



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

**Boys Town of Central Florida**

975 Oklahoma Street  
Oviedo, Florida 32765

**December 4-5, 2024**

**Compliance Monitoring Services Provided by**



## EXECUTIVE SUMMARY

Forefront LLC conducted a Quality Improvement (QI) monitoring visit on behalf of the Florida Network of Youth and Family Services (FNYFS) for the Boys Town of Central Florida for the FY 2024-2025 at its program office located at 975 Oklahoma Street Oviedo, Florida 32765. Forefront LLC (Forefront) is an independent compliance monitoring firm that is contracted by the FNYFS to perform onsite program reviews to assess the agency's adherence to fiscal, programmatic and overall contract requirements. Boys Town of Central Florida is contracted with the Florida Network of Youth and Family Services (FNYFS) to provide direct services to Children/Families in Need of Services (CINS/FINS). The services to be provided are identified in Contract Section A - Descriptions and Specifications and Section B - Delivery and Performance, and are funded with General Revenue Funds effective from July 2024 through June 30, 2025.

The compliance monitoring review was conducted by Andrea Haugabook, Consultant for Forefront LLC. Agency representatives from Boys Town of Central Florida present for the entrance interview were: Laurie Stern, Executive Director, Davine Hardy, Administrator, Desmond Crayton, Senior Director of Operations, Melissa White, License Mental Health Counselor, Devonte Johnson, Supervisor, Vee Coreram Site Financial Officer, Arlene Smith, In-Home Family Service Administrative Assistant, N'Kayah Kersey, Supervisor of In-Home Family Services, Carmen Rodriguez, Business Manager, and Rochelle Davis, Program Support. Last onsite QI visit was conducted on January 17-18, 2024.

In general, the Reviewer found that Boys Town of Central Florida is in compliance with specific contract requirements. **Boys Town of Central Florida received an overall compliance rating of 100% for achieving full compliance with 12 indicators** of the CINS/FINS Monitoring Tool. 1)There was one recommendation as a result of the monitoring visit.

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

## 2024-2025 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL

Report Number: CM 12-04-05-2024

<b>Agency Name: Boys Town of Central Florida</b>					<b>Monitor Name: Andrea Haugabook, Lead Reviewer</b>		
<b>Contract Type : CINS/FINS</b>					<b>Region/Office: 975 Oklahoma Street, Oviedo, Florida 32765</b>		
<b>Service Description: Comprehensive Onsite Compliance Monitoring</b>					<b>Site Visit Date(s): December 4-5, 2024</b>		
<b>Major Programmatic Requirements</b>	<b>Explain Rating</b>					<b>Ratings Based Upon:</b> I = Interview O = Observation D = Documentation PTV = Submitted Prior To Visit (List Who and What)	<b>Notes</b>  <b>Explain Unacceptable or Conditionally Acceptable:</b>
	Unacceptable	Conditionally Acceptable	Fully Met	Exceeded	Not Applicable		
<b>I. Administrative and Fiscal</b>							
<b>DJJ Quality Improvement Peer Reviewer</b> a. Provider shall demonstrate that a minimum of two (2) staff members have been trained to be certified as DJJ QI Peer reviewers. Provider shall participate in a minimum of one (1) on-site quality assurance review of a similar type of program in another judicial circuit during each 12-month period of the contract, if requested.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Boys Town of Central Florida currently has one certified Peer Reviewer, Rochelle Davis, Program Services Coordinator. The previous certified peer resigned. The program reports awaiting the next training to add an additional certified peer member for the agency. The current peer reviewer has completed one on-site quality assurance review during this contract period thus far.	Recommendation: The program shall have one or more staff members trained at the next available peer training to meet the contract requirement.
<b>Additional Contracts</b> a. Provider shall provide a listing of all current federal, state, or local government contracts, as well as other contracts entered into with for profit and not-for-profit organizations. Such a listing shall identify the awarding entity and contract start & end dates. <b>PTV</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	The provider receives funds from various sources including but not limited to: The Florida Network of Youth and Family Services (2014-2024), Sunshine Health 2014–auto renewing), Beacon Health (2019-2024, Aetna Behavioral Health (2017-auto renewing), Cigna Behavioral Health (2014-auto renewing), Behavioral Services Network (2022-auto renewing), Communities Connected for Kids (2022-2026), Embrace Families (2023-2025), Florida	

**2024-2025 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL**  
**Report Number: CM 12-04-05-2024**

<b>Agency Name: Boys Town of Central Florida</b>					<b>Monitor Name: Andrea Haugabook, Lead Reviewer</b>		
<b>Contract Type : CINS/FINS</b>					<b>Region/Office: 975 Oklahoma Street, Oviedo, Florida 32765</b>		
<b>Service Description: Comprehensive Onsite Compliance Monitoring</b>					<b>Site Visit Date(s): December 4-5, 2024</b>		
<b>Major Programmatic Requirements</b>	<b>Explain Rating</b>					<b>Ratings Based Upon:</b> <b>I = Interview</b> <b>O = Observation</b> <b>D = Documentation</b> <b>PTV = Submitted Prior To Visit</b> <b>(List Who and What)</b>	<b>Notes</b>  <b>Explain Unacceptable or Conditionally Acceptable:</b>
	<b>Unacceptable</b>	<b>Conditionally Acceptable</b>	<b>Fully Met</b>	<b>Exceeded</b>	<b>Not Applicable</b>		
						Department of Children and Families (2024-2025), Family Partnerships (2024-2025), Heartland for Children (2024-2025), Children Network of Southwest Florida (2024-2025), Children’s Network of Hillsborough LLC (2024-2025)m Seminole County (2024-2025).	
<b>Limits of Coverage</b> a. Provider shall provide and maintain during this contract, the following minimum kinds of insurance: Worker's Compensation and Employer's liability insurance as required by Chapter 440, F.S. with a minimum of \$100,000 per accident, \$100,000 per person and \$500,000 policy aggregate. Commercial General Liability with a limit of \$500,000 per occurrence, and \$1,000,000 policy aggregate. Automobile Liability Insurance shall be required and shall provide bodily injury and property damage liability covering the operation of all vehicles used in conjunction with performance of this contract, with a minimum limit for bodily injury of \$250,000 per person; with a minimum limit for bodily injury of \$500,000 per accident; with a minimum limit for property damage of \$100,000 per accident and with a minimum limit for	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	The agency provided a certificate of insurance produced by Arthur Gallagher Risk Management Services, LLC. with the following insurers affording coverage: Philadelphia Indemnity Insurance Company and Sentry Insurance Company. All coverages are effective from 10/01/2024-10/01/2025 with the exception of Worker's Compensation from 12/31/2023-12/31/2024. The certificate lists the following coverages and limits: Commercial General Liability; \$1,000,000 for each occurrence, \$100,000 damage to rented premises, \$20,000 medical expense, \$1,000,000 for personal injury, \$3,000,000 each for general	

## 2024-2025 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL

Report Number: CM 12-04-05-2024

<b>Agency Name: Boys Town of Central Florida</b>					<b>Monitor Name: Andrea Haugabook, Lead Reviewer</b>		
<b>Contract Type : CINS/FINS</b>					<b>Region/Office: 975 Oklahoma Street, Oviedo, Florida 32765</b>		
<b>Service Description: Comprehensive Onsite Compliance Monitoring</b>					<b>Site Visit Date(s): December 4-5, 2024</b>		
<b>Major Programmatic Requirements</b>	<b>Explain Rating</b>					<b>Ratings Based Upon:</b> I = Interview O = Observation D = Documentation PTV = Submitted Prior To Visit <b>(List Who and What)</b>	<b>Notes</b>  <b>Explain Unacceptable or Conditionally Acceptable:</b>
	Unacceptable	Conditionally Acceptable	Fully Met	Exceeded	Not Applicable		
medical payments or \$5,000-\$10,000 per person. Florida Network is listed as payee or co-payee. <b>PTV</b>						aggregate and product aggregate; Automobile Liability with a combined single limit of \$1,000,000; umbrella liability with a \$10,000,000 limit per occurrence and \$10,000,000 aggregate and worker's compensation and employee liability for each \$1,000,000, \$1,000,000 employee and \$1,000,000 policy limit. The certificate lists The Florida Network of Youth and Families as a certificate holder.	
<b>External/Outside Contract Compliance</b> a. Provider has corrective action item(s) cited by an external funding source (Fiscal or Non-Fiscal). <b>ON SITE</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	An interview with the Executive Director reports Boys Town of Central Florida has no corrective action items cited by any external funding sources.	
<b>Fiscal Practice</b> a. Agency must have employee and fiscal policy/procedures manuals that are in compliance with GAAP and provide sound internal controls. Agency maintains fiscal files that are audit ready. <b>PTV</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	A review of the agency's policies showed compliance with GAAP and provisions for sound internal controls. The agency maintains fiscal files that are audit ready.	
b. Agency maintains a general ledger and the corresponding source documents. A general ledger must be set up to track the activity of the grant separately	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	A review of the agency's general ledger for fiscal year 2024/2025 shows the agency maintains a general ledger	

**2024-2025 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL**  
**Report Number: CM 12-04-05-2024**

<b>Agency Name: Boys Town of Central Florida</b>					<b>Monitor Name: Andrea Haugabook, Lead Reviewer</b>		
<b>Contract Type : CINS/FINS</b>					<b>Region/Office: 975 Oklahoma Street, Oviedo, Florida 32765</b>		
<b>Service Description: Comprehensive Onsite Compliance Monitoring</b>					<b>Site Visit Date(s): December 4-5, 2024</b>		
<b>Major Programmatic Requirements</b>	<b>Explain Rating</b>					<b>Ratings Based Upon:</b> <b>I = Interview</b> <b>O = Observation</b> <b>D = Documentation</b> <b>PTV = Submitted Prior To Visit</b> <b>(List Who and What)</b>	<b>Notes</b>  <b>Explain Unacceptable or Conditionally Acceptable:</b>
	<b>Unacceptable</b>	<b>Conditionally Acceptable</b>	<b>Fully Met</b>	<b>Exceeded</b>	<b>Not Applicable</b>		
(standard account numbers / separate funds for each revenue source, etc.). <b>PTV</b>						and corresponding source documents. The agency's general ledger is set up to track the activity of the grant separately for each revenue source.	
c. Petty cash ledger system is balanced and all cash disbursements are compliant with financial policies and allowable under the contract. (Disbursements/invoices are approved & monitored by management.) – <b>ON SITE</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Interview with the Business Manager outlines a very comprehensive petty cash management system that is balanced and reconciled monthly by the Business Manager who maintains the petty cash log and verifies cash on hand. There is a current cash balance of \$200, which is replenished as needed. Staff are encouraged to use purchase cards with pre-set spending limits in lieu of making requests for petty cash. Purchase cards are used for groceries, meals out, outings, etc. Receipts are uploaded into WorkDay every week, by the purchaser and their supervisor approves each purchase for the Business Office to review and approve for reimbursement from the corporate office by the 28 <sup>th</sup> of each month.	
d. Financial records and reports are current. Includes bank statements reconciled within 6 weeks of receipt. Vendor	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Interview with the Business Manager indicated there is no local banking	

**2024-2025 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL**  
**Report Number: CM 12-04-05-2024**

<b>Agency Name: Boys Town of Central Florida</b>					<b>Monitor Name: Andrea Haugabook, Lead Reviewer</b>		
<b>Contract Type : CINS/FINS</b>					<b>Region/Office: 975 Oklahoma Street, Oviedo, Florida 32765</b>		
<b>Service Description: Comprehensive Onsite Compliance Monitoring</b>					<b>Site Visit Date(s): December 4-5, 2024</b>		
<b>Major Programmatic Requirements</b>	<b>Explain Rating</b>					<b>Ratings Based Upon:</b> <b>I = Interview</b> <b>O = Observation</b> <b>D = Documentation</b> <b>PTV = Submitted Prior To Visit</b> <b>(List Who and What)</b>	<b>Notes</b>  <b>Explain Unacceptable or Conditionally Acceptable:</b>
	<b>Unacceptable</b>	<b>Conditionally Acceptable</b>	<b>Fully Met</b>	<b>Exceeded</b>	<b>Not Applicable</b>		
invoices past 6 months. Invoices are submitted on a monthly basis with supporting documentation and documentation provided contained 2 signatures. (Disbursements/invoices are approved & monitored by management). <b>ON SITE</b>						conducted by the local provider. All banking is managed on a corporate level. Documentation: Bank statements and corresponding reconciliations from May 2024-October 2024 were reviewed. Bank reconciliations are conducted monthly by the corporate accounting staff. Observation of reconciliation reports confirms the bank statements are reconciled within six weeks of receipt. Invoices are processed and paid by the corporate business office. Local expenses are uploaded on WorkDay and can be reviewed and approved on WorkDay. Daily payments for expenses are made directly from the corporate accounting department electronically or via regular mail to the vendor.	
e. Agency maintains inventory in accordance with a written policy and FNYFS contractual requirements. If over \$1,000 inventory has DJJ Property Inventory Number/Tag. In the event the provider has purchased computer equipment an Informational Resources Request (IRR) has been submitted to DJJ. <b>PTV/ON SITE</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	An interview with the Executive Director reported that the agency does not have any inventory purchased with funds from the Florida Network of Youth and Family Services. The agency does not have an inventory,	

**2024-2025 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL**  
**Report Number: CM 12-04-05-2024**

<b>Agency Name: Boys Town of Central Florida</b>					<b>Monitor Name: Andrea Haugabook, Lead Reviewer</b>		
<b>Contract Type : CINS/FINS</b>					<b>Region/Office: 975 Oklahoma Street, Oviedo, Florida 32765</b>		
<b>Service Description: Comprehensive Onsite Compliance Monitoring</b>					<b>Site Visit Date(s): December 4-5, 2024</b>		
	<b>Explain Rating</b>						
<b>Major Programmatic Requirements</b>	<b>Unacceptable</b>	<b>Conditionally Acceptable</b>	<b>Fully Met</b>	<b>Exceeded</b>	<b>Not Applicable</b>	<b>Ratings Based Upon:</b> <b>I = Interview</b> <b>O = Observation</b> <b>D = Documentation</b> <b>PTV = Submitted Prior To Visit</b> <b>(List Who and What)</b>	<b>Notes</b>  <b>Explain Unacceptable or Conditionally Acceptable:</b>
						(including computers) over \$1000 requiring a DJJ property inventory number/ tag.	
f. Agency submits payroll taxes and deposits (and retirement deposits as applicable), <u>Employee</u> IRS Form W-2 and <u>Independent Contractors</u> IRS Form 1099 forms prior to federal requirements. <b>ON SITE</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	The agency provided the two most recent quarterly tax reports for the period ending March 30, 2024 and June 30, 2024 with proof of corresponding payments. The agency's quarterly tax payment reports and payments are managed by a third-party payroll company, ADP. Employee IRS W-2 and 1099 forms are all produced and managed by ADP.	
g. Budget to actual reports prepared and reviewed by appropriate management. Variance from the budget are investigated and explained. <b>PTV/ON SITE</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	A review of the agency budget to actual report shows that the agency prepares an annual budget that shows the month to date, year to date, variance, full year budget and fiscal year budget remaining. Budget variances are monitored, reviewed, and explained on a regular basis by the Site Fiscal Officer, Executive	

