



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

CDS Family & Behavioral Health, Inc.
(Interface Youth Program - Northwest)

1884 SW Grandview Street
Lake City, FL 32025

April 23-24, 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 & Behavioral Health, Inc. - Interface Youth Program (IYP) – Northwest (CDS NW) for the FY 2024-2025 at its program office located at 1884 SW Grandview Street Lake City, FL 32025. 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. The CDS NW is contracted with the 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 Keith Carr, Consultant for Forefront LLC. Agency representatives from CDS NW present for the entrance interview included Brandi Bell, Regional Director, Alex Culbreth, Quality Assurance Director, Kathy Hardy, Registered Nurse, Stephanie Paschal, LMHC, and other residential, non-residential and administrative staff members. The last onsite QI visit was conducted on May 15-16, 2024.

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

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

2024-2025 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM April 23-24-2025

Agency Name: CDS Interface Youth Program - Northwest					Monitor Name: Keith Carr, Lead Reviewer		
Contract Type : CINS/FINS					Region/Office: 1884 SW Grandview Street Lake City, FL 32025		
Service Description: Comprehensive Onsite Compliance Monitoring					Site Visit Date(s): April 23-24, 2025		
Major Programmatic Requirements	Explain Rating					Ratings Based Upon: I = Interview O = Observation D = Documentation PTV = Submitted Prior To Visit (List Who and What)	Notes Explain Unacceptable or Conditionally Acceptable:
	Unacceptable	Conditionally Acceptable	Fully Met	Exceeded	Not Applicable		
I. Administrative and Fiscal							
DJJ Quality Improvement Peer Reviewer a. Provider shall demonstrate that a minimum of two (2) staff members have been trained to be certified as DJJ QI Peer reviewers. Provider shall participate in a minimum of one (1) on-site quality assurance review of a similar type of program in another judicial circuit during each 12-month period of the contract, if requested.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I,D: The program has several staff members who are certified as peer reviewers for this location. The agency has several certified peers across all three program locations: Phil Kabler, Alex Culbreth, LaToya Robinson, Naomi Thompson, Brian Smith, and Kevin Lee.	No Recommendation or Corrective Action.
Additional Contracts a. Provider shall provide a listing of all current federal, state, or local government contracts, as well as other contracts entered into with for profit and not-for-profit organizations. Such a listing shall identify the awarding entity and contract start & end dates. PTV	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	D,PTV: The agency provided a list of all current contracts for the FY2024-2025 including the grantees name and grant amount awarded for the fiscal term. The list of contracts included FNYFS contracts and a total of ten additional contracts from other funding sources.	No Recommendation or Corrective Action.
Limits of Coverage a. Provider shall provide and maintain during this contract, the following minimum kinds of insurance: Worker's 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	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	D,PTV: General Liability through Berkshire Hathaway Specialty Insurance Company, for limits of coverage \$1,000,000 each \$3,000,000 aggregate, \$20,000 individual medical, \$1,000,000 personal & adv injury, and	No Recommendation or Corrective Action.

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<p>\$500,000 policy aggregate. Commercial General Liability with a limit of \$500,000 per occurrence, and \$1,000,000 policy aggregate. Automobile Liability Insurance shall be required and shall provide bodily injury and property damage liability covering the operation of all vehicles used in conjunction with performance of this contract, with a minimum limit for bodily injury of \$250,000 per person; with a minimum limit for bodily injury of \$500,000 per accident; with a minimum limit for property damage of \$100,000 per accident and with a minimum limit for medical payments or \$5,000-\$10,000 per person. Florida Network is listed as payee or co-payee. PTV</p>						<p>\$1,000,000 employee benefits, effective 1/10/25 – 1/10/2026.</p> <p>Automobile insurance through Berkshire Hathaway Specialty Insurance Company, for combined single limits of \$1,000,000, and PIP Basic for \$10,000. Policy effective for 1/10/25 – 1/10/2026.</p> <p>An umbrella liability policy through Berkshire Hathaway Specialty Insurance Company, for \$1,000,000 each/aggregate. Policy effective for 1/10/25 – 1/10/2026.</p> <p>Workers Compensation through Bridgefield Casualty Insurance Company for \$500,000 each accident. Effective 5/1/2025 – 5/1/2026. Abuse and Molestation coverage through Berkshire Hathaway Specialty Insurance Company for \$1,000,000 each and \$3,000,000 aggregate. Effective 1/10/25 – 1/10/2026.</p>	

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						Professional Liability Coverage through Berkshire Hathaway Specialty Insurance Company for \$1,000,000 each and \$3,000,000 aggregate. Effective 1/10/25 – 1/10/2026. Management Liability through the Travelers Casualty and Surety Company of America Company for \$1,000,000 for D&O/EPLI, fiduciary liability and/or employee theft that is effective 4/6/2025-4/6/2065. Florida Network of Youth and Family Services is listed as certificate holder.	
External/Outside Contract Compliance a. Provider has corrective action item(s) cited by an external funding source (Fiscal or Non-Fiscal). ON SITE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	I: During the Entrance Conference, the provider indicated that there are no outstanding corrective action item(s) cited by any of the agency's external funding sources.	Not Applicable.
Fiscal Practice a. Agency must have employee and fiscal policy/procedures manuals that are in compliance with	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I,PTV: Agency reports that they have fiscal Policies and Procedures which are contained in the CDS and Behavioral Health Services' Financial	No Recommendation or Corrective Action.

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GAAP and provide sound internal controls. Agency maintains fiscal files that are audit ready. PTV						Management Policy. The P-1257 Petty Cash Policy reviewed. The most recent update and review of all policies including Fiscal policies and procedures January 10, 2025.	
b. Agency maintains a general ledger and the corresponding source documents. A general ledger must be set up to track the activity of the grant separately (standard account numbers / separate funds for each revenue source, etc.). PTV	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	D: Detailed General Ledger for the current FY July 2024 through March 2025 was provided and reviewed. The agency maintains a detailed general ledger that tracks all funding sources, as well as activities for the shelter and each program separately. Funding categories captured by the agency include Date, Transaction Type, Name, Number, Memo, Description, Split and Amount.	No Recommendation or Corrective Action.
c. Petty cash ledger system is balanced and all cash disbursements are compliant with financial policies and allowable under the contract. (Disbursements/invoices are approved & monitored by management.) – ON SITE	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	O,D: The agency reported no change in petty cash practice was reported for the agency since the last onsite program review. The petty cash is reconciled on a consistent basis monthly/quarterly) by the Residential Supervisor and reviewed by the Regional Director, Comptroller/Chief Financial Officer and Chief Operations	No Recommendation or Corrective Action.

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						Officer. Disbursements and invoices are approved by the Regional Director. The Administrative Assistant conducted a reconciliation of the petty cash onsite during the onsite QI program review.	
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). ON SITE	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	PTV,D: The agency provided Bank Statements and Bank Reconciliations for the past six months, September 2024 – January 2025, for bank accounts held with financial bank statements are reported on a monthly basis are current. The agency's bank reconciliations are conducted each month for the activities and bank statements for the preceding month. Each reconciliation report includes the designated staff member which has signed the reconciliation invoice documents. These documents are submitted on a monthly basis with supporting documentation.	No Recommendation or Corrective Action.
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"/>	I,D: The agency has not purchased any property with FNYFS funds for the current fiscal year.	Not Applicable.

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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. PTV/ON SITE							
f. Agency submits payroll taxes and deposits (and retirement deposits as applicable), <u>Employee</u> IRS Form W-2 and <u>Independent Contractors</u> IRS Form 1099 forms prior to federal requirements. ON SITE	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	PTV,D: Agency provided documentation in bank statements that payroll taxes are paid each payroll period to the IRS, for the last six months. Agency provided copies of 941 documents for July– September 2024 and October 2024– December 2024.	No Recommendation or Corrective Action.
g. Budget to actual reports prepared and reviewed by appropriate management. Variance from the budget are investigated and explained. PTV/ON SITE	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	D: CDS FY 2024-2025 Budget versus Actual document provided by the agency includes the Income, Total Income, Expenses, Total Expenses, Total Revenue over Expense.	No Recommendation or Corrective Action.
h. A Single Audit is performed as part of the annual audit if expenses are greater than \$750,000. The agency must submit a Corrective Action Plan for findings cited in the management letter and single audit. An annual financial audit was completed within 120 days after the previous fiscal year/calendar year and that a copy was provided to the Network unless and extension has been requested	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	D,PTV: Financial audit conducted for year ending June 30, 2024, and 2023 was completed by Thomas & Company, CPA, P.A. Certified Public Accountants and Business Consultants, and dated December 5, 2024. Per the audit report, a separate	No Recommendation or Corrective Action.

