



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

**CDS Family and Behavioral Health Services, Inc. (East)**

2919 Kennedy Street  
Palatka, FL 32177

**May 14-15, 2025**

**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 CDS Family and Behavioral Health Services, Inc. (East) for the FY 2024-2025 at its program office located at 2919 Kennedy Street, Palatka, Florida 32177. 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. CDS Family and Behavioral Health Services, Inc. (East) 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 CDS Family and Behavioral Health Services, Inc. (East) present for the entrance interview were: Phil Kabler/ CEO, Angela Lay/ HR Manager, Cindy Starling/ COO, Alex Culbreth/ Quality Assurance Director, and Karen Bethel/ Administrative Assistant. The last onsite QI visit was conducted on –March 6-7, 2024.

In general, the Reviewer found that CDS Family and Behavioral Health Services, Inc. (East) is in compliance with specific contract requirements. **CDS Family and Behavioral Health Services, Inc. (East) received an overall compliance rating of 100% for achieving full compliance with 12 indicators** of the CINS/FINS Monitoring Tool. 1) There were no recommendations or corrective action identified 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 05-14-15-2025**

<b>Agency Name: CDS Family and Behavioral Health Services, Inc. (East)</b>			<b>Monitor Name: Andrea Haugabook, Lead Reviewer</b>					
<b>Contract Type: CINS/FINS</b>			<b>Region/Office: 2919 Kennedy Street, Palatka, FL 32217</b>					
<b>Service Description: Comprehensive Onsite Compliance Monitoring</b>			<b>Site Visit Date(s): May 14-15, 2025</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>			
<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"/>	The agency has six certified peer reviewers; Phil Kabler/ 2024, Alex Culbreth/ COO, LaToya Robinson/ Residential Counselor, Kevin Lee/ Senior Youth Care Worker, Belinda Ross/ Residential Counselor, and Brian Smith/ Residential Supervisor. LaToya Robinson and the agency has met the contractual requirement for QI reviews this fiscal year.
<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 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 program has a Basic Center grant with effective dates 09/30/2023-09/29/2026.
<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			<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Evidence of the agency's limits of coverage was observed in a certificate of insurance issued 05/06/2025. The producer of the certificate of insurance was Brown and Brown Insurance Services, Inc.

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<p>\$500,000 per occurrence, and \$1,000,000 policy aggregate. Automobile Liability Insurance shall be required and shall provide bodily injury and property damage liability covering the operation of all vehicles used in conjunction with performance of this contract, with a minimum limit for bodily injury of \$250,000 per person; with a minimum limit for bodily injury of \$500,000 per accident; with a minimum limit for property damage of \$100,000 per accident and with a minimum limit for medical payments or \$5,000-\$10,000 per person. Florida Network is listed as payee or co-payee. <b>PTV</b></p>						<p>Coverages are afforded by: Berkshire Hathaway Specialty Insurance Company, Bridgfield Employers Insurance Company, and Travelers Casualty and Surety Company of America.</p> <p>The following types of coverages are listed: Commercial General Liability, for limits of coverage \$1,000,000 each \$3,000,000 aggregate, \$20,000 individual medical, \$1,000,000 personal &amp; adv injury, and \$1,000,000 employee benefits, Abuse and Molestation coverage for \$1,000,000 each and \$3,000,000 aggregate effective 5/1/25 – 5/1/26.</p> <p>Automobile insurance, for combined single limits of \$1,000,000, and PIP Basic for \$10,000. Policy effective for 5/1/25 – 5/1/26.</p> <p>An umbrella liability policy for \$1,000,000 each/aggregate. Policy effective for 5/1/25 – 5/1/26.</p>

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	<b>Unacceptable</b>	<b>Conditionally Acceptable</b>	<b>Fully Met</b>	<b>Exceeded</b>	<b>Not Applicable</b>		
						<p>Workers Compensation for \$500,000 each accident effective 5/1/2025 – 5/1/2026.</p> <p>Management Liability Coverage including Directors and Officers Liability, Fiduciary Liability and Employee theft for \$1,000,000 each, effective 4/06/25 – 5/1/2026.</p> <p>Florida Network of Youth and Family Services is listed on the certificate as certificate holder.</p>	
<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"/>	<p>Interview with the COO indicates the program has no corrective action items cited by an external funding source.</p>	
<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"/>	<p>A review of the agency's employee and fiscal policies/ procedures indicated they follow GAAP and provide sound internal controls. The agency maintains fiscal files that are audit ready. The most recent update and revision is related to fiscal policies and procedures is January 2022.</p>	

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b. Agency maintains a general ledger and the corresponding source documents. A general ledger must be set up to track the activity of the grant separately (standard account numbers / separate funds for each revenue source, etc.). <b>PTV</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	The agency's general ledger for July 2024 through February 2025 was provided and reviewed. The agency maintains a detailed general ledger that is structured to track all funding sources as well as activities for the shelter and each program separately. Categories captured on the general ledger includes: date, transaction type, number, adjustment, name, description, split and amount and balance.	
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"/>	The program maintains a \$150 petty cash fund. It is managed by the Administrative Assistant. A locked cash box is maintained in the Administrative Assistant's office and was reconciled and shown to be in balance with the receipts and cash on hand. The Administrative Assistant uses the petty cash fund at the discretion and authorization of the COO. Interview with the Administrative Assistant indicates each	

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						transaction is authorized by the COO prior to initiation. The Administrative Assistant reconciles all receipts at least monthly. The reconciliation is reviewed and approved by the Regional Director, then submitted to the Comptroller for review and payment and signed by the COO.	
d. Financial records and reports are current. Includes bank statements reconciled within 6 weeks of receipt. Vendor invoices past 6 months. Invoices are submitted on a monthly basis with supporting documentation and documentation provided contained 2 signatures. (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"/>	Agency provided Bank Statements and Bank Reconciliations for the past six months, November 2024 – April 2025, for bank accounts held with South State. Financial Statements reported on a monthly basis are current. Bank reconciliations are completed monthly by the Comptroller for all activities on the previous month's bank statements. Each reconciliation report includes the signature of the Comptroller and the signature of the CEO who reviews the report. Invoices are submitted and paid monthly with supporting documentation.	
e. Agency maintains inventory in accordance with a written policy and FNYFS contractual requirements. If over	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Interview with the COO indicates the agency has not purchased	

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\$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>						any property with FNYFS funds for the current fiscal year.	
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 documentation of proof of E-file transactions for payment of payroll taxes, with acknowledgment of acceptance by the IRS for all 941 reports for the past six months.	
g. Budget vs. actual reports prepared and reviewed by appropriate management. Variance from the budget is investigated and explained. <b>PTV/ON SITE</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	The agency provided the CDS FY 2024-2025 budget versus actual report. Interview with the COO indicated the budget is prepared by the Comptroller, CEO and COO at the beginning of the fiscal year. The budget is reported to the executive management team and the board of directors. Once accepted and approved, the CEO, COO, and Comptroller review the budget monthly for variances and make appropriate adjustments and reports to leadership and stakeholders.	
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	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	The agency provided an audit report completed December 5, 2024 by Thomas and Company, CPA P.A. for the year ending June 30, 2024. There	

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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>						was one finding cited in the audit report regarding the timely submission of quarterly payroll tax reports. Evidence of a corrective action response from the agency was observed.	
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 provided policies and Procedures for IT, Confidentiality, HIPAA, Personnel Policies and Personnel Records, Record Elimination, Security, and Loss Prevention for review. Accounting data files are backed up every night. Other critical servers, microcomputers, and laptops complete scheduled back-ups on a secured portable hard drive. Obsolete fiscal record documents may be shredded after six years. Participant records follow the funders timeframes and personnel files for a period of not less than seven years.	

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j. Agency provided evidence that every direct care staff employee, as of October 1, 2023, is being paid at least \$19.00 per hour. This also includes funding for additional staff as approved by the Department. <b>ON SITE</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Evidence that every direct care staff is being paid at least \$19.00 per hour was observed in documentation of the employees' payroll history which included each employee, start date, base rate of pay, per check salary, hours, and annual salary.	

**2024-2025 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL**  
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**CONCLUSION**

CDS Family and Behavioral Health Services, Inc. (East) 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 did not have any corrective action items with external funders and there was no inventory purchased with funds from the Florida Network of Youth and Family Services. Consequently, **the overall compliance rate for this contract monitoring visit is 100%**. There are no recommendations cited, and no corrective action is required as a result of the contract monitoring. 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**

**Corrective Action**

None

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

Date: May 14-15, 2025

Compliance Monitoring Services Provided by



## CINS/FINS Rating Profile

**Standard 1: Management Accountability**

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

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

**Standard 2: Intervention and Case Management**

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

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

**Standard 3: Shelter Care & Special Populations**

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

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

**Standard 4: Mental Health/Health Services**

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

**Percent of Indicators rated Satisfactory: 80 %**  
**Percent of Indicators rated Limited: 20 %**  
**Percent of Indicators rated Failed: 0 %**

### Overall Rating Summary

**Percent of indicators rated Satisfactory: 92.86 %**  
**Percent of indicators rated Limited: 7.14 %**  
**Percent of indicators rated Failed: 0 %**

**Rating Definitions**

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

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

**Reviewers**

Members

- Andrea Haugabook - Lead Reviewer Consultant-Forefront LLC/Florida Network of Youth and Family Services
- Lori Bright – Regional Monitor, Department of Juvenile Justice
- Teresa Clove – Thaise Educational and Exposure Tours
- Jarma Morgan – Family Resources - Clearwater
- Wendy Pierre-McNealy – Florida Network of Youth and Family Services

## 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

<input checked="" type="checkbox"/> Chief Executive Officer	<input checked="" type="checkbox"/> Case Manager	<input type="checkbox"/> Nurse – Full time
<input type="checkbox"/> Chief Financial Officer	<input type="checkbox"/> Counselor Non-Licensed	<input type="checkbox"/> Nurse – Part time
<input checked="" type="checkbox"/> Chief Operating Officer	<input type="checkbox"/> Advocate	<input type="checkbox"/> # Case Managers
<input type="checkbox"/> Executive Director	<input checked="" type="checkbox"/> Direct – Care Full time	<input type="checkbox"/> 1 # Program Supervisors
<input type="checkbox"/> Program Director	<input type="checkbox"/> Direct – Part time	<input type="checkbox"/> 1 # Food Service Personnel
<input checked="" type="checkbox"/> Program Manager	<input type="checkbox"/> Direct – Care On-Call	<input type="checkbox"/> # Healthcare Staff
<input type="checkbox"/> Program Coordinator	<input type="checkbox"/> Intern	<input type="checkbox"/> # Maintenance Personnel
<input type="checkbox"/> Clinical Director	<input type="checkbox"/> Volunteer	<input type="checkbox"/> 1 # Other (listed by title): <u>Compliance</u>
<input type="checkbox"/> Counselor Licensed	<input checked="" type="checkbox"/> Human Resources	