## 2024-2025 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL

Report Number: CM 12-04-05-2024

Agency Name: Boys Town of Central Florida					Monitor Name: Andrea Haugabook, Lead Reviewer		
Contract Type : CINS/FINS					Region/Office: 975 Oklahoma Street, Oviedo, Florida 32765		
Service Description: Comprehensive Onsite Compliance Monitoring					Site Visit Date(s): December 4-5, 2024		
Major Programmatic Requirements	Explain Rating					<b>Ratings Based Upon:</b> I = Interview O = Observation D = Documentation PTV = Submitted Prior To Visit (List Who and What)	<b>Notes</b>  Explain Unacceptable or Conditionally Acceptable:
	Unacceptable	Conditionally Acceptable	Fully Met	Exceeded	Not Applicable		
						Director to the agency's corporate office and Board of Directors.	
h. A Single Audit is performed as part of the annual audit if expenses are greater than \$750,000. The agency must submit a Corrective Action Plan for findings cited in the management letter and single audit. An annual financial audit was completed within 120 days after the previous fiscal year/calendar year and that a copy was provided to the Network unless and extension has been requested and approved in writing. Copy of Audit is submitted to the FNYFS by December 31st. <b>Can obtain from FNYFS</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	A review of the agency's most recent audit report dated June 10, 2024 shows, the audit was conducted by KPMG, LLP and covers the fiscal year ending December 31, 2023. There were no corrective action plan items resulting from this audit and a copy has been submitted to the FNYFS.	
i. Agency maintains confidentiality policy with written policies and procedures to ensure the security and privacy of all employee and client data. Personal information is not easily accessible. Agency maintains a backup system in case of accidental loss of financial information. Security procedures are in place to protect laptops. Obsolete documents are shredded and computer hard drives are wiped prior to discarding. <b>ON SITE</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	The agency maintains policies and procedures to ensure the security and privacy of all employee and client data and ensures personal information is not easily accessible. The following policies were made available for review: Privacy and Confidentiality, Information Security Program, Retention, Storage, Destruction, and Safeguarding Protected Health Information. These policies address back-up systems in case of accidental	

**2024-2025 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL**  
**Report Number: CM 12-04-05-2024**

<b>Agency Name: Boys Town of Central Florida</b>					<b>Monitor Name: Andrea Haugabook, Lead Reviewer</b>		
<b>Contract Type : CINS/FINS</b>					<b>Region/Office: 975 Oklahoma Street, Oviedo, Florida 32765</b>		
<b>Service Description: Comprehensive Onsite Compliance Monitoring</b>					<b>Site Visit Date(s): December 4-5, 2024</b>		
<b>Major Programmatic Requirements</b>	<b>Explain Rating</b>					<b>Ratings Based Upon:</b> I = Interview O = Observation D = Documentation PTV = Submitted Prior To Visit (List Who and What)	<b>Notes</b>  <b>Explain Unacceptable or Conditionally Acceptable:</b>
	<b>Unacceptable</b>	<b>Conditionally Acceptable</b>	<b>Fully Met</b>	<b>Exceeded</b>	<b>Not Applicable</b>		
						loss of financial information, security procedures for protecting laptops, discarding of obsolete documents and computer hard drives.	
j. Agency provided evidence that every direct care staff employee, as of October 1, 2023, is being paid at least \$19.00 per hour. This also includes funding for additional staff as approved by the Department. <b>ON SITE</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	A review of the agency's current salary list shows evidence that every direct care staff is being paid at least \$19.00 per hour.	

**2024-2025 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL**  
**Report Number: CM 12-04-05-2024**

**CONCLUSION**

Boys Town of Central Florida has met the requirements for the CINS/FINS contract as a result of full compliance with 12 applicable indicators of the Administrative and Fiscal Contract Monitoring Tool. Two of the fourteen indicators were not applicable because the agency purchased no inventory for funds from the Florida Network of Youth and Family Services and the agency has no corrective action items from external funding sources. Consequently, **the overall compliance rate for this contract monitoring visit is 100%**. There is one recommendation cited and no corrective action required as a result of the contract monitoring visit. Overall, the provider is performing satisfactorily in meeting the fiscal and administrative terms of its contract. In addition, the majority of indicators reviewed were carried out in a manner that meets the standard described in the report findings.

**SUMMARY OF CORRECTIVE ACTIONS or RECOMMENDATIONS**

**Recommendation (1)**

The agency shall have one or more staff members trained at the next available peer training to meet the contract requirement.

Required, the provider must submit a corrective action plan to address corrective actions cited in the corresponding section of this report. The provider's Corrective Action Plan should address the issues, corrective actions item cited, time frames and staff responsible. Responses to items cited for corrective actions are due to the Florida Network and the Florida Network Contract Manager within fourteen (14) working days of receipt of this report (See Florida Network Site for the Service Provider Corrective Action Form). The Florida Network Contract Manager will then review the response to the corrective action(s) to determine if the response adequately addresses the problem identified in the report within three (3) days. Upon approval the provider will then implement the approved measure to address the item(s) cited in the report. If the corrective action is successful in resolving the items cited in the report the contract monitor will notify the Provider in writing that the desired resolution has been achieved. Log on to the Florida Network ([www.floridanetwork.org](http://www.floridanetwork.org)) website forms section and download the Service Provider Corrective Action Tracking Form.



# **Florida Network of Youth and Family Services Quality Improvement Program Report**

Review of Boys Town of Central Florida  
CINS/FINS Program

Date: December 4-5, 2024

Compliance Monitoring Services Provided by



## CINS/FINS Rating Profile

### Standard 1: Management Accountability

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

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

### Standard 2: Intervention and Case Management

2.01 Screening and Intake	Satisfactory
2.02 Needs Assessment	Satisfactory
2.03 Case/Service Plan	Satisfactory
2.04 Case Management & Service Delivery	Limited
2.05 Counseling Services	Failed
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: 77.78 %**  
**Percent of Indicators rated Limited: 11.11 %**  
**Percent of Indicators rated Failed: 11.11 %**

### 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	Failed
3.07 Video Surveillance System	Satisfactory

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

### 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: 3.57 %**  
**Percent of indicators rated Failed: 7.14 %**

## Rating Definitions

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

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

## Reviewers

### Members

Andrea Haugabook - Lead Reviewer Consultant-Forefront LLC/Florida Network of Youth and Family Services  
 Gustavo Mazorra – Regional Monitor, Department of Juvenile Justice  
 Scoundrel Oliver - Lutheran Services Florida SE Lippman  
 Kimberly Stone – SMA Healthcare  
 Alex Culbreth - CDS Central

## Methodology

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

### Persons Interviewed

<ul style="list-style-type: none"> <li>Chief Executive Officer</li> <li>Chief Financial Officer</li> <li>Chief Operating Officer</li> <li><b>X</b> Executive Director</li> <li><b>X</b> Program Director</li> <li>Program Manager</li> <li>Program Coordinator</li> <li>Clinical Director</li> <li><b>X</b> Counselor Licensed</li> </ul>	<ul style="list-style-type: none"> <li>Case Manager</li> <li>Counselor Non-Licensed</li> <li>Advocate</li> <li><b>X</b> Direct – Care Full time</li> <li>Direct – Part time</li> <li>Direct – Care On-Call</li> <li>Intern</li> <li>Volunteer</li> <li>Human Resources</li> </ul>	<ul style="list-style-type: none"> <li><b>X</b> Nurse – Full time</li> <li>Nurse – Part time</li> <li>1 # Case Managers</li> <li>1 # Program Supervisors</li> <li># Food Service Personnel</li> <li># Healthcare Staff</li> <li># Maintenance Personnel</li> <li>5 # Other (listed by title): <u>Business Manager,</u> <u>Program Support, Senior Director of Operations,</u> <u>Administrator, Site Financial Officer</u></li> </ul>
---	---	---

### Documents Reviewed

<ul style="list-style-type: none"> <li>Accreditation Reports</li> <li><b>X</b> Affidavit of Good Moral Character</li> <li><b>X</b> CCC Reports</li> <li><b>X</b> Logbooks</li> <li>Continuity of Operation Plan</li> <li><b>X</b> Contract Monitoring Reports</li> <li>Contract Scope of Services</li> <li>Egress Plans</li> <li><b>X</b> Fire Inspection Report</li> <li>Exposure Control Plan</li> </ul>	<ul style="list-style-type: none"> <li><b>X</b> Table of Organization</li> <li>Fire Prevention Plan</li> <li><b>X</b> Grievance Process/Records</li> <li><b>X</b> Key Control Log</li> <li><b>X</b> Fire Drill Log</li> <li><b>X</b> Medical and Mental Health Alerts</li> <li><b>X</b> Precautionary Observation Logs</li> <li><b>X</b> Program Schedules</li> <li><b>X</b> List of Supplemental Contracts</li> <li><b>X</b> Vehicle Inspection Reports</li> </ul>	<ul style="list-style-type: none"> <li>Visitation Logs</li> <li><b>X</b> Youth Handbook</li> <li>2 # Health Records</li> <li>3 # MH/SA Records</li> <li>10 # Personnel /Volunteer Records</li> <li>5 # Training Records</li> <li>8 # Youth Records (Closed)</li> <li>10 # Youth Records (Open)</li> <li># Other: ____</li> </ul>
--	---	--

### Observations During Review

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

### Surveys

<ul style="list-style-type: none"> <li>6 # of Youth</li> </ul>	<ul style="list-style-type: none"> <li>7 # of Direct Staff</li> </ul>	<ul style="list-style-type: none"> <li># of Other</li> </ul>
--	---	--

## 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

Boys Town of Central Florida is located at 975 Oklahoma Street, Oviedo, FL 32765. The campus opened in 1986 and now serves boys and girls through partnerships with the State of Florida to combat child abuse and neglect through the short-term Intervention and Assessment Center. Community Support Services includes Children in Need of Services/Family in Need of Services, Common Sense Parenting® classes, and Project Safe Place, a national program that assists at-risk girls and boys in crisis. Boys Town offers a unique research-proven model that focuses on prevention rather than intervention. Nearly 1,000 children were served and impacted by Boys Town Central Florida services in 2023 and anticipates exceeding that number in 2024.

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

**Standard 1:** There are seven indicators for Standard 1.

Indicator 1.01 Background Screening of Employees/Volunteers was rated **Satisfactory**.

Indicator 1.02 Provision of an Abuse Free Environment was rated **Satisfactory with Exception**.

Indicator 1.03 Incident Reporting was rated **Satisfactory with Exception**.

Indicator 1.04 Training Requirements was rated **Satisfactory with Exception**.

Indicator 1.05 Analyzing and Reporting Information was rated **Satisfactory**.

Indicator 1.06 Client Transportation was rated **Satisfactory with Exception**.

Indicator 1.07 Outreach Services was rated **Satisfactory**.

**Standard 2:** There are nine indicators for Standard 2.

Indicator 2.01 Screening and Intake was rated **Satisfactory with Exception**.

Indicator 2.02 Needs Assessment was rated **Satisfactory with Exception**.

Indicator 2.03 Case/Service Plan was rated **Satisfactory with Exception**.

Indicator 2.04 Case Management and Service Delivery was rated **Limited**.

Indicator 2.05 Counseling Services was rated **Failed**.

Indicator 2.06 Adjudication/Petition Process was rated **Satisfactory**.

Indicator 2.07 Youth Records was rated **Satisfactory with Exception**.

Indicator 2.08 Specialized Additional Program Services was rated **Satisfactory 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**.

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 **Failed**.

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**.

Indicator 4.03 Medications was rated **Satisfactory with Exception**.

Indicator 4.04 Medical/Mental Health Alert Process was rated **Satisfactory**.

Indicator 4.05 Episodic/Emergency Care was rated **Satisfactory**.

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

**Standard 2:**

Indicator 2.04 Case Management and Service Delivery was rated **Limited** due to five residential files not demonstrating the coordination of service plan implementation. One residential file did not contain case termination notes. One closed residential file had no evidence staff provided case monitoring.

Indicator 2.05 Counseling Services was rated **Failed** due to no clinical or chronological case notes present in any of the five residential files reviewed, therefore, the reviewer was unable to validate if individual and family counseling services are provided by the program. The absence of chronological case notes or case service plan reviews maintained for residential case files, prevented validation of coordination between presenting problem(s), psychosocial assessment, case/service plan, case/service plan reviews, case management and follow-ups being conducted as required along with justification of progress or lack of progress made toward case service plan goals. The majority of groups were not in compliance with the 30 minute minimum requirement.

**Standard 3:**

Indicator 3.06 Staffing and Youth Supervision was rated **Failed** due to a review of the camera on the following random dates revealing failure to complete bed checks: Girls Wing on 11/6/2024 from 4:00am-5:50am all swipes to reader were within 15 minute time frames and made at the initiation of each check, however 6 out of the 11 times that staff swiped the reader, they did not physically go to the client rooms to complete a bed check. Girls Wing on 11/9/2024 from 1:13am - 3:04am all swipes to reader were within 15 minute time frame, however 5 out of the 10 checks, staff did not go to the clients room to complete checks. Boys Wing 11/10/2024 from 2:00am-4:01am all swipes were with were within the 15 minute time frames, however, 3 out of the 11 checks staff was observed not checking bedrooms. A call was initiated to the Central Communications Center by the Executive Director at 1:30pm to report failure to complete bed checks.

<b>CINS/FINS QUALITY IMPROVEMENT TOOL</b>		
<b>Quality Improvement Indicators and Results:</b> Please select the appropriate outcome for each indicator for each item within the indicator.	<b>Summary/Narrative Findings:</b> The narrative write-up is a thorough summary of each assigned QI indicator, explaining how finding(s) are determined.	<b>Deficiencies/Exceptions:</b> Please add additional detailed explanations for any items that have any deficiencies or exceptions.
<b>Standard One – Management Accountability</b>		
<b>1.01: Background Screening of Employees, Contractors and Volunteers</b>		<b>Satisfactory</b>
<b>Provider has a written policy and procedure that meets the requirement for Indicator 1.01</b>	<b>YES</b>	
	If NO, explain here: The agency has several policies, 1.01-1 Background Checks and Re-Screenings, 1.01-2 Background Checks, 1.01-3 Mandatory Requirements for Employees Procedure reviewed by the Executive Director 09/16/2024.	
All positions providing direct services to youth has successfully passed pre-employment suitability assessment on the initial attempt.	<b>Compliance</b>	Eight of eight new hire employee files reviewed contained evidence of successful completion of the agency's pre-employment suitability assessment on the initial attempt.
For any applicant that did not pass the initial suitability assessment, there was evidence that the applicant retook the assessment and passed within five (5) business days of the initial attempt, not exceeding three (3) attempts within thirty (30) days.	<b>No eligible items for review</b>	All new hires successfully passed the suitability assessment on the initial attempt.
Agency has evidence for employees who have had a break in service for 18 months or more, and/or when the agency had a change or update in the suitability assessment tool used was different from the employee's original assessment, that a new suitability assessment and background screening was completed as required.	<b>No eligible items for review</b>	None of the agency's new hires had been previously employed with a break in service of 18 months or more.
Background screening completed prior to hire/start date (or exemption obtained prior to working with youth if rated ineligible) for new hires, volunteers/interns, and contractors. <i>(Employees who have had a break in service and are in good standing may be reemployed with the same agency without background screening if the break is less than 90 days.)</i>	<b>Compliance</b>	Eight of eight employee files reviewed showed evidence of a completed background screening prior to hire/start date.
Five-year re-screening is completed every 5 years from the date of the last screening for all applicable employees and volunteers.	<b>Compliance</b>	Three of three applicable employee files reviewed showed evidence of a completed 5-year rescreening based on the date of the employee's last screening.
Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?	<b>Compliance</b>	A completed Annual Affidavit of Compliance with Level Two Screening Standards (Form IG/BSU-006) and confirmation email sent to Background Screening Unit (BSU) on 01/31/2024.