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and approved in writing. Copy of Audit is submitted to the FNYFS by December 31st. Can obtain from FNYFS						Management Letter requiring a Corrective Action Plan is not required and was not issued by the auditor. A copy of the completed audit was submitted to the FNYFS.	
i. Agency maintains confidentiality policy with written policies and procedures to ensure the security and privacy of all employee and client data. Personal information is not easily accessible. Agency maintains a backup system in case of accidental loss of financial information. Security procedures are in place to protect laptops. Obsolete documents are shredded and computer hard drives are wiped prior to discarding. ON SITE	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	D: Record Elimination, Security, and Loss Prevention was provided 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.	No Recommendation or Corrective Action.
j. Agency provided evidence that every direct care staff employee, as of October 1, 2023, is being paid at least \$19.00 per hour. This also includes funding for additional staff as approved by the Department. ON SITE	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	PTV, D: The agency provided an employee listing for all Shelter, Family Action and SNAP staff members that evidences the minimum wage was increased to \$19 per hour effective October 1, 2023, to present.	No Recommendation or Corrective Action.

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CONCLUSION

CDS NW has met the requirements for the CINS/FINS contract as a result of full compliance with --- applicable indicators of the Administrative and Fiscal Contract Monitoring Tool. A total of two out of the 14 indicators were not applicable because the agency did not have any documented corrective actions cite by outside funding sources and the agency did not purchase any equipment with FNYFS funds. Consequently, **the overall compliance rate for this contract monitoring visit is 100%**. There are no recommendations or corrective actions required as a result of the contract monitoring visit. Overall, the provider is performing satisfactorily in meeting the fiscal and administrative terms of its contract.

SUMMARY OF CORRECTIVE ACTIONS or RECOMMENDATIONS

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) 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 - NW
CINS/FINS Program

April 23-24, 2025

Compliance Monitoring Services Provided by



CINS/FINS Rating Profile

Standard 1: Management Accountability

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

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

Standard 2: Intervention and Case Management

2.01 Screening and Intake	Satisfactory
2.02 Needs Assessment	Satisfactory
2.03 Case/Service Plan	Satisfactory
2.04 Case Management & Service Delivery	Satisfactory
2.05 Counseling Services	Satisfactory
2.06 Adjudication/Petition Process	Satisfactory
2.07 Youth Records	Satisfactory
2.08 Special Populations	Satisfactory
2.09 Stop Now and Plan (SNAP)	Satisfactory

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

Standard 3: Shelter Care & Special Populations

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

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

Standard 4: Mental Health/Health Services

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

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

Overall Rating Summary

Percent of indicators rated Satisfactory: 96.43 %
Percent of indicators rated Limited: 3.57 %
Percent of indicators rated Failed: 0 %

Rating Definitions

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

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

Reviewers

Members

- Keith Carr - Lead Reviewer, Consultant-Forefront LLC/Florida Network of Youth and Family Services
- Felicia Jones, Program Director, Youth and Family Alternatives, Inc.
- Christina Baker, LCSW, Lutheran Services Florida - Northwest
- Laura Moneyham, Quality Improvement & Compliance Manager, Florida Network of Youth and Family Services
- Tara Giligan, Regional Program Monitor, Florida Department of Juvenile Justice

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 checked="" type="checkbox"/> Nurse – Full time |
| <input type="checkbox"/> Chief Financial Officer | <input checked="" type="checkbox"/> Counselor Non-Licensed | <input type="checkbox"/> Nurse – Part time |
| <input checked="" type="checkbox"/> Chief Operating Officer | <input type="checkbox"/> Advocate | 3 # Case Managers |
| <input type="checkbox"/> Executive Director | <input checked="" type="checkbox"/> Direct – Care Full time | 1 # Program Supervisors |
| <input checked="" type="checkbox"/> Program Director | <input type="checkbox"/> Direct – Part time | 1 # Food Service Personnel |
| <input 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 | 2 # Other (listed Admin Asst, SNAP Coord. |
| <input checked="" 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 checked="" type="checkbox"/> Visitation Logs |
| <input checked="" type="checkbox"/> Affidavit of Good Moral Character | <input checked="" type="checkbox"/> Fire Prevention Plan | <input checked="" type="checkbox"/> Youth Handbook |
| <input checked="" type="checkbox"/> CCC Reports | <input checked="" type="checkbox"/> Grievance Process/Records | 7 # Health Records |
| <input checked="" type="checkbox"/> Logbooks | <input checked="" type="checkbox"/> Key Control Log | 5 # MH/SA Records |
| <input type="checkbox"/> Continuity of Operation Plan | <input checked="" type="checkbox"/> Fire Drill Log | 8 # Personnel /Volunteer Records |
| <input checked="" type="checkbox"/> Contract Monitoring Reports | <input checked="" type="checkbox"/> Medical and Mental Health Alerts | 10 # Training Records |
| <input checked="" type="checkbox"/> Contract Scope of Services | <input checked="" type="checkbox"/> Precautionary Observation Logs | 4 # Youth Records (Closed) |
| <input checked="" type="checkbox"/> Egress Plans | <input checked="" type="checkbox"/> Program Schedules | 8 # Youth Records (Open) |
| <input checked="" type="checkbox"/> Fire Inspection Report | <input checked="" type="checkbox"/> List of Supplemental Contracts | 6 # Other: ___ |
| <input checked="" type="checkbox"/> Exposure Control Plan | <input type="checkbox"/> Vehicle Inspection Reports | ___ |

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 checked="" type="checkbox"/> Group |
| <input checked="" type="checkbox"/> Security Video Tapes | <input type="checkbox"/> Treatment Team Meetings | <input checked="" type="checkbox"/> Meals |
| <input checked="" 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"/> 6 # of Youth | <input type="checkbox"/> 4 # of Direct Staff | <input type="checkbox"/> # of Other | <input type="checkbox"/> |
|--|---|-------------------------------------|--------------------------|

April 23-24, 2025

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 a private non-profit social services agency that is contracted through the Florida Network of Youth and Family Services (FNYFS) to be a full-service provider of Children in Need Services and Families in Need Services (CINS/FINS). The agency has offices across three locations in Florida; Central (Gainesville), Northwest (Lake City), and East (Palatka). The agency's headquarter is located in Gainesville, Florida. The CDS Family and Behavioral Health Services, Inc. - Northwest (CDS NW) location serves youth and families in Columbia, Dixie, Hamilton, Lafayette, and Suwannee Counties. The CDS agency is currently in their second year of a three-year Commission on Accreditation of Rehabilitation Facilities (CARF) accreditation. A Stop Now And Plan (SNAP) for Probation Supervisor has been promoted from within the organization. The FNYFS recently hired the incumbent SNAP Northwest Supervisor to be the statewide SNAP Program Coordinator. CDS has increased its partnerships, and continued its ongoing partner relationships. CDS 55th Anniversary occurred on March 20, 2025. Our 55th Annual Celebration will be held on November 13, 2025. The agency has an active public presence, including a website, active Facebook, Instagram, Threads, and LinkedIn pages for both CDS and SNAP at CDS, and a small YouTube page. The agency is a SNAP, Staff Secure, Domestic Violence and Probation Respite service provider.

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

Standard 1: There are seven indicators for Standard 1.

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

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

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

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

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

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

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

Standard 2: There are nine indicators for Standard 2.

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

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

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

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

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

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

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

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

Indicator 2.09 Stop Now and Plan (SNAP) was rated **Satisfactory**.

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 **Limited**.

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 with Exception**.

Indicator 4.02 Suicide Prevention was rated **Satisfactory**.