### Documents Reviewed

<input type="checkbox"/> Accreditation Reports	<input checked="" type="checkbox"/> Table of Organization	<input type="checkbox"/> Visitation Logs
<input checked="" type="checkbox"/> Affidavit of Good Moral Character	<input type="checkbox"/> Fire Prevention Plan	<input type="checkbox"/> Youth Handbook
<input checked="" type="checkbox"/> CCC Reports	<input checked="" type="checkbox"/> Grievance Process/Records	<input type="checkbox"/> 5 # Health Records
<input checked="" type="checkbox"/> Logbooks	<input type="checkbox"/> Key Control Log	<input type="checkbox"/> 6 # MH/SA Records
<input type="checkbox"/> Continuity of Operation Plan	<input checked="" type="checkbox"/> Fire Drill Log	<input type="checkbox"/> 4 # Personnel /Volunteer Records
<input checked="" type="checkbox"/> Contract Monitoring Reports	<input checked="" type="checkbox"/> Medical and Mental Health Alerts	<input type="checkbox"/> 8 # Training Records
<input type="checkbox"/> Contract Scope of Services	<input checked="" type="checkbox"/> Precautionary Observation Logs	<input type="checkbox"/> 18 # Youth Records (Closed)
<input checked="" type="checkbox"/> Egress Plans	<input checked="" type="checkbox"/> Program Schedules	<input type="checkbox"/> 9 # Youth Records (Open)
<input checked="" type="checkbox"/> Fire Inspection Report	<input checked="" type="checkbox"/> List of Supplemental Contracts	<input type="checkbox"/> # Other: ___
<input checked="" type="checkbox"/> Exposure Control Plan	<input checked="" type="checkbox"/> Vehicle Inspection Reports	<input type="checkbox"/> ___

### Observations During Review

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

### Surveys

<input type="checkbox"/> 5 # of Youth	<input type="checkbox"/> 7 # of Direct Staff	<input type="checkbox"/> # of Other	<input type="checkbox"/>
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## 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

CDS Family and Behavioral Health Services, Inc. is located at 2919 Kennedy Street, Palatka, Florida, 32177. This program is called the Interface Youth Program East and provides residential services to youth ages 10-17. The residential program provides crisis stabilization and counseling to help youth and families address both short-term and long-term goals.

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

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

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

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

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

Indicator 1.04 Training Requirements was rated **Limited**.

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

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

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**.

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

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

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

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

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

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

Indicator 2.08 Specialized Additional Program Services was rated **Not Applicable**.

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**.

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 **Satisfactory**.

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 **Limited**.

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

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

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

Standard 1: Indicator 1.04 Training Requirements was rated limited due to the following deficiencies identified: Of the four reviewed training files, two did not include a record of First Aid completion. One training file did not include documentation of previous trainings that were reviewed and approved by the program, the training log was not up-to-date, thirteen required courses were completed outside the 90-day timeframe, and there was no record of completion of ACE. Additionally, the first file did not include FNYFS Suicide Prevention for FY 23-24 or FY 24-25 with no notation in the tracking log. The second file reviewed did not accurately reflect the completion date of Medication Management Refresher/PYXIS training or contain additional notation in the tracking log. The third file reviewed excluded Medication Management and Managing Aggressive Behavior Refresher trainings with no notation in the tracking log. The fourth file reviewed excluded Fire Safety, Medication Management and Managing Aggressive Behavior Refresher trainings, with no notation in the tracking log. There was no documentation of training tracking by a designated staff, as there were multiple versions of trackers in the training files, which did not reflect accurate training hours or notation of missing or late training completion. The program has since assigned the newly promoted Quality Assurance Director to manage training compliance for all staff. Two files did not include some documentation (i.e.; certificates, sign-in sheets, or transcripts) to verify the completion of required refresher trainings.

**Standard 4:** Indicator 4.03 Medications was rated limited because: The program does not currently have a Registered Nurse(RN) and or LPN that is supervised by an RN. Two incidents of medication errors occurred on 1/30/25 and 4/21/25 and neither staff member has received refresher training by a Registered Nurse. Neither staff was suspended from medication pass until completion of the refresher training. The program only has one site-specific System Manager for the Pyxis ES Station. The program's nurse served as one site-specific system manager for the Pyxis and the nurse exited the agency at the end of April 2025. Six staff members on the authorized list to assist in the self-administration of medication distribution do not have a current annual medication training re-certification.

<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 a policy titled Background check, Reference check, Fingerprinting for Personnel, Volunteers, or Interns, Pre-employment Suitability Assessment last reviewed by the COO January 10, 2025.	
All positions providing direct services to youth have successfully passed the pre-employment suitability assessment on the initial attempt prior to an offer of employment.	<b>Compliance</b>	A review of four new-hire employee files showed evidence of all positions providing direct services to youth having successfully passed a suitability assessment on the initial attempt and prior to an offer of employment.	
For any applicant that did not pass the initial suitability assessment, there was evidence that the applicant retook the assessment and passed within five (5) business days of the initial attempt, not exceeding three (3) attempts within thirty (30) days.	<b>No eligible items for review</b>	There were no new-hire employees that did not pass the initial suitability assessment.	
Agency has evidence for employees who have had a break in service for 18 months or more, and/or when the agency had a change or update in the suitability assessment tool used was different from the employee's original assessment, that a new suitability assessment and background screening was completed as required.	<b>Compliance</b>	The program had one employee who had a break in service less than 18 months and did complete all pre-screening requirements prior to rehire.	
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>	Four of four new-hire employee files were reviewed contained completed background screening documents with eligibility dates prior to the employees' 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>No eligible items for review</b>	The agency's staff verification roster did not indicate any employees in need of a five year rescreen since the date of the last on-site QI review.	

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>	Evidence of a completed Annual Affidavit of Compliance with Level 2 background screening standards was observed as being completed and emailed to the Department of Juvenile Justice (DJJ) Background Screening Unit 01/09/2025.	
Proof of E-Verify for all new employees obtained from the Department of Homeland Security	<b>Compliance</b>	Four of four new-hire employee files reviewed contained evidence of E-Verify obtained from the Department of Homeland Security.	
<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 titled Florida Abuse Reporting P-1044; Behavioral Expectations for Staff P-1032; Complaint/Grievances P-1105; Standard of Conduct P-1212; Rule Violations P-1128 reviewed on 7/5/24 and 1/10/25 by the COO.		
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 program has a Code of Conduct, where staff review and sign through their orientation.	
The agency has a process in place for reporting and documenting child abuse hotline calls.	<b>Compliance</b>	The program has a process for reporting abuse and has the abuse hotline displayed throughout the program, and is reviewed with youth upon intake and orientation. There were no reports of abuse calls within the past six months.	
Youth were informed of the Abuse and Contact Number	<b>Compliance</b>	The abuse hotline number was observed displayed throughout the program, and is reviewed with youth upon intake and orientation.	
<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's grievance policy is reviewed with each youth, where grievance boxes and forms were available throughout the program, and is check by the shelter manager and supervisors.	
<u>Shelter only:</u> Grievances are maintained on file at minimum for 1 year.	<b>Compliance</b>	The program maintains a grievance logbook, which contains all incidents for at least 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>	The grievance boxes observe red during review were accessible to youth and locked upon inspection.	

<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 program's policy requires daily checks, with the exception of holidays and weekends</p>	<p>Of the 19 submitted grievances during the review period, one was reviewed by a supervisor one day late, following a holiday weekend.</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>Of the 19 reviewed grievances, all were resolved within the required timeframe.</p>	
<p><b>Additional Comments: There are no additional comments for this indicator.</b></p>			
<p><b>1.03: Incident Reporting</b></p>			<p><b>Satisfactory</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 several policies titled Incident Reporting Procedure P-1045; Rule Violation P-1128; Complaint/Grievance P-1105; Standard of Conduct P-1212; and Unusual Event Internal P-1051, which was reviewed on 1/10/25 and 7/5/24 by the COO.</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>Compliance</b></p>	<p>All incidents within the past six months reflected the staff notified the CCC within the required timeframe, as documented within the logbooks and email communications.</p>	
<p>The program completes follow-up communication tasks/special instructions as required by the CCC</p>	<p><b>Compliance</b></p>	<p>The reviewed reported CCCs included documentation to support the program's communication with the CCC unit, including follow-up inquiries.</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>The program's logs included documentation of all incidents, including reportable CCC incidents.</p>	
<p>Incidents are documented in the program logs and on incident reporting forms</p>	<p><b>Compliance</b></p>	<p>The program's logbooks and incident forms validated the program's practice of documenting and tracking all incidents.</p>	
<p>All incident reports are reviewed and signed by program supervisors/ directors</p>	<p><b>Compliance</b></p>	<p>Of the nine reviewed incidents, which included five medical and three staff complaints, all had documentation of supervisor and leadership review and completed follow-ups.</p>	
<p><b>Additional Comments: There are no additional comments for this indicator.</b></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 )		<b>Limited</b>	
<b>Provider has a written policy and procedure that meets the requirement for Indicator 1.04</b>	<b>YES</b>		
	If NO, explain here:		
	The program's policy, Training Policy P-1030, was reviewed on 7/5/24 and 1/10/25 by the COO.		
<b>First Year Direct Care Staff</b>			
<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>	<b>Exception</b>	<p>Four new hire files were reviewed. Two files contained all required trainings, which were completed within the required timeframe and documented within the tracking form.</p>	<p>Of the four reviewed training files, two did not include the orientation requirements outlined in the policy.</p>
<p>All staff completed the United States Department of Justice (DOJ) Civil Rights &amp; Federal Funds training within 30 days from date of hire.</p>	<b>Compliance</b>	<p>All four reviewed new hire training files included documentation the Civil Rights and Federal Funds training was completed within the required timeframe.</p>	
<p>All direct care CINS/FINS staff for shelter and community counseling services, including independent contractors (full-time, part-time, and on-call) and interns met the minimum requirement of 80 hours of training for the first full year of employment.</p>	<b>Compliance</b>	<p>Of the four reviewed files, three included documentation within the tracking form of having the minimum required hours for new hires. One reviewed file included documentation of 64.3 hours, however they have until 06/ first full year of employment ends.</p>	

<p>All staff receives all mandatory training during the first 90 days of employment from date of hire.</p>	<p><b>Exception</b></p>	<p>Two of the four reviewed files included documentation staff completed all required trainings within 90 days.</p>	<p>Of the four reviewed training files, two did not include the requirements outlined in the policy. The first file did not include: documentation of previous trainings that were reviewed and approved by the program, the training log was not up-to-date, thirteen required courses were completed outside the 90-day timeframe, and there was no record of completion of Adverse Childhood Experience (ACE).</p>
<p><b>Non Licensed Staff Assisting with Medication Distribution</b></p>			
<p>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.</p>	<p><b>Compliance</b></p>	<p>Of the four reviewed files, two were applicable for this requirement, and completed the course by a registered nurse.</p>	
<p><b>Staff that are Utilizing NETMIS</b></p>			
<p>Any staff that is utilizing NETMIS has evidence of completing NetMIS Training in their training file.</p>	<p><b>No eligible items for review</b></p>	<p>The staff training files reviewed do not utilize NetMis.</p>	
<p><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></p>			
<p>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).</p>	<p><b>No eligible items for review</b></p>	<p>The staff training files reviewed do not participate in case staffing and CINS petitions.</p>	

<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>	None of the staff training files reviewed were non-licensed mental health clinical shelter staff.	
<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>Exception</b>	Four in-service training files were reviewed which included supportive documentation of compliance except where described in the exceptions.	None of the four reviewed in-service training files included documentation of required course completion. The first file excluded FNYFS Suicide Prevention for FY 23-24, with no notation in the tracking log. The second file did not accurately reflect the completion date of Medication Management Refresher/PYXIS training or additional notation in the tracking log. The third file excluded Medication Management and Managing Aggressive Behavior Refresher trainings with no notation in the tracking log and the total of completed hours was inaccurate, which was corrected during the review. The fourth file excluded Fire Safety, Medication Management and Managing Aggressive Behavior Refresher trainings with no notation in the tracking log.
Community Counseling Direct Care staff completes 24 hours of mandatory refresher Florida Network, SkillPro, and job-related training annually.	<b>Compliance</b>	One reviewed file was eligible for this indicator, which included documentation of having 61 completed training hours, well beyond the minimum required.	
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>	All four reviewed files included documentation of training hours above the requirement, however, one file was corrected during the review, as the tracking log did not accurately reflect completed trainings, which were validated by the training certificates and transcripts.	

