of Classroom Environment (MoCE) completed documents for the class reviewed.	**Not Applicable**	FKCS is not contracted to provide SNAP services.	
The program maintained evidence of completed pre and post evaluation documents for the class reviewed.	**Not Applicable**	FKCS is not contracted to provide SNAP services.	
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**	FKCS is not contracted to provide SNAP services.	
There is evidence of one (1) Fidelity Adherence Checklist completed per classroom for the 13-week classroom sessions which is located in the file.	**Not Applicable**	FKCS is not contracted to provide SNAP services.	
Additional Comments: **There are no additional comments for this indicator.**			
Standard Three – Shelter Care			
3.01 - Shelter Environment			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 3.01		**YES** If NO, explain here: The provider has the required policy and procedures 3.09 - Shelter Program Services that was approved on 11/1/2024 by the CEO and COO.	
Facility Inspection: a. Furnishings are in good repair. b. The program is free of insect infestation. c. Bathrooms and shower areas are clean and functional, free of foul odors, leaks, dust, and mildew and in good working order. d. There is no graffiti on walls, doors, or windows. e. Lighting is adequate for tasks performed there. f. Exterior areas are free of debris; grounds are free of hazards. g. Dumpster and garbage can(s) are covered. h. All doors are secure, in and out access is limited to staff members and key control is in compliance. i. Detailed map and egress plans of the facility, general client rules, grievance forms, abuse hotline information, DJJ Incident Reporting Number and other related notices are posted. j. Interior areas (bedrooms, bathrooms, common areas) do not contain contraband and are free from hazardous unauthorized metal/foreign objects.	**Compliance**	All furnishings are in good shape and the facility is free of insect infestation. The bathrooms and shower areas are showing their age but are clean and functional. The exterior and grounds of the facility are well kept and free of hazards. All doors are secure and access is limited, with key control evidenced by the logbook documentation. Egress plans are in every room on the back of the doors, in the common area and at exits. Client general rules are in the common area, down the hall and in the client handbook. Grievance forms are located in the hallway of the common room with a grievance box. There is also a box in the main lobby that can be accessed by visitors. The Abuse Hotline Information is throughout the shelter, in the common area, staff office area, in the client handbook, and in the counselor's office. The DJJ Reporting number is displayed inside a glass wall unit and in the client handbook. The interior of the facility is free of any hazardous unauthorized objects, is well maintained, and is homelike in its appearance. Walls throughout the youth residence are beautifully painted with various mural themes that add color and life to the facility.	

Facility Inspection: a. All agency and staff vehicles are locked. b. Agency vehicles are equipped with major safety equipment including first aid kit, (all items in the first aid kit are current and do not have expired items; all expired items should be replaced regularly), fire extinguisher, flashlight, glass breaker and, seat belt cutter.	**Compliance**	The agency has three vans in service currently, a 2018 White Honda Odyssey Van, 2019 Silver Honda Odyssey Van, and a 2015 GMC 2500 12 passenger van. All had the required safety equipment, including first aid kits with non-expired items. It was reported the shelter nurse inspects these first aid kits monthly and replaces items as required. Last date of inspection was 12/4/2024 as evidenced by dates in the first aid kits.	
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.	**Exception**	Sample reviewed: week of 6/24/2024, week of 8/26/2024, week of 10/28/2024, week of 12/16/2024. The weeks of 11/4/2024, 11/11/2024 and 11/18/2024 were missing during the first day of the review and were provided on one sheet on the second day.	Not all chemicals revealed realistic usage or showed very little usage for shelter housekeeping. During the week of 6/24/2024, usage was only 4 oz. of Simple Green and 6/26, 0.2 oz glass cleaner and Dawn dish soap 0.2 and 0.4. During the week of 8/26/2024 - label of chemical used was missing, however 8.0 oz. used. Week of 10/28/2024, two disinfectant wipes used on 11/3/24 and 0.2 oz of Dawn dish soap on the same day for the entire week. Week of 12/16/2024, while some chemicals were being used on 12/15/2024, there was no end stock calculated, while all others did.
Facility Inspection: Washer/dryer are operational & general area/lint collectors are clean. Agency has a current DCF Child Care License which is displayed in the facility. Each youth has own individual bed with clean covered mattress, pillow, sufficient linens and blanket. Youth have a safe, lockable place to keep personal belongings, if requested.	**Compliance**	The facility has a washer and dryer for both the girls and boys that are operational with the areas and lint collectors clean and are located in each of the wings. Each child has their own bed with a covered mattress and adequate linens and pillow. In each bedroom there is an assigned dresser for each youth's clothing storage. Any valuables are inventoried, labeled, and stored in a safe if requested. The agency also has a current DCF License that is displayed in the common room of the facility.	
Additional Facility Inspection Narrative (if applicable)			