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

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

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

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

Standard 3: Indicator 3.05 - Limited: Four residents do not have completed FACEBOOK Assessments that capture the status of Targeting Skills, Assessment Level, and Daily Skills Reviewed. Six of the seven clients' files reflect intermittent occurrences of inconsistent documentation of specific behavior, YCW initials, and daily points tally across some work shifts (8-4 and 4-12). Interviews with both staff members and supervisors indicate inconsistent understanding and application, and consistency in the use of the current behavior management system. Proof of reviews of staff member application of the Behavior Management System and provided detailed use of all staff members proficiency in the use of the awards system are vague and inconsistent across staff members.

CINS/FINS QUALITY IMPROVEMENT TOOL			
Quality Improvement Indicators and Results: Please select the appropriate outcome for each indicator for each item within the indicator.	Summary/Narrative Findings: The narrative write-up is a thorough summary of each assigned QI indicator, explaining how finding(s) are determined.	Deficiencies/Exceptions: Please add additional detailed explanations for any items that have any deficiencies or exceptions.	
Standard One – Management Accountability			
1.01: Background Screening of Employees, Contractors and Volunteers			Satisfactory with Exception
Provider has a written policy and procedure that meets the requirement for Indicator 1.01	YES	If NO, explain here:	
		The agency has a policy and procedure P-1025 Background Check, Reference Check, Fingerprinting for Personnel, Volunteers, or Interns; P-1292 Pre-employment Suitability Assessment; P-1268 E-Verify. These policies were approved 1/10/2025 by the Chief Operations Officer.	
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.	Exception	The agency utilizes a prescreening assessment for all direct care staff members. Background screenings related to eight staff members were reviewed. Seven staff members were direct-care and were applicable. All seven staff members contained evidence documenting a passing score on the prescreening assessment.	Four staff members did not complete a pre-employment suitability assessment prior to an offer for 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.	Not Applicable	No employees failed their 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.	Not Applicable	No employees reviewed for annual compliance review were applicable to a break in service.	
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>	Compliance	The agency completed eight background screenings, seven of which were new hires. All seven new hires have evidence of a background screening completed prior to their start date.	

Five-year re-screening is completed every 5 years from the date of the last screening for all applicable employees and volunteers.	Compliance	The agency completed a five year rescreening for employees. One of eight were applicable for five year rescreens. Documentation was provided and showed the applicant had a five year rescreen completed every five years, as required.	
Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?	Compliance	The Annual Affidavit of Compliance with Level 2 Screening Standard form was provided and submitted on January 10, 2024. An email was provided to document submission to the background screening unit on January 10, 2024.	
Proof of E-Verify for all new employees obtained from the Department of Homeland Security	Compliance	Eight employee records were reviewed. The agency provided documentation of the E-verify for each of the eight employees viewed.	
Additional Comments: There are no additional comments for this indicator.			
1.02: Provision of an Abuse Free Environment			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 1.02	YES		
	If NO, explain here:		
	The agency has policies 1.02 Provision of an Abuse Free Environment; Florida Abuse Reporting; Behavioral expectations for staff; Rule Violations and P-1212 Standards of Conduct. Revised: 2/2022 and Reviewed by the agency Chief Operations Officer on 1/10/2025.		
Agency has a code of conduct of policy and there is evidence that staff are aware of agency's code of conduct.	Compliance	A review of the agency's code of conduct confirmed staff members are aware the agency policy prohibits physical abuse, profanity, threats or intimidation.	
The agency has a process in place for reporting and documenting child abuse hotline calls.	Compliance	The agency has a process in place for reporting and documenting any child abuse hotline calls, which included a binder with all reported abuse calls.	
Youth were informed of the Abuse and Contact Number	Compliance	Youth are informed of the abuse hotline during orientation and the contact number is posted throughout the facility.	
Grievance			
The program(s) have an accessible and responsive grievance process for youth to provide feedback and address complaints. Program director/ supervisor has access to and can manage grievances unless it is towards themselves.	Compliance	An interview with the regional director confirmed the shelter program has an accessible and responsive grievance process for youth to provide feedback and address complaints.	
<u>Shelter only:</u> Grievances are maintained on file at minimum for 1 year.	Compliance	The agency had three grievances on file during the compliance review period.	

Shelter only: There are formal grievance procedures for youth, including grievance forms, and a locked box which are easily accessible to youth in a common area.	Compliance	Formal grievance forms are located in youth rooms and a locked box is located in the common area.	
Shelter only: There is evidence that grievance boxes are checked by management or a designated supervisor at least daily (excluding weekends and holidays) and documented in the program logbook.	Compliance	The grievance box is checked once a day by staff and all grievances are documented in the logbook.	
Shelter only: Grievances are resolved within 72 hours of being submitted or there was documentation explaining the cause for the delay in providing a resolution.	Compliance	The agency's Grievances are required to be resolved within 72 hours.	
Additional Comments: There are no additional comments for this indicator.			
1.03: Incident Reporting			Satisfactory with Exception
Provider has a written policy and procedure that meets the requirement for Indicator 1.03	YES		
	If NO, explain here:		
	The agency has a policy and procedure P-1044 Florida Abuse Reporting; P-1045 Incident Reporting Procedure and P-1051 Unusual Event Report - Internal. The policies are approved 1/20/2025 by the Chief Operations Officer.		
During the past 6 months, the program notified the Department's CCC (Central Communication Center) no later than two hours after any reportable incident occurred or within two hours of the program learning of the incident	Compliance	The facility had four CCC incidents in the last 6 months which were reported to the CCC no later than two hours after the incident occurred or the program learned of the incident.	
The program completes follow-up communication tasks/special instructions as required by the CCC	Compliance	One of the four CCC incidents required follow-up, and the program completed the follow-up as required.	
Agency internal incidents are documented on incident reporting forms and all CCC reportable incidents were consistently reported to CCC as required.	Compliance	Documentation showed internal incidents were documented on Unusual Incident Forms, and CCC incidents were reported to the CCC as required.	
Incidents are documented in the program logs and on incident reporting forms	Exception	The facility had four CCC incidents during the annual compliance review period.	Two of the CCCs were not reported in the facility logbooks for the CCC binder.
All incident reports are reviewed and signed by program supervisors/ directors	Exception	Two of four CCC incidents reports were reviewed and signed by the program supervisor/director.	Two of four CCC incident reports were not reviewed and signed by the program supervisor/director.
Additional Comments: There are no additional comments for this indicator.			

1.04: Training Requirements (Staff receives training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions)		Satisfactory with Exception	
Provider has a written policy and procedure that meets the requirement for Indicator 1.04	YES		
	If NO, explain here:		
	Agency policy and procedure P-1030 is called 1.04 Training Requirements. The policy was reviewed and approved on 1/10/2025 by the Chief Operations Officer.		
First Year Direct Care Staff			
All direct care staff have completed a new hire pre-service training provider orientation before they work independently. At a minimum, the orientation included the following: <ul style="list-style-type: none"> • Agency policies and procedures • Behavior Management (Shelter Only) • Building/Facility layout • File Documentation/development of paperwork requirements and confidentiality • CCC & Incident Reporting • Child Abuse Reporting • Client Intake & Screening • Client Orientation (direct care staff training on delivering new client orientation) • Fire Equipment Safety • Medical and Mental Health Alert System (Shelter) • Risk Management--Including but not limited to the following: <ul style="list-style-type: none"> - Disaster Preparedness and Emergency Response - First Aid/CPR - Universal Precautions • Video Camera Surveillance & Equipment • All other necessary information to orient a new hire to perform their job role and duties. 	Compliance	Reviewed 5 new hire files, 4 PT YCWs and 1 PT House Manager. Four of the four applicable files reviewed contained documentation that all required trainings were complete prior to working independently.	
All staff completed the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days from date of hire.	Compliance	Three of the four applicable files reviewed contained documentation that Civil Rights & Federal Funds training was completed within the first 30 days.	
All direct care CINS/FINS staff for shelter and community counseling services, including independent contractors (full-time, part-time, and on-call) and interns met the minimum requirement of 80 hours of training for the first full year of employment.	Compliance	Five of five files reviewed indicate that staff either completed the 80 hours or had ample time remaining in their first year of employment to complete training.	