Required Training Documentation			
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 program's training plan is outlined within their policy for new hire and in-service training requirements.	
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>Exception</b>	During the review period, multiple staff updated training records, however, there were no dedicated staff assigned to maintaining the tracking of training compliance.	There was no documentation of training tracking by a designated staff, as there were multiple versions of trackers in the training files, which did not reflect accurate training hours or notation of missing or late training completion. The program has since assigned the newly promoted Quality Assurance Director to managing training compliance for all staff.
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>Exception</b>	Each of the four reviewed files contained a tracking log and certificates.	Each of the four reviewed files contained multiple versions of a tracker log, however, each did not reflect accurate training hours, completion dates, due dates, or notation of missing or late training completion. Two did not include documentation, certificate, sign-in sheets, or transcripts, to verify the completion of required refresher trainings.
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:		Each of the four reviewed files contained documentation of the completion of Naloxone training.	
<b>Additional Comments: There are no additional comments for this indicator.</b>			
<b>1.05 - Analyzing and Reporting Information</b>			<b>Satisfactory</b>
<b>Provider has a written policy and procedure that meets the requirement for Indicator 1.05</b>	<b>YES</b>		
	If NO, explain here:		
	The agency has a policy titled Analyzing and Reporting, which was reviewed on 1/10/25 and 7/5/24 by the COO.		
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>	<b>Compliance</b>	The program completes monthly client file reviews, which was validated during the review.	

The program conducts reviews of incidents, accidents, and grievances quarterly, at a minimum	<b>Compliance</b>	The program has a policy and practice of reviewing incidents and grievances, which was validated during the review.	
The program conducts an annual review of customer satisfaction data	<b>Compliance</b>	The program has a policy and practice of completing annual customer satisfaction review, which was validated during the review.	
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.	<b>Compliance</b>	The program has a process and practice of reviewing monthly reports, and validated by the COO.	
The program has a process in place to review and improve accuracy of data entry & collection	<b>Compliance</b>	The program conducts report reviews, documented in meeting minutes, of reviews with all directors and supervisors and the executive management team (EMT) who review/reconcile areas for QI, trends, staff meeting minutes.	
There is documentation that findings are regularly reviewed by management and communicated to staff and stakeholders.	<b>Compliance</b>	Meeting minutes and calendar records were reviewed which showed evidence that findings are regularly reviewed by management and discussed with 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>	A review of board meeting minutes verifies the program performance is routinely reviewed with the Board of Directors. All final reports are submitted electronically to the Executive Committee on the Board of Directors.	
There is evidence that strengths and weaknesses are identified, improvements are implemented or modified, and staff are informed and involved throughout the process.	<b>Compliance</b>	During an interview with the COO, documentation of logs and calendar of events demonstrated the program conducts monthly review during CINS/FINS meeting with staff who review and reconcile areas for QI, trends, and performance status.	

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

<b>1.06: Client Transportation</b>		<b>Satisfactory</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 Transportation of Youth P-1304; Vehicle Use and Safety Inspection P-1013 last reviewed by the COO 1/10/25.		

Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	<b>Compliance</b>	The program has a list of eight approved drivers. All drivers are approved by the HR Manager prior to being added to the approved driver's list.	
Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	<b>Compliance</b>	Each of the eight drivers on the approved driver's list have a valid driver's license and the current motor vehicle record was observed. Prior to being added to the approved driver's list the employee was added to the agency's automobile insurance. Proof of automobile insurance coverage was provided.	
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 include exceptions in the event that a 3 <sup>rd</sup> party is NOT present in the vehicle while transporting.	
In the event that a 3 <sup>rd</sup> 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 states in policy, "In the event that a 3 <sup>rd</sup> 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 program's policy states the 3 <sup>rd</sup> party is an approved volunteer, intern, agency staff or other youth. Observation of transportation events in the program's transportation log show transportation events with other parties present in the vehicle.	
The agency demonstrated evidence via logbook or other written verification that supervisor approval was obtained prior to all single youth transports.	<b>Compliance</b>	During the six month period reviewed, the program had a total of 90 single transports between both vehicles used for client transportation. Ten of ten single transports chosen for review showed evidence of written verification of supervisor approval prior to transport of the youth.	
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.	<b>Compliance</b>	The program's logbook showed documentation by a manager or designee of the transporting employee check-in by phone at agreed upon intervals or upon departure and arrival. Observations were made on 01/09/2025,01/15/2025, 01/17/2025, 01/27/2025, 02/07/2025, 02/11/2025, 02/13/2025, 04/22/2025, 04/232025, and 05/01/2025.	
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.	<b>Compliance</b>	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.	

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

1.07 - Outreach Services		Satisfactory
<b>Provider has a written policy and procedure that meets the requirement for Indicator 1.07</b>		<b>YES</b>
		If NO, explain here:
		The agency has a policy titled Prevention Outreach P-1053; reviewed on 1/10/25 and 7/5/24 by the COO.
The program has a lead staff member designated to participate in local DJJ board, Circuit and Council meetings with evidence that includes minutes of the event or other verification of staff participation.	<b>Compliance</b>	The program has a dedicated position for outreach activities through the Outreach Specialist, which is included in the policy. The Outreach Specialist was interviewed during the review and outlined her role and duties in representing the program by participating in meetings and events with community organizations and partners. The Outreach Specialist provided meeting minutes, as well as shared her calendar and notes.
The program maintains written agreements with other community partners which include services provided and a comprehensive referral process.	<b>Compliance</b>	The program maintains several interagency agreements and memorandum of understanding with community partners which includes Putnam County Department of Health, Lee Conlee Domestic Violence Shelter, Palatka Police Department/PAL, Putnam County School District IA, University of Florida (UF Health), and Meridian Health Care.
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.	<b>Compliance</b>	The program maintains documentation of events and activities in NetMIS, logbooks, and a scrapbook, maintained by the Outreach Specialist. The residential supervisor is responsible for entering events into NetMIS, which was validated during the review, which included all required information such as date, location, audience, etc. Activities and meetings from the previous six months logged into NetMIS included the Mental Health Awareness at County Commissioner Meeting, the UF Health BRAVE summit, Safe Place Awareness Week, and City and County Proclamations, the Putnam County Behavioral Health Consortium/Forum (monthly), the Putnam County Health & Wellness Coalition meeting, the Bradford County Coalition Meeting HE Taskforce meeting, and the Putnam County Chamber of Commerce meeting.
The program has designated staff that conducts outreach which is defined in their job description.	<b>Compliance</b>	The program has a dedicated position for outreach activities through the Outreach Specialist, which is included in the policy.
<b>Additional Comments: There are no additional comments for this indicator.</b>		

Standard Two – Intervention and Case Management		
2.01 - Screening and Intake		<b>Satisfactory</b>
Provider has a written policy and procedure that meets the requirement for Indicator 2.01		<b>YES</b>
		If NO, explain here:
		The program has a policy 2.01 Screening Process, last reviewed by the COO on 1/10/2025.
<b>Shelter youth:</b> Eligibility screening form is completed immediately for all shelter placement inquiries.	<b>Compliance</b>	Five Residential case files were reviewed, three closed, and two open. Evidence of eligibility screening forms completed immediately was contained within.
<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.	<b>Compliance</b>	Five Community Counseling case files were reviewed, two closed and three opened. Eligibility screening forms were completed within one to two days of referral by trained staff using the Florida Network form.
There is evidence all referrals for service is screened for eligibility and is logged in NetMIS within 72 hours of screening completion.	<b>Compliance</b>	After reviewing 10 Residential and Community counseling case files it was evident that all the case files were screened for eligibility and logged in NETMIS within 72 hours.
Youth and parents/guardians receive the following in writing: a. Available service options b. Rights and responsibilities of youth and parents/guardians	<b>Compliance</b>	All ten residential and community counseling case files had the parent's signatures confirming they received a written copy of service options and their rights and responsibilities at intake.
The following is also available to the youth and parents/guardians: a. Possible actions occurring through involvement with CINS/FINS services (case staffing committee, CINS petition, CINS adjudication) b. Grievance procedures	<b>Compliance</b>	In all ten case files, the parents or guardians acknowledged their awareness of the potential actions that could result from involvement with CINS/FINS services, including case staffing, CINS petitions, and CINS adjudication, as well as the grievance procedures.
During intake, all youth were screened for suicidality and correctly assessed as required if needed.	<b>Compliance</b>	All ten case files were evaluated for suicide risk during intake. Among the five residential cases, four indicated suicide risk and were appropriately addressed by licensed clinical staff. No suicide risk was found in the community counseling case files.
<b>Additional Comments:</b> There are no additional comments for this indicator.		
2.02 - Needs Assessment		<b>Satisfactory with Exception</b>
Provider has a written policy and procedure that meets the requirement for Indicator 2.02		<b>YES</b>
		If NO, explain here:
		2.02 Needs Assessment Reviewed by Cindy Starling on 1/10/2025.

Shelter Youth: NIRVANA is initiated within 72 hours of admission	<b>Compliance</b>	Three out of five case files reviewed had Nirvana Assessments initiated and completed on the same day as intake. The remaining two were completed within 2 to 3 days of intake, in accordance with the policy.	
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	<b>Compliance</b>	Four out of five case files reviewed had Nirvana Assessments initiated and completed on the same day as intake. The remaining one was completed within 1 days of intake, in accordance with the policy.	
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.	<b>Exception</b>	All other supervisor signatures were present in the case files as required by the policy.	The supervisor's signature appeared on all Nirvana Assessments except one in the Community Counselor's case file.
(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.	<b>Exception</b>	There were five residential case files reviewed, four closed and one opened. Three files were in compliance.	One of the closed residential files didn't contain a completed NSR (Nirvana Self-Assessment Report) within 24 hours of intake as required by the policy. The youth completed it within 3 days. There was no documentation in NETMIS or in the youth file explaining the barriers to completion.
A NIRVANA Post-Assessment is completed at discharge for all youth who have a length of stay that is greater than 30 days.	<b>Compliance</b>	Out of the ten case files reviewed, three were closed, which were open for more than 30 days and had the NIRVANA Post-Assessment completed at discharge.	
A NIRVANA Re-Assessment is completed every 90 days excluding files for youth receiving SNAP services.	<b>Compliance</b>	Two out of the ten cases reviewed were applicable and had a NIRVANA re-assessment completed before the 90-day due date.	
All files include the interview guide and/or printed NIRVANA.	<b>Compliance</b>	All interview guides and printed NIRVANAS were included in the ten case files that were reviewed.	
<b>Additional Comments: There are no additional comments for this indicator.</b>			
<b>2.03 - Case/Service Plan</b>			<b>Satisfactory</b>
<b>Provider has a written policy and procedure that meets the requirement for Indicator 2.03</b>	<b>YES</b>		
	If NO, explain here:		
	The program has a policy P-1162 Individual Plan DJJ QA approved 1/10/25 by the COO.		
The case/service plan is developed on a local provider-approved form or through NETMIS and is based on information gathered during the initial screening, intake, and NIRVANA.	<b>Compliance</b>	Upon reviewing ten case files, it was determined that all case service plans were developed using the CDS Family and Behavioral Health approved form and were based on information gathered from the Nirvana Assessment, screening, and intake process.	