Fire and Safety Health Hazards: a. Annual facility fire inspection was conducted, and the facility is in compliance with local fire marshal and fire safety code within jurisdiction. b. Agency completes a minimum of 1 fire drill on each shift monthly (within 2 minutes or less). c. Completes 1 mock emergency drill per shift per quarter. d. All annual fire safety equipment inspections are valid and up to date (extinguishers, sprinklers, alarm system and kitchen overhead hood, including fire extinguishers in all vehicles).	**Compliance**	The annual facility fire inspection was conducted on 7/17/2024 and is in compliance with local fire marshal and fire safety code within the jurisdiction. The agency completed at least one fire drill on each shift monthly reviewed. 1st Shift: 7/3/2024, 8/1/2024, 9/3/2024, 10/2/2024,11/7/2024, 12/3/2024 2nd Shift: 7/4/2024, 8/3/2024, 9/18/2024, 10/5/2024,11/6/2024, 3rd Shift: 7/5/2024, 8/3/2024, 9/5/2024, 10/22/2024, 11/5/2024, 12/3/2024. Time of each fire drill took less than the required 2 minutes. The agency also completed one mock emergency drill per shift per quarter, completing a debriefing/critique of each drill included in their documentation. All annual fire safety equipment inspections are valid and up to date, including extinguisher, sprinklers, alarm system, kitchen overhead hood and extinguishers in all vehicles.	
Fire and Safety Health Hazards: a. Agency has a current Satisfactory Residential Group Care inspection report from the Department of Health. b. Agency has a current Satisfactory Food Service inspection report from the Department of Health and food menus are posted, current and signed by Licensed Dietician annually. c. All cold food is properly stored, marked and labeled and dry storage/pantry area is clean and food is properly stored. d. Refrigerators/Freezers are clean and maintained at required temperatures and all small and medium sized appliances are operable and clean for use as needed.	**Compliance**	The agency has a current Satisfactory Residential Group Care Inspection from the Department of Health, 10/28/2024 with no violations. They also have a current Satisfactory Food Service inspection report from the Department of Health, with one finding – date marking and disposition. The agency's food menus are current, signed by a licensed dietician annually, and posted in the common room. All cold food was seen to be properly stored, marked and labeled, and dry storage area is clean. Refrigerators and freezers were clean and well maintained, registering the required temperatures for safe food storage.	
Additional Fire and Safety Health Hazards Narrative (if applicable)			

Youth Engagement			
a. Youth are engaged in meaningful, structured activities (e.g., education, recreation, counseling services, life and social skill training) seven days a week during awake hours. Idle time is minimal. b. At least one hour of physical activity is provided daily. c. Youth are provided the opportunity to participate in a variety of faith-based activities. Non-punitive structured activities are offered to youth who do not choose to participate in faith-based activities. d. Daily programming includes opportunities for youth to complete homework and access a variety of age appropriate, program approved books for reading. Youth are allowed quiet time to read. e. Daily programming schedule is publicly posted and accessible to both staff and youth.	**Compliance**	The agency engages the youth in meaningful activities to include groups, outings, literacy and social skill development evident by the program's daily activity log. The facility is equipped with a health and wellness workout area, fully shaded outdoor activity area with table tennis and other games, has a fully functional and well-kept basketball area that are all fully accessible for use for multiple hours daily as long as weather conditions permit. The agency has four local churches that provide opportunities for faith-based exposure and activities. These are frequently scheduled, yet optional for youth participation. Alternative activities are identified and available for youth who wish not to participate. Daily programming schedules were observed posted in the common and frequented areas of the facility and include an hour-to-hour schedule for daily activities for both weekdays and weekends. Youth were seen engaging in homework, reading and other activities according to the schedule.	
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 and procedures, 2.05 - Orientation to the Program, that was approved on 11/1/2024 by the CEO and COO.	
Youth received a comprehensive orientation and handbook provided within 24 hours	**Compliance**	Reviewed documentation validated each youth received a comprehensive orientation within twenty-four hours of admission and each youth was provided a copy of the program handbook. Receipt of the handbook is documented on the Youth Inventory/Room Check-in form.	

Orientation includes the following: a. Youth is given a list of contraband items b. Disciplinary action is explained c. Dress code explained d. Review of access to medical and mental health services e. Procedures for visitation, mail and telephone f. Grievance procedure g. Disaster preparedness instructions h. Physical layout of the facility i. Sleeping room assignment and introductions j. Suicide prevention- alerting staff of feelings or awareness of others having suicidal thoughts	**Compliance**	The program's orientation addresses all required topics. An orientation checklist documents the information shared with youth during admission. The checklist includes program rules including contraband, possible disciplinary action, the grievance procedure, emergency and disaster procedures, suicide prevention and alert notification, as well as the program's physical layout and daily activity schedule. Suicide alert notification is documented on the intake as well as Risk Screening Guardian Notification form. Each youth's room assignment is documented on the Intake form which is signed by the youth.	
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**	Each reviewed youth record included the signature of the youth and parent/guardian on the Shelter Voluntary Placement Agreement to acknowledge receipt of the orientation as well as signature of the staff conducting the orientation.	
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 policies and procedures, 2.01 - Screening and Intake, and 2.05 - Orientation to the Program, that were approved on 11/1/2024 by the CEO and COO.	