<p>All staff receives all mandatory training during the first 90 days of employment from date of hire.</p>	<p>Exception</p>	<p>Reviewed 5 new hire files, 4 PT YCWs and 1 PT House Manager. Three of the five files reviewed contained documentation that all required trainings were completed within the 90 day timeframe. One of the five files reviewed contained documentation that all required training was completed within the 90 day time frame except two trainings, which were 2 months late.</p>	<p>One of the five files reviewed contained documentation that two trainings (CINS/FINS Core Training and Adverse Childhood Experiences) were completed 2 months late. One of the five files reviewed (PT YCW staff working overnight shift) indicates that the following training was not completed: Child Abuse Recognition, Reporting and Prevention, Equal Employment Opportunity, Human Trafficking Intervention, Information Security, PREA Parts I & II, Sexual Harassment, Trauma Responsive Practices, and CINS/FINS Core training. Additionally, the same staff completed CPR/First Aid training 1.5 months late.</p>
<p>Non Licensed Staff Assisting with Medication Distribution</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>Compliance</p>	<p>Two of two applicable staff files contained evidence that in-person training was provided by the RN prior to staff administering medication to youth.</p>	
<p>Staff that are Utilizing NETMIS</p>			
<p>Any staff that is utilizing NETMIS has evidence of completing NetMIS Training in their training file.</p>	<p>No eligible items for review</p>	<p>None of the five staff member files reviewed for new hire training were applicable for NetMIS training.</p>	
<p>Staff Participating in Case Staffing & CINS Petitions (within the first year of employment BUT no later 7/1/24 for previous staff)</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>No eligible items for review</p>	<p>None of the five staff member files reviewed for new hire training were applicable for FS 984 training.</p>	

Non-licensed Mental Health Clinical Shelter Staff (within first year of employment)			
Documentation of non-licensed mental health clinical staff person's training in Assessment of Suicide Risk form or written confirmation by a licensed mental health professional of training (includes date, signature and license number of the licensed mental health professional supervisor).	No eligible items for review	None of the five staff member files reviewed for new hire training were applicable for non-licensed suicide assessment training.	
In-Service Direct Care Staff			
In-service staff completes all of the required annual or 2-year mandatory refresher Florida Network, SkillPro, or other job-related trainings within the required timeframe.	Exception	Five annual training files were reviewed, one Residential Counselor and four YCWs. All four YCW files included documentation that all required annual/bi-annual training was completed within the required timeframe.	The Residential Counselor file reviewed did not contain documentation of completion of Child Abuse Recognition or Human Trafficking Intervention.
Community Counseling Direct Care staff completes 24 hours of mandatory refresher Florida Network, SkillPro, and job-related training annually.	No eligible items for review	The five files reviewed did not contain a Community Counseling file.	
Shelter Program Direct Care staff completes 40 hours of mandatory refresher Florida Network, SkillPro, and job-related training annually (E.g. the program has a DCF child caring license).	Compliance	All five of five files reviewed exceeded the 40 hour in-service training requirement with training hour totals ranging from 48.8-78.8.	
Required Training Documentation			
The agency has a training plan that includes all of the required training topics including the pre-service and in-service.	Compliance	The agency's training plan includes all required training topics including pre-service and in-service.	
The agency has a designated staff member responsible to manage all employee's individual training files and completes routine tracking and reviews of staff files to ensure compliance.	Compliance	The agency has a designated staff member, the Administrative Assistant, who is responsible for managing all employee training files and tracking completion/compliance. In an interview with this staff member, it is very clear that he is extremely consciousness of his responsibilities.	

<p>The program maintains an individual training file or employee file AND a FLN Training Log (or similar document that includes all requirements) for each staff, which includes an annual employee training hours tracking form and related documentation, such as electronic record/transcript, training certificates, sign-in sheets, and agendas for each training attended.</p>	<p>Compliance</p>	<p>Each employee has an individual training file which includes a training log containing all the FN and their other funder's requirements, and sections for training certificates, agendas and sign-in sheets. The files reviewed were extremely well organized and it was easy to find required documentation.</p>	
<p>All Staff have completed the Naloxone Training as required within 90 days of hire or 1 year from the policy effective date 7/1/24:</p>		<p>Three of the five new hire training files contained documentation of completion for Naloxone training. Two of the five newly hired staff have until June 30, 2025 to complete the training. Four of the five in-service training files reviewed contained documentation of completion for Naloxone training and the remaining staff has until June 20, 2025 to complete the training.</p>	
<p>Additional Comments: There are no additional comments for this indicator.</p>			
<p>1.05 - Analyzing and Reporting Information</p>			<p>Satisfactory</p>
<p>Provider has a written policy and procedure that meets the requirement for Indicator 1.05</p>		<p>YES</p>	
		<p>If NO, explain here:</p>	
		<p>Agency policies related to this indicator include P-1180 is called Quality Improvement Program; P-1107 Data Integrity Policies; P1079 Data Collection; P-1049 Risk Management Planning approved on 1/10/2025 by the Chief Operations Officer.</p>	
<p>Case record review reports demonstrate reviews are conducted quarterly, at a minimum. <i>(A summary report of case record reviews, identifying compliance with the CINS/FINS requirements, which is reviewed by management and communicated with staff on a quarterly basis at minimum.)</i></p>	<p>Compliance</p>	<p>The agency conducts client case file reviews on a monthly basis to ensure that all client cases meet minimum requirements. The agency provided evidence of case file reviews conducted on a monthly basis over the last six months.</p>	
<p>The program conducts reviews of incidents, accidents, and grievances quarterly, at a minimum</p>	<p>Compliance</p>	<p>The agency reviews numerous areas of categories of risk management including all reportable and internal incidents, injuries, accidents and grievances. The agency provided evidence of monthly reviews on the accuracy and completion of several areas risk management.</p>	
<p>The program conducts an annual review of customer satisfaction data</p>	<p>Compliance</p>	<p>The agency provided evidence of six months of monthly customer satisfaction data.</p>	
<p>The program demonstrates a monthly review of the statewide End-of-Month ("EOM") report generated by the Florida Network Office. This includes monthly data, fiscal year to date data, benchmarks for residential and community counseling, screening data, report card measures, follow-up reporting measures.</p>	<p>Compliance</p>	<p>The agency reviews all FNYFS monthly data extracts. The agency provided evidence of reviews all FNYFS data extracts and all related contract and service delivery categories on a monthly basis for the previous six months.</p>	

The program has a process in place to review and improve accuracy of data entry & collection	Compliance	The agency has data entry staff which are required to enter data within the timeline. The agency conducts monthly reviews of data entered to ensure all data is entered within the required timeframe and to review for accuracy.	
There is documentation that findings are regularly reviewed by management and communicated to staff and stakeholders.	Compliance	The agency conducts review sessions on all areas including performance, risk management, quality improvement and accreditation. The agency provided evidence of conducting monthly reviews of these areas of performance.	
There is evidence the program demonstrates that program performance is routinely reviewed with the Board of Directors. All final reports that include a Limited or Failed score is submitted electronically or by mail to the providers Executive Committee on the Board of Directors.	Compliance	The agency provided evidence of data and reports submitted to the Board of Directors. The agency provides Board members with copies of all contract performance and accreditation reports on an annual basis. The agency did not have any recent reports with Limited or Failed ratings.	
There is evidence that strengths and weaknesses are identified, improvements are implemented or modified, and staff are informed and involved throughout the process.	Compliance	The agency conducts comprehensive reviews of all areas of service delivery that do not meet the contract and compliance requirements. The agency reviews performance in the areas of annual data collection of screenings, admissions, discharges, emergency shelter participants, NetMIS, data entry, medical emergencies, incident summary report, and personnel summaries.	

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

1.06: Client Transportation	Satisfactory with Exception
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Provider has a written policy and procedure that meets the requirement for Indicator 1.06	YES	
	If NO, explain here:	
	Agency policies related to this indicator include P-1013 is called Vehicle Use and Safety Information approved on 1/10/2025 by the Chief Operations Officer.	
Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	Compliance	The program's policies and procedures were reviewed and found to be compliant with all requirements pertaining to driver eligibility. The agency produced a list of approved drivers for this service region.
Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	Compliance	The agency maintains a process to screen each staff member's driver's record to ensure each staff member has a valid driver's license. The agency produced a list of approved driver's for this service region.
Agency's Transportation policy prohibit transporting a client without maintaining at least one other passenger in the vehicle during the trip and include exceptions in the event that a 3 rd party is NOT present in the vehicle while transporting	Compliance	The agency policy required that all resident's not be allowed to be transported in a one on one transport situation with the exception of the approved third party not being available.