Proof of E-Verify for all new employees obtained from the Department of Homeland Security	<b>Compliance</b>	Proof of E-Verify obtained for the Department of Homeland Security was observed in nine applicable employee files reviewed.	
<b>Additional Comments: There are no additional comments for this indicator.</b>			
<b>1.02: Provision of an Abuse Free Environment</b>			<b>Satisfactory with Exception</b>
<b>Provider has a written policy and procedure that meets the requirement for Indicator 1.02</b>	<b>YES</b>		
	If NO, explain here:		
	The agency has a policy 1.02 Provision of an Abuse Free Environment, last reviewed on 09/16/24 by the Executive Director.		
Agency has a code of conduct of policy and there is evidence that staff are aware of agency's code of conduct.	<b>Compliance</b>	The agency has a code of conduct policy and evidence was observed that staff receive the code of conduct at their new hire orientation.	
The agency has a process in place for reporting and documenting child abuse hotline calls.	<b>Compliance</b>	The agency has a process in place for reporting and documenting child abuse hotline calls.	
Youth were informed of the Abuse and Contact Number	<b>Compliance</b>	Abuse reporting information is included in the programs handbook and postings were observed in multiple places throughout the shelter.	
<b>Grievance</b>			
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.	<b>Compliance</b>	The program has an accessible and responsive grievance process for youth to provide feedback and address complaints. Program Handbooks are provided to youth at intake which explains the grievance process. The Program Support Coordinator provided communication memo/emails to program staff on 06/07/2024, providing instruction and expectations of governance surrounding program's grievance process.	
<u>Shelter only:</u> Grievances are maintained on file at minimum for 1 year.	<b>Compliance</b>	The Program Support Coordinator maintains grievances with the corporate filing system which ensures all documents including grievances are archived for a minimum of one year.	
<u>Shelter only:</u> There are formal grievance procedures for youth, including grievance forms, and a locked box which are easily accessible to youth in a common area.	<b>Compliance</b>	There is one Grievance Box in the shelter; located in the dining hall. Grievance Forms were accessible to youth, located in both male and female dorms.	

<p><u>Shelter only:</u> 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.</p>	<p><b>Exception</b></p>	<p>The programs' log book and Grievance Forms were reviewed for the months of May, July, September, October, and November there were a total of 13 received grievances. Two (2) grievances for the month of May; no grievances were reported for June and August, for the month of July, there were a total of three (3) grievances received all three (3) were acknowledged in the programs logbook by the Program Supervisor.</p>	<p>The program's log book does not show evidence of a daily check of the grievance box. The program experienced significant turnover and restructuring as well as a incident involving a set of misplaced or lost keys (which included keys to the grievance box) that may have resulted in the lapse of standard expectations. One (1) grievance received on 5/29/2024 was not documented in the logbook.</p>
<p><u>Shelter only:</u> Grievances are resolved within 72 hours of being submitted or there was documentation explaining the cause for the delay in providing a resolution.</p>	<p><b>Compliance</b></p>	<p>A review of grievances observed from May through November showed grievances are resolved within 72 hours of being submitted.</p>	
<p><b>Additional Comments:</b> There are no additional comments for this indicator.</p>			
<p><b>1.03: Incident Reporting</b></p>			<p><b>Satisfactory with Exception</b></p>
<p><b>Provider has a written policy and procedure that meets the requirement for Indicator 1.03</b></p>	<p><b>YES</b></p> <p>If NO, explain here:</p> <p>The agency has a policy 1.06 Incident Reporting, last reviewed by the Executive Director on 09/16/2024.</p>		
<p>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</p>	<p><b>Exception</b></p>	<p>During the past six months, the program office notified the CCC within two hours of learning of an incident on thirteen of fifteen occasions.</p>	<p>Two of fifteen CCC Reports failed to meet the reporting criteria within the two-hour reporting window. One of the two reports was a medical transport/program disruption incident involving youth that happened at 3:00 am but was called in at 7:35 am, 4 hours and 45 mins late; the second report of missing facility keys failed to meet reporting; on 11/23/24, the keys were confirmed missing at 9:30 am, however, it was reported 2.5 hours later.</p>
<p>The program completes follow-up communication tasks/special instructions as required by the CCC</p>	<p><b>Compliance</b></p>	<p>The program completes follow-up communication and tasks as reflected in the review of the CCC Logs confirming the agency does provided timely updates to CCC.</p>	
<p>Agency internal incidents are documented on incident reporting forms and all CCC reportable incidents were consistently reported to CCC as required.</p>	<p><b>Compliance</b></p>	<p>All internal incidents reviewed were observed on incident reporting forms and CCC reportable incidents were consistently reported to CCC as required.</p>	

<p>Incidents are documented in the program logs and on incident reporting forms</p>	<p><b>Exception</b></p>	<p>Thirteen of fifteen incidents were documented in the program log books and incident reporting forms.</p>	<p>The programs log book reflected all incidents with the exception of two occurring on 09/19/2024 and 09/17/2024.</p>
<p>All incident reports are reviewed and signed by program supervisors/ directors</p>	<p><b>Compliance</b></p>	<p>All incident reports observed were reviewed and signed by the program's supervisor. A total of 15 incidents of the following types were reviewed: three program disruption incidents, four medical incidents, three mental health and substance abuse incidents, three complaints against staff incidents, and two youth behavior incidents.</p>	
<p><b>Additional Comments:</b> There are no additional comments for this indicator.</p>			
<p><b>1.04: Training Requirements</b> (Staff receives training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions)</p>			<p><b>Satisfactory with Exception</b></p>
<p><b>Provider has a written policy and procedure that meets the requirement for Indicator 1.04</b></p>	<p><b>YES</b></p> <p>If NO, explain here:</p> <p>The agency has a policy 1.06 Training Requirements, last reviewed by the Executive Director on 09/16/2024.</p>		
<p><b>First Year Direct Care Staff</b></p>			
<p>All direct care staff have completed a new hire pre-service training provider orientation before they work independently. At a minimum, the orientation included the following:</p> <ul style="list-style-type: none"> <li>• Agency policies and procedures</li> <li>• Behavior Management (Shelter Only)</li> <li>• Building/Facility layout</li> <li>• File Documentation/development of paperwork requirements and confidentiality</li> <li>• CCC &amp; Incident Reporting</li> <li>• Child Abuse Reporting</li> <li>• Client Intake &amp; Screening</li> <li>• Client Orientation (direct care staff training on delivering new client orientation)</li> <li>• Fire Equipment Safety</li> <li>• Medical and Mental Health Alert System (Shelter)</li> <li>• Risk Management--Including but not limited to the following:                             <ul style="list-style-type: none"> <li>- Disaster Preparedness and Emergency Response</li> <li>- First Aid/CPR</li> <li>- Universal Precautions</li> </ul> </li> <li>• Video Camera Surveillance &amp; Equipment</li> <li>• All other necessary information to orient a new hire to perform their job role and duties.</li> </ul>	<p><b>Compliance</b></p>	<p>Four employee training files were reviewed for pre-service requirements and four of four contained proof of completion of the following trainings: Agency policies and procedures, building and facility layout, file documentation/ development of paperwork requirements and confidentiality, CCC &amp; Incident Reporting, Child Abuse Reporting, Client Intake &amp; Screening, Client Orientation, Fire Equipment Safety, Medical and Mental Health Alert System, Risk Management, Disaster Preparedness and Emergency Response, First Aid/ CPR, Universal Precautions, Video Camera Surveillance &amp; Equipment, and all other necessary information to orient a new hire to perform their job role and duties. Three new hires had completed Behavior Management and one employee was still within the 90-day window and has time to complete it.</p>	

All staff completed the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days from date of hire.	<b>Compliance</b>	Four of four staff training files reviewed contained evidence of completion of the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days of hire.	
All direct care CINS/FINS staff for shelter and community counseling services, including independent contractors (full-time, part-time, and on-call) and interns met the minimum requirement of 80 hours of training for the first full year of employment.	<b>Compliance</b>	Three of four direct care CINS/FINS staff for shelter and community counseling services employee files reviewed completed a minimum of 80 hours of training in the first year and one employee has completed 76.8 hours but has time to complete the remaining hours needed.	
All staff receives all mandatory training during the first 90 days of employment from date of hire.	<b>Exception</b>	Two of four staff training files reviewed contained evidence that all staff received mandatory training during the first 90 days of hire and one employee has time to complete the required Behavior Management training.	One staff member received the CCC and Incident Reporting training outside of the 90-day window and one staff has not completed CINS/FINS Core Training.
<b>Non Licensed Staff Assisting with Medication Distribution</b>			
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.	<b>Compliance</b>	Four of four employee training files reviewed contained evidence of completion of Medication Distribution in-person training from a Registered Nurse.	
<b>Staff that are Utilizing NETMIS</b>			
Any staff that is utilizing NETMIS has evidence of completing NetMIS Training in their training file.	<b>No eligible items for review</b>	Four staff training files reviewed are not required to use NetMIS and this training is not applicable.	
<b>Staff Participating in Case Staffing &amp; CINS Petitions (within the first year of employment BUT no later 7/1/24 for previous staff)</b>			
Documentation of instructor-led FL Statute 984 CINS Petition Training by a local DJJ Attorney <u>within 1 year of employment or no later than 7/1/24 if hired before 7/1/23.</u> (Policy went into effect 7/1/23).	<b>No eligible items for review</b>	This training is not applicable for the four staff training files reviewed.	
<b>Non-licensed Mental Health Clinical Shelter Staff (within first year of employment)</b>			
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).	<b>No eligible items for review</b>	There were no first year non-licensed mental health clinical staff training files reviewed.	

<b>In-Service Direct Care Staff</b>			
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.	<b>Compliance</b>	One of one in-service staff file reviewed completed all of the required annual refresher Florida Network, SkillPro, or other job related trainings within the required timeframe.	
Community Counseling Direct Care staff completes 24 hours of mandatory refresher Florida Network, SkillPro, and job-related training annually.	<b>Not Applicable</b>	One of one in-service staff file reviewed completed was not a community counseling direct care staff.	
Shelter Program Direct Care staff completes 40 hours of mandatory refresher Florida Network, SkillPro, and job-related training annually ( <i>E.g. the program has a DCF child caring license</i> ).	<b>Compliance</b>	One of one in-service staff file reviewed completed a minimum of 40 hours of mandatory refresher training as evidenced on the employee's training log.	
<b>Required Training Documentation</b>			
The agency has a training plan that includes all of the required training topics including the pre-service and in-service.	<b>Compliance</b>	The agency has a training plan included in the policy that has all of the required training topics including the pre-service and in-service.	
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.	<b>Compliance</b>	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.	
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.	<b>Compliance</b>	The program has an individual training file for each employee which contains a training log with all the requirements of the Florida Network Training Log. Each employee's training file has related documentation for each training attended.	
All Staff have completed the Naloxone Training as required within 90 days of hire or 1 year from the policy effective date 7/1/24:		The in-service staff file review showed evidence of completion of Naloxone training.	
<b>Additional Comments: There are no additional comments for this indicator.</b>			

1.05 - Analyzing and Reporting Information		Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 1.05	YES	
	If NO, explain here:	
	The agency has a policy 1.05-1 Data Collection and CINS/FINS Quality Assurance - CF, last reviewed by the Executive Director on 09/16/2024.	
Case record review reports demonstrate reviews are conducted quarterly, at a minimum. <i>(A summary report of case record reviews, identifying compliance with the CINS/FINS requirements, which is reviewed by management and communicated with staff on a quarterly basis at minimum.)</i>	Compliance	Observation of case record review reports over the past six months demonstrate the program conducts reviews at least quarterly. Case record reviews are reviewed by management and communicated with staff in various meetings. The program has leadership meetings, CINS/ FINS monthly meetings, In-home family services bi-monthly meetings and monthly shelter meetings. Various meeting minutes were reviewed from May 2024- Novemeber 2024.
The program conducts reviews of incidents, accidents, and grievances quarterly, at a minimum	Compliance	The program discussed incidents, accidents, and grievances at several different meetings (i.e., monthly shelter meetings, in-home family services bi-monthly meetings, leadership meetings) and specifically QMC - Safety and Health Committee meetings where minutes were reviewed from 11/14/2024, 09/12/2024, 07/10/2024, 05/31/2024.
The program conducts an annual review of customer satisfaction data	Compliance	The program showed evidence of conducting an annual review of customer satisfaction data.
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	Observation of monthly reviews of statewide End-of-Month reports, over the past six months, confirm the program is monitoring: monthly data, fiscal year to date data, benchmarks for residential and community counseling, screening data, report card measures, and follow-up reporting measures.
The program has a process in place to review and improve accuracy of data entry & collection	Compliance	The program has many processes in place to review and improve accuracy of data entry and collection.
There is documentation that findings are regularly reviewed by management and communicated to staff and stakeholders.	Compliance	Observation of staff meeting minutes, leadership meeting minutes, and board of director's meetings from February 2024 to November 2024 indicate that findings are regularly reviewed by management and communicated to staff and stakeholders.

There is evidence the program demonstrates that program performance is routinely reviewed with the Board of Directors. All final reports that include a Limited or Failed score is submitted electronically or by mail to the providers Executive Committee on the Board of Directors.	<b>Compliance</b>	Program performance is routinely reviewed with the board of directors as reflected in the meeting minutes reviewed from February 2024 to November 2024. All information is electronically submitted to the Executive Committee on the Board of Directors through the Director's Desk electronic portal.	
There is evidence that strengths and weaknesses are identified, improvements are implemented or modified, and staff are informed and involved throughout the process.	<b>Compliance</b>	It is evident in all meeting minutes reviewed over the past six months, that strengths and weaknesses are identified, improvements are implemented or modified, and staff are informed and involved throughout the process.	
<b>Additional Comments: There are no additional comments for this indicator.</b>			
<b>1.06: Client Transportation</b>			<b>Satisfactory with Exception</b>
<b>Provider has a written policy and procedure that meets the requirement for Indicator 1.06</b>	<b>YES</b>		
	If NO, explain here:		
	The agency has a policy 1.06 Client Transportation, last reviewed by the Executive Director on 09/16/2024.		
Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	<b>Compliance</b>	All drivers who transport clients in agency vehicles have been approved by administrative personnel prior to transporting youth.	
Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	<b>Compliance</b>	All approved drivers have a valid driver's license which are checked annually and are covered under the company's insurance policy.	
Agency's Transportation policy prohibit transporting a client without maintaining at least one other passenger in the vehicle during the trip and include exceptions in the event that a 3 <sup>rd</sup> party is NOT present in the vehicle while transporting	<b>Compliance</b>	The agency's transportation policy prohibits transporting a client without maintaining at least one other passenger in the vehicle during the trip and includes exceptions in the event that a 3 <sup>rd</sup> party is NOT present in the vehicle while transporting.	
In the event that a 3rd party cannot be obtained for transport, the agency's supervisor or managerial personnel consider the clients' history, evaluation, and recent behavior	<b>Compliance</b>	The agency's transportation policy states, 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.	
The 3 <sup>rd</sup> party is an approved volunteer, intern, agency staff, or other youth	<b>Compliance</b>	The 3 <sup>rd</sup> party in most transportation events reviewed, is either an approved agency staff or other youth.	