Case/Service plan is developed within 7 working days of NIRVANA	<b>Compliance</b>	Service Plans for all ten case files were developed within 7 working days of intake. Six of the 10 Service Plans were completed on the same day and four were completed on the second to the third day of the Nirvana Assessment.	
<b>Case plan/service plan includes:</b> 1. Individualized and prioritized need(s) and goal(s) identified by the NIRVANA 2. Service type, frequency, location 3. Person(s) responsible 4. Target date(s) for completion and actual completion date(s) 5. Signature of youth, parent/guardian, counselor, and supervisor 6. Date the plan was initiated	<b>Compliance</b>	The ten case files reviewed included service plans with individualized needs and goals, service details such as type, frequency, location, responsible person, target date, and completion date, plus signatures from the youth, parent, counselor, and supervisor, all complying with policy.	
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	<b>Compliance</b>	The ten cases were reviewed for progress with the parent/guardian and youth every 30 days for up to three months. The review form was signed by the youth, the parent or guardian, the counselor, and the supervisor.	
<b>Additional Comments:</b> There are no additional comments for this indicator.			
<b>2.04 - Case Management and Service Delivery</b>			<b>Satisfactory</b>
Provider has a written policy and procedure that meets the requirement for Indicator 2.04	<b>YES</b>		
	If NO, explain here:		
	2.04 Case Management, Counseling and Service Delivery Reviewed by Cindy Starling -COO on 1/10/2025		
Counselor/Case Manager is assigned	<b>Compliance</b>	All ten cases reviewed were assigned a counselor after intake as indicated in the case files.	

<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>Compliance</b></p>	<p>CDS Family and Behavioral Health counselors completed all required information for the 10 case files reviewed, as mandated by the Network which included the following information.                  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>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>CDS Family and Behavioral Health has 16 written agreements with agencies such as mental health services, substance abuse programs, the Putnam County school board, and the police department which also includes a comprehensive referral process. Several clients were referred to and from these community agencies, as noted on their Referral and Discharge/Aftercare form.</p>	
<p><b>Additional Comments:</b> There are no additional comments for this indicator.</p>			
<p><b>2.05 - Counseling Services</b></p>			<p><b>Satisfactory</b></p>
<p><b>Provider has a written policy and procedure that meets the requirement for Indicator 2.05</b></p>	<p><b>YES</b></p>		
	<p>If NO, explain here: The agency has a policy 2.05 Counseling Services reviewed by the COO on 1/10/2025.</p>		
<p><b>Shelter Program</b></p>			
<p>Shelter programs provides individual and family counseling</p>	<p><b>Compliance</b></p>	<p>The five residential case files reviewed all indicated in the progress notes that the family is receiving individual and family counseling.</p>	
<p>Group counseling sessions held a minimum of five days per week</p>	<p><b>Compliance</b></p>	<p>CDS Family and Behavioral Health holds group counseling in the shelter five days a week as documented in their progress/case notes.</p>	

<p>Groups are conducted by staff, youth, or guests and group counseling sessions consist of :</p> <ol style="list-style-type: none"> <li>1. A clear leader or facilitator</li> <li>2.Relevant topic - educational/informational or developmental</li> <li>3. Opportunity for youth to participate</li> <li>4. 30 minutes or longer</li> </ol>	<p><b>Compliance</b></p>	<p>As indicated in the progress/case notes, groups are conducted by staff, guest and/or youth and consist of:</p> <ol style="list-style-type: none"> <li>1. A clear leader or facilitator</li> <li>2.Relevant topic - educational/informational or developmental</li> <li>3. Opportunity for youth to participate</li> <li>4. 30 minutes or longer</li> </ol>	
<p>Documentation of groups must include date and time, a list of participants, length of time, and topic.</p>	<p><b>Compliance</b></p>	<p>The CDS residential group documentation reviewed in the progress notes section of each residential file reviewed included: date, time, participants, duration, and topic of groups the youth participated in.</p>	
<p><b>Community Counseling</b></p>			
<p>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.</p>	<p><b>Compliance</b></p>	<p>CDS community counseling program provides therapeutic intervention necessary to stabilize the families with community base services, The services are provided in the home, school and local office. No virtual services were provided in the reviewed case files.</p>	
<p><b>Counseling Services</b></p>			
<p>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.</p>	<p><b>Compliance</b></p>	<p>All ten case files reviewed showed that the program reviews coordination between presenting problems, psychosocial assessment, case/service plan, case/service plan reviews, case management, and follow-up.</p>	
<p>Maintain individual case files on all youth and adhere to all laws regarding confidentiality.</p>	<p><b>Compliance</b></p>	<p>All ten case files were maintained as individual records for each youth and complied with all confidentiality laws.</p>	
<p>Case notes maintained for all counseling services provided and documents youth’s progress.</p>	<p><b>Compliance</b></p>	<p>All ten CHS case files reviewed had contained progress notes for counseling services provided and documents the youth's progress.</p>	
<p>On-going internal process that ensures clinical reviews of case records and staff performance.</p>	<p><b>Compliance</b></p>	<p>CHS's monthly supervisor reviews demonstrated an internal process in place for clinical reviews of case records and staff performance. Both the counselor and supervisor signed these monthly reviews.</p>	

<p>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.</p>	<p><b>Compliance</b></p>	<p>There were no virtual intakes completed in the ten cases files that were reviewed. The counselors and the supervisor confirmed they have not done any virtual intakes.</p>	
<p><b>Additional Comments: There are no additional comments for this indicator.</b></p>			
<p><b>2.06 - Adjudication/Petition Process</b></p>			<p><b>Satisfactory</b></p>
<p><b>Provider has a written policy and procedure that meets the requirement for Indicator 2.06</b></p>	<p><b>YES</b> If NO, explain here: The agency has a policy P-1160 Case Staffing Committee: Plan of Services and P-1159 Case Staffing Committee: Parent/ Guardian Request reviewed by COO 1/10/2025.</p>		
<p>Must include: a. DJJ rep. or CINS/FINS provider b. Local school district representative</p>	<p><b>Compliance</b></p>	<p>The program's policy and procedures address DJJ rep or CINS/ FINS provider and a local district representative being present at case staffing.</p>	
<p>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</p>	<p><b>Compliance</b></p>	<p>Other members who may be present at case staffing meetings include: State Attorney, others requested by youth/ family, substance abuse representative, law enforcement representative, DCF representatives, Mental Health representative.</p>	
<p>The program has an established case staffing committee, and has regular communication with committee members</p>	<p><b>Compliance</b></p>	<p>The program utilizes the local services and systems in place with truancy courts and student intervention teams. Committee members meet and services are recommended and can be court ordered by the truancy judge if necessary.</p>	
<p>The program has an internal procedure for the case staffing process, including a schedule for committee meetings</p>	<p><b>Compliance</b></p>	<p>Committee meetings are held monthly and the residential counselor attends.</p>	
<p>The youth and family are provided a new or revised plan for services</p>	<p><b>Compliance</b></p>	<p>Four of four files reviewed were provided new or revised plans for services.</p>	
<p>Written report is provided to the parent/guardian within 7 days of the case staffing meeting, outlining recommendations and reasons behind the recommendations</p>	<p><b>Compliance</b></p>	<p>A written report was provided to the parents within seven days of the case staffing meeting for each of the four cases reviewed.</p>	

If applicable, the program works with the circuit court for judicial intervention for the youth/family	<b>Compliance</b>	Evidence of the program working with the truancy court for judicial intervention for the youth/ family was present in each of the four court ordered cases reviewed.	
Case Manager/Counselor completes a review summary prior to the court hearing	<b>Compliance</b>	There were four court ordered cases reviewed, two residential and two non-residential. Three cases were open and one closed. Each of the cases contained evidence the counselor completes a review prior to the court hearing.	
<b>Additional Comments:</b> There are no additional comments for this indicator.			
<b>2.07 - Youth Records</b>			<b>Satisfactory</b>
<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 agency has a policy number P-1046 titled Youth Case Record last reviewed on 1/10/2025 by the agency's COO.		
All records are clearly marked 'confidential'.	<b>Compliance</b>	The ten case files reviewed were marked confidential.	
All records are kept in a secure room or locked in a file cabinet that is marked "confidential"	<b>Compliance</b>	CDS case files are stored in a locked file cabinets with secure assess and marked confidential. The files are kept for seven years.	
When in transport, all records are locked in an opaque container marked "confidential"	<b>Compliance</b>	When transporting case files the files are locked in an opaque container marked confidential.	
All records are maintained in a neat and orderly manner	<b>Compliance</b>	All ten case files reviewed were maintained in a neat and orderly manner.	

<p>SHELTER 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>• Photograph of the youth</li> <li>• Shelter Intake Form</li> <li>• Suicide Assessment (if needed)</li> <li>• NIRVANA Self Report (NSR)</li> <li>• NIRVANA full Assessment</li> <li>• Plan of Service</li> <li>• Chronological Notes</li> <li>• Medication Inventory Form</li> <li>• Approved contact list</li> <li>• Copies of referrals made &amp; Follow-Up (if needed)</li> <li>• Discharge summary once case is closed</li> </ul>	<p><b>Compliance</b></p>	<p>CDS Residential case files contained the following Table of Content as required by the policy.</p> <ul style="list-style-type: none"> <li>•Screening</li> <li>•Informed Consent</li> <li>• Photograph of the youth</li> <li>• Shelter Intake Form</li> <li>• Suicide Assessment (if needed)</li> <li>• NIRVANA Self Report (NSR)</li> <li>• NIRVANA full Assessment</li> <li>• Plan of Service</li> <li>• Chronological Notes</li> <li>• Medication Inventory Form</li> <li>• Approved contact list</li> <li>• Copies of referrals made &amp; Follow-Up (if needed)</li> <li>• Discharge summary once case is closed</li> </ul>	
<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>Compliance</b></p>	<p>CDS Community Counseling case files contained the following Table of Contents:</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>All records kept electronically, are maintained securely and can be made immediately available upon request for audit purposes.</p>	<p><b>Compliance</b></p>	<p>CDS case files are kept in a binder and can be immediately available upon request for audit purposes. There were no electronic case files.</p>	
<p>Records are retained for the duration of the time specified by the contract.</p>	<p><b>Compliance</b></p>	<p>Records are retained for seven years as specified by CDS contract.</p>	
<p><b>Additional Comments:</b> There are no additional comments for this indicator.</p>			

2.08 - Specialized Additional Program Services		Satisfactory	
<p><b>Provider has a written policy and procedure that meets the requirement for Indicator 2.08</b></p>	<b>YES</b>		
	If NO, explain here:		
	The agency has a policy P-1301 Specialized Additional Program Services (reviewed by COO July 2023), Staff Secure Shelter (Program Overview and Services last reviewed by the COO September 2021, Domestic Minor Sex Trafficking (reviewed by COO January 2023), Domestic Violence Respite (reviewed by COO July 2023), Probation Respite (reviewed by COO January 2023), and Family/ Youth Respite Aftercare Services (FYRAC) Non-residential Services (reviewed by COO July 2023.		
<b>Staff Secure</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 program had no staff secure cases in the past six months or back to the date of the last review.	
Staff Secure policy and procedure outlines the following: a. In-depth orientation on admission b. Assessment and service planning c. Enhanced supervision and security with emphasis on control and appropriate level of physical intervention d. Parental involvement e. Collaborative aftercare	<b>Yes</b>	The program's policy and procedures address all the required elements of staff secure as stated in the Florida Network's QI standard.	
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 program had no staff secure cases in the past six months or back to the date of the last 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 program had no staff secure cases in the past six months or back to the date of the last review.	
Agency provides a written report for any court proceedings regarding the youth's progress	<b>No eligible items for review</b>	The program had no staff secure cases in the past six months or back to the date of the last 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 program had no 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 program had no 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 program had no 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 program had no 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 program had no 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 program had no 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	<b>No eligible items for review</b>	The program had no 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	<b>No eligible items for review</b>	The program had no domestic minor sex trafficking cases in the past six months or back to the date of the last review.	
<b>Domestic Violence</b> <input type="checkbox"/>			
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 program had no domestic violence cases in the past six months or back to the date of the last review.	
Youth admitted to DV Respite placement have evidence in the file of a pending DV charge	<b>No eligible items for review</b>	The program had no domestic violence cases in the past six months or back to the date of the last review.	