A process is in place that includes an initial classification of the youths, to include:			
a. Review of available information about the youth's history, status and exposure to trauma b. Initial collateral contacts, c. Initial interactions with and observations or the youth d. Separation of younger youth from older youth, e. Separation of violent youth from non-violent youth f. Identification of youth susceptible to victimization g. Presence of medical, mental or physical disabilities h. Suicide risk i. Sexual aggression and predatory behavior j. Acute health symptoms requiring quarantine or isolation	**Exception**	The program has a process in place for assessing and initially classifying each youth admitted to the program. The classification process considers each youth's history, status, and exposure to trauma as well as the youth's associated contacts. The program's youth screening, youth profile, and intake forms are utilized to document the initial interactions and observations of the youth, and whether there is any indication the youth needs to be separated from other youth based upon age, presenting problems of aggression, violence, and/or assaultive behavior, susceptibility to victimization, the presence of medical, mental health, or physical disabilities, suicide risk, sexual aggression or predatory behavior, and any health symptoms requiring isolation or quarantine. Four of the five records reviewed demonstrated youth were adequately assessed and placed in an appropriate room.	One youth record reviewed indicated the youth was a domestic violence intake; however, the room assignment section of the form did not indicate youth has a history of aggressive behavior to be consistent with the classification for appropriate room assignment.
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 utilizes an electronic alert system which can be immediately updated and displayed on a LED TV screen to staff in the monitoring station when a youth is admitted with special needs or risks including risk of suicide, mental health, substance abuse, physical health, or security risk factors.	
Additional Comments: **There are no additional comments for this indicator.**			
3.04 - Log Books			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 3.04		**YES** If NO, explain here: The provider has the required policy and procedures, 3.17 - Logbook, that was approved on 11/1/2024 by the CEO and COO.	
Log book entries that could impact the security and safety of the youth and/or program are highlighted	**Compliance**	A thorough review of the program's logbooks confirmed use of highlighted entries for notification of potential or identified safety and security issues that may impact youth and staff for the six month period reviewed.	

All entries are brief, legibly written in ink and include: • Date and time of the incident, event or activity • Names of youth and staff involved • Brief statement providing pertinent information • Name and signature of person making the entry	**Compliance**	Logbooks were reviewed for the following two week periods: 6/15-6/29/2024; 7/11/-7/25/2024; 8/1-8/15/2024; 9/7-9/21/2024; 10/14-10/28/2024; and 11/8-11/22/2024. Each entry was written in ink, brief, and legible. The date, time of the event or activity with the youth and staff involved included a brief statement of the pertinent information. All entries included the writer's name and signature.	
Recording errors are struck through with a single line. The staff person must initial and date the correction. The use of whiteout and erasures is prohibited.	**Compliance**	Errors in the logbook were struck through with a single line and were both initialed and dated by the person. No whiteout or erasures were observed throughout the logbook.	
The program director or designee reviews the facility logbook(s) every week and makes a note chronologically in the logbook indicating the dates reviewed and if any correction, recommendations and follow-up are required and sign/date the entry	**Compliance**	Every week reviewed included a notation that the supervisor reviewed the logbook. Corrections, recommendations, or areas of attention are noted. Supervisory review is signed, dated and highlighted.	
All staff review the logbook of the previous two shifts and makes an entry signed and dated into the logbook indicating the dates reviewed	**Exception**	Of the 12 weeks of logbook entries reviewed, a favorable practice was observed when staff on each shift that worked a double shift, made an entry that they "continued double shift" to assist in the signing in/verification of two staff on the shift. All but one staff indicated at the start of their shifts, a review of the program's logbook of past shifts.	One staff consistently failed to include the dates that were reviewed when signing in for shift.
At the beginning of their shift, oncoming supervisor and shelter counselor reviews the logbook of all shifts since their last log entry and makes a signed and dated entry and into log book indicating the dates reviewed.	**Compliance**	Review of the logbook by both the oncoming supervisor and shelter counselor were observed with entries noting a review of all shifts since their last log entry. The entry included the dates reviewed and were signed and dated by the writer.	
Logbook entries include: a. Supervision and resident counts b. Visitation and home visits	**Compliance**	Logbook entries include supervision and resident counts as well as visitation and home visits. The program utilizes the youth's initials to reference the youth throughout the logbook.	
Additional Comments: **There are no additional comments for this indicator.**			