<p>The agency demonstrated evidence via logbook or other written verification that supervisor approval was obtained prior to all single youth transports.</p>	<p><b>Exception</b></p>	<p>Twelve randomly selected transport entries were reviewed. Eight of twelve met expectations with prior approvals.</p>	<p>Four of eight single transportation events reviewed: 11/1/2024: 6:24 am and 7:15am 6:42am, had multiple transports and no prior approval or acknowledgement by the program's supervisor. On 10/26/24 a single transport was facilitated at 7:25am, staff returned 8:15am and prior approval was not received; observation of approval was documented at 8:00pm. On 5/27/24 staff exited with single transport at 7:31am and approval was not granted until 9:30am.</p>
<p>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.</p>	<p><b>Compliance</b></p>	<p>When transporting a single client in a vehicle, the program documents single transport notifications and check-ins by utilizing a 'group chat' titled "Transports" which is communication staff use for the specific reason of transport notifications and interval check-ins. Staff communication in the group chat includes manager/supervisor.</p>	
<p>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.</p>	<p><b>Compliance</b></p>	<p>There are three vehicles utilized for youth transport; a review of transportation logs for all three show the logs contain the name or initials of the driver, date and time, mileage, number of passengers, purpose of travel and location for each of the program's Red, Blue and Grey, 12-passenger vans.</p>	

**Additional Comments:** There are no additional comments for this indicator.

<p><b>1.07 - Outreach Services</b></p>		<p><b>Satisfactory</b></p>	
<p><b>Provider has a written policy and procedure that meets the requirement for Indicator 1.07</b></p>	<p><b>YES</b></p>		
	<p>If NO, explain here:</p>		
	<p>The agency has a policy, 1.07-1 Interagency Agreements and Outreach Services, last reviewed by the Executive Director 09/16/2024.</p>		
<p>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.</p>	<p><b>Compliance</b></p>	<p>The Program Director of In-Home Family Services is the lead staff member designated to participate in local DJJ board, Circuit and Council meetings. Evidence of meeting minutes, agendas, handouts and sign-in sheets was observed from May 2024 - November 2024.</p>	

<p>The program maintains written agreements with other community partners which include services provided and a comprehensive referral process.</p>	<p><b>Compliance</b></p>	<p>Evidence of interagency agreements which included services provided and a comprehensive referral process was observed from the following community partners: Aspire Health Partners, Inc., Universal Agreement for Emergency Disaster Shelters, Orange County Youth and Family Services, Crosswinds Youth Service, Inc. Emergency Disaster Shelter, Crosswinds Youth Service, Inc. Transitional Living Program, Boys Town of North Florida, National Runaway Safeline, Second Harvest Food Bank (Intervention &amp; Assessment), Children's Home Society, Children's Home Society, The Mustard Seed of Central Florida, Kids House of Seminole, Inc., Interpretek, Dr. Veda R. Vyas, University Behavioral Center, New Hope for Kids, Chrysalis Health, and the Center for Child Counseling.</p>	
<p>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.</p>	<p><b>Compliance</b></p>	<p>A NetMIS report of fifteen events from May 2024 - November 2024 was reviewed, showing entries of all outreach activities including; title, date, duration, zip code, location, number of people reached, modality, target audience and topic.</p>	
<p>The program has designated staff that conducts outreach which is defined in their job description.</p>	<p><b>Compliance</b></p>	<p>The Program Director of In-Home Family Services is the lead staff member designated to participate in local DJJ board, Circuit and Council meetings. Evidence of meeting minutes, agendas, handouts and sign-in sheets was observed from May 2024 - November 2024.</p>	
<p><b>Additional Comments:</b> There are no additional comments for this indicator.</p>			

2.01 - Screening and Intake		Satisfactory with Exception
Provider has a written policy and procedure that meets the requirement for Indicator 2.01	YES	
	If NO, explain here:	
	The agency has a policy 2.01-1 Program Orientation, last reviewed on 9/16/24 by the Executive Director.	
<b>Shelter youth:</b> Eligibility screening form is completed immediately for all shelter placement inquiries.	Compliance	Four open and one closed residential files were reviewed and all had the eligibility screening completed immediately.
<b>Community counseling:</b> Eligibility screening form is completed within 3 business days of referral by a trained staff using the Florida Network screening form.	Compliance	Two open and three closed community counseling files were reviewed and all had the eligibility screening form completed within three business days of referral by trained staff using the FL Network screening form.
There is evidence all referrals for service is screened for eligibility and is logged in NetMIS within 72 hours of screening completion.	Compliance	All ten files reviewed demonstrated evidence all referrals for service screened for eligibility and logged in NetMIS within 72 hours of screening completion.
Youth and parents/guardians receive the following in writing: a. Available service options b. Rights and responsibilities of youth and parents/guardians	Compliance	All ten files reviewed demonstrated the parents/guardians and youth received the following in writing: Available service options and rights and responsibilities of youth and parents/guardians.
The following is also available to the youth and parents/guardians: a. Possible actions occurring through involvement with CINS/FINS services (case staffing committee, CINS petition, CINS adjudication) b. Grievance procedures	Compliance	All ten files demonstrated that the following were available for youth and parents/guardians: possible actions occurring through involvement with CINS/FINS services (case staffing committee, CINS petition, CINS adjudication) and grievance procedures.
During intake, all youth were screened for suicidality and correctly assessed as required if needed.	Exception	During intake, all youth were screened for suicidality. One of two open residential file was screened and correctly assessed and placed on a heightened level of supervision.  One open residential file was screened for suicidality, it could not be determined if the youth was correctly assessed due to the suicide assessment missing in the file upon initial observation. A suicide assessment was provided by the Program Support Services Coordinator, on the second day of the review, showing the youth was correctly assessed as required.
<b>Additional Comments: It is recommended that highly important documents remain in the files at all times.</b>		

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 a policy 2.02-1 Network Inventory of Risks and Needs Assessment, last reviewed 9/16/24 by the Executive Director.		
Shelter Youth: NIRVANA is initiated within 72 hours of admission	Compliance	All five shelter files reviewed contained a NIRVANA that was initiated within 72 hours of admission.	
Non-Residential youth: NIRVANA is initiated at intake and completed within 2 to 3 face-to-face contacts after the initial intake <b>OR</b> updated, if most recent assessment is over 6 months old	Compliance	All five community counseling files contained a NIRVANA that was initiated at intake and completed within two to three face-to-face contacts after initial intake.	
Supervisor signatures is documented for all completed NIRVANA assessments and/or the chronological note and/or interview guide that is located in the youths' file.	Compliance	All ten files reviewed included the supervisor signature for all completed NIRVANA assessments located in the youth files.	
(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.	Exception	Three open and one closed residential file contained a NIRVANA Self-Assessment that was completed within 24- hours of the youth being admitted into shelter.	One open residential file contained a NIRVANA Self-Report that did not have a date for the youth signature, a report from NetMIS was provided on the second day of review to show the NIRVANA self-report was entered on the date of intake.

<p>A NIRVANA Post-Assessment is completed at discharge for all youth who have a length of stay that is greater than 30 days.</p>	<p><b>Exception</b></p>	<p>One of two closed residential youth files, with a length of stay greater than 30 days, contained a completed NIRVANA Post-Assessment completed at discharge.</p>	<p>A file index document observed in one closed residential file during the on-site review, showed an intake date of 10/11/24 and discharge date of 11/26/24, but there was no Post-Assessment NIRVANA contained within the file upon initial review. Further research into NETMIS (post on-site review) showed an intake date of 10/11/2024 and a discharge date of 10/27/2024, therefore not requiring a NIRVANA Post-Assessment due to the length of stay being less than 30 days. Peer reviewers do not have access to an agency's NETMIS records and would not have means to verify this indicator on-site with the documentation provided in the file at the time of the review.</p>
<p>A NIRVANA Re-Assessment is completed every 90 days excluding files for youth receiving SNAP services.</p>	<p><b>Compliance</b></p>	<p>A NIRVANA Re-Assessment was not applicable for all the residential files and two open community counseling files. Three closed community counseling files required a NIRVANA Re-Assessment and all were completed within 90 days.</p>	
<p>All files include the interview guide and/or printed NIRVANA.</p>	<p><b>Compliance</b></p>	<p>All ten files included the printed NIRVANA.</p>	
<p><b>Additional Comments: It is recommended that all supporting documentation be kept in each file to support service provision and compliance.</b></p>			

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 a policy 2.03-1 titled: Service Plans, Implementation, Review, and Revision, last Reviewed 9/16/24 by the Executive Director.		
The case/service plan is developed on a local provider-approved form or through NETMIS and is based on information gathered during the initial screening, intake, and NIRVANA.	Compliance	Ten of ten files reviewed contained case plans developed on the agency's local provider-approved form and based on information gathered during the initial screening, intake, and NIRVANA.	
Case/Service plan is developed within 7 working days of NIRVANA	Compliance	All ten files contained a case plan that was developed within 7 working days of the NIRVANA.	
<p><b>Case plan/service plan includes:</b></p> <ol style="list-style-type: none"> <li>1. Individualized and prioritized need(s) and goal(s) identified by the NIRVANA</li> <li>2. Service type, frequency, location</li> <li>3. Person(s) responsible</li> <li>4. Target date(s) for completion and actual completion date(s)</li> <li>5. Signature of youth, parent/guardian, counselor, and supervisor</li> <li>6. Date the plan was initiated</li> </ol>	Exception	All ten case files contained a case plan that included individualized and prioritized needs and goals identified by the NIRVANA, persons responsible, signature of counselor and supervisor, and date the plan was initiated. All ten case files contained a case plan that identified service type and frequency. All five community counseling files contained the location of services. Four open residential files contained the signature of the youth. Two open residential files and all five community counseling files contained the signature of the parent/guardian.	One closed residential file, two open community counseling files, and one closed community counseling file was missing the signature of the youth. Two open and one closed residential file was missing the signature of the parent/guardian.
Case/service plans are reviewed for progress/revised by counselor and parent (if available) every 30 days for the first three months and every 6 months after	Compliance	Of five residential files reviewed, one open residential file had not been open for 30 days, therefore, a 30-day review was not applicable. One closed residential file reviewed, there is no evidence that the plan was reviewed for progress throughout the stay. Plan states "Progress Made", however, the dates on the whole plan only cover 10/11-10/16/24. All five community counseling files reviewed demonstrated evidence in the case notes and on case plans, that the plans were reviewed for progress/revised and signed by counselor and parent.	
<b>Additional Comments:</b> There are no additional comments for this indicator.			

2.04 - Case Management and Service Delivery		Limited	
<p><b>Provider has a written policy and procedure that meets the requirement for Indicator 2.04</b></p>		<p><b>YES</b></p>	
		<p>If NO, explain here:</p>	
		<p>The agency has a policy 2.04-1 Case Management, Service Delivery, and Mental Health Services, and Referrals, last reviewed 9/16/24 by the Executive Director.</p>	
<p>Counselor/Case Manager is assigned</p>	<p><b>Compliance</b></p>	<p>Five of five community counseling files had a case manager assigned. All five residential files had a staff sign the case plans, but the Program Support Services Coordinator stated that not one particular staff is assigned to each youth, all staff work with all of the youth.</p>	
<p>The Counselor/Case Manager completes the following as applicable:                      1. Establishes referral needs and coordinates referrals to services based upon the on-going assessment of the youth's/family's problems and needs                      2. Coordinates service plan implementation                      3. Monitors youth's/family's progress in services                      4. Provides support for families                      5. Monitoring progress of court ordered youth in shelter                      6. Makes referrals to the case staffing to address problems and needs of the youth/family                      7. Accompanies youth and parent/guardian to court hearings and related appointments                      8. Refers the youth/family for additional services when appropriate                      9. Provides case monitoring and reviews court orders                      10. Provides case termination notes                      11. Provides follow-up after 30 days post discharge                      12. Provides follow-up after 60 days post discharge</p>	<p><b>Exception</b></p>	<p>All ten files reviewed had established referral needs and coordinated referrals to services based upon the on-going assessment of the youth's/family's problems and needs, provided support for families, and referred the youth/family for additional services when appropriate. Four open residential files and all five community counseling files monitored the youth's/family's progress in services. None of the files reviewed had youth that were court ordered, had case staffing's, were recommended or pursued for judicial intervention, or had to attend court. All five community counseling files and three open and one closed residential file provided case monitoring. Three of the five community counseling files provided case termination notes, the other two were still open and did not necessitate these notes. Four open residential and two open community counseling files did not necessitate a 30-day follow up. The three closed community counseling files that necessitated a 30-day follow-up contained it in the file. All five of the residential files and two of the open and one of the closed community counseling files did not necessitate a 60-day follow-up. The two closed community counseling files that needed a 60 day follow-up continued them in the files. One closed residential case file had a 30-day follow-up post discharge.</p>	<p>Five residential files did not demonstrate the coordination of the service plan implementation. One residential file did not contain case termination notes. Upon review of one closed residential file, it was not evident that staff provided case monitoring.</p>
<p>The program maintains written agreements with other community partners that include services provided and a comprehensive referral process</p>	<p><b>Compliance</b></p>	<p>Evidence of written agreements with other community partners that include services provided and a referral process was observed.</p>	
<p><b>Additional Comments:</b> There are no additional comments for this indicator.</p>			

<b>2.05 - Counseling Services</b>		<b>Failed</b>	
<b>Provider has a written policy and procedure that meets the requirement for Indicator 2.05</b>	<b>YES</b>		
	If NO, explain here:		
	The program has a policy 2.05-1 Crisis Intervention Counseling and Access to Mental Health Services, last reviewed 9/16/24 by the Executive Director.		
<b>Shelter Program</b>			
Shelter programs provides individual and family counseling	<b>Exception</b>	Five residential were reviewed for evidence of individual and family counseling. The agency connects youth to outside counseling resources, if needed, to foster a continuum of care with a regular clinical provider.	No clinical or chronological case notes were present in any of the five files reviewed to validate individual and family counseling services provided by the program. The Program Support Services Coordinator reported that the program does not provide counseling as part of the program. She further stated that youth can request to speak with the therapist.
Group counseling sessions held a minimum of five days per week	<b>Compliance</b>	Group sessions are held 5 times a week.	
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	<b>Exception</b>	Groups are conducted by staff, have a relevant topic, and have an opportunity for youth to participate.	It was noted that the majority of groups did not reach the 30 minute minimum requirement. Upon review of the Boy's group logbook, on 11/29/24-25 min., 11/18/24-20 min., 11/26/24- no end time, 11/24/24-15 min., 11/25/24-15 min., 11/23/24-17 min., 11/22/24- 7 min., 11/20/24- 6 min., 11/19/24- 14 min., 11/18/24-10 min., 11/17/24- no times, 11/14/24-15 min. There were multiple other examples noted. For November, 30 groups were documented. 20 did not meet the 30 min. requirement. The remaining 10 either did not have times at all or had a start time but no end time. The same shortages were noted for October as well. These issues were also noted in the girls' group logbook.