Data entry into NetMIS within (3) business days of intake and discharge	<b>No eligible items for review</b>	The program had no domestic violence cases in the past six months or back to the date of the last review.	
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.	<b>No eligible items for review</b>	The program had no domestic violence cases in the past six months or back to the date of the last review.	
Case plan in file reflects goals for aggression management, family coping skills, or other intervention designed to reduce propensity for violence in the home	<b>No eligible items for review</b>	The program had no domestic violence cases in the past six months or back to the date of the last review.	
All other services provided to Domestic Violence Respite youth are consistent with all other general CINS/FINS program requirements	<b>No eligible items for review</b>	The program had no domestic violence cases in the past six months or back to the date of the last review.	
<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")	<b>No eligible items for review</b>	The program had no probation respite cases in the past six months or back to the date of the last review.	
All probation respite referrals are submitted to the Florida Network.	<b>No eligible items for review</b>	The program had no probation respite cases in the past six months or back to the date of the last review.	
All Probation Respite Referral come from DJJ Probation and there is evidence that the youth is on Probation regardless of adjudication status.	<b>No eligible items for review</b>	The program had no probation respite cases in the past six months or back to the date of the last review.	
Data entry into NetMIS and JJIS within (3) business days of intake and discharge	<b>No eligible items for review</b>	The program had no probation respite cases in the past six months or back to the date of the last review.	
Length of stay is no more than fourteen (14) to thirty (30) days. Any placement beyond thirty (30) days contains evidence in the file that the JPO was contacted in writing to request the need of an extension no later than the 25th day the youth was admitted into the program.	<b>No eligible items for review</b>	The program had no probation respite cases in the past six months or back to the date of the last review.	
All case management and counseling needs have been considered and addressed	<b>No eligible items for review</b>	The program had no probation respite cases in the past six months or back to the date of the last review.	
All other services provided to Probation Respite youth are consistent with all other general CINS/FINS program requirements	<b>No eligible items for review</b>	The program had no probation respite cases in the past six months or back to the date of the last review.	
<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>No eligible items for review</b>	The program had no intensive case management cases in the past six months or back to the date of the last review.	
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>No eligible items for review</b>	The program had no intensive case management cases in the past six months or back to the date of the last review.	
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>No eligible items for review</b>	The program had no intensive case management cases in the past six months or back to the date of the last review.	
Assessments include a. NIRVANA at intake b. NIRVANA Re-Assessment every 90 days c. Post NIRVANA at discharge as aligned with timeframe requirements	<b>No eligible items for review</b>	The program had no intensive case management cases in the past six months or back to the date of the last review.	
Service/case plan demonstrates a strength-based, trauma-informed focus	<b>No eligible items for review</b>	The program had no intensive case management cases in the past six months or back to the date of the last review.	
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>No eligible items for review</b>	The program had no intensive case management cases in the past six months or back to the date of the last review.	
<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 program had no family and youth respite aftercare cases in the past six months or back to 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 program had no family and youth respite aftercare cases in the past six months or back to 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 program had no family and youth respite aftercare cases in the past six months or back to 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 program had no family and youth respite aftercare cases in the past six months or back to 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 program had no family and youth respite aftercare cases in the past six months or back to 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 program had no family and youth respite aftercare cases in the past six months or back to 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 program had no family and youth respite aftercare cases in the past six months or back to 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 program had no family and youth respite aftercare cases in the past six months or back to 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 program had no family and youth respite aftercare cases in the past six months or back to 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 program had no family and youth respite aftercare cases in the past six months or back to 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 program had no family and youth respite aftercare cases in the past six months or back to 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>YES</b>		
	If NO, explain here:		
	The agency has a policy P-1299 SNAP Screening and Intake (reviewed by COO September 2024), SNAP for schools and communities (reviewed by COO October 2024), SNAP fidelity Adherence Monitoring (reviewed by COO September 2024), SNAP Discharge Requirements (reviewed by COO September 2024), SNAP group Delivery (reviewed by COO September 2024).		
<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 program does not provide 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 program does not provide SNAP services.	
The NIRVANA was completed at initial intake, or within two sessions.	<b>Not Applicable</b>	This program does not provide 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 program does not provide 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 program does not provide SNAP services.	
There is evidence of the following documents located within the file: a. SNAP® Parent Goal Sheet b. Child Way To Go Goal Sheet <i>(This may be in progress for open files but is required for all closed files. )</i>	<b>Not Applicable</b>	This program does not provide 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 program does not provide 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 program does not provide SNAP services.	
There is evidence of the completed SNAP Discharge Report located within the file for any discharged youth.	<b>Not Applicable</b>	This program does not provide SNAP services.	
There is evidence of the SNAP Boys/SNAP Girls Child Group Evaluation Form located in the file.	<b>Not Applicable</b>	This program does not provide SNAP services.	
There is evidence of the SNAP Boys/SNAP Girls Parent Group Evaluation Form located in the file.	<b>Not Applicable</b>	This program does not provide 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 program does not provide SNAP services.	
The file contains the completed Florida Network Community Counseling Intake Form and is located within the file.	<b>Not Applicable</b>	This program does not provide SNAP services.	

The Consent to Treatment and Participation in Research Form is completed, signed by the parent/guardian before receiving services, and located within the file.	<b>Not Applicable</b>	This program does not provide SNAP services.	
The NIRVANA was completed at initial intake, or within two sessions.	<b>Not Applicable</b>	This program does not provide SNAP services.	
There is evidence of the completed 'How I Think Questionnaire' (HIT) form located within the file or evidence of at least three (3) documented attempts in the youths' file to obtain this information.	<b>Not Applicable</b>	This program does not provide SNAP services.	
There is evidence of the completed Social Skills Improvement System (SSIS) Student form located within the file or evidence of at least three (3) documented attempts in the youths' file to obtain this information.	<b>Not Applicable</b>	This program does not provide SNAP services.	
There is evidence of the completed Social Skills Improvement System (SSIS) Teacher/Adult form located within the file or evidence of at least three (3) documented attempts in the youths' file to obtain this information.	<b>Not Applicable</b>	This program does not provide SNAP services.	
All closed files contained evidence in the file a NIRVANA was completed at discharge.	<b>Not Applicable</b>	This program does not provide 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 program does not provide SNAP services.	
The program maintained evidence of a completed 'Way to Go Goal' Sheet within the file.	<b>Not Applicable</b>	This program does not provide 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 program does not provide SNAP services.	

<p>The program maintained evidence of completed pre and post evaluation documents for the class reviewed.</p>	<p><b>Not Applicable</b></p>	<p>This program does not provide SNAP services.</p>	
<p>There is evidence of the SNAP® for Schools &amp; Communities Feedback Form completed by the supervisory adult responsible for the support of the youth receiving services and entered into NetMIS.</p>	<p><b>Not Applicable</b></p>	<p>This program does not provide SNAP services.</p>	
<p>There is evidence of one (1) Fidelity Adherence Checklist completed per classroom for the 13-week classroom sessions which is located in the file.</p>	<p><b>Not Applicable</b></p>	<p>This program does not provide SNAP services.</p>	
<p><b>Additional Comments:</b> There are no additional comments for this indicator.</p>			
<p><b>Standard Three – Shelter Care</b></p>			
<p><b>3.01 - Shelter Environment</b></p>			<p><b>Satisfactory</b></p>
<p><b>Provider has a written policy and procedure that meets the requirement for Indicator 3.01</b></p>	<p><b>YES</b></p>		
	<p>If NO, explain here:</p>		
	<p>The agency's policy number is P-1293 and is titled Shelter Environment. It was last reviewed on January 10, 2025 by the agency's Chief Operations Officer.</p>		

<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>When entering the facility, the foyer area contains three chairs and a tall sofa table. All walls contain postings of licenses, imperative information, and information for various resources. The youth are separated by gender. Girls Section: the walls are painted yellow with butterflies flying along the top border, with the inscription "Spread Your Wings &amp; Fly" on the main wall above the television and window. The grievance box is located on the wall as you enter into the room. The staff desk is located on the left side of the room. Youth have access to four black office chairs and two dark brown accent chairs. There is a collapsible table where the youth may color or put together puzzles next to a six drawer organization bin. As you enter the room, the egress, a bulletin board with the daily schedule is listed, along with postings for Drug Overdose, Bullying, Germs, Active Shooting, Behavior Management Responsibilities are all located on the left side of the wall. There are three small inspirational pictures on the wall. A Fire Extinguisher is also located on the back wall. There is no couch, carpet, nor tables in this room, there is an open floor. The furniture is in good condition. The girls bathroom is equipped with one shower, toilet, and sink. The bathroom is very clean. Boys Section: The walls are painted a light green with three slim windows and one large window. Below the large window is a floating desk, which holds four desktop computers. There were no observations of any graffiti on any furnishing. There was proper lighting throughout the facility. Additional details below.</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>The facility has two vehicles: 2016 Ford Transit van and 2011 Chevy Express G3500. 2016 Ford Transit is a 12-passenger van that is very clean. On the back row, the second seat belt is missing a connector (Female part). With this malfunction it converts the van to an 11-passenger, until this is rectified. The headliner needs to be adjusted and there needs to be two vent covers replaced. 2011 Chevy first row has a rip on the back of the seat and the vent cover for the back row needs to be replaced. All items are up-to-date. each vehicle is occupied with a fire extinguisher, flashlight, glass 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><b>Compliance</b></p>	<p>Logbook entries were reviewed for November 17th-23rd, December 22nd-28th, January 12th-18th, February 2nd-8th, March 23rd-29th, and April 6th-12th. Items that were inventoried were: Clorox Bleach, Dawn dish detergent, Pine-sol, Pledge, Lysol All Purpose Cleaner, Lysol, Toilet Bowl Cleaner, Windex, Soft Scrub, Lysol Wipes, Clorox Multi-Surface Cleaner, Armor All Cleaning Wipes. All items are signed out multiple time a day and returned daily. All items are signed out multiple time a day and returned daily.</p> <p>Logbook entries were reviewed for November 17th-23rd, December 22nd-28th, January 12th-18th, February 2nd-8th, March 23rd-29th, and April 6th-12th. Items observed on list were: Deodorant, Gain Laundry detergent, Hand Sanitizer, Shampoo, Conditioner, Bodywash, Febreze, Odor Ban, Clorox Bleach, Clorox Clean-up, Clorox Disinfecting Wipes, Dawn Dish Detergent, Dial Liquid Soap, Lysol, Lysol All Purpose, Toothpaste, S.O.S. scrubbing pads, Lotion, Shaving Gel, Windex, Tide Laundry Detergent, Soft Scrub, Stove Top Cleaner, Armor All Wipes, Mr. Clean Magic Erasers, Pine Sol, Oven and Grill Cleaner, Pledge Wipes, and Floor Cleaner. There is a MSDS book located in the laundry room and kitchen. All chemicals that are listed are represented with an MSDS sheet.</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><b>Compliance</b></p>	<p>The laundry one contains one washer and one dryer. The reviewer observed the vent and behind each machine. There was no sightings of anything. Each room contains three bunk beds. Beds that were being occupied have all clean items. Those beds that were not being occupied were not made. It was stated that once a client is admitted, they receive their linen upon entry. All personal items are located in a locked closet. Each youth is assigned a plastic tote that their belongings are placed in.</p>	