3.05 - Behavior Management Strategies			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 3.05		**YES** If NO, explain here: The provider has the required policy and procedures, 3.13-Behavior Management System, that was approved on 11/1/2024 by the CEO and COO.	
The program has a detailed written description of the BMS and it is explained during program orientation	**Compliance**	The program has a detailed Behavior Management System (BMS) which is written and reviewed at intake with every youth as part of their orientation to the program. The written Behavior Management System is also provided to each youth as part of the program's handbook as a resource and reference.	
Behavior Management Strategies must include:			
a. BMS is designed to teach youth new behaviors and help youth understand the natural consequences for their actions b. Behavioral interventions are applied immediately, with certainty, and reflect the severity of the behavior c. BMS uses a wide variety of awards/incentives to encourage participation and completion of the program d. Appropriate consequences and sanctions are used by the program and consequences for behavior are logical and designed to promote skill-building for the youth e. Counseling, verbal intervention and de-escalation techniques are used prior to physical intervention (Only techniques approved by the Florida Network and DJJ are used if physical intervention is required) f. Only staff discipline youth. Group discipline is not imposed g. Room restriction is not used as part of the system or for youth who are physically and/or emotionally out of control h. Youth should never be denied basic rights such as meals, clothing, sleep, services, exercise, or correspondence privileges	**Compliance**	The BMS utilized by the program shows staff use appropriate interventions that are non-punitive and help the youth process and understand natural consequences. The behavioral interventions are applied immediately and reflect the level of severity of the behavior. Staff intervene appropriately, redirect and or resolve any issues within the program structure. The program's incentives are point based; incentives are also tiered (two levels) based on the youth total point accumulation. The BMS also delineates behavioral consequences and specifies minor and major infractions which have appropriate consequences, that are easy for the youth to understand. Incentives vary from canteen prizes, incentivized outings, monetary incentives, and bus passes. As observed with the program documentation, the BMS incorporates consequences for violations that are logical and consistent. While the BMS is not designed to be punitive, consequences for shelter rule violations will result in a youth's inability to accumulate points for those infractions at that time. The BMS does not use room restriction or for youth who are emotionally and/or physically out of control, nor does it negatively impact any youths' rights, needs or provision of services.	

Program's use of the BMS			
All staff are trained in the theory and practice of administering BMS rewards and consequences	**Compliance**	All staff are trained in Managing Aggressive Behaviors. They are also trained in the theory and practice of administering the BMS the program utilizes along with the use of rewards and consequences. This training is part of the staff's pre-service, and refreshers are provided regularly for review of effectiveness.	
There is a protocol for providing feedback and evaluation of staff regarding their use of BMS rewards and consequences	**Compliance**	The program leadership reviews the BMS effectiveness and provides refreshers at staff meetings on the importance of consistency in providing rewards and processing consequences with youth to use as a teaching moment. This feedback and evaluation allows those staff less experienced to hear about the benefits of the BMS from other staff.	
Supervisors are trained to monitor the use of rewards and consequences by their staff	**Compliance**	Program supervisors are trained to monitor interventions implemented by staff to ensure there is no misuse of power and that the interventions are appropriate and both align with the program's BMS.	
Additional Comments: **There are no additional comments for this indicator.**			
3.06 - Staffing and Youth Supervision			**Limited**
Provider has a written policy and procedure that meets the requirement for Indicator 3.06		**YES** If NO, explain here: The provider has the required policy and procedures, 1.14 - Staffing and Youth Supervision, that was approved on 11/1/2024 by the CEO and COO.	
The program maintains minimum staffing ratios as required by Florida Administrative Code and contract. • 1 staff to 6 youth during awake hours and community activities • 1 staff to 12 youth during the sleep period	**Compliance**	The program maintains adequate staffing ratios as required by Florida Administrative Code and contract, 1:6 staff to youth during awake hours and community activities, and 1:12 during sleep hours. These staffing ratios were confirmed with the program logbook and staff schedules. As evidenced, there is at a minimum two staff on first shift, three on second shift, and two on third shift/overnight.	
All shifts must always provide a minimum of two direct care staff present that have met the minimum training requirements	**Compliance**	Schedules reviewed provided evidence that all shifts provide a minimum of two direct care staff present on each shift.	
Program staff included in staff-to-youth ratio includes only staff that are background screened and properly trained youth care workers, supervision staff, and treatment staff	**Compliance**	Background screening and training records reviewed validated only background screened and properly trained youth care workers, supervision staff and treatment staff are included in the staff to youth ratio.	

The staff schedule is provided to staff or posted in a place visible to staff	**Compliance**	Staff schedules are provided for a two-week period and are both emailed to staff and posted in the staff office where it is visible for all to see. It is color coded, indicating staff responsible for medication pass, shift lead, staff that has kitchen duty, staff responsible to conduct group and highlighting the supervisor on call- including the phone number.	
There is a holdover or overtime rotation roster which includes the telephone numbers of staff who may be accessed when additional coverage is needed	**Compliance**	The program has a list of on-call staff for each day of the week of the bi-weekly schedule along with staff listed on the side with their contact phone number.	
Staff observe youth at least every 15 minutes while they are in their sleeping room, either during the sleep period or at other times, such as during illness or room restriction	**Exception**	Bed check dates/times selected for review are as follows: •November 25th , 12am-2am •November 22nd, 2am-4am •November 30th, 4am-6am •December 3rd, 1am-3am •December 7th, 3am-5am. The provider has an electronic system that registers and monitors the completion of bed checks. A device at the end of each dorm hallway is activated by staff at the completion of each bed check. The system records each activation and a report is generated. Reviewer looked at the generated report and compared it with bed checks documented in the logbook as well as video recordings for the dates and times above. On November 25th, the following is a report of bed check times electronically recorded as compared to times documented in logbook. Hallway 1 - (23:58:37), (00:13:11),(00:27:59), and (00:43:52) documented in the logbook as (00:00), (00:15), (00:30), and (0045), respectively. Hallway 2 - (23:58:29), (00:08:50), (00:28:52)- 20 minutes, (00:38:55), and (00:48:59), recorded in the logbook as (00:00), (00:10), (00:20), (00:30), and (00:40), respectively. Video revealed staff observing youth at least every 15 minutes while in their sleeping room, with one exception being late at 20 minutes on November 25th.	While staff observation was seen for each of the five dates/samples reviewed, the bed checks across all of the samples were not documented in the logbook in “real time” as required and consistent with the electronic monitoring system. The logbook entries noted the exact time checks were expected to be completed, either every 10 minutes or 15 minutes depending upon the time interval for the supervision, while video revealed many variances from one-six minutes compared to the written entry. One of the bed checks was conducted more than 15 minutes apart on hallway 2, November 25th, between 00:08:50 and 00:28:52.