In the event that a 3rd party cannot be obtained for transport, the agency's supervisor or managerial personnel consider the clients' history, evaluation, and recent behavior	Compliance	The policy the agency utilizes requires that it assesses the resident's behavior, evaluations and assessment information prior to deeming them appropriate to be in a single transport situation. The agency utilizes a multi-phase process to evaluate the resident prior to granting third party status. The agency conducts an assessment process in individual client sessions.	
The 3 rd party is an approved volunteer, intern, agency staff, or other youth	Compliance	The program's policy outlines third party transport as staff members, volunteers, interns and residents. A review of the Vehicle Travel Log/Van log form for the last six months found evidence of staff, members, residents and volunteers listed in the transportation log on outings.	
The agency demonstrated evidence via logbook or other written verification that supervisor approval was obtained prior to all single youth transports.	Exception	Twenty-six single youth transports were reviewed.	Three single youth transports from 12/16/2024 were missing the approval and time, and one was also missing the supervisor signature.
When transporting a single client in a vehicle, there was documentation of the following: a. the transporting employee completed check-in by phone at agreed-upon intervals with the senior program leader, or designee, upon departure and arrival. b. the employee check-ins were documented by the manager or designee receiving the call.	Compliance	The Vehicle Travel Log/Van Log includes transport logs which included employee check-in by phone at agreed-upon intervals and upon departure and arrival whenever a single client was being transported. Employee check ins were documented by the manager receiving the call.	
There is documentation of use of vehicle that notes name or initials of driver, date and time, mileage, number of passengers, purpose of travel and location.	Compliance	The agency utilizes a Travel Log/Van form to document all general transport events. The form includes Destination/purpose, departure time, start of trip-mileage, end of trip return time, end of trip-mileage, and name and number of adults.	
Additional Comments: There are no additional comments for this indicator.			
1.07 - Outreach Services			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 1.07	YES		
	If NO, explain here:		
	Agency policies related to this indicator include P-1050 is called Outreach Plan for Targeting Youth For Program Services approved and Roles and P-1053 Responsibilities - Prevention Outreach. These policies were reviewed and approved on 1/10/2025 by the Chief Operations Officer		
The program has a lead staff member designated to participate in local DJJ board, Circuit and Council meetings with evidence that includes minutes of the event or other verification of staff participation.	Compliance	The agency provided verification of attendance to meetings with the local DJJ Circuit Advisory Board (CAB7) and the Putnam County Juvenile Justice Council at all scheduled meetings over the last six months.	

<p>The program maintains written agreements with other community partners which include services provided and a comprehensive referral process.</p>	<p>Compliance</p>	<p>The agency has proof of established partnership agreements with local community based organizations. The agreements include school board, mental health receiving facilities, law enforcement, and law enforcements. The agency has evidence of providing referrals to local facilities such as mental health and substance abuse prevention services organizations.</p>	
<p>The program will maintain documentation of outreach activities and enter into NetMIS the title, date, duration (hours), zip code, location description, estimated number of people reached, modality, target audience and topic.</p>	<p>Compliance</p>	<p>The agency utilizes multiple staff members to provide outreach services. The agency documents all outreach events and includes the event, date, location, duration of the event, target group and contacts made.</p>	
<p>The program has designated staff that conducts outreach which is defined in their job description.</p>	<p>Compliance</p>	<p>The agency has community counseling and other designated program staff members to conduct outreach activities. Staff serving in this role are The me of position title for staff reviewed Community counseling</p>	

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

Standard Two – Intervention and Case Management

2.01 - Screening and Intake

		<p>Satisfactory</p>	
<p>Provider has a written policy and procedure that meets the requirement for Indicator 2.01</p>		<p>YES If NO, explain here: Agency policies related to this indicator include P-1112 is called Screening Process. This policy was reviewed and approved on 1/10/2025 by the Chief Operations Officer.</p>	
<p>Shelter youth: Eligibility screening form is completed immediately for all shelter placement inquiries.</p>	<p>Compliance</p>	<p>Six residential files, one open and five closed, were reviewed. All six files contained evidence of screening forms being completed immediately for all placement inquiries.</p>	
<p>Community counseling: Eligibility screening form is completed within 3 business days of referral by a trained staff using the Florida Network screening form.</p>	<p>Compliance</p>	<p>Four community counseling files, one open and three closed, were reviewed. All four files contained evidence of screening forms being completed within three business days of a referral.</p>	
<p>There is evidence all referrals for service is screened for eligibility and is logged in NetMIS within 72 hours of screening completion.</p>	<p>Compliance</p>	<p>Ten files, six residential and four community counseling, were reviewed. All ten files contain evidence that all referrals are screened for eligibility and logged into NetMIS within 72 hours.</p>	
<p>Youth and parents/guardians receive the following in writing: a. Available service options b. Rights and responsibilities of youth and parents/guardians</p>	<p>Compliance</p>	<p>All ten files reviewed (six residential and four community counseling) contain evidence that youth and parents/guardians receive the following in writing: a. Available service options b. Rights and responsibilities of youth and parents/guardians</p>	

<p>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</p>	<p>Compliance</p>	<p>All ten files reviewed (six residential and four community counseling contain evidence that the following is 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</p>	
<p>During intake, all youth were screened for suicidality and correctly assessed as required if needed.</p>	<p>Compliance</p>	<p>Ten files, six residential and four community counseling, were reviewed. All ten files contain evidence of youth being screened for suicidality and further assessed of necessary.</p>	
<p>Additional Comments: There are no additional comments for this indicator.</p>			
<p>2.02 - Needs Assessment</p>			<p>Satisfactory with Exception</p>
<p>Provider has a written policy and procedure that meets the requirement for Indicator 2.02</p>	<p>YES</p>		
	<p>If NO, explain here:</p>		
	<p>The agency has the required policy and procedure P-1019 called Needs Assessment that was last reviewed and approved on 1/10/2025 by the Chief Operations Officer.</p>		
<p>Shelter Youth: NIRVANA is initiated within 72 hours of admission</p>	<p>Exception</p>	<p>All six residential files reviewed contained evidence of Nirvana being initiated within 72 hours of admission.</p>	<p>All six residential files reviewed contain Nirvana assessments completed by a counselor who has not completed the Nirvana assessment training. She is scheduled to complete training on 6/30/25. The staff member completing the Nirvana assessment is under the supervision of a licensed clinician. One of the six residential files reviewed contain a NIRVANA assessment that is missing the assessor's signature.</p>
<p>Non-Residential youth: NIRVANA is initiated at intake and completed within 2 to 3 face-to-face contacts after the initial intake OR updated, if most recent assessment is over 6 months old</p>	<p>Compliance</p>	<p>All four community counseling files contained evidence of Nirvana being initiated at intake and completed within two-three face-to-face contacts.</p>	
<p>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.</p>	<p>Compliance</p>	<p>All ten files reviewed (six residential and four community counseling) contain evidence of the supervisor's signature on completed Nirvana assessments.</p>	
<p>(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.</p>	<p>Exception</p>	<p>Five of the six residential files reviewed contain evidence of the NIRVANA Self-Assessment being completed within 24 hours of admission.</p>	<p>One of the six residential files reviewed contained a NIRVANA Self-Assessment dated three days after admission to shelter.</p>