<p><b>Additional Facility Inspection Narrative (if applicable)</b></p>	<p>The facility only has one green city issued garbage can, that has a covered lid located on the side of the road. There was no sightings of insects. Every window seal within the facility was observed and there was no sightings for droppings. There is a total of four bathrooms. There is one bathroom for staff and one for guest, which are considered half-bathrooms due to there not being a shower. There is one bathroom within each living quarter. The girls and boys bathrooms contained no sightings of mold. All bathrooms were free of any foul odors, leaks, and dust. All appear to be in great working condition. There is no sightings of debris on the facilities lawn. All doors are secured. Doors are only operated by key entry. The egress and detailed map is located in very room next to each door. Grievance/box, general client rules are located in the boy and girl common areas.</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><b>Compliance</b></p>	<p>The Fire Safety Inspection was completed on 10/17/2024 at 10:32:51. 1st Shift: 11/4/24, 12/13/24, 1/28/25, 2/3/25, 3/2/25, 4/3/25, 5/12/25. 2nd Shift: 11/6/24, 12/5/24, 1/7/25, 2/1/25, 3/25/25, 4/26/25, 5/5/25. As applicable 3rd Shift: 11/1/24, 12/1/24, 1/1/25, 2/1/25, 3/1/25, 4/1/25, 5/1/25. 1st Shift: Medical Emergency 11/6/24, Safety for Violent/Threatening Situation 12/7/24, Bomb Threat 1/29/25, Utility Failure 2/7/25, Bomb Threat 3/11/25, and Natural Disaster 4/1/25. 2nd Shift: Medical Emergency 11/15/24, Safety for Violent/Threatening Situation 12/2/24, Bomb Threat 1/29/25, Utility Failure 2/9/25, Bomb Threat 3/14/25, and Natural Disaster 4/25/25. As applicable, 3rd Shift: Medical Emergency 11/4/24, Safety for Violent/Threatening Situation 12/2/24, Bomb Threat 1/28/25, Utility Failure 2/26/25, Bomb Threat 3/24/25, and Natural Disaster 4/28/25. Staff are completing Drills for Bomb Threats, Utility Failure, Natural Disaster, Medical Emergency, and Safety for Violent/Threatening Situation Drill. Date of fire safety equipment inspection(s): 10/4/2024- Fire Alarm System, 12/11/24- Semi-Annual Exhaust Hood Fire Suppression System, 10/22/24- Fire Extinguisher Inspection. There are no Fire Sprinklers within the facility.</p>	

<p><b>Fire and Safety Health Hazards:</b>                  a. Agency has a current Satisfactory Residential Group Care inspection report from the Department of Health.                  b. Agency has a current Satisfactory Food Service inspection report from the Department of Health and food menus are posted, current and signed by Licensed Dietician annually.                  c. All cold food is properly stored, marked and labeled and dry storage/pantry area is clean and food is properly stored.                  d. Refrigerators/Freezers are clean and maintained at required temperatures and all small and medium sized appliances are operable and clean for use as needed.</p>	<p><b>Compliance</b></p>	<p>Most recent inspection date and any comments: 1/15/25 with No violations observed. Most recent inspection date and any comments: The Satisfactory Residential Group Care Inspection meets the requirements for the Satisfactory Food Service Inspections. Food are properly stored in containers with its appropriate labels (name &amp; date). Each shelf is clean and free of any debris or spillage. Fridge Temperature: 37 degrees Fahrenheit. Freezer Temperature:-4 degrees Fahrenheit and each appliance was free and clear of spillage and/or debris.</p>	
<p><b>Additional Fire and Safety Health Hazards Narrative (if applicable)</b></p>			
<p><b>Youth Engagement</b></p>			
<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.                  b. At least one hour of physical activity is provided daily.                  c. Youth are provided the opportunity to participate in a variety of faith-based activities. Non-punitive structured activities are offered to youth who do not choose to participate in faith-based activities.                  d. Daily programming includes opportunities for youth to complete homework and access a variety of age appropriate, program approved books for reading. Youth are allowed quiet time to read.                  e. Daily programming schedule is publicly posted and accessible to both staff and youth.</p>	<p><b>Compliance</b></p>	<p>Youth are engaged in activities throughout the day. Idle time is very minimal. Physical activities range from the hours of 6-7pm. There is a youth group that comes to the facility to provide youth faith-based information and activities on Sunday for those that are interested. For those that are not interested staff create activities for those youth. Youth are able to complete their homework during leisure time. Daily schedules are posted throughout the facility.</p>	
<p><b>Additional Comments: There are no additional comments for this indicator.</b></p>			

<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 program has a policy 3.02 Program Orientation signed by COO on 1/10/2025.	
Youth received a comprehensive orientation and handbook provided within 24 hours	<b>Compliance</b>	The program has a policy in which residential youth shall have a comprehensive orientation and handbook provided to them within twenty-four (24) hours of entering. Five (5) Youth records were reviewed and they all had an orientation and handbook within twenty-four (24) of entering the program.	
Orientation includes the following: a. Youth is given a list of contraband items b. Disciplinary action is explained c. Dress code explained d. Review of access to medical and mental health services e. Procedures for visitation, mail and telephone f. Grievance procedure g. Disaster preparedness instructions h. Physical layout of the facility i. Sleeping room assignment and introductions j. Suicide prevention- alerting staff of feelings or awareness of others having suicidal thoughts	<b>Compliance</b>	The program has a policy in which the orientation given to the youth upon arrival at program is shared with the youth in detail. In all five (5) records reviewed, each one (1) of the following items were reviewed and some of the items came with forms that were signed and in the file. The items included are youth is given a list of contraband items, disciplinary action, dress code, review of medical and mental health services, procedures for visitation, grievance procedure, disaster preparedness instructions, physical layout of facility, sleeping room assignment and introductions 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>	The five (5) files reviewed had documentation of each component of orientation including orientation topics and dates of presentation, as well as signatures of the youth and staff involved maintained in each youth's record.	
<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 and procedures titled P-1116 Residential Admission: Sleeping Arrangements last reviewed on January 10, 2025 by the Chief Operations Officer.	
<b>A process is in place that includes an initial classification of the youths, to include:</b>			

<p>a. Review of available information about the youth's history, status and exposure to trauma b. Initial collateral contacts, c. Initial interactions with and observations of the youth d. Separation of younger youth from older youth, e. Separation of violent youth from non-violent youth f. Identification of youth susceptible to victimization g. Presence of medical, mental or physical disabilities h. Suicide risk i. Sexual aggression and predatory behavior j. Acute health symptoms requiring quarantine or isolation</p>	<p><b>Compliance</b></p>	<p>There was a total of five files that were reviewed. Out of the five three were closed and the other two were open. All history, status, exposure to trauma, and collateral contacts information were reviewed. Staff completed their paperwork in the presence of the youth based on their interactions and observations of the youth. Unfortunately, youth are unable to be separated due to the facility having limited space and therefore does not permit separation based on age, violent or non-violent individuals, sexually aggressive, acute health symptoms, and/or susceptible to victimization within the living quarters, etc. All files had the youth's medical, mental or physical disabilities and suicide risks completed during their initial intake. Of the five files, none were youth that had any sexual aggression and/or predatory behavior nor any acute health systems that required for them to be quarantined while within the facility.</p>	
<p>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</p>	<p><b>Compliance</b></p>	<p>Of the five files selected to be reviewed all five indicated which alerts the youth presented. The alerts were located on each youths file and on the staff information board inside of the staff room.</p>	
<p><b>Additional Comments:</b> There are no additional comments for this indicator.</p>			
<p><b>3.04 - Log Books</b></p>			<p><b>Satisfactory with Exception</b></p>
<p><b>Provider has a written policy and procedure that meets the requirement for Indicator 3.04</b></p>	<p><b>YES</b></p>		
	<p>If NO, explain here: The agency has a policy and procedures titled P1149 Logbook. The policy was last reviewed on January 10, 2025 by the Chief Operations Officer.</p>		
<p>Log book entries that could impact the security and safety of the youth and/or program are highlighted</p>	<p><b>Compliance</b></p>	<p>Logbook entries reviewed for November 17th-23rd, December 22nd-28th, January 12th-18th, February 2nd-8th, March 23rd-29th, and April 6th-12th. Residential Director advised that any Safety and Security issues would be found in the "Pass on Information" and "Shift Leader Summary". There was evidence that events did occur on 3.26.25 and 3.28.25. These events are documented in the logbook.</p>	