Additional Comments: **There are no additional comments for this indicator.**			
3.07 - Video Surveillance System			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 3.07		**YES** If NO, explain here: The provider has the required policy and procedures, 4.11 - Video Surveillance System, that was approved on 11/1/2024 by the CEO and COO.	
Surveillance System			
The agency, at a minimum, shall demonstrate: a. A written notice that is conspicuously posted on the premises for the purpose of security b. System can capture and retain video photographic images which must be stored for a minimum of 30 days c. System can record date, time, and location; maintain resolution that enables facial recognition d. Back-up capabilities consist of cameras' ability to operate during a power outage e. Have cameras placed in interior (e.g. intake office, counseling office, cafeteria, day room) and exterior (e.g. entrance/exit, recreation area, parking lot) general locations of the shelter where youth and staff congregate and where visitors enter and exit; to include locations where youth searches are conducted. Cameras are never placed in bathrooms or sleeping quarters. f. All cameras are visible	**Compliance**	The program has a written notice in the client handbook as well as signage at the entrance of the facility stating facility is under video surveillance. Additional signage is throughout the facility that states, "smile you are on camera." The system has 26 cameras that can capture and retain video images for a minimum of 30 days. The surveillance system records the date, time and location of the surveillance and can maintain resolution that enables facial recognition. All cameras are visible. The system has back-up capabilities and can operate during a power outage. Cameras are placed in strategic areas to capture location where youth and staff congregate and where visitors enter and exit, including areas where youth searches are conducted. Cameras were not seen in bathrooms or sleeping areas.	
A list of designated personnel who can access the video surveillance system is maintained (includes off-site capability per personnel)?	**Compliance**	The program maintains a list of designated personnel who can access the video surveillance system, specifically the program coordinator, the CEO and COO.	
Supervisory review of video is conducted a minimum of once every 14 days and timeframes reviewed are noted in the logbook.	**Compliance**	The program conducts a supervisory review of the video at a minimum of every 14 days. Evidenced by an log of the Surveillance Camera Reviews and the logbook, most reviews were conducted approximately every 10 days or less. A new log was developed which includes space to document "Logbook Page review was documented" that provided another layer of review for other leadership.	
The reviews assess the activities of the facility and include a review of random sample of overnight shifts	**Compliance**	Supervisory reviews of the shelter activities on camera were conducted at varying times of the day, including weekends and overnights to assess various activities, including bed checks. These were documented in the log book and on a Surveillance Camera Review log, with notes being offered for correction or highlight the activity.	

Grant the requesting of video recordings to yield a result within 24-72 hours from program quality improvement visits and when an investigation is pursued after an allegation of an incident	**Compliance**	The agency has a written policy and procedure in place surrounding third party request to access video recordings. The policy allows access within 24 hours but not to exceed 72 hours.	
Camera service order/requests will be made within 24 hours of discovery of camera malfunctioning or being inoperable. All efforts made to obtain repairs are documented and maintained	**Compliance**	The shelter has a process in place to include immediate notification to leadership, CCC and a work order to rectify any camera malfunctions or issues discovered within 24 hours of discovery. All efforts made to obtain repairs are documented and retained, however the program has not had any issues with the surveillance system during the annual review.	
Additional Comments: **There are no additional comments for this indicator.**			
Standard Four – Mental Health/Health Services			
4.01 - Healthcare Admission Screening			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 4.01		**YES** If NO, explain here: The provider has the required policy and procedures, 3.09 - Shelter Program Services, that was approved on 11/1/2024 by the CEO and COO.	
Preliminary Healthcare Screening			
Screening includes : a. Current medications b. Existing (acute and chronic) medical conditions c. Allergies d. Recent injuries or illnesses e. Presence of pain or other physical distress f. Observation for evidence of illness, injury, physical distress, difficulty moving, etc. g. Observation for presence of scars, tattoos, or other skin markings h. Acute health symptoms requiring quarantine or isolation	**Compliance**	The program procedure in place to ensure healthcare screening for each youth upon admission into the program. Five reviewed youth healthcare records indicated each contained a completed preliminary healthcare screening form on the date of admission, with all the required elements .	
Referral and Follow-Up			
Youth with chronic medical conditions have a referral to ensure medical care (e.g. diabetes, pregnancy, seizure disorder, cardiac disorders, asthma, tuberculosis, hemophilia, head injuries, etc.)	**No eligible items for review**	None of the health care screening records reviewed required referrals for chronic medical condition.	