A NIRVANA Post-Assessment is completed at discharge for all youth who have a length of stay that is greater than 30 days.	Compliance	One residential and three community counseling files required a NIRVANA Post-Assessment. All four files contain evidence of completion.	
A NIRVANA Re-Assessment is completed every 90 days excluding files for youth receiving SNAP services.	Compliance	One community counseling file required a NIRVANA Re-Assessment and the file contained evidence of completion.	
All files include the interview guide and/or printed NIRVANA.	Compliance	All ten files reviewed (six residential and four community counseling) included the printed NIRVANA.	
Additional Comments: There are no additional comments for this indicator.			
2.03 - Case/Service Plan			Satisfactory with Exception
Provider has a written policy and procedure that meets the requirement for Indicator 2.03	YES		
	If NO, explain here:		
	The agency has the required policy and procedure P-1162 called Individual Plan. This policy was last reviewed and approved on 1/10/2025 Cindy Starling, Chief Operations Officer.		
The case/service plan is developed on a local provider-approved form or through NETMIS and is based on information gathered during the initial screening, intake, and NIRVANA.	Compliance	All ten files reviewed (six residential and four community counseling) had service plans that were developed on a provider-approved form. Documentation revealed the service plans were developed based upon information gathered at initial intake/screening.	
Case/Service plan is developed within 7 working days of NIRVANA	Exception	Nine of the ten (six residential and 4 community counseling) files reviewed contained documentation that the service plan was developed within seven days of admission.	One of the six residential files reviewed contained a service plan that was initiated nine days after admission.
Case plan/service plan includes: 1. Individualized and prioritized need(s) and goal(s) identified by the NIRVANA 2. Service type, frequency, location 3. Person(s) responsible 4. Target date(s) for completion and actual completion date(s) 5. Signature of youth, parent/guardian, counselor, and supervisor 6. Date the plan was initiated	Exception	Nine out of ten (six residential and four community counseling) files reviewed contain documentation that the service plan includes: 1. Individualized and prioritized need(s) and goal(s) identified by the NIRVANA 2. Service type, frequency, location 3. Person(s) responsible 4. Target date(s) for completion and actual completion date(s) 5. Signature of youth, parent/guardian, counselor, and supervisor 6. Date the plan was initiated	One of the six residential files reviewed contained a service plan that is missing the signature of the supervisor.

Case/service plans are reviewed for progress/revised by counselor and parent (if available) every 30 days for the first three months and every 6 months after	Exception	Eight of the ten (six residential and four community counseling) files reviewed contained documentation that service plans were reviewed for progress or revised by the counselor and parent (if available) every 30 days during the first three months.	Two of the six residential files reviewed did not have evidence of the service plan being renewed once the clients reached 30 days in shelter.
Additional Comments: There are no additional comments for this indicator.			
2.04 - Case Management and Service Delivery			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 2.04	YES		
	If NO, explain here:		
	The agency has the required policy and procedure P-1162 called the Individual Plan. This policy was last reviewed and approved on 1/10/2025 by the Chief Operations Officer.		
Counselor/Case Manager is assigned	Compliance	All ten files reviewed contain evidence of a counselor or case manager being assigned.	
<p>The Counselor/Case Manager completes the following as applicable:</p> <ol style="list-style-type: none"> 1. Establishes referral needs and coordinates referrals to services based upon the on-going assessment of the youth's/family's problems and needs 2. Coordinates service plan implementation 3. Monitors youth's/family's progress in services 4. Provides support for families 5. Monitoring progress of court ordered youth in shelter 6. Makes referrals to the case staffing to address problems and needs of the youth/family 7. Accompanies youth and parent/guardian to court hearings and related appointments 8. Refers the youth/family for additional services when appropriate 9. Provides case monitoring and reviews court orders 10. Provides case termination notes 11. Provides follow-up after 30 days post discharge 12. Provides follow-up after 60 days post discharge 	Compliance	<p>All ten files reviewed contain evidence that a counselor or case manager has completed (if applicable):</p> <ol style="list-style-type: none"> 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 	
The program maintains written agreements with other community partners that include services provided and a comprehensive referral process	Compliance	The agency's Chief Operations Officer provided the reviewer with documentation that outlines agreements with community partners which includes available services and a comprehensive referral process.	
Additional Comments: There are no additional comments for this indicator.			

2.05 - Counseling Services		Satisfactory with Exception	
Provider has a written policy and procedure that meets the requirement for Indicator 2.05	YES		
	If NO, explain here:		
	The agency has a policy P-1163 and procedure called Case Management, Counseling and Service Delivery. This policy was last reviewed and approved on 1/10/2025 by the Chief Operations Officer.		
Shelter Program			
Shelter programs provides individual and family counseling	Compliance	All residential counseling client files have proof of providing individual and family counseling services to each client and their families.	
Group counseling sessions held a minimum of five days per week	Exception	Group log binders from October 1, 2024 to April 23, 2025 were reviewed to assess the agency's adherence to the requirements of this indicator.	The group log binder was reviewed. During the week of March 16, 2025 only four groups were conducted. During the week of March 23, 2025 only four groups were conducted. During the week of March 30, 2025 only 1 group was conducted. During the week of April 6, 2025 only three groups were conducted.
Groups are conducted by staff, youth, or guests and group counseling sessions consist of : 1. A clear leader or facilitator 2.Relevant topic - educational/informational or developmental 3. Opportunity for youth to participate 4. 30 minutes or longer	Compliance	Group log binders were reviewed and it was documented that groups are conducted by staff members, youth, or guests and group counseling sessions consist of: 1. A clear leader or facilitator 2.Relevant topic - educational/informational or developmental 3. Opportunity for youth to participate 4. 30 minutes or longer	
Documentation of groups must include date and time, a list of participants, length of time, and topic.	Compliance	Group log binders revealed group documentation that includes: date, time, list of participants, length of time, and topic.	
Community Counseling			
Community counseling programs provide therapeutic community-based services designed to provide the intervention necessary to stabilize the family. Services are provided in the youth's home, a community location, the local provider's counseling office or virtually if written documentation is provided in the youth's file for reasons why it is in the best interest of the youth and family.	Compliance	The agency's community counseling program has evidence of providing therapeutic services with appropriate intervention methods to assist families based on their specific needs. The agency has evidence of applicable client files address the youth's needs.	

Counseling Services			
There is evidence the program completes review of all case files for coordination between presenting problem(s), psychosocial assessment, case/service plan, case/service plan reviews, case management, and follow-up.	Exception	Eight of the ten (six residential and four community counseling) file reviewed contained 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.	Two of the six residential files reviewed did not have evidence of the service plan being reviewed once the client reached 30 days in shelter.
Maintain individual case files on all youth and adhere to all laws regarding confidentiality.	Compliance	The agency has evidence of an individual case file on all residential and non-residential clients. Each client files have evidence of following the agency's confidentiality protocols.	
Case notes maintained for all counseling services provided and documents youth's progress.	Compliance	All ten (six residential and four community counseling files) contained evidence of case notes being maintained and documenting youth's progress.	
On-going internal process that ensures clinical reviews of case records and staff performance.	Compliance	The reviewer interviewed the counseling supervisor whom is a licensed LMHC. A binder with documentation of regular, consistent supervision of case records and staff performance was provided.	
When an intake is conducted through virtual means, consent is confirmed by the counselor, documented in the file, and reviewed with the supervisor during supervision/case review. There is written documentation provided in the youths file for reasons why virtual sessions are in the best interest of the youth and family.	No eligible items for review	The agency had no applicable cases for this indicator.	
Additional Comments: There are no additional comments for this indicator.			
2.06 - Adjudication/Petition Process			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 2.06	YES		
	If NO, explain here:		
	P-1159 Case Staffing Committee: Parent/Guardian Request. Revised 2/2008; Approved 1/12/2024 by Chief Operations Officer. P- 1160 Case Staffing Committee: Plan of Services. Revised 2/2008; Approved 1/10/2025 by Chief Operations Officer.		
Must include: a. DJJ rep. or CINS/FINS provider b. Local school district representative	Compliance	The agency did not have any applicable client files in order to review this indicator. The agency does have applicable adjudication or petition procedures required to be able service clients as needed. Additionally, the program has an established process to receive CINS petition cases. The committee includes the CINS/ FINS provider and representation from the local school district.	

Other members may include: a. State Attorney's Office b. Others requested by youth/ family c. Substance abuse representative d. Law enforcement representative e. DCF representative f. Mental health representative	Compliance	No applicable cases. Additional members may include the State Attorney's office, mental health/ substance abuse representative, law enforcement representative, DCF representative, and other requested by youth.	
The program has an established case staffing committee, and has regular communication with committee members	Compliance	Regularly scheduled meetings between the Clinical Director and Residential Supervisors and counselors are held to address case staffing case needs.	
The program has an internal procedure for the case staffing process, including a schedule for committee meetings	Compliance	Regularly scheduled meetings between the Clinical Director and Residential Supervisors are held to address case staffing needs.	
The youth and family are provided a new or revised plan for services	No eligible items for review	No applicable cases.	
Written report is provided to the parent/guardian within 7 days of the case staffing meeting, outlining recommendations and reasons behind the recommendations	No eligible items for review	No applicable cases.	
If applicable, the program works with the circuit court for judicial intervention for the youth/family	No eligible items for review	No applicable cases.	
Case Manager/Counselor completes a review summary prior to the court hearing	No eligible items for review	No applicable cases.	
Additional Comments: There are no additional comments for this indicator.			
2.07 - Youth Records			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 2.07	YES		
	If NO, explain here:		
	The agency's policy number is P-1046 titled Youth Case Record last reviewed on 1/10/2025 by the agency's Chief Operations Officer.		
All records are clearly marked 'confidential'.	Compliance	All files reviewed were marked confidential.	
All records are kept in a secure room or locked in a file cabinet that is marked "confidential"	Compliance	All records are kept in the counseling supervisor's office in locked filing cabinets. The cabinets are marked confidential.	