Documentation of groups must include date and time, a list of participants, length of time, and topic.	<b>Exception</b>	Upon review of the group logs in October 2024 and November 2024, it was noted that the logs did contain a list of participants, date, and topic.	Some logs were missing start time and some were missing both start and end time.
<b>Community Counseling</b>			
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.	<b>Compliance</b>	Upon review of the case notes, the Community counseling program provides therapeutic community-based services designed to provide the intervention necessary to stabilize the family. Services are provided in the youth's home, a community location, 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.	
<b>Counseling Services</b>			
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.	<b>Exception</b>	Upon review of the case notes and case/ service plan reviews (for community counseling files), 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.	No chronological case notes or case service plan reviews were maintained for residential case files, therefore it could not be verified that coordination between presenting problem(s), psychosocial assessment, case/ service plan, case/ service plan reviews, case management and follow-up is being conducted as required.
Maintain individual case files on all youth and adhere to all laws regarding confidentiality.	<b>Compliance</b>	All files reviewed (five residential, five community counseling, one DV respite, two Probation Respite) were maintained in individual case files for each youth and adhered to all laws regarding confidentiality.	
Case notes maintained for all counseling services provided and documents youth's progress.	<b>Exception</b>	All five community counseling files contained case notes for all counseling services provided and documented youth's progress.	None of the five residential files reviewed contained case notes and did not adequately document youths' progress.
On-going internal process that ensures clinical reviews of case records and staff performance.	<b>Compliance</b>	The agency holds multiple meetings as part of an on-going internal process to ensure clinical reviews of case records occur.	
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.	<b>No eligible items for review</b>	Intakes reviewed were not conducted through virtual means.	
<b>Additional Comments: There are no additional comments for this indicator.</b>			

2.06 - Adjudication/Petition Process		Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 2.06	YES	
	If NO, explain here:	
	The agency has a policy 2.06-1 Case Staffing Committee-CFL, last reviewed 9/16/24 by the Executive Director.	
Must include: a. DJJ rep. or CINS/FINS provider b. Local school district representative	Compliance	The program's policy states that a representative from the Department of Juvenile Justice, a contract provider for CINS/FINS, a representative of the service recipient's school district, and an additional contract provider from CINS/FINS must be represented on the case staffing committee.
Other members may include: a. State Attorney's Office b. Others requested by youth/ family c. Substance abuse representative d. Law enforcement representative e. DCF representative f. Mental health representative	Compliance	The program's policy states that case staffing committee may include: a representative from the State Attorney's Office, the alternative sanctions coordinator, a representative from the areas of health, mental health, or social services, a supervisor of the department's contract provider, any persons recommended by the service recipient, department, or CINS/ FINS program. the service recipient, and a parent and/ or legal guardian.
The program has an established case staffing committee, and has regular communication with committee members	Compliance	The program has an established case staffing committee and has regular communication with committee members.
The program has an internal procedure for the case staffing process, including a schedule for committee meetings	Compliance	The program demonstrates they have an internal procedure for the case staffing process which includes a schedule for committee meetings.
The youth and family are provided a new or revised plan for services	No eligible items for review	The agency had no adjudication/ petition cases in the past six months or back to the date of the last onsite 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 agency had no adjudication/ petition cases in the past six months or back to the date of the last onsite QI review.
If applicable, the program works with the circuit court for judicial intervention for the youth/family	No eligible items for review	The agency had no adjudication/ petition cases in the past six months or back to the date of the last onsite QI review.
Case Manager/Counselor completes a review summary prior to the court hearing	No eligible items for review	The agency had no adjudication/ petition cases in the past six months or back to the date of the last onsite QI review.
<b>Additional Comments:</b> There are no additional comments for this indicator.		

2.07 - Youth Records		Satisfactory with Exception	
<b>Provider has a written policy and procedure that meets the requirement for Indicator 2.07</b>		<b>YES</b>	
		If NO, explain here:	
		The provider has a written policy and procedure that meets the requirement. #2.07-1, titled, Youth Records Contents last reviewed 9/16/24 by the Executive Director.	
All records are clearly marked 'confidential'.	<b>Exception</b>	All Community Counseling records were marked confidential and three open and one closed residential files were marked confidential.	One open residential file was not marked confidential on the first day of audit but was marked confidential the second day.
All records are kept in a secure room or locked in a file cabinet that is marked "confidential"	<b>Compliance</b>	All records are kept in a secure room in a locked file cabinet that is marked confidential.	
When in transport, all records are locked in an opaque container marked "confidential"	<b>Exception</b>	When in transport, the records are locked in an opaque container.	The opaque container observed was not marked confidential.
All records are maintained in a neat and orderly manner	<b>Compliance</b>	All records are maintained in a neat and orderly manner.	
SHELTER FILES contain the following: Table of Contents that outlines documents in each section: •Screening •Informed Consent • Photograph of the youth • Shelter Intake Form • Suicide Assessment (if needed) • NIRVANA Self Report (NSR) • NIRVANA full Assessment • Plan of Service • Chronological Notes • Medication Inventory Form • Approved contact list • Copies of referrals made & Follow-Up (if needed) • Discharge summary once case is closed	<b>Exception</b>	The Table of Contents contained notations for: Screening, Informed Consent, Shelter Intake Form, Suicide Assessment, Plan of Service, Medication Inventory Form, and Approved Contact List.	The Table of Contents did not contain listings for photograph of youth, NIRVANA Self-Report, NIRVANA, chronological notes, copies of referrals made & follow-up, or discharge summary.

<p>COMMUNITY COUNSELING FILES contain the following: Table of Contents that outlines documents in each section:</p> <ul style="list-style-type: none"> <li>• Screening</li> <li>• Informed Consent</li> <li>• Community Counseling Intake Form</li> <li>• Suicide Assessment (if needed)</li> <li>• NIRVANA full Assessment</li> <li>• Plan of Service</li> <li>• Chronological case notes</li> <li>• Copies of referrals made &amp; Follow-Up (if needed)</li> <li>• Discharge summary once the case is closed</li> </ul>	<p><b>Exception</b></p>	<p>The Table of Contents contained notations for: Screening, Informed Consent, Community Counseling Intake Form, Suicide Assessment, NIRVANA Full Assessment, Plan of Service, Copies of Referrals made &amp; Follow-Up, and Discharge Summary.</p>	<p>The Table of Contents was missing notation for chronological case notes.</p>
<p>All records kept electronically, are maintained securely and can be made immediately available upon request for audit purposes.</p>	<p><b>Not Applicable</b></p>	<p>The agency does not maintain electronic records.</p>	
<p>Records are retained for the duration of the time specified by the contract.</p>	<p><b>Compliance</b></p>	<p>All records are retained for the duration of the time specified by the contract.</p>	
<p><b>Additional Comments:</b> There are no additional comments for this indicator.</p>			
<p><b>2.08 - Specialized Additional Program Services</b></p>			<p><b>Satisfactory with Exception</b></p>
<p><b>Provider has a written policy and procedure that meets the requirement for Indicator 2.08</b></p>	<p><b>YES</b></p>		
	<p>If NO, explain here:</p>		
	<p>The agency has a #2.08-1 titled Staff Secure and Special Populations, last reviewed 9/16/24 by the Executive Director.</p>		
<p><b>Staff Secure</b></p>			
<p>Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? <b>(If no, select rating “No eligible items for review”)</b></p>	<p><b>No eligible items for review</b></p>	<p>The agency had no Staff Secure cases in the last six months or since the last onsite QI review.</p>	
<p>Staff Secure policy and procedure outlines the following:</p> <ol style="list-style-type: none"> <li>In-depth orientation on admission</li> <li>Assessment and service planning</li> <li>Enhanced supervision and security with emphasis on control and appropriate level of physical intervention</li> <li>Parental involvement</li> <li>Collaborative aftercare</li> </ol>	<p><b>Compliance</b></p>	<p>The agency policy and procedure outlines the following: in-depth orientation on admission, assessment and service planning, enhanced supervision and security with emphasis on control and appropriate level of physical intervention, parental involvement, and collaborative aftercare.</p>	

Program only accept youth that meet legal requirements of F.S. 984 for being formally court ordered in to Staff Secure Services	<b>No eligible items for review</b>	The agency had no Staff Secure cases in the last six months or since the last onsite 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	<b>No eligible items for review</b>	The agency had no Staff Secure cases in the last six months or since the last onsite QI review.	
Agency provides a written report for any court proceedings regarding the youth's progress	<b>No eligible items for review</b>	The agency had no Staff Secure cases in the last six months or since the last onsite QI review.	
<b>Domestic Minor Sex Trafficking (DMST)</b>			
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")	<b>No eligible items for review</b>	The agency did not serve any Domestic Minor Sex Trafficking cases in the past six months or back to the date of the last review.	
Agency has evidence that the FNYFS was contacted for approval prior to admission for all Domestic Minor Sex Trafficking (DMST) placements.	<b>No eligible items for review</b>	The agency did not serve any Domestic Minor Sex Trafficking cases in the past six months or back to the date of the last 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.	<b>No eligible items for review</b>	The agency did not serve any Domestic Minor Sex Trafficking cases in the past six months or back to the date of the last review.	
Services provided to these youth specifically designated services designed to serve DMST youth	<b>No eligible items for review</b>	The agency did not serve any Domestic Minor Sex Trafficking cases in the past six months or back to the date of the last 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?	<b>No eligible items for review</b>	The agency did not serve any Domestic Minor Sex Trafficking cases in the past six months or back to the date of the last 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.)	<b>No eligible items for review</b>	The agency did not serve any Domestic Minor Sex Trafficking cases in the past six months or back to the date of the last review.	

Agency has evidence that staff assigned to DMST youth under this provision are to enhance the regular services available through direct engagement in positive activities designed to encourage the youth to remain in shelter	No eligible items for review	The agency did not serve any Domestic Minor Sex Trafficking cases in the past six months or back to the date of the last review.	
All other services provided to DMST youth are consistent with all other general CINS/FINS program requirements	No eligible items for review	The agency did not serve any Domestic Minor Sex Trafficking cases in the past six months or back to the date of the last review.	
<b>Domestic Violence</b>			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	Yes	The agency had 1 closed case that was classified as DV respite.	
Youth admitted to DV Respite placement have evidence in the file of a pending DV charge	Compliance	The youth admitted to DV respite placement had evidence in the file of a pending DV charge as evidenced by the factsheet from DJJ.	
Data entry into NetMIS within (3) business days of intake and discharge	Compliance	One DV Respite case file was reviewed to validate entry into NetMIS within three business days of intake and discharge.	
Youth length of stay in DV Respite placement does not exceed 21 days. If more than 21 days, documentation exists in youth file of transition to CINS/FINS or Probation Respite placement, if applicable.	Compliance	One DV Respite case file was reviewed to determine compliance with length of stay. The closed residential DV respite case entered 4/26/24 and was discharged 5/29/24 (1 month, 3 days) and re-entered 5/31/24 and was discharged 6/3/24 (4 days). Youth exceeded the 21 day DV stay and there is no documentation in the file that youth was transferred to a different program/contract. On the second day of the QI review, a printout from NetMIS was provided to show that the youth was discharged from DV status on 5/16/24 and was placed into CINS/FINS status on 5/17/24 and discharged 5/29/24.	
Case plan in file reflects goals for aggression management, family coping skills, or other intervention designed to reduce propensity for violence in the home	Compliance	The case plan for the file reflects goals for aggression management, family coping skills, and other interventions to reduce the propensity for violence in the home.	
All other services provided to Domestic Violence Respite youth are consistent with all other general CINS/FINS program requirements	Compliance	As evidenced by the file, all other services provided to the youth are consistent with all other general CINS/FINS program requirements.	
<b>Probation Respite</b>			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	Yes	The agency had 2 closed cases that were classified as Probation Respite.	

All probation respite referrals are submitted to the Florida Network.	<b>Exception</b>	Two closed files were reviewed for respite referrals submitted to the Florida Network.	Two of two files reviewed did not contain evidence of a referral submitted to the FL Network.
All Probation Respite Referral come from DJJ Probation and there is evidence that the youth is on Probation regardless of adjudication status.	<b>Compliance</b>	Both files reviewed contained a Face sheet from DJJ indicating the youth's probation status.	
Data entry into NetMIS and JJIS within (3) business days of intake and discharge	<b>Compliance</b>	Data entry was completed within 3 business days and confirmation contained within both Probation Respite files reviewed.	
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.	<b>Compliance</b>	Two Probation Respite files were reviewed to determine length of stay between fourteen and 30 days. One Probation Respite file reviewed was in compliance with the length of stay requirements. Upon initial review of one Probation Respite file, the youth's stay exceeded the time period (5/15/24 to 8/9/24 (2 months, 25 days). On the second day of audit an email showing correspondence between staff and DJJ was provided that showed approval for the extension.	
All case management and counseling needs have been considered and addressed	<b>Compliance</b>	All case management needs have been considered and addressed in each of the youth cases reviewed.	
All other services provided to Probation Respite youth are consistent with all other general CINS/FINS program requirements	<b>Compliance</b>	All other services provided to Probation Respite youth are consistent with all other general CINS/FINS program requirements as evidenced in the youth case/ service plans reviewed.	
<b>Intensive Case Management (ICM)</b>			
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")	<b>Not Applicable</b>	The agency is not contracted to provide Intensive Case Management 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.	<b>Not Applicable</b>	The agency is not contracted to provide Intensive Case Management 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.	<b>Not Applicable</b>	The agency is not contracted to provide Intensive Case Management Services.	
Assessments include a. NIRVANA at intake b. NIRVANA Re-Assessment every 90 days c. Post NIRVANA at discharge as aligned with timeframe requirements	<b>Not Applicable</b>	The agency is not contracted to provide Intensive Case Management Services.	
Service/case plan demonstrates a strength-based, trauma-informed focus	<b>Not Applicable</b>	The agency is not contracted to provide Intensive Case Management 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	<b>Not Applicable</b>	The agency is not contracted to provide Intensive Case Management Services.	
<b>Family and Youth Respite Aftercare Services (FYRAC)</b>			
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")	<b>No eligible items for review</b>	The agency has no Family and Youth Respite Aftercare Services in the last six months or since the date of the last 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.	<b>No eligible items for review</b>	The agency has no Family and Youth Respite Aftercare Services in the last six months or since the date of the last review.	
Agency has evidence that all FYRAC referrals have documented approval from the Florida Network office	<b>No eligible items for review</b>	The agency has no Family and Youth Respite Aftercare Services in the last six months or since the date of the last review.	

<p>Intake and initial assessment sessions meets the following criteria:  a. Services shall be documented through the signature of the youth and his/her parent/guardian as well as orientation to the program which is kept in the youths file.  b. The initial assessment shall be face-to-face, in person or through virtual means, to include a gathering of all family history and demographic information, as well as the development of the service plan.  c. For youth on probation, a copy of the youths Community Assessment Tool (CAT) to assist with development of the family service plan.</p>	<p><b>No eligible items for review</b></p>	<p>The agency has no Family and Youth Respite Aftercare Services in the last six months or since the date of the last review.</p>	
<p>Life Management Sessions meets the following criteria:  a. Sessions are face-to-face, sixty (60) minutes in length and focus on strengthening the family unit  b. Services are highly supportive, individualized, and flexible and require a "whole family" approach to dealing with the problems affecting the youth and family.</p>	<p><b>No eligible items for review</b></p>	<p>The agency has no Family and Youth Respite Aftercare Services in the last six months or since the date of the last review.</p>	
<p>Individual Sessions:  a. The program conducted sessions with the youth and family to focus on work to engage the parties and identify strengths and needs of each member that help to improve family functioning.  b. Issues to be covered through each session include but are not limited to:  Identifying emotional triggers; body cues; healthy coping strategies through individual, group and family counseling; understanding the cycle of violence and the physical and emotional symptoms of anger; developing safety plans; and educating families on the legal process and rights.</p>	<p><b>No eligible items for review</b></p>	<p>The agency has no Family and Youth Respite Aftercare Services in the last six months or since the date of the last review.</p>	
<p>Group Sessions:  a. Focus on the same issues as individual/family sessions with application to youth pulling on similar experiences with other group members with the overall goal of strengthening relationships and prevention of domestic violence.  b. Shall be no more than eight (8) youth at one (1) time and shall be for a minimum of sixty (60) minutes per session</p>	<p><b>No eligible items for review</b></p>	<p>The agency has no Family and Youth Respite Aftercare Services in the last six months or since the date of the last review.</p>	

There is evidence of completed 30 and/or 60 day follow-ups and is documented in NetMIS following case discharge.	<b>No eligible items for review</b>	The agency has no Family and Youth Respite Aftercare Services in the last six months or since the date of the last 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	<b>No eligible items for review</b>	The agency has no Family and Youth Respite Aftercare Services in the last six months or since the date of the last review.	
Any service that is offered virtually, is documented in the youth's file why it was in the youth and families best interest.	<b>No eligible items for review</b>	The agency has no Family and Youth Respite Aftercare Services in the last six months or since the date of the last review.	
All data entry in NetMIS is completed within 3 business days as required.	<b>No eligible items for review</b>	The agency has no Family and Youth Respite Aftercare Services in the last six months or since the date of the last review.	
<b>Additional Comments: There are no additional comments for this indicator.</b>			
<b>2.09- Stop Now and Plan (SNAP)</b>			<b>Not Applicable</b>
<b>Provider has a written policy and procedure that meets the requirement for Indicator 2.09</b>	<b>N/A</b>		
	If NO, explain here:		
	Indicate policy number, authorized signee, date(s) of last review/revision/approval:		
<b>SNAP Clinical Groups Under 12</b>			
Youth are screened to determine eligibility of services with the required documents: a. Florida Network Youth Screening Form b. SNAP® Brief Intake Screening Checklist	<b>Not Applicable</b>	This agency is not contracted to do SNAP services.	
All files contain <b>each</b> 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	<b>Not Applicable</b>	This agency is not contracted to do SNAP services.	
The NIRVANA was completed at initial intake, or within two sessions.	<b>Not Applicable</b>	This agency is not contracted to do SNAP services.	
There is evidence of the completed the Pre - Child Behavior Checklist (CBCL) by the caregiver and is located within the file.	<b>Not Applicable</b>	This agency is not contracted to do SNAP services.	