<p>All entries are brief, legibly written in ink and include:</p> <ul style="list-style-type: none"> <li>• Date and time of the incident, event or activity</li> <li>• Names of youth and staff involved</li> <li>• Brief statement providing pertinent information</li> <li>• Name and signature of person making the entry</li> </ul>	<p><b>Compliance</b></p>	<p>Logbook entries were reviewed for November 17th-23rd, December 22nd-28th, January 12th-18th, February 2nd-8th, March 23rd-29th, and April 6th-12th. All entries consisted of all required entries. Each day is broken by the shift. Each shift consists of: Program Logbook, Participant's Name, Pass on Information, Chronological Shift Events, Shift Reminders, Shift Leader Summary, and the Shift Leader Review.</p>	
<p>Recording errors are struck through with a single line. The staff person must initial and date the correction. The use of whiteout and erasures is prohibited.</p>	<p><b>Exception</b></p>	<p>Logbook entries reviewed for November 17th-23rd, December 22nd-28th, January 12th-18th, February 2nd-8th, March 23rd-29th, and April 6th-12th. On 2/5/25, scribbled out was observed on Head Count Number. On 2/7/25- multiple lines were placed on an error. No use of white out or erasers.</p>	<p>On 2/5/25, scribbled out text was observed on head count number. On 2/7/25, multiple lines instead of a single line were used to mark out an error.</p>
<p>The program director or designee reviews the facility logbook(s) every week and makes a note chronologically in the logbook indicating the dates reviewed and if any correction, recommendations and follow-up are required and sign/date the entry</p>	<p><b>Compliance</b></p>	<p>Logbook entries were reviewed for November 17th-23rd, December 22nd-28th, January 12th-18th, February 2nd-8th, March 23rd-29th, and April 6th-12th. Residential Supervisor is creating documentation of the reviews daily/weekly.</p>	
<p>All staff review the logbook of the previous two shifts and makes an entry signed and dated into the logbook indicating the dates reviewed</p>	<p><b>Exception</b></p>	<p>Logbook entries were reviewed for November 17th-23rd, December 22nd-28th, January 12th-18th, February 2nd-8th, March 23rd-29th, and April 6th-12th.</p>	<p>It was observed that staff are not notating the dates that they are reviewing the logbook in their shift review documentation.</p>
<p>At the beginning of their shift, oncoming supervisor and shelter counselor reviews the logbook of all shifts since their last log entry and makes a signed and dated entry and into log book indicating the dates reviewed.</p>	<p><b>Exception</b></p>	<p>Logbook entries were reviewed for November 17th-23rd, December 22nd-28th, January 12th-18th, February 2nd-8th, March 23rd-29th, and April 6th-12th. Within these dates the Residential Supervisor reviewed and documented in the logbook on 11.18.24, 11.19.24, 11.20.24, 11.21.24, 11.22.24, 12.23.24, 1.13.25, 1.14.25, 1.15.25, 1.16.25, 1.17.25, 2.3.25, 2.4.25, 2.5.25, 2.6.25, 2.7.25, 3.24.25, 3.25.25, 3.26.25, 3.27.25, 4.6.25, 4.7.25, 4.8.25, 4.9.25, 4.10.25, and 4.11.25.</p>	<p>The Residential Counselor is not consistently documenting a review of the logbook for all shifts since their last log entry. Documentation/entry dates observed were: 1.12.25, 1.15.25, 1.17.25, 3.26.25, 4.7.25, 4.8.25, and 4.11.25. Other dates worked by the Residential Counselor were not documented in the logbook.</p>
<p>Logbook entries include: a. Supervision and resident counts b. Visitation and home visits</p>	<p><b>Compliance</b></p>	<p>Logbook entries contained House Counts conducted for every shift. Youth receiving temporary passes for outing with parents/guardians are notated in the logbook.</p>	

<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 and procedures titled P-1123 Behavior Management Strategies. The policy last reviewed on January 10, 2025 by the Chief Operations Officer.		
The program has a detailed written description of the BMS and it is explained during program orientation	<b>Compliance</b>	Youth are informed of their expectations for the program through the FACE (Facilitating Activities & Communication Effectively) System during Orientation.	
<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>	Staff are trained through Participant /staff Interactions & Interventions, Seclusion and Restraint & Aggression Control. All interventions are addressed immediately in a respectful manner and handled as a teachable moment. The FACE System accommodates youth at three different phases: the Assessment Phase, Daily Phase, and Achievement Phase. In the Assessment phase, the youth is maintained in this phase for three days so that he/she may become familiar with the system and the expectations. Daily Phase participants are expected to understand the system and demonstrate the appropriate life skills behavior, while accumulating points assigned by staff towards privileges. The Achievement Phase is when the youth have the opportunity to engage with staff in negotiating their points to obtain their privileges for the next 24 hours. Youth earn points as a result of demonstrating specifically defined life skills. Privileges are acquired as a result of earning the expected number of points. Youth are aware of the consequences of their violations based on the information they are provided during Orientation in their F.A.C.E. Book. Staff are trained through MAB on how to incorporate techniques to prevent physical intervention. Staff do not allow other youth to discipline other youth, nor are room restrictions allowed to be used as a form of punishment. Program consequences are connected to specific behaviors and serve as incentives for youth to be successful in the program. At the very most, youth will receive a minimum of three (3) day suspension of privileges or removal from the program.	

Program's use of the BMS			
All staff are trained in the theory and practice of administering BMS rewards and consequences	<b>Compliance</b>	After two weeks of computer trainings, Reviewing the policy & Standards, Behavior Management System, prior to working the floor, staff are trained through participant /staff Interactions & interventions, seclusion and restraint & aggression control, and behavior expectations for staff. These topics are also revisited during staff meetings.	
There is a protocol for providing feedback and evaluation of staff regarding their use of BMS rewards and consequences	<b>Compliance</b>	Residential Director addresses staff immediately after researching the allegations and when being knowledgeable of positive and negative behavior.	
Supervisors are trained to monitor the use of rewards and consequences by their staff	<b>Compliance</b>	The Residential Director and Counselor review during Case Staffing and are the only two individuals approved to demote a youth. Consequences are addressed according to their violations.	
<b>Additional Comments: There are no additional comments for this indicator.</b>			
3.06 - Staffing and Youth Supervision			Satisfactory
<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 and procedures titled P-1121 Supervision and Staffing Ratio/Scheduling. The policy was last reviewed on January 10,2025 by the Chief Operations Officer.		
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>	Residential Director ensures that every shift is covered with two staff members. There were times when there were three staff members working.	
All shifts must always provide a minimum of two direct care staff present that have met the minimum training requirements	<b>Compliance</b>	Residential Director ensures that every shift is covered with two staff members. There were times when there were three staff members working.	
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>	During the hiring process potential staff receive background screenings prior to them working on the floor. Staff receive proper trainings and shadowing once they have receive clearance.	

<p>The staff schedule is provided to staff or posted in a place visible to staff</p>	<p><b>Compliance</b></p>	<p>Staff schedules are printed out and posted in the Main Office/Staffing Office. It is placed on the Left corner of staff desk.</p>	
<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>Staff have access to all employees contact information. In the event that a staff member is unable to arrive for their shift, either a staff on shift will stay and cover or find coverage for the shift.</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>Compliance</b></p>	<p>Bed check dates were selected based on the entries reviewed for November 17th-23rd, December 22nd-28th, January 12th-18th, February 2nd-8th, March 23rd-29th, and April 6th-12th. There were one day from each week selected: November 20th, 2024, December 19th, 2024, January 16th, 2025, February 6th, 2025, March 27th, 2025, and April 10th, 2025. It was observed that on these selected dates bed check were conducted in increments ranging from 6-11 minutes. Residential Director stated that staff are expected to conduct bed checks in 10 minutes intervals.</p>	
<p><b>Additional Comments:</b> There are no additional comments for this indicator.</p>			
<p><b>3.07 - Video Surveillance System</b></p>			<p><b>Satisfactory</b></p>
<p><b>Provider has a written policy and procedure that meets the requirement for Indicator 3.07</b></p>	<p><b>YES</b></p> <p>If NO, explain here:</p> <p>The agency has a policy and procedures titled P-1280 Video Surveillance System. The policy was last reviewed on January 10, 2025 by the Chief Operations Officer.</p>		

<b>Surveillance System</b>			
<p>The agency, at a minimum, shall demonstrate:</p> <ul style="list-style-type: none"> <li>a. A written notice that is conspicuously posted on the premises for the purpose of security</li> <li>b. System can capture and retain video photographic images which must be stored for a minimum of 30 days</li> <li>c. System can record date, time, and location; maintain resolution that enables facial recognition</li> <li>d. Back-up capabilities consist of cameras' ability to operate during a power outage</li> <li>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.</li> <li>f. All cameras are visible</li> </ul>	<b>Compliance</b>	<p>A notification of video and audio surveillance posting is located in the foyer area. Camera footage is obtained for 30 days. Date and time are located on the top; the building and specific area are located at the bottom of the screen. There is a backup battery located above the camera system in the staff room. Cameras are located in the entry area, hallways, and common areas. There are no cameras located in the sleeping quarters nor the bathrooms.</p>	
<p>A list of designated personnel who can access the video surveillance system is maintained (includes off-site capability per personnel)?</p>	<b>Compliance</b>	<p>Residential Director, QI, IT Technician, and COO has access to camera footage.</p>	
<p>Supervisory review of video is conducted a minimum of once every 14 days and timeframes reviewed are noted in the logbook.</p>	<b>Compliance</b>	<p>Logbook entries reviewed for November 17th-23rd, December 22nd-28th, January 12th-18th, February 2nd-8th, March 23rd-29th, and April 6th-12th, displayed camera review documentations by the Residential Director. During these weeks, there were video footage observed weekly, every seven days.</p>	
<p>The reviews assess the activities of the facility and include a review of random sample of overnight shifts</p>	<b>Compliance</b>	<p>It was documented that the Residential Director conducted camera reviews throughout all three shifts, on different shifts, days, and times.</p>	
<p>Grant the requesting of video recordings to yield a result within 24-72 hours from program quality improvement visits and when an investigation is pursued after an allegation of an incident</p>	<b>Compliance</b>	<p>Once the Residential Director receives the request for footage, the request is sent over to the IT technician, who sends the footage off to CCC. However, there was an instance where CCC stated that they had not received, but IT states that it had. There are times when footage is sent over multiple times.</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>	<b>Compliance</b>	<p>After an Unusual Event Report is completed by staff, the Supervisor is notified, and the Administrative Assistant contacts the company for repairs.</p>	

<b>Additional Comments:</b> There are no additional comments for this indicator.			
<b>Standard Four – Mental Health/Health Services</b>			
<b>4.01 - Healthcare Admission Screening</b>			<b>Satisfactory</b>
<b>Provider has a written policy and procedure that meets the requirement for Indicator 4.01</b>	<b>YES</b>		
	If NO, explain here:		
	The program has a policy 4.01 Mental Health/Health Services signed on 1/10/25 by the COO.		
<b>Preliminary Healthcare Screening</b>			
Screening includes : a. Current medications b. Existing (acute and chronic) medical conditions c. Allergies d. Recent injuries or illnesses e. Presence of pain or other physical distress f. Observation for evidence of illness, injury, physical distress, difficulty moving, etc. g. Observation for presence of scars, tattoos, or other skin markings h. Acute health symptoms requiring quarantine or isolation	<b>Compliance</b>	The program completes and admission screening with the admission screening form completed by direct care staff. Five (5) files were reviewed and had all of the required elements of current medications, existing medical conditions, allergies, recent injuries and presence of pain or other physical distress. The direct care staff observed the youth for evidence of illness and injury, presence of scars, tattoos or other skin markings and any acute health symptoms requiring quarantine or other isolation.	
<b>Referral and Follow-Up</b>			
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.)	<b>No eligible items for review</b>	The program has a referral process for follow-up medical services as required or needed, however no case records were applicable for review	
When needed, the parent is involved with the coordination and scheduling of follow-up medical appointments	<b>No eligible items for review</b>	The program has a referral process involving coordination and scheduling of follow up medical appointments with parental involvement, however the five (5) files had no eligible items for review.	
All medical referrals are documented on a daily log.	<b>No eligible items for review</b>	The program has a daily log for medical referrals, however none of the files were eligible for review.	
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 program has a thorough referral process for necessary follow-up medical care as required or needed.	
<b>Additional Comments:</b> There are no additional comments for this indicator.			