When needed, the parent is involved with the coordination and scheduling of follow-up medical appointments	**No eligible items for review**	None of the records reviewed required parent to coordinate medical appointment of follow-ups.	
All medical referrals are documented on a daily log.	**Compliance**	The program maintains an Episodic Emergency log that upon review confirmed all medical referrals are documented on a daily log.	
The program has a thorough referral process and a mechanism for necessary follow-up medical care as required and/or needed	**Compliance**	The program maintains procedures detailing the referral process and mechanism for necessary follow-up medical care for any youth admitted with a chronic medical condition	
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 and procedures, 4.08 - Suicide Assessment, that was approved on 11/1/2024 by the CEO and COO.	
Suicide Risk Screening and Approval (*Residential and Community Counseling*)			
Suicide risk screening occurred during the initial intake and screening process. Suicide screening results reviewed and signed by the supervisor and documented in the youth's case file.	**Compliance**	A review of six youth records which consist of four residential youth and two community counseling youth was conducted. All six youth were screened for suicide risk at the time of intake, with screening results reviewed by the supervisor and documented in the youth's case record.	
The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	**Compliance**	The agency's suicide risk assessment was approved by the Florida Network of Youth and Family Service and has not changed since the last review.	
Supervision of Youth with Suicide Risk *(Shelter Only)*			
Youth are placed on the appropriate level of supervision based on the results of the suicide risk assessment.	**Compliance**	Each reviewed residential youth was placed on the appropriate level of supervision based on the results of the suicide risk assessment.	
Staff person assigned to monitor youth maintained one-to-one supervision or constant supervision and documented his/her observations of the youth's behavior at 30 minute or less intervals	**Exception**	Three of the four residential records indicated staff documented youth's behavior at thirty minute or less interval and includes time of day, behavioral observations, and warning signs observed, and the observer's initials.	Upon further review of one residential youth record, the times on the suicide observation logs appeared to be prepopulated as well as the staff's signature on the logs.

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.	**Exception**	Review documentation includes the time of day, behavioral observations, any warning signs observed, and the observers' initials and was maintained on an observation log for three of the four residential records reviewed.	The record referenced above did not include the code/behaviors observed by staff while youth was on sight and sound supervision.
Supervision level was not changed/reduced until a licensed professional or a non-licensed mental health professional under the supervision of a licensed professional completed a further assessment OR Baker Act by local law enforcement	**Compliance**	Each reviewed supervision level was not changed until a licensed professional or a non-licensed mental health professional under the supervision of a licensed professional completed a further assessment. No reviewed record were applicable for Baker Act by law enforcement.	
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**	Reviewed documentation of supervisory staff signature was observed on the observation logs, on each shift, for each of the four residential youth. The observation logs were kept in the youth's case file.	
Youth with Suicide Risk *(Community Counseling Only)*			
Youth identified for suicide risk during intake was immediately assessed by a licensed professional or non-licensed professional (under the direct supervision of a licensed mental health professional) and the parents and supervisor were both notified of the results.	**Compliance**	Two community counseling youth records were reviewed for suicide risk and the parents and supervisor were notified of the screening results.	
During the intake, if the appropriate staff is unavailable, youth identified for suicide risk was immediately referred by the provider and the parent/guardian is notified of the suicide risk findings disclosed and advised that an Assessment of Suicide Risk should be completed ASAP by a licensed professional.	**Compliance**	The program refers all community counseling youth to Guidance Care Center mobile crisis assessment team. The parent/guardian were notified of the suicide risk findings disclosed and advised that an Assessment of Suicide Risk should be completed ASAP by the Guidance Care Center.	

Information on resources available in the community for further assessment was provided to the parent/guardian and is documented in the youth's file and signed by the parent/guardian OR a written follow-up notification was sent by certified mail if the parent/guardian was not present during the screening and was notified by telephone.	**Compliance**	The parent/guardian was provided information on the resources available through the Guidance Care Center and documentation of receipt is maintained in the youth's file.	
If the parent/guardian cannot be contacted, all efforts to contact them are documented in the case file.	**Compliance**	Reviewed youth case records indicated if the parent/guardian cannot be contacted, all efforts to contact them are documented in the case file.	
When the screening was completed during school hours on school property, the appropriate school authorities were notified.	**Compliance**	Reviewed case note confirmed the screening was completed during school hours on school property for one of the two community counseling youth and the appropriate school authorities were notified.	
Additional Comments: **There are no additional comments for this indicator.**			
4.03 - Medications			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 4.03		**YES** If NO, explain here: The provider has the required policy and procedure 3.16-Medication Management, which was approved on 11/1/2024 by CEO and COO.	
The agency has a Registered Nurse (RN) and/or a Licensed Practical Nurse (LPN) that is being supervised by RN and all of their credentials have been verified.	**Compliance**	The agency has a registered nurse (RN) with a verified clear and active license.	