There is evidence of the completed Pre - TOPSE is completed by the caregiver and is located within the file.	<b>Not Applicable</b>	This agency is not contracted to do 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.)	<b>Not Applicable</b>	This agency is not contracted to do SNAP services.	
<b>SNAP Clinical Groups Under 12 - Discharge</b>			
There is evidence of the completed the Post - Child Behavior Checklist (CBCL) by the caregiver and is located within the file.	<b>Not Applicable</b>	This agency is not contracted to do SNAP services.	
There is evidence of the completed Post - TOPSE is completed by the caregiver and is located within the file.	<b>Not Applicable</b>	This agency is not contracted to do SNAP services.	
There is evidence of the completed SNAP Discharge Report located within the file for any discharged youth.	<b>Not Applicable</b>	This agency is not contracted to do SNAP services.	
There is evidence of the SNAP Boys/SNAP Girls Child Group Evaluation Form located in the file.	<b>Not Applicable</b>	This agency is not contracted to do SNAP services.	
There is evidence of the SNAP Boys/SNAP Girls Parent Group Evaluation Form located in the file.	<b>Not Applicable</b>	This agency is not contracted to do SNAP services.	
<b>SNAP Clinical Groups for Youth 12-17</b>			
Youth are screened to determine eligibility of services using the Florida Network Youth Screening Form.	<b>Not Applicable</b>	This agency is not contracted to do SNAP services.	
The file contains the completed Florida Network Community Counseling Intake Form and is located within the file.	<b>Not Applicable</b>	This agency is not contracted to do 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.	<b>Not Applicable</b>	This agency is not contracted to do SNAP services.	
The NIRVANA was completed at initial intake, or within two sessions.	<b>Not Applicable</b>	This agency is not contracted to do 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.	<b>Not Applicable</b>	This agency is not contracted to do 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.	<b>Not Applicable</b>	This agency is not contracted to do 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.	<b>Not Applicable</b>	This agency is not contracted to do SNAP services.	
---	-----------------------	--	--

All closed files contained evidence in the file a NIRVANA was completed at discharge.	<b>Not Applicable</b>	This agency is not contracted to do SNAP services.	
<b>SNAP for Schools &amp; Communities</b>			
The program demonstrated all of the required weekly attendance sheets that included youth names and/or identifying numbers completed with the teacher and trained SNAP Facilitator signatures. <i>(This must include a total of 13 attendance sheets for a full cycle)</i>	<b>Not Applicable</b>	This agency is not contracted to do SNAP services.	
The program maintained evidence of a completed 'Way to Go Goal' Sheet within the file.	<b>Not Applicable</b>	This agency is not contracted to do SNAP services.	
The program maintained evidence of both pre AND post Measure of Classroom Environment (MoCE) completed documents for the class reviewed.	<b>Not Applicable</b>	This agency is not contracted to do SNAP services.	
The program maintained evidence of completed pre and post evaluation documents for the class reviewed.	<b>Not Applicable</b>	This agency is not contracted to do 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.	<b>Not Applicable</b>	This agency is not contracted to do 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.	<b>Not Applicable</b>	This agency is not contracted to do SNAP services.	
<b>Additional Comments: There are no additional comments for this indicator.</b>			
<b>3.01 - Shelter Environment</b>			<b>Satisfactory with Exception</b>
<b>Provider has a written policy and procedure that meets the requirement for Indicator 3.01</b>	<b>YES</b>		
	If NO, explain here:		
	The agency has several policies: 3.01-1 Shelter Services, 3.01-5 Recreational and Cultural Enrichment Activities, 3.01-7 Fire and Emergency Drills, 3.01-14 Chemicals, Flammable, Poisonous & Toxic Control, 3.01-15 Fire Prevention Program and 3.02-3 Youth Hygiene. All policies approved by Executive Director on 9/16/2024.		

<p><b>Facility Inspection:</b></p> <ul style="list-style-type: none"> <li>a. Furnishings are in good repair.</li> <li>b. The program is free of insect infestation.</li> <li>c. Bathrooms and shower areas are clean and functional, free of foul odors, leaks, dust, and mildew and in good working order.</li> <li>d. There is no graffiti on walls, doors, or windows.</li> <li>e. Lighting is adequate for tasks performed there.</li> <li>f. Exterior areas are free of debris; grounds are free of hazards.</li> <li>g. Dumpster and garbage can(s) are covered.</li> <li>h. All doors are secure, in and out access is limited to staff members and key control is in compliance.</li> <li>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.</li> <li>j. Interior areas (bedrooms, bathrooms, common areas) do not contain contraband and are free from hazardous unauthorized metal/foreign objects.</li> </ul>	<p><b>Compliance</b></p>	<p>All Furnishings appeared to be in good repair. There is no evidence of insect infestation on campus. Bathrooms and shower areas were clean and functional, with no evidence of foul odors, leaks, dust or mildew. There was no evidence of graffiti on walls, doors or windows. Lighting was adequate throughout the shelter. The exterior grounds were free of debris and no evident hazards were identified. The dumpster outside the shelter was covered appropriately with a lid. The shelter uses badge entry and key entry to all areas. The shelter map and egress plans were identified throughout the building in all common areas. General client rules, abuse hotline information and DJJ incident reporting number were posted in the common areas of both client wings. The grievance forms were also located on each client wing in shelter. There was no evidence of contraband or hazardous material in any of the client rooms, common areas or bathrooms.</p>	
<p><b>Facility Inspection:</b></p> <ul style="list-style-type: none"> <li>a. All agency and staff vehicles are locked.</li> <li>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.</li> </ul>	<p><b>Compliance</b></p>	<p>All vehicles were locked on the day of the tour. The agency has two vehicles, 2023 Red Ford Van and a 2024 Silver Ford Van, which were both locked at the time of inspection. Each vehicle was equipped with major safety equipment including a first aid kit, fire extinguisher, flashlight, glass breaker and seat belt cutter.</p>	

<p><b>Facility Inspection:</b></p> <p>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).</p> <p>A perpetual inventory will be the primary means of maintaining a current and real-time inventory.</p> <p>The weekly inventory will be conducted weekly at a minimum to ensure that a perpetual inventory is being maintained consistently and accurately. If more than one location is used to store chemicals, there is an inventory wherever chemicals are stored that is current and well maintained unless previously approved by the Network.</p>	<p style="text-align: center;"><b>Exception</b></p>	<p>The chemicals are kept in one location in shelter, next to the pantry, in the kitchen area in its own closet. The closet remains locked at all times. The chemicals are organized and kept on a shelf in the closet. A matching MSDS sheet was identified for each chemical in the closet. The program Director maintains the weekly chemical inventory while staff maintain the perpetual inventory and is the primary means of maintaining a current and real time inventory.</p>	<p>Weekly inventory was reviewed from May 2024 to October 1, 2024. There were no weekly inventory sheets provided for review at the time of audit. Perpetual inventory sheets were reviewed from May 2024 through November 2024. The agency has a signature line at the bottom of each page intended for supervisor review of the perpetual count. At the time of the review there were multiple missing signatures.</p>
<p><b>Facility Inspection:</b></p> <p>Washer/dryer are operational &amp; general area/lint collectors are clean.</p> <p>Agency has a current DCF Child Care License which is displayed in the facility.</p> <p>Each youth has own individual bed with clean covered mattress, pillow, sufficient linens and blanket.</p> <p>Youth have a safe, lockable place to keep personal belongings, if requested.</p>	<p style="text-align: center;"><b>Compliance</b></p>	<p>The facility has a current DCF Child Care License effective 12/5/2024, located on the wall in the staff office. There are two functioning washers/dryers in shelter, one set in each wing of the building. At the time of the audit, one lint trap was clean the other dirty only due to a load in the dryer which just finished drying. Each youth had its own individual bed with a clean covered mattress and pillow with sufficient linens as well as blanket. Youth are able to request a storage bin to keep their belongings safe. The bin is kept in the staff office, which remains locked.</p>	
<p><b>Additional Facility Inspection Narrative (if applicable)</b></p>			
<p><b>Fire and Safety Health Hazards:</b></p> <p>a. Annual facility fire inspection was conducted, and the facility is in compliance with local fire marshal and fire safety code within jurisdiction.</p> <p>b. Agency completes a minimum of 1 fire drill on each shift monthly (within 2 minutes or less).</p> <p>c. Completes 1 mock emergency drill per shift per quarter.</p> <p>d. All annual fire safety equipment inspections are valid and up to date (extinguishers, sprinklers, alarm system and kitchen overhead hood, including fire extinguishers in all vehicles).</p>	<p style="text-align: center;"><b>Compliance</b></p>	<p>The annual facility fire inspection was conducted on 11/22/2024. The facility is in compliance with local fire marshal and fire safety code withing jurisdiction. A review of the agency fire drills was conducted from May 2024 through November 2024. The review indicated that the agency conducted at least one fire drill per shift each month. All drills were within two minutes or less. A review of the agency mock drill was conducted from May 2024 through November 2024. The review indicated that the agency conducted There was at least one drill per shift per quarter. All annual fire safety equipment inspections are valid and up to date. Fire equipment was inspected on 5/10/2024 all was in compliance; the sprinkler system was inspected on 9/13/2024 and was determined operational with no issues; Fire alarms were inspected on 11/20/2024, there were no issues noted.</p>	

<p><b>Fire and Safety Health Hazards:</b></p> <p>a. Agency has a current Satisfactory Residential Group Care inspection report from the Department of Health.</p> <p>b. Agency has a current Satisfactory Food Service inspection report from the Department of Health and food menus are posted, current and signed by Licensed Dietician annually.</p> <p>c. All cold food is properly stored, marked and labeled and dry storage/pantry area is clean and food is properly stored.</p> <p>d. Refrigerators/Freezers are clean and maintained at required temperatures and all small and medium sized appliances are operable and clean for use as needed.</p>	<p><b>Compliance</b></p>	<p>The agency has a current Satisfactory Residential Group care inspection dated 11/19/2024 from the Department of Health. The agency has a current Satisfactory Food Service Inspection report dated 11/19/2024 from the Department of Health. The food menus are posted in the kitchen and last signed by a dietician on 5/22/2024. All cold food is properly stored, marked and labeled. The refrigerator temperature was found to be 37 degrees Fahrenheit. The two freezer temperature were found to be -19 degrees Fahrenheit. Refrigerator and freezers were found to be clean, well maintained and at required temperatures. The dry food and storage pantry was clean, orderly and food is properly stored.</p>	
<p><b>Additional Fire and Safety Health Hazards Narrative (if applicable)</b></p>			

<b>Youth Engagement</b>			
<p>a. Youth are engaged in meaningful, structured activities (e.g., education, recreation, counseling services, life and social skill training) seven days a week during awake hours. Idle time is minimal.</p> <p>b. At least one hour of physical activity is provided daily.</p> <p>c. Youth are provided the opportunity to participate in a variety of faith-based activities. Non-punitive structured activities are offered to youth who do not choose to participate in faith-based activities.</p> <p>d. Daily programming includes opportunities for youth to complete homework and access a variety of age appropriate, program approved books for reading. Youth are allowed quiet time to read.</p> <p>e. Daily programming schedule is publicly posted and accessible to both staff and youth.</p>	<b>Compliance</b>	<p>The daily programming schedule is publicly posted throughout the facility. They are posted in the dining area as well as on both the male and female dorms. The schedule indicates that youth are engaged in meaningful structured activities during awake hours and idle time is limited. Youth are provided the opportunity to participate in a variety of faith bases activates and other structured activities for those youth who chose not to participate. Daily programming includes the opportunity for homework, reading and at least one hour of recreation time per day.</p>	
<b>Additional Comments: There are no additional comments for this indicator.</b>			
<b>3.02 - Program Orientation</b>			<b>Satisfactory</b>
<b>Provider has a written policy and procedure that meets the requirement for Indicator 3.02</b>	<b>YES</b>		
	If NO, explain here:		
	The agency has a policy 3.02-1 Program Orientation, last reviewed by Executive Director on 9/16/2024.		
Youth received a comprehensive orientation and handbook provided within 24 hours	<b>Compliance</b>	All five youth files include a checklist that indicates that the youth received a comprehensive orientation and handbook within 24 hours.	
<p>Orientation includes the following:</p> <p>a. Youth is given a list of contraband items</p> <p>b. Disciplinary action is explained</p> <p>c. Dress code explained</p> <p>d. Review of access to medical and mental health services</p> <p>e. Procedures for visitation, mail and telephone</p> <p>f. Grievance procedure</p> <p>g. Disaster preparedness instructions</p> <p>h. Physical layout of the facility</p> <p>i. Sleeping room assignment and introductions</p> <p>j. Suicide prevention- alerting staff of feelings or awareness of others having suicidal thoughts</p>	<b>Compliance</b>	All five youth files include a checklist with the youth's signature that indicates having received a comprehensive orientation, given a list of contraband items and an explanation of the following: disciplinary action, dress code, access to medical and mental health services, visitation, mail and telephone procedures, grievance procedures, disaster preparedness instructions, room assignment, introductions, tour and suicide prevention.	