When in transport, all records are locked in an opaque container marked "confidential"	Compliance	Counselors are provided with lock boxes marked confidential for the transport of files.	
All records are maintained in a neat and orderly manner	Compliance	All files were well kept and organized with easy-to-read table of contents.	
SHELTER FILES contain the following: Table of Contents that outlines documents in each section: •Screening •Informed Consent • Photograph of the youth • Shelter Intake Form • Suicide Assessment (if needed) • NIRVANA Self Report (NSR) • NIRVANA full Assessment • Plan of Service • Chronological Notes • Medication Inventory Form • Approved contact list • Copies of referrals made & Follow-Up (if needed) • Discharge summary once case is closed	Compliance	All six residential files reviewed contain the following: Table of Contents that outlines documents in each section: •Screening •Informed Consent • Photograph of the youth • Shelter Intake Form • Suicide Assessment (if needed) • NIRVANA Self Report (NSR) • NIRVANA full Assessment • Plan of Service • Chronological Notes • Medication Inventory Form • Approved contact list • Copies of referrals made & Follow-Up (if needed) • Discharge summary once case is closed	
COMMUNITY COUNSELING FILES contain the following: Table of Contents that outlines documents in each section: • Screening • Informed Consent • Community Counseling Intake Form • Suicide Assessment (if needed) • NIRVANA full Assessment • Plan of Service • Chronological case notes • Copies of referrals made & Follow-Up (if needed) • Discharge summary once the case is closed	Compliance	All four community counseling files reviewed contain the following: Table of Contents that outlines documents in each section: • Screening • Informed Consent • Community Counseling Intake Form • Suicide Assessment (if needed) • NIRVANA full Assessment • Plan of Service • Chronological case notes • Copies of referrals made & Follow-Up (if needed) • Discharge summary once the case is closed	
All records kept electronically, are maintained securely and can be made immediately available upon request for audit purposes.	Compliance	Administrative assistant and counseling supervisor made available electronic documentation as requested.	
Records are retained for the duration of the time specified by the contract.	Compliance	The agency has documentation that outlines the requirements for the retaining of records.	
Additional Comments: There are no additional comments for this indicator.			

2.08 - Specialized Additional Program Services		Satisfactory with Exception	
Provider has a written policy and procedure that meets the requirement for Indicator 2.08	YES		
	If NO, explain here:		
	Indicate policy title(s), policy number(s), authorized signee, date(s) of last review/revision/approval: The agency's policy number is P-1248 titled Staff Secure Shelter Services, P-1249 titled Staff Secure Shelter - Program Overview, P-1267 titled Domestic Violence Respite, P-1279 titled Probation Respite, P1282 titled Domestic Minor Sex Trafficking, P-1283 titled FYRAC Non-Residential Services, P-1301 Specialized Additional Program services. Each policy numbers were last reviewed on 1/10/2025 by the agency's COO Cindy Starling.		
Staff Secure			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	No eligible items for review	The agency reported they did not have any youth receiving these Staff Secure services since the last QI review.	
Staff Secure policy and procedure outlines the following: a. In-depth orientation on admission b. Assessment and service planning c. Enhanced supervision and security with emphasis on control and appropriate level of physical intervention d. Parental involvement e. Collaborative aftercare	No eligible items for review		
Program only accept youth that meet legal requirements of F.S. 984 for being formally court ordered in to Staff Secure Services	No eligible items for review		
Staff Assigned: a. One staff secure bed and assigned staff supervision to one staff secure youth at any given time b. Program assign specific staff during each shift to monitor location/ movement of staff secure youth c. Agency clearly documents the specific staff person assigned to the staff secure youth in the logbook or any other means on each shift	No eligible items for review		
Agency provides a written report for any court proceedings regarding the youth's progress	No eligible items for review		

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

Youth length of stay in DV Respite placement does not exceed 21 days. If more than 21 days, documentation exists in youth file of transition to CINS/FINS or Probation Respite placement, if applicable.	Compliance	Both files revealed the youths' did not remain in DV Respite Placement for more than 21 days.	
Case plan in file reflects goals for aggression management, family coping skills, or other intervention designed to reduce propensity for violence in the home	Compliance	Both files contain documentation of a case plan that reflects goals for aggression management, family coping skills, or other intervention designed to reduce propensity for violence in the home	
All other services provided to Domestic Violence Respite youth are consistent with all other general CINS/FINS program requirements	Compliance	Both files demonstrated that all other services provided to youth are consistent with all of the other general CINS/FINS program requirements.	
Probation Respite			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	No eligible items for review	The program has not served this program type since the last QI review. The agency did not have any Probation Respite referrals. Agency does have an up to date policy and procedure which specifically addresses the requirements of this indicator in the event the services are requested.	
All probation respite referrals are submitted to the Florida Network.	No eligible items for review		
All Probation Respite Referral come from DJJ Probation and there is evidence that the youth is on Probation regardless of adjudication status.	No eligible items for review		
Data entry into NetMIS and JJIS within (3) business days of intake and discharge	No eligible items for review		
Length of stay is no more than fourteen (14) to thirty (30) days. Any placement beyond thirty (30) days contains evidence in the file that the JPO was contacted in writing to request the need of an extension no later than the 25th day the youth was admitted into the program.	No eligible items for review		
All case management and counseling needs have been considered and addressed	No eligible items for review		
All other services provided to Probation Respite youth are consistent with all other general CINS/FINS program requirements	No eligible items for review		

Intensive Case Management (ICM)			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	Not Applicable	The agency reports they are not contracted to provide ICM services.	
Youth receiving services were deemed chronically truant and/or runaway and require more intensive and lengthy services. The youth was determined to be eligible because they have gone through petition and/or case staffing and was in need of case management services.	Not Applicable		
Services for youth and family include: a. Two (2) direct contacts per month b. Two (2) collateral contacts per week c. Direct and collateral contacts not obtained must have documentation to support attempts made to obtain them. All reasonable attempts (at minimum of three) must be made to reach all contacts (direct and collateral) and documented in the case file and NetMIS.	Not Applicable		
Assessments include a. NIRVANA at intake b. NIRVANA Re-Assessment every 90 days c. Post NIRVANA at discharge as aligned with timeframe requirements	Not Applicable		
Service/case plan demonstrates a strength-based, trauma-informed focus	Not Applicable		
For any virtual services provided, there is written documentation in the youths' file as to why virtual contact is in the best interest of the youth and family	Not Applicable		
Family and Youth Respite Aftercare Services (FYRAC)			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	Yes	The agency had three FYRAC cases in the last six months.	
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.	Compliance	All three files contain evidence of being referred by DJJ following a domestic violence arrest and/or the youth was on probation and at risk of violating.	
Agency has evidence that all FYRAC referrals have documented approval from the Florida Network office	Exception	Two of the three files reviewed had documentation of approval from the Florida Network.	One of the three FYRAC files reviewed did not contain evidence of documentation of approval from the Florida Network office.