The agency has evidence of the following for all non-nursing shelter staff designated to assist with the self-administration of medication: a. Documentation of in-person self-administration of medication distribution training provided by a Registered Nurse b. Evidence demonstrating their competency to assist with self-administration of medication distribution c. Maintenance of their annual medication training re-certification	**Compliance**	Reviewed documentation of staff training file and informal interview with the RN confirmed all non-nursing shelter staff designated to assist with the self-administration of medication had in-person self-administration of medication distribution training provided by a registered nurse and there is annual medication training re-certification.	
The agency held at least quarterly staff meetings conducted by RN and/or Shelter Manager to review and assess: a. strategies implemented to reduce medication errors shelter wide b. analyze factors that contributed to medication errors c. allow staff the opportunity to practice and role-play solutions	**Compliance**	Informal interview with the RN and reviewed documentation of monthly program staff meetings indicated medication errors and medication administration topics were included on the staff meeting agenda in the past six months.	
The agency has strategies implemented to ensure medications are provided within the 2-hour time frame.	**Compliance**	The program utilizes a posted reminder and schedule on the medical clinic door as a strategy to ensure medication is provided within the required two-hour timeframe.	
All non-licensed staff members are clearly identified and designated on the staff schedule and shift change report/shift responsibility form for assisting with the self-administration of medications on each shift	**Compliance**	Reviewed documentation of staff schedules show non-licensed staff are clearly identified and designated on the staff schedule, designating who is responsible for assisting with the self-administration of medications on each shift.	
The agency has clear methods of communicating which youth are on medications with the times and dosage easily discernable by all staff on each shift.	**Compliance**	The agency utilizes a computer program which is projected on a large screen, to display alerts. It also records medication dosage time on the medication distribution log.	
The delivery process of medications is consistent with the FNYFS Medication Management and Distribution Policy and the agency has an internal quality assurance process to include the following: a. to ensure appropriate medication management and distribution methods b. to track medication errors c. to identify systemic issues and implement mitigation strategies, as appropriate.	**Compliance**	The program has a delivery process for medications that is consistent with the FNYFS Medication Management and Distribution Policy. There is a an internal quality assurance process in place. The program identifies medication issues and discusses medication management and errors during staff meetings.	

Admission/Intake of Youth			
a. Upon admission, the youth and parent/guardian (if available) were interviewed by the Registered Nurse (when on-site) about the youth's current medications as part of the Medical and Mental Health Assessment screening process and/or an interview was conducted by the RN within three (3) business days if the RN was not on the premise at admission. **If the agency does not have an RN, there was a medication review conducted by an LPN or certified Leadership position.* b. Upon intake/admission, there is evidence that the on-shift certified supervisor of higher level staff did review all medication forms by the next business day.	**Compliance**	Informal interview with the Registered Nurse (RN) and reviewed documentation confirmed the RN signs and dates the intake form to document the review of medication forms within one business day of each youth admission.	
Medication Storage			
a. All medications are stored in a Pyxis ES Medication Cabinet that is inaccessible to youth (when unaccompanied by authorized staff) b. Pyxis machine is stored in accordance with guidelines in FS 499.0121 and policy section in Medication Management c. Oral medications are stored separately from injectable epi-pen and topical medications d. Medications requiring refrigeration are stored in a secure refrigerator that is used only for this purpose, at temperature range 2-8 degrees C or 36-46 degrees F. (If the refrigerator is not secure, the room is secure and inaccessible to youth.) e. Narcotics and controlled medications are stored in the Pyxis ES Station f. Pyxis keys with the following labels are accessible to staff in the event they need to access medications if there is a Pyxis malfunction: a TOP COVER b BACK PANEL-LEFT TALL CABINET LOCK- LEFT, c BACK PANEL-RIGHT TALL CABINET LOCK- RIGHT	**Compliance**	Observation of the nurse station confirmed all oral medication, including over the counter, narcotics and controlled medications are stored separately from topical or epi-pens in the Pyxis ES Medication cabinet. The medication cabinet is stored in accordance with Florida Statues in a secure room behind a locked door. There is a medical refrigerator in the medication room that stores all medications that need to be refrigerated. No medication needing to be refrigerated was stored at the time of the review. The thermometer of the refrigerator was at 40 degrees Fahrenheit. The Pyxis keys, with required labels, were observed and available to staff in the event they are needed.	

Medication Distribution			
a. Agency maintains a minimum of 2 site-specific System Managers for the Pyxis ES Station b. Only designated staff delineated in User Permissions have access to secured medications, with limited access to controlled substances (narcotics) c. A Medication Distribution Log shall be used for distribution of medication by non-licensed and licensed staff d. Agency verifies medication using one of three methods listed in the FNYFS Policies & Procedures Manual e. When nurse is on duty, medication processes are ALWAYS conducted by the nurse or when the nurse is not onsite, then the designated staff who has been trained by a licensed Registered Nurse provides the medication. f. Agency does not accept youth currently prescribed injectable medications, except for epi-pens h. Non-licensed staff have received training in the use of epinephrine auto-injectors provided by a registered nurse	**Compliance**	The agency maintains a minimum of 2 site-specific System Managers for the Pyxis ES Station. There are seventeen trained staff members who are assigned specific roles with designated permissions and have access to secure medication, with limited access to controlled substances. A review of youth records confirmed a Medication Distribution Log is used for distribution of medication by non-licensed and licensed staff. The program verifies medication using one of the three methods listed in the FNYFS Policies & Procedures Manual. The agency ensures when a registered nurse is on duty, they handle the medication administration process. If the nurse is not on-site, designated staff members trained by the license are responsible for administering the medication. The agency do not accept youth currently prescribed injectable medications, except for epi-pens. All non-licensed staff have received training in the use of epinephrine auto-injectors provided by a registered nurse.	
The medication distribution log documentation includes: a. the time of medication administration b. evidence of youth initials that the dosage was given c. evidence of staff initials that the dosage was given	**Compliance**	Reviewed documentation confirmed the time of medication administration, dosage, and staff initials are documented on the medication distribution log.	
There is evidence that staff provide youth with medications within one hour of the scheduled time of delivery as ordered by the medication. Documentation is provided for instances this does not occur within the required timeframe.	**Compliance**	Reviewed documentation confirmed each medication records the delivery of medications for each youth within one hour of the scheduled time of delivery as ordered. The nurse also has this information posted in the nurse station.	
During the review period, there were no instances where youth missed their medication due to failure to open the pyxis machine.	**Compliance**	During the review, there were no incident of missed medication caused by a failure of the machine.	