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	<b>Compliance</b>	All five youth files include documentation of each component of orientation topics and dates of presentation as well as signatures of both staff and youth.	
<b>Additional Comments: There are no additional comments for this indicator.</b>			
<b>3.03 - Youth Room Assignment</b>			<b>Satisfactory</b>
<b>Provider has a written policy and procedure that meets the requirement for Indicator 3.03</b>	<b>YES</b>		
	If NO, explain here:		
	The agency has a policy 3.03-1 Classification last reviewed by Executive Director on 9/16/2024.		
<b>A process is in place that includes an initial classification of the youths, to include:</b>			
<ul style="list-style-type: none"> <li>a. Review of available information about the youth's history, status and exposure to trauma</li> <li>b. Initial collateral contacts,</li> <li>c. Initial interactions with and observations of the youth</li> <li>d. Separation of younger youth from older youth,</li> <li>e. Separation of violent youth from non-violent youth</li> <li>f. Identification of youth susceptible to victimization</li> <li>g. Presence of medical, mental or physical disabilities</li> <li>h. Suicide risk</li> <li>i. Sexual aggression and predatory behavior</li> <li>j. Acute health symptoms requiring quarantine or isolation</li> </ul>	<b>Compliance</b>	An initial summary of the youth's intake is thoroughly documented in the logbook. The facility speaks with youth's parents/guardians and collateral contacts regarding their behavior. Upon intake to the facility, a youth is administered a health risk screening as well as the Suicide Probability Scale to help identify any special needs. All five youth files reviewed contain documentation of staff obtaining information regarding youth's history of trauma, age, gender, history of violence, physical size, any disabilities and possible gang affiliation. All files show documentation of sexual history, sexual orientation and possible suicide risk. Program Director and supervisors are only allowed to determine room assignments.	
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	<b>Compliance</b>	All five youth files included documentation of special alerts such as risks of suicide, mental health, substance abuse, physical health or security risk, in the youth record and in the program's logbooks.	
<b>Additional Comments: There are no additional comments for this indicator.</b>			

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:	
		Policy 3.04-1 Log Books Last reviewed by ED on 9/16/2024.	
Log book entries that could impact the security and safety of the youth and/or program are highlighted	Compliance	A review of the log books over the past six months, indicate that staff highlighted all major incidents that could impact the security and safety of the youth and or program.	
All entries are brief, legibly written in ink and include: • Date and time of the incident, event or activity • Names of youth and staff involved • Brief statement providing pertinent information • Name and signature of person making the entry	Compliance	All entries are brief, legibly written in ink and include dates and times of youth and staff involved. Staff are signing at the end of each entry as observed in a review of the program's logbooks over the last six months.	
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.	Exception	Observation of staff recording errors with a single line and marking it void as well as initialing the error were made in the programs logbooks.	Of the random entries reviewed over the past six months, staff are not dating the corrected errors per Florida Network Policy.
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	Of the random entries reviewed in the logbooks over the past six months, the supervisors are regularly reviewing the log book, indicated by red ink, indicating dates reviewed, corrections, recommendations or follow-ups. All entries observed were signed and dated.	
All staff review the logbook of the previous two shifts and makes an entry signed and dated into the logbook indicating the dates reviewed	Compliance	Of the random entries reviewed over the past six months, evidence of staff reviewing the previous two shifts and making an entry indicating the dates and times reviewed was present.	
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	Of the random entries reviewed over the past six months, it was observed that on-coming supervisors are reviewing the log book since their last log entry. Supervisors are making an entry, signing and dating the dates reviewed.	
Logbook entries include: a. Supervision and resident counts b. Visitation and home visits	Compliance	The log book entries were reviewed for the past six months and entries documented resident counts ever 30 minutes and clearly indicates when youth are on visitation and home visits.	
<b>Additional Comments:</b> There are no additional comments for this indicator.			

<b>3.05 - Behavior Management Strategies</b>		<b>Satisfactory</b>	
<b>Provider has a written policy and procedure that meets the requirement for Indicator 3.05</b>	<b>YES</b>		
	If NO, explain here:		
	The agency has a policy 3.05-1 Behavioral Redirection and Safety Hold last reviewed by the Executive Director on 9/16/2024.		
The program has a detailed written description of the BMS and it is explained during program orientation	<b>Compliance</b>	The program has a detailed written description of the Behavior Management System which is thoroughly explained during the orientation process. Behavior Management: The Motivation System: a point economy system that encourages appropriate behaviors by having to earn and lose points. 1) Daily 2) Progress 3) Subsystem	
<b>Behavior Management Strategies must include:</b>			
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	<b>Compliance</b>	The program uses a Point Card Short Term Client Report as a visual of the applied BMS by staff and the effectiveness of their interactions with youth including positive corrections. The written description of the BMS includes a large variety of awards and incentives to encourage participation and completion of the program. The Basics level of the point economy system allows youth access to board games, playing cards, listening to radio, free time, special goodies (i.e., candy, donuts, cakes, chips, cookies). Youth can watch TV: including watching entertainment shows; appropriate comedies, dramas and movies at staff's discretion and youth can earn the privilege of calling friends or other non-family members.  Appropriate consequences and sanctions are used and consequences are logical, designed to promote skill-building for the youth. Youth on Progress have a daily conference with YCW to talk about the skills role modeled. Youth are not denied basic privileges and room restriction is not a part of the system or for youth who are physically and/ or emotionally out of control.  The Subsystem level of the point economy system is divided into two types of subsystems: Credit vs. Straight Fine. Credit Subsystem is the least restrictive and used to address chronic low-level problem behaviors. Straight Fine Subsystem is used for youth who are involved in serious misbehaviors and can range from one day or longer depending on the severity of misbehavior.	

Program's use of the BMS			
All staff are trained in the theory and practice of administering BMS rewards and consequences	<b>Compliance</b>	The program trains all staff on the practice of the Behavior Management System as part of their teaching process.	
There is a protocol for providing feedback and evaluation of staff regarding their use of BMS rewards and consequences	<b>Compliance</b>	Supervisors provide feedback and evaluation of staff's use of the BMS at staff meetings.	
Supervisors are trained to monitor the use of rewards and consequences by their staff	<b>Compliance</b>	Supervisors are trained to monitor the use of rewards and consequences by their staff. All staff, including supervisors, are required to take the following trainings: Motivational system overview and point card mechanics, Motivational system practice, Observing and describing behaviors, Principles of behaviors, and non-crisis intervention.	
<b>Additional Comments: There are no additional comments for this indicator.</b>			
<b>3.06 - Staffing and Youth Supervision</b>			<b>Failed</b>
<b>Provider has a written policy and procedure that meets the requirement for Indicator 3.06</b>	<b>YES</b>		
	If NO, explain here:		
	The agency has a policy 3.06-1 Security, Youth Counts and staffing ratio last reviewed by Executive Director on 9/16/24.		
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	<b>Compliance</b>	Staff scheduled were reviewed from May 2024 through November 2024. There are three shifts to cover a 24 hour period. The program maintains staffing ratios as required by Florida Administrative Code and contract for each shift during the entire period reviewed.	
All shifts must always provide a minimum of two direct care staff present that have met the minimum training requirements	<b>Compliance</b>	All staff schedules reviewed between May 2024 and November 2024 had a minimum of two direct care staff scheduled. All staff scheduled have completed minimum training requirements.	
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	<b>Compliance</b>	Program policy states that all staff have completed the required background screenings and trainings prior to being in ratio with youth. No new staff work independently with youth until they have completed the minimum required trainings. Verification of staff background screening was observed and training records reviewed for a random selection of youth care workers supervisors and treatment staff.	
The staff schedule is provided to staff or posted in a place visible to staff	<b>Compliance</b>	The staff schedule is provided and posted in the staff office in shelter where it is visible to all staff.	

<p>There is a holdover or overtime rotation roster which includes the telephone numbers of staff who may be accessed when additional coverage is needed</p>	<p><b>Compliance</b></p>	<p>A staff contact list was reviewed. The staff contact list is located in the supervisor's office and includes the telephone numbers of staff who may be accessed when additional coverage is needed.</p>	
<p>Staff observe youth at least every 15 minutes while they are in their sleeping room, either during the sleep period or at other times, such as during illness or room restriction</p>	<p><b>Exception</b></p>	<p>Cameras were reviewed on random dates to ensure staff observe youth at least every 15 minutes while they are in their room sleeping, during the sleep period, during illness or room restriction. The program's staff scan a key card to one reader which is centrally located in each wing (girls wing and boys wing) then subsequently walk to each bedroom to complete the bed check by physically observing each youth in their room. The following observations were made: Girls Wing on 11/6/2024 from 4:00am-5:50am all swipes to reader were within 15 minute time frames and made at the initiation of each check. Girls Wing on 11/9/2024 from 1:13am - 3:04am all swipes to reader were within 15 minute time frame. Boys Wing 11/10/2024 from 2:00am-4:01am all swipes were with were within the 15 minute time frames. Girls Wing 11/19/2024 from 1:24am-3:12am all swipes were within the 15 minute time frame. Staff was observed completing bed checks each time. Boys Wing 11/23/2024 from 12am-02:00am all swipes were within the 15 minute time frames and all bed checks were completed.</p>	<p>The following observation was made on each of the review dates: Girls Wing on 11/6/2024 from 4:00am -05:50am, six out of eleven times, staff swiped the reader and did not physically go to the client rooms to complete a bed check. Girls Wing on 11/9/2024 from 1:13am-3:04am, five out of ten checks, staff did not go to the clients room to complete checks. Boys Wing 11/10/2024 from 2:00am-4:01am, three out of eleven checks staff was observed not checking bedrooms.</p> <p>A report was called in to the CCC (report #2024-06569) on 12/05/2024 at 1:30pm, by the ED for the failure of completing bed checks.</p>
<p><b>Additional Comments:</b> There are no additional comments for this indicator.</p>			

3.07 - Video Surveillance System		Satisfactory	
Provider has a written policy and procedure that meets the requirement for Indicator 3.07	YES		
	If NO, explain here:		
	The agency has a policy Program video monitoring last reviewed by ED on 9/16/24.		
<b>Surveillance System</b>			
<p>The agency, at a minimum, shall demonstrate:</p> <p>a. A written notice that is conspicuously posted on the premises for the purpose of security</p> <p>b. System can capture and retain video photographic images which must be stored for a minimum of 30 days</p> <p>c. System can record date, time, and location; maintain resolution that enables facial recognition</p> <p>d. Back-up capabilities consist of cameras' ability to operate during a power outage</p> <p>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.</p> <p>f. All cameras are visible</p>	Compliance	<p>Written notice of video surveillance was observed posted at exit doors. The video surveillance system has the ability to capture and retain for a minimum of 30 days. The system records date, time, location and maintains resolution. Cameras are located both in the interior and exterior of the shelter in general locations where youth and staff congregate, where visitors enter and exit, where youth searches are conducted and recreation areas. There are no cameras in bedrooms or bathrooms. All cameras are visible. Interview with ED explained that during a power outage, video surveillance is only operable for a short time (2-3) hours. There is currently no additional source of battery back-up, however the agency's policy states, in case of a power outage, the Intervention and Assessment Services facility will switch over to an on-site generator, ensuring cameras will continue to operate during the outage.</p>	
A list of designated personnel who can access the video surveillance system is maintained (includes off-site capability per personnel)?	Compliance	The only staff who are granted access to the camera system (including off-site capabilities) are the Executive Director, Senior Director and Program Director. All access to the camera system is managed by the agency's national office.	
Supervisory review of video is conducted a minimum of once every 14 days and timeframes reviewed are noted in the logbook.	Compliance	The Program Director keeps a separate log book to record a supervisory camera reviews and are completed at a minimum of once every two weeks. Documentation of supervisory video reviews being completed from 6/28/2024 through 12/3/2024 was observed.	
The reviews assess the activities of the facility and include a review of random sample of overnight shifts	Compliance	Review documentation indicate the cameras are reviewed during different times of the day, including but not limited to overnight and weekends.	

<p>Grant the requesting of video recordings to yield a result within 24-72 hours from program quality improvement visits and when an investigation is pursued after an allegation of an incident</p>	<p><b>Compliance</b></p>	<p>Any requests of video footage are made through the agency's IT Department which is able to yield results within 24-72 hours from quality improvement visits and when an investigation is pursued after an allegation of an incident.</p>	
<p>Camera service order/requests will be made within 24 hours of discovery of camera malfunctioning or being inoperable. All efforts made to obtain repairs are documented and maintained</p>	<p><b>No eligible items for review</b></p>	<p>There have been not service order/ requests made in the past six months due to camera malfunctioning or being inoperable. There was a reported loss of power due to a recent hurricane however there was no need request repair due to the surveillance system returning to normal once the power was restored.</p>	
<p><b>Additional Comments:</b> There are no additional comments for this indicator.</p>			
<p><b>4.01 - Healthcare Admission Screening</b></p>			<p><b>Satisfactory</b></p>
<p><b>Provider has a written policy and procedure that meets the requirement for Indicator 4.01</b></p>	<p><b>YES</b> If NO, explain here: The agency has several policies: 4.01-1 Physical Health Screening and 4.01-2 Mental Health Services/Referrals, last reviewed by the Executive Director on September 16, 2024.</p>		
<p><b>Preliminary Healthcare Screening</b></p>			
<p>Screening includes :</p> <ul style="list-style-type: none"> <li>a. Current medications</li> <li>b. Existing (acute and chronic) medical conditions</li> <li>c. Allergies</li> <li>d. Recent injuries or illnesses</li> <li>e. Presence of pain or other physical distress</li> <li>f. Observation for evidence of illness, injury, physical distress, difficulty moving, etc.</li> <li>g. Observation for presence of scars, tattoos, or other skin markings</li> <li>h. Acute health symptoms requiring quarantine or isolation</li> </ul>	<p><b>Compliance</b></p>	<p>Five residential youth records were reviewed (four open and one closed). All contained detailed screenings which were completed on the day of admission. The screenings included any current medications the youth was taking, existing medical conditions, known allergies, any recent injury or illness, scars, body markings, tattoos, and any acute health issue which may require isolation.</p>	
<p><b>Referral and Follow-Up</b></p>			
<p>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.)</p>	<p><b>Compliance</b></p>	<p>All five records contained screenings for any chronic medical conditions. One of the five youth was applicable for a chronic medical condition and showed evidence of referral for medical care and observation of one youth had medical referral for a follow-up due to an injury sustained at the program.</p>	

When needed, the parent is involved with the coordination and scheduling of follow-up medical appointments	<b>Compliance</b>	The applicable youth's record contained documentation confirming the parent was involved with scheduling and follow-up of any medical appointments.	
All medical referrals are documented on a daily log.	<b>Compliance</b>	All medical referrals for both youth were 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	<b>Compliance</b>	The youth records contain treatment notes, which include follow-up care as required.	
<b>Additional Comments: There are no additional comments for this indicator.</b>			
<b>4.02 - Suicide Prevention</b>			<b>Satisfactory</b>
<b>Provider has a written policy and procedure that meets the requirement for Indicator 4.02</b>	<b>YES</b>		
	If NO, explain here:		
	The agency has a policy 4.02-1 At Risk Screening and Assessment, last reviewed by the Executive Director on September 16, 2024.		
<b>Suicide Risk Screening and Approval (Residential and Community Counseling)</b>			
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.	<b>Compliance</b>	Ten youth records were reviewed (four open residential, one closed residential, two open community counseling, three closed community counseling) and three were applicable for being in need of a suicide risk screening at intake. All three were residential youth. All suicide risk screenings were conducted during the initial intake and screening results were reviewed by the supervisor and documented in each of the youth files.	
The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	<b>Compliance</b>	The program uses an approved suicide risk assessment form.	
<b>Supervision of Youth with Suicide Risk (Shelter Only)</b>			
Youth are placed on the appropriate level of supervision based on the results of the suicide risk assessment.	<b>Compliance</b>	All three applicable youth were placed on the appropriate level of supervision (one was on precautionary monitoring and the other two on one-on-one monitoring). This level was determined by the results of the suicide risk assessment. The program uses one form which has a place to indicate the appropriate level of supervision for the youth. One youth observation log did not indicate the level of observation the youth was on, but this was indicated on the youth's suicide screening form.	