<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 program has a policy 4.02 Suicide Prevention reviewed on 1/10/25 by the COO.		
<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>	The program has a process for suicide risk screening during the initial screening process. Six (6) files reviewed indicated results reviewed and signed by the supervisor and documented in the youth's case file.	
The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	<b>Compliance</b>	The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services.	
<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>	The program places youth on an appropriate level of supervision based on the results of the suicide risk assessment. Five (5) files of the six (6) records were in shelter.	
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	<b>Compliance</b>	The program has a policy for staff to maintain one-to-one supervision or constant observation which is documented by observation of a youth's behavior at thirty (30) minute or less intervals.	
Documentation includes the time of day, behavioral observations, any warning signs observed, and the observers' initials and was maintained in either an observation log or in the shelter daily log.	<b>Compliance</b>	The program has a policy to use a form which includes the time of day, behavioral observations, any warning signs observed and the observer's initials. The form is kept in the youth's files.	
Supervision level was not changed/reduced until a licensed professional or a non-licensed mental health professional under the supervision of a licensed professional completed a further assessment OR Baker Act by local law enforcement	<b>Compliance</b>	The program does not change or reduce youth's level of supervision until a licensed professional under the supervision of a licensed professional completed a further assessment or Baker Act by local law enforcement.	
There was evidence that documentation was reviewed by supervisory staff each shift. If program uses an observation log, completed logs are maintained in the youth's file.	<b>Compliance</b>	The program documented on forms the supervision level and times of observing youth in all five( 5) files reviewed. The observation form(s) are maintained in the youth's files.	

<b>Youth with Suicide Risk (Community Counseling Only)</b>			
<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>Compliance</b></p>	<p>The program had one (1) record where a community counseling youth needed to be assessed. The youth was assessed immediately by a licensed professional and the parents and supervisor were both notified of the results.</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 program had appropriate staff available to screen youth for suicide risk making this not eligible for review.</p>	
<p>Information on resources available in the community for further assessment was provided to the parent/guardian and is documented in the youth's file and signed by the parent/guardian OR a written follow-up notification was sent by certified mail if the parent/guardian was not present during the screening and was notified by telephone.</p>	<p><b>Compliance</b></p>	<p>In one (1) record reviewed information on resources was given to the parent/guardian and were provided to them as they were involved in the intake with the youth.</p>	
<p>If the parent/guardian cannot be contacted, all efforts to contact them are documented in the case file.</p>	<p><b>No eligible items for review</b></p>	<p>Parent/Guardian were in the staffing with the youth; therefore, this item is not eligible for review.</p>	
<p>When the screening was completed during school hours on school property, the appropriate school authorities were notified.</p>	<p><b>No eligible items for review</b></p>	<p>The screening for suicide risk for the record reviewed was not completed on school property; therefore, it is on eligible for review.</p>	
<p><b>Additional Comments:</b> There are no additional comments for this indicator.</p>			

4.03 - Medications		Limited	
<p><b>Provider has a written policy and procedure that meets the requirement for Indicator 4.03</b></p>		YES	
		If NO, explain here:	
		The program has a policy 4.03 Medications, last reviewed on 1/25/2025 by the COO.	
<p>The agency has a Registered Nurse (RN) and/or a Licensed Practical Nurse (LPN) that is being supervised by RN and all of their credentials have been verified.</p>	Exception	<p>Recruitment efforts for a Registered Nurse are in process to fill the vacancy and a candidate is currently in the hiring process. In the interim, trained non-medical staff are responsible for medication delivery.</p>	<p>The Registered Nurse left her position with the program at the end of April 2025.</p>
<p>The agency has evidence of the following for all non-nursing shelter staff designated to assist with the self-administration of medication:</p> <ul style="list-style-type: none"> <li>a. Documentation of in-person self-administration of medication distribution training provided by a Registered Nurse</li> <li>b. Evidence demonstrating their competency to assist with self-administration of medication distribution</li> <li>c. Maintenance of their annual medication training re-certification</li> </ul>	Exception	<p>The program has a policy in place addressing non-nursing staff who assist with the self-administration of medication. There are eight staff documented on a medication distribution log located in the nursing station. Evidence of two new-hire staff receiving training and demonstrating competency to assist in self-administration of medication distribution provided by a RN was observed. The program has started the paperwork for a new Registered Nurse.</p>	<p>There is no evidence of the annual medication re-certification for six (6) staff.</p>
<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>	Compliance	<p>The program holds quarterly staff meetings conducted by the manager through an email agenda. The agenda includes strategies implemented to reduce medication errors, factors that have contributed to medication errors and allowing staff 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>	Compliance	<p>The facility follows a med pass schedule that is incorporated in their program schedule for residential youth.</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>	Compliance	<p>The program has created a schedule which is inclusive of the medication pass responsibility clearly noted. A review of the schedule shows the one staff member is assigned per shift.</p>	

<p>The agency has clear methods of communicating which youth are on medications with the times and dosage easily discernable by all staff on each shift.</p>	<p><b>Compliance</b></p>	<p>The program has clear methods of communicating which youth are on medications. The nursing station has the youth's medications on two (2) marker boards. The youth also have a small picture of a pill next to their names in an updated log book in the nursing station.</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: a. to ensure appropriate medication management and distribution methods b. to track medication errors c. to identify systemic issues and implement mitigation strategies, as appropriate.</p>	<p><b>Compliance</b></p>	<p>The delivery process is consistent with the FNYFS Medication Management and Distribution Policy. The program was observed processing medication to a youth. The program tracks medication errors in a notebook on the bookcase in the nursing station. The program indicates a way to find systemic issues and implement strategies as appropriate.</p>	
<p><b>Admission/Intake of Youth</b></p>			
<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>Five youth closed files were reviewed and all five youth and or their parent's/guardians were interviewed by the Registered Nurse regarding current medications as a part of the Medical and Mental Health Assessment screening process. This was conducted on the date of admission for all five youth. Additionally, a certified supervisor did review medication forms in all five youth files by the next business day as evidenced by date and signature.</p>	

<b>Medication Storage</b>			
<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 medications are stored in the Pyxis ES Medication Cabinet which is located in the secured medical area. Youth are restricted from access to this room. Oral medications were found to be stored separately from injectable EpiPens and topical medications. The program has a refrigerator for the storage of any medication requiring refrigeration and this appliance is locked. The temperature of the refrigerator was found to be in acceptable range. Narcotics and other controlled medications were stored in the Pyxis ES station. Pyxis keys were viewed and found to be appropriately labeled in the event the Pyxis malfunction.</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>Exception</b></p>	<p>The program has the following processes in place: 1. A minimum of two (2) site specific system managers for the Pyxis ES Station, however there is not only one site-specific system manager currently. 2. Only designated staff delineated in User Permissions have access to secured medications, with limited access to controlled substances. 3. A medication distribution log is used by the program for distribution of medication by non-licensed and licensed staff. 4. The program verifies medication using one of three methods listed in the FNYFS Policies and Procedures Manual. 5. Medication process is currently being conducted by the designated staff who have been trained by a licensed Registered Nurse due to the Nurse exiting the agency at the end of April 2025. 6. The program does not accept any youth on injectable medications except epi-pens. 7.</p>	<p>The program currently only has one site-specific system manager. The second site-specific system manager was the program's registered nurse who exited the agency at the end of April, 2025. Six staff members on the list of staff authorized to assist with the self-administration of medication do not have current annual medication training.</p>

<p>The medication distribution log documentation includes: a. the time of medication administration b. evidence of youth initials that the dosage was given <input type="checkbox"/> c. evidence of staff initials that the dosage was given <input type="checkbox"/></p>	<p><b>Compliance</b></p>	<p>A review of five youth files and the medication administration logs for each youth included the time of medication administration, youth initials and staff initials which evidenced 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 of the program schedule and the individual medication distribution records(MAR) for the past six months to verify adherence to the daily medication pass schedule.</p>	<p>Two instances were observed where medication errors occurred on 01/30/2025 and 04/21/2025.</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>There have been no instances where youth have missed medications due the failure of the pyxis machine during the review period.</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>Exception</b></p>	<p>The program has not had any staff member deemed responsible for 3 med errors within a one year time frame. There have been two medication errors which occurred on January 30, 2025 and April 21, 2025.</p>	<p>Neither staff received refresher training nor were they taken off the medication distribution list since the time of the med error occurrence.</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>Controlled substances, over the counter medications and all sharps and syringes are secured and accounted for in a perpetual inventory with running balances. Controlled substances are inventoried shift to shift and over the counter medications and syringes and sharps are inventoried weekly. A review of the program logbooks supported compliance with this process.</p>	
<p>There are monthly reviews of the Pyxis reports to monitor medication management practice.</p>	<p><b>Compliance</b></p>	<p>Monthly reports are pulled and reviewed to ensure compliance with medication management practices.</p>	
<p>Medication discrepancies are cleared after each shift.</p>	<p><b>Compliance</b></p>	<p>Medication discrepancies are cleared shift to shift per program policy.</p>	
<p><b>Additional Comments: There are no additional comments for this indicator.</b></p>			

4.04 - Medical/Mental Health Alert Process		Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 4.04	YES	
	If NO, explain here: The program has a policy 4.04 Medical/Mental Health Alert Process signed on 1/10/25 by the COO.	
Youth with a medical, mental health, or food allergy was appropriately placed on the program's alert system	Compliance	Five youth files were reviewed and all youth had medical, mental health and or food allergy alerts appropriately placed on the program's alert system. A board and a binder is utilized to track current alerts for youth. Alerts are also noted on each youth's case file.
Alert system includes precautions concerning prescribed medications, medical/mental health conditions	Compliance	The program has an alert system that includes precautions concerning prescribed medications and medical/mental health conditions as witnessed by observation of both the alert board and binder onsite.
Staff are provided sufficient training, information and instructions to recognize/respond to the need for emergency care for medical/mental health problems	Compliance	Staff training was reviewed in the areas of first aid and CPR and all staff were trained and all certifications were current. The program keeps a binder with all current staff's certificates filed for both of these trainings.
A medical and mental health alert system is in place that ensures information concerning a youth's medical condition, allergies, common side effects of prescribed medications, foods and medications that are contraindicated, or other pertinent mental health treatment information, is communicated to all staff	Compliance	An alert board is located in the medical office which lists all youth with active alerts. A numeric code associated with specific alerts is utilized to ensure confidentiality. A logbook with diet and food allergies is kept in the kitchen area for applicable program youth. Both were viewed for accuracy and inclusiveness with no issues noted.
<b>Additional Comments:</b> There are no additional comments for this indicator.		

<b>4.05 - Episodic/Emergency Care</b>		<b>Satisfactory</b>	
<b>Provider has a written policy and procedure that meets the requirement for Indicator 4.05</b>	<b>YES</b>		
	If NO, explain here:		
	The program has a policy 4.05 Episodic/Emergency Care signed 1/10/2025 by the COO.		
<b>Off Site Emergency Care</b>			
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	<b>Compliance</b>	Three applicable youth file were reviewed. All three youth received off-site emergency care as a result of being transported by EMS to the local hospital. An incident report was called to the Department's Central Communication Center and the youth's parents were notified for all three youth. Medical clearances and discharge instructions were found in all three youth's files. The program maintains a daily logbook for all off-site medical and dental care provided for residential youth.	
All staff are trained on emergency medical procedures	<b>Compliance</b>	The program maintains training records for staff and upon review, all staff have been trained in first aid and CPR with all certification being current.	
The program has a Knife-for-life and wire cutters accessible to staff in a secure location(s)	<b>Compliance</b>	The program has both the knife for life and wire cutters securely stored in the medical office area. Additionally, both transport vehicles are each equipped with a knife for life.	
<b>Additional Comments: There are no additional comments for this indicator.</b>			