If applicable: Any staff member deemed responsible for a medication error, there was evidence that the staff member received refresher training from an RN and demonstrated competency prior to being assigned future medication administration responsibilities. There is evidence that any staff member deemed responsible for 3 errors within a 1-year time frame, had their certification suspended and was not recertified until the completion of the full **in-person** medication administration training, demonstrating competency and re-certification from an RN.	**Compliance**	Reviewed documentation confirmed there was evidence staff needing refresher training, received refresher training from the RN.	
Medication Inventory			
a. For controlled substances, a perpetual inventory with running balances is maintained as well as a shift-to shift count verified by a witness and documented b. Over-the-counter medications that are accessed regularly and inventoried weekly c. Syringes and sharps (needles, scissors, etc.) are secured, and counted and documented weekly	**Compliance**	Informal interview with the RN and reviewed documentation confirmed medication inventory for controlled substances, a perpetual inventory with running balances is maintained as well as a shift-to shift count verified by a witness is documented. Also, over-the-counter medications are accessed regularly and inventoried weekly. Sharps are secured and inventoried weekly.	
There are monthly reviews of the Pyxis reports to monitor medication management practice.	**Compliance**	Reviewed documentation and informal interview with the RN confirmed monthly review of the PYXIS reports were conducted by the RN.	
Medication discrepancies are cleared after each shift.	**Compliance**	Reviewed documentation with mock drill and informal interview with the RN confirmed the program conducts daily clearing of medication discrepancies on each shift in which it occurs.	
Additional Comments: **There are no additional comments for this indicator.**			

4.04 - Medical/Mental Health Alert Process			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 4.04		**YES** If NO, explain here: The provider has the required policy and procedures 4.12 - Medical and Mental Health Alerts, that was approved on 11/1/2024 by the CEO and COO.	
Youth with a medical, mental health, or food allergy was appropriately placed on the program's alert system	**Compliance**	A review of five youth records indicated each youth was appropriately placed on the program's alert system. The information is located in the monitoring station and kitchen.	
Alert system includes precautions concerning prescribed medications, medical/mental health conditions	**Compliance**	The program's alert system includes safeguards related to prescribed medications, medical needs, and health conditions.	
Staff are provided sufficient training, information and instructions to recognize/respond to the need for emergency care for medical/mental health problems	**Compliance**	Staff received sufficient training, information and instructions to recognize emergency care for medical, mental health problems. Training is completed during orientation and was observed to be completed in the four new hire training records reviewed. All four staff had also completed CPR/First Aid training.	
A medical and mental health alert system is in place that ensures information concerning a youth's medical condition, allergies, common side effects of prescribed medications, foods and medications that are contraindicated, or other pertinent mental health treatment information, is communicated to all staff	**Compliance**	Updates to the alert system at the program are immediately available in real time to the staff through the electronic alert notifications viewable on the electronic monitor in the which is wall mounted in the monitoring station.	
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 provider has the required policy and procedure 4.06-Episodic/Emergency Care, which was approved on 11/1/2024 by CEO and COO.	
Off Site Emergency Care			
a. If off-site emergency medical or dental care was provided, an incident report was submitted for the medical or dental care b. Upon youth return, there is a verification receipt of medical clearance via discharge instructions with follow-up is present in file c. Youth's parent/guardian was notified d. A daily log is maintained for emergency care provided	**Compliance**	A review of three close youth records confirmed off-site emergency medical or dental care was provided, an incident report was submitted for the medical or dental care upon youth return, there is a verification receipt of medical clearance via discharge instructions with follow-up is present in file youth's parent/guardian was notified. The program has a binder which contain daily log of emergency care provided.	
All staff are trained on emergency medical procedures	**Compliance**	Reviewed documentation confirmed all staff are trained on medical procedures.	
The program has a Knife-for-life and wire cutters accessible to staff in a secure location(s)	**Compliance**	The program has three Knife-for-Life tools. Two are wall mounted in a locked closet at the end of each dormitory hallway and another is located in the central monitor station.	
Additional Comments: **There are no additional comments for this indicator.**			