<p>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</p>	<p><b>Compliance</b></p>	<p>Two of the three applicable youth were placed on one-on-one monitoring, and required to have constant supervision. This supervision was documented on the one-on-one observation log every ten minutes.</p>	
<p>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.</p>	<p><b>Compliance</b></p>	<p>The observation logs reviewed include: behavioral observations, warning signs if applicable, the name and initials of the staff making the observation, and the time of day the observation was made. These are maintained in an observation log binder while the youth is on observation status, then filed in the youth record once the youth is stepped down to standard observation.</p>	
<p>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</p>	<p><b>Compliance</b></p>	<p>The three applicable youth reviewed for suicide precautions remained on the supervision level until a licensed mental health professional completed a follow-up assessment and changed the supervision level.</p>	
<p>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.</p>	<p><b>Compliance</b></p>	<p>Observation logs for the two applicable youth were reviewed and signed off by supervisory staff on each shift while the youth was on one-on-one supervision. Observation logs are removed from the observation log binder and filed in the youth record once the youth is stepped down to standard observation.</p>	
<p><b>Youth with Suicide Risk (Community Counseling Only)</b></p>			
<p>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.</p>	<p><b>No eligible items for review</b></p>	<p>The community counseling program had no youth identified for suicide risk during intake over the past six months.</p>	
<p>During the intake, if the appropriate staff is unavailable, youth identified for suicide risk was immediately referred by the provider and the parent/guardian is notified of the suicide risk findings disclosed and advised that an Assessment of Suicide Risk should be completed ASAP by a licensed professional.</p>	<p><b>No eligible items for review</b></p>	<p>The community counseling program had no youth identified for suicide risk during intake over the past six months.</p>	

Information on resources available in the community for further assessment was provided to the parent/guardian and is documented in the youth's file and signed by the parent/guardian OR a written follow-up notification was sent by certified mail if the parent/guardian was not present during the screening and was notified by telephone.	No eligible items for review	The community counseling program had no youth identified for suicide risk during intake over the past six months.	
If the parent/guardian cannot be contacted, all efforts to contact them are documented in the case file.	No eligible items for review	The community counseling program had no youth identified for suicide risk during intake over the past six months.	
When the screening was completed during school hours on school property, the appropriate school authorities were notified.	No eligible items for review	The community counseling program had no youth identified for suicide risk during intake over the past six months.	
<b>4.03 - Medications</b>			<b>Satisfactory with Exception</b>
<b>Provider has a written policy and procedure that meets the requirement for Indicator 4.03</b>	<b>YES</b>		
	If NO, explain here:		
	The agency has a policy 4.03-1/Medication Verification, Storage, Access, Inventories, Medication Administration Log, and Provision, last reviewed the Executive Director on September 16, 2024.		
The agency has a Registered Nurse (RN) and/or a Licensed Practical Nurse (LPN) that is being supervised by RN and all of their credentials have been verified.	<b>Compliance</b>	The program has a registered nurse (RN) who provides services a minimum of twenty hours each week and credentials were verified.	
The agency has evidence of the following for all non-nursing shelter staff designated to assist with the self-administration of medication: a. Documentation of in-person self-administration of medication distribution training provided by a Registered Nurse b. Evidence demonstrating their competency to assist with self-administration of medication distribution c. Maintenance of their annual medication training re-certification	<b>Compliance</b>	Designated non-nursing staff are trained by the RN to assist with the self-administration of medication. A list of the trained staff was reviewed. Evidence of in-person self-administration of medication distribution training provided by a Registered Nurse with evidence of demonstrating their competency to assist with self-administration of medication distribution was observed for each staff member on the list, in addition to current annual medication training re-certification.	

<p>The agency held at least quarterly staff meetings conducted by RN and/or Shelter Manager to review and assess:</p> <ul style="list-style-type: none"> <li>a. strategies implemented to reduce medication errors shelter wide</li> <li>b. analyze factors that contributed to medication errors</li> <li>c. allow staff the opportunity to practice and role-play solutions</li> </ul>	<p><b>Compliance</b></p>	<p>A review of documentation for the past two quarters confirmed the program held quarterly meetings conducted by the shelter manager to review and assess any strategies implemented to reduce medication errors shelter wide, to analyze factors which may have contributed to medication errors, and to allow staff the opportunity to practice and role-play solutions.</p>	
<p>The agency has strategies implemented to ensure medications are provided within the 2-hour time frame.</p>	<p><b>Compliance</b></p>	<p>The program has an electronic board in the shelter office with pertinent information, to include any youth who take medication, and the times medication is to be administered to any applicable youth. This is done to ensure medications are provided within the required two-hour time frame.</p>	
<p>All non-licensed staff members are clearly identified and designated on the staff schedule and shift change report/shift responsibility form for assisting with the self-administration of medications on each shift</p>	<p><b>Compliance</b></p>	<p>A list of non-licensed medical staff who have been trained to assist with self-administration of medication is was reviewed. This list identified trained staff by name, and assigned shift who are designated to assist with the self-administration of medication.</p>	
<p>The agency has clear methods of communicating which youth are on medications with the times and dosage easily discernable by all staff on each shift.</p>	<p><b>Compliance</b></p>	<p>The program has an electronic board in the shelter office with pertinent information, to include any youth who take medication, and the times medication is to be administered to all applicable youth with dosage easily discernable by all staff on each shift.</p>	
<p>The delivery process of medications is consistent with the FNYFS Medication Management and Distribution Policy and the agency has an internal quality assurance process to include the following:</p> <ul style="list-style-type: none"> <li>a. to ensure appropriate medication management and distribution methods</li> <li>b. to track medication errors</li> <li>c. to identify systemic issues and implement mitigation strategies, as appropriate.</li> </ul>	<p><b>Compliance</b></p>	<p>As observed, the program's delivery process of medication is consistent with the FNYFS Medication Management and Distribution Policy. Additionally, the program has an internal quality assurance process to ensure appropriate medication distribution and accountability measures are adhered to, to track any medication errors, and to identify and address any issues as they arise. These issues are discussed during the program's CINS/FINS meetings and safety and health committee meetings.</p>	

Admission/Intake of Youth			
<p>a. Upon admission, the youth and parent/guardian (if available) were interviewed by the Registered Nurse (when on-site) about the youth's current medications as part of the Medical and Mental Health Assessment screening process and/or an interview was conducted by the RN within three (3) business days if the RN was not on the premise at admission. <i>*If the agency does not have an RN, there was a medication review conducted by an LPN or certified Leadership position.</i></p> <p>b. Upon intake/admission, there is evidence that the on-shift certified supervisor of higher level staff did review all medication forms by the next business day.</p>	<p><b>Compliance</b></p>	<p>Two of two (one open and one closed) residential youth records reviewed were applicable for taking medication at the time of intake. Each applicable youth record contained documentation which confirmed the youth and parent/guardian were interviewed by the RN about the youth's current medication on the day of intake. The on-shift certified supervisor reviewed all medication forms for the applicable youth.</p>	
Medication Storage			
<p>a. All medications are stored in a Pyxis ES Medication Cabinet that is inaccessible to youth (when unaccompanied by authorized staff)</p> <p>b. Pyxis machine is stored in accordance with guidelines in FS 499.0121 and policy section in Medication Management</p> <p>c. Oral medications are stored separately from injectable epi-pen and topical medications</p> <p>d. Medications requiring refrigeration are stored in a secure refrigerator that is used only for this purpose, at temperature range 2-8 degrees C or 36-46 degrees F. (If the refrigerator is not secure, the room is secure and inaccessible to youth.)</p> <p>e. Narcotics and controlled medications are stored in the Pyxis ES Station</p> <p>f. Pyxis keys with the following labels are accessible to staff in the event they need to access medications if there is a Pyxis malfunction: a TOP COVER b BACK PANEL-LEFT TALL CABINET LOCK- LEFT, c BACK PANEL-RIGHT TALL CABINET LOCK- RIGHT</p>	<p><b>Compliance</b></p>	<p>All medication is stored in a secured Pyxis cabinet, which is inaccessible to youth. All oral medications are stored separately from injectable epi-pen and topical medication. There is a refrigerator which is only utilized for medications, as needed; however, at the time of the review, there were no youth taking medication requiring refrigeration. The refrigerator is specifically designated for medication, and no other items were observed in the refrigerator. Narcotics and controlled medications are stored in the secure Pyxis cabinet. The keys, with the required labels of Top Cover, Back Panel-Left Tall Cabinet Lock-Left, and Back Panel Right Tall Cabinet Lock-Right, were available to staff in the event they are needed.</p>	

<b>Medication Distribution</b>			
<p>a. Agency maintains a minimum of 2 site-specific System Managers for the Pyxis ES Station</p> <p>b. Only designated staff delineated in User Permissions have access to secured medications, with limited access to controlled substances (narcotics)</p> <p>c. A Medication Distribution Log shall be used for distribution of medication by non-licensed and licensed staff</p> <p>d. Agency verifies medication using one of three methods listed in the FNYFS Policies &amp; Procedures Manual</p> <p>e. When nurse is on duty, medication processes are ALWAYS conducted by the nurse or when the nurse is not onsite, then the designated staff who has been trained by a licensed Registered Nurse provides the medication.</p> <p>f. Agency does not accept youth currently prescribed injectable medications, except for epi-pens</p> <p>h. Non-licensed staff have received training in the use of epinephrine auto-injectors provided by a registered nurse</p>	<p><b>Compliance</b></p>	<p>The program has two site-specific system managers for the Pyxis cabinet. Only trained staff who are designated and granted user permissions have access to secured medications. Access to controlled substances is limited. An observation was conducted of med pass which confirmed a Medication Distribution Log was 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 &amp; Procedures Manual. The program advised when the RN is on duty, medication distribution will be conducted by the RN; however the RN was newly hired and undergoing training. Currently designated staff who have been properly trained, provide the medication to youth. The program does not accept youth currently prescribed injectable medications, with the exception of epi-pens. Non-licensed staff have received training by a RN in the use of epinephrine auto-injectors.</p>	
<p>The medication distribution log documentation includes:</p> <p>a. the time of medication administration</p> <p>b. evidence of youth initials that the dosage was given</p> <p>c. evidence of staff initials that the dosage was given</p>	<p><b>Compliance</b></p>	<p>A review of the program's Medication Distribution log over the past six months, shows proper documentation which includes: time of the medication administration, the dose given, and the initials of the youth and staff verifying the dose given.</p>	
<p>There is evidence that staff provide youth with medications within one hour of the scheduled time of delivery as ordered by the medication. Documentation is provided for instances this does not occur within the required timeframe.</p>	<p><b>Exception</b></p>	<p>A review was conducted of medication logs for the past six months and observation of the program's practice was observed.</p> <p>There was documentation for one youth receiving the incorrect dose of medication and the other documentation explained the other youth was on an outing during the prescribed timeframe.</p>	<p>A review of CCC reports verified three occurrences where medication is not provided within one hour of the scheduled time of medication delivery, has been reported.</p> <p>The documentation did not provide explanation for one medication not being provided as required.</p>
<p>During the review period, there were no instances where youth missed their medication due to failure to open the pyxis machine.</p>	<p><b>Compliance</b></p>	<p>Interview with staff and a review of CCC reports over the past six months confirmed there were no instances of youth missing medication due to a failure of being able to open the Pyxis cabinet.</p>	

<p><b>If applicable:</b> 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 <b>in-person</b> medication administration training, demonstrating competency and re-certification from an RN.</p>	<p><b>Compliance</b></p>	<p>A review of CCC reports over the past 6 months indicated there were three instances of staff being responsible for medication errors during the review period 6/3/24-12/3/24. Evidence of refresher training from an RN was provided for one out of three staff members.</p> <p>The 2nd staff member is no longer with the agency and an email confirmation (dated within the time of the med error incident) that the staff member was removed from the medication distribution list was provided post-review.</p>	
<p><b>Medication Inventory</b></p>			
<p>a. For controlled substances, a perpetual inventory with running balances is maintained as well as a shift-to shift count verified by a witness and documented b. Over-the-counter medications that are accessed regularly and inventoried weekly c. Syringes and sharps (needles, scissors, etc.) are secured, and counted and documented weekly</p>	<p><b>Compliance</b></p>	<p>Ten youth records were reviewed (four open residential, one closed residential, two open community counseling, three closed community counseling) and two were applicable for taking medication. Both had a Medication Distribution Log for each medication they received. One youth had a controlled medications prescribed, and a review of the medication inventory confirmed shift to shift counts were conducted and witnessed. Over-the-counter medications were inventoried weekly. Sharps are secured in a locked box which is maintained in a locked cabinet inside of the shelter office and inventoried weekly.</p>	
<p>There are monthly reviews of the Pyxis reports to monitor medication management practice.</p>	<p><b>Compliance</b></p>	<p>Monthly Pyxis reports from the time of the last review were observed verifying program leadership monitors the medication management practice.</p>	
<p>Medication discrepancies are cleared after each shift.</p>	<p><b>Compliance</b></p>	<p>In the event of a medication discrepancy, the program ensures they are cleared prior to the end of the current shift.</p>	

<b>Additional Comments:</b> Medication distribution was observed on 12/4/24. The youth approached the medication pass window and was properly identified by the supervisor who was distributing the medication. Medication was distributed by a supervisor because the program has a newly hired nurse who is undergoing training. The supervisor was trained in the administration of medication on April 25, 2024, and received a refresher training on July 23, 2024. In addition, the supervisor was trained on the Seven Rights of Medication Administration on October 30, 2024. The youth confirmed the medications being taken. The supervisor properly documented the inventory prior to and after distributing the medication. The supervisor observed the youth taking each medication, and conducted a visual observation of the youth's mouth to ensure the medication was ingested. The supervisor and youth both initialed the prescription medication log, confirming the proper dose was taken at the prescribed time.			
<b>4.04 - Medical/Mental Health Alert Process</b>			<b>Satisfactory</b>
<b>Provider has a written policy and procedure that meets the requirement for Indicator 4.04</b>	<b>YES</b>		
	If NO, explain here:		
	The agency has a policy 4.04-1 Medical Alert Process and Mental Health and Medical Follow-up, last reviewed by the Executive Director on September 16, 2024.		
Youth with a medical, mental health, or food allergy was appropriately placed on the program's alert system	<b>Compliance</b>	Five residential youth records were reviewed (four open and one closed) and two were applicable for having medical or mental health alerts during intake. Both were added to the program's alert system at intake.	
Alert system includes precautions concerning prescribed medications, medical/mental health conditions	<b>Compliance</b>	The program's alert system includes precautions concerning medications, medical and mental health conditions. The alert board located in the shelter office, documents the youth name and alert in a confidential manner. In addition, all alert details are contained in the youth record.	
Staff are provided sufficient training, information and instructions to recognize/respond to the need for emergency care for medical/mental health problems	<b>Compliance</b>	Staff (pre-service and in-service) training records were reviewed, and staff received appropriate training in the recognition and response with emergency care for medical or mental health issues.	
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	<b>Compliance</b>	The two applicable youth with medical alerts were listed on the alert board located in the shelter office. The alert information included precautions concerning prescribed medication, medical or mental health conditions, and any applicable food allergies and is communicated to all staff.	
<b>Additional Comments:</b> There are no additional comments for this indicator.			

4.05 - Episodic/Emergency Care		Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 4.05	YES	
	If NO, explain here:	
	The agency has a policy 4.05-1 First Aid and Episodic/Emergency Care last reviewed the Executive Director on September 16, 2024.	
Off Site Emergency Care		
a. If off-site emergency medical or dental care was provided, an incident report was submitted for the medical or dental care b. Upon youth return, there is a verification receipt of medical clearance via discharge instructions with follow-up is present in file c. Youth's parent/guardian was notified d. A daily log is maintained for emergency care provided	Compliance	One youth record was identified as receiving off-site emergency medical care. Upon review of the youth record, verification receipt of medical clearance was evident via the presence of discharge instructions with follow-up. Indication of notification of the youth's parents was observed. The program maintains a daily log for all emergency care provided.
All staff are trained on emergency medical procedures	Compliance	A total of five pre-service and in-service training records were reviewed which confirmed all five staff were trained on emergency medical procedures.
The program has a Knife-for-life and wire cutters accessible to staff in a secure location(s)	Compliance	The program has a knife-for-life in the shelter office, as well as two first-aid kits and Naloxone (NARACN).
<b>Additional Comments:</b> There are no additional comments for this indicator.		