<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>Compliance</p>	<p>All three files contain documentation that reveals 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>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>Compliance</p>	<p>All three files contain documentation that reveals 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>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>Compliance</p>	<p>All three files contain evidence that 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>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>No eligible items for review</p>	<p>The agency reported that a limited number of clients of only 3 clients served at different times significantly reduced the opportunities to conduct group sessions with these clients.</p>	

There is evidence of completed 30 and/or 60 day follow-ups and is documented in NetMIS following case discharge.	Exception	A review of three FYRAC files were reviewed to assess the agency's adherence to the requirement of this indicator.	All three of the FYRAC files reviewed did not have 30 or 60 day follow-ups completed and documented in Netmis.
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	Compliance	One of the files had evidence of participating in services for 90 consecutive days. Two of the files did not contain evidence of participation for at least 13 sessions or 90 consecutive days. However; DJJ sent out a directive to discharge cases who were close to the end of services due to elimination of FYRAC on December 31, 2024.	
Any service that is offered virtually, is documented in the youth's file why it was in the youth and families best interest.	Compliance	Only one of the three files reviewed required virtual sessions in which documentation revealed why it was in the best interest of the youth and family.	
All data entry in NetMIS is completed within 3 business days as required.	Compliance	All three files provided documentation that revealed all data entry in NetMIS is completed withing three business days.	
Additional Comments: There are no additional comments for this indicator.			
2.09- Stop Now and Plan (SNAP)			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 2.09	YES		
	If NO, explain here:		
	Indicate policy number, authorized signee, date(s) of last review/revision/approval: The agency's policy number is P-1291 titled SNAP for school and communities P-1299 titled SNAP Screening and Intake P-1300 titled SNAP Discharge Requirements. It was last reviewed on 1/10/2025 by the agency's Chief Operations Officer.		
SNAP Clinical Groups Under 12			
Youth are screened to determine eligibility of services with the required documents: a. Florida Network Youth Screening Form b. SNAP® Brief Intake Screening Checklist	Compliance	Four SNAP (under 12) files were reviewed and all four contained evidence that youth are screened to determine eligibility of services with the required documents: a. Florida Network Youth Screening Form b. SNAP® Brief Intake Screening Checklist	
All files contain each of the required documents below: a. SNAP Child Screening Interview Report b. Florida Network Community Counseling Intake Form c. Reinforcement Trap/Coercive Cycle Diagram d. Consent to Treatment and Participation in Research Form	Compliance	All four files contain each of the required documents below: a. SNAP Child Screening Interview Report b. Florida Network Community Counseling Intake Form c. Reinforcement Trap/Coercive Cycle Diagram d. Consent to Treatment and Participation in Research Form	

The NIRVANA was completed at initial intake, or within two sessions.	Compliance	All four files reviewed contain evidence that the NIRVANA was completed during initial intake.	
There is evidence of the completed the Pre - Child Behavior Checklist (CBCL) by the caregiver and is located within the file.	Compliance	All four files contain evidence of the completed the Pre - Child Behavior Checklist (CBCL) by the caregiver and is located within the file.	
There is evidence of the completed Pre - TOPSE is completed by the caregiver and is located within the file.	Compliance	All four files contain evidence of the completed Pre - TOPSE is completed by the caregiver and is located within the file.	
There is evidence of the following documents located within the file: a. SNAP® Parent Goal Sheet b. Child Way To Go Goal Sheet (This may be in progress for open files but is required for all closed files.)	Compliance	In all four files there is evidence of the following documents located within the file: a. SNAP® Parent Goal Sheet b. Child Way To Go Goal Sheet	
SNAP Clinical Groups Under 12 - Discharge			
There is evidence of the completed the Post - Child Behavior Checklist (CBCL) by the caregiver and is located within the file.	Compliance	All four files have evidence of the completed the Post - Child Behavior Checklist (CBCL) by the caregiver and is located within the file.	
There is evidence of the completed Post - TOPSE is completed by the caregiver and is located within the file.	Compliance	All four files contain evidence of the completed Post - TOPSE is completed by the caregiver and is located within the file.	
There is evidence of the completed SNAP Discharge Report located within the file for any discharged youth.	Compliance	All four files contain evidence of the completed SNAP Discharge Report located within the file for any discharged youth.	
There is evidence of the SNAP Boys/SNAP Girls Child Group Evaluation Form located in the file.	Compliance	All four files have evidence of the SNAP Boys/SNAP Girls Child Group Evaluation Form located in the file.	
There is evidence of the SNAP Boys/SNAP Girls Parent Group Evaluation Form located in the file.	Compliance	All four files have evidence of the SNAP Boys/SNAP Girls Parent Group Evaluation Form located in the file.	
SNAP Clinical Groups for Youth 12-17			
Youth are screened to determine eligibility of services using the Florida Network Youth Screening Form.	No eligible items for review	The agency does not have a contract with the Florida Network of Youth and Family Services to provide this specific Stop Now and Plan (SNAP) program.	
The file contains the completed Florida Network Community Counseling Intake Form and is located within the file.	No eligible items for review		

The Consent to Treatment and Participation in Research Form is completed, signed by the parent/guardian before receiving services, and located within the file.	No eligible items for review		
The NIRVANA was completed at initial intake, or within two sessions.	No eligible items for review		
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.	No eligible items for review		
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.	No eligible items for review		
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.	No eligible items for review		
All closed files contained evidence in the file a NIRVANA was completed at discharge.	No eligible items for review		
SNAP for Schools & Communities			
The program demonstrated all of the required weekly attendance sheets that included youth names and/or identifying numbers completed with the teacher and trained SNAP Facilitator signatures. <i>(This must include a total of 13 attendance sheets for a full cycle)</i>	Compliance	Two SNAP (in school) files were reviewed and both provided 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>	
The program maintained evidence of a completed 'Way to Go Goal' Sheet within the file.	Compliance	Both files maintained evidence of a completed 'Way to Go Goal' Sheet within the file.	
The program maintained evidence of both pre AND post Measure of Classroom Environment (MoCE) completed documents for the class reviewed.	Compliance	Both files contained evidence of both pre AND post Measure of Classroom Environment (MoCE) completed documents for the class reviewed.	
The program maintained evidence of completed pre and post evaluation documents for the class reviewed.	Compliance	Both files contained evidence of completed post evaluations. Documentation was provided to show that the pre evaluation is no longer required.	

<p>There is evidence of the SNAP® for Schools & Communities Feedback Form completed by the supervisory adult responsible for the support of the youth receiving services and entered into NetMIS.</p>	<p>Compliance</p>	<p>Both files had evidence of the SNAP® for Schools & Communities Feedback Form completed by the supervisory adult responsible for the support of the youth receiving services and entered into NetMIS.</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>Compliance</p>	<p>Both files contained evidence of one (1) Fidelity Adherence Checklist completed per classroom for the 13-week classroom sessions which is located in the file.</p>	
<p>Additional Comments: There are no additional comments for this indicator.</p>			
<p>Standard Three – Shelter Care</p>			
<p>3.01 - Shelter Environment</p>			<p>Satisfactory</p>
<p>Provider has a written policy and procedure that meets the requirement for Indicator 3.01</p>	<p>YES</p>		
	<p>If NO, explain here:</p>		
	<p>Policy # P-1293 Shelter Environment reviewed 12/24. Policy # 1165 Maintenance Plan & Safety Inspection reviewed 2/22. The policy was reviewed and signed / approved by COO on 1/10/25.</p>		
<p>Facility Inspection: a. Furnishings are in good repair. b. The program is free of insect infestation. c. Bathrooms and shower areas are clean and functional, free of foul odors, leaks, dust, and mildew and in good working order. d. There is no graffiti on walls, doors, or windows. e. Lighting is adequate for tasks performed there. f. Exterior areas are free of debris; grounds are free of hazards. g. Dumpster and garbage can(s) are covered. h. All doors are secure, in and out access is limited to staff members and key control is in compliance. i. Detailed map and egress plans of the facility, general client rules, grievance forms, abuse hotline information, DJJ Incident Reporting Number and other related notices are posted. j. Interior areas (bedrooms, bathrooms, common areas) do not contain contraband and are free from hazardous unauthorized metal/foreign objects.</p>	<p>Exception</p>	<p>All Furnishing appeared to be in good repair. The facility is free of insect infestation & no evidence of insect dropping or infestation in the shelter. The exit plans were located throughout the facility at the exit doors. The DCF / DJJ incident reporting is number is located throughout the shelter along with the abuse hotline. Observation on the exterior : white trim around the roof needs power washing and gutters. A side panel is missing. The side door has deterioration around the bottom of it on both sides. The gutter above the door is sinking downward. Observation on the bathrooms : Both girl & boy bathrooms have rust buildup around the showerheads.</p>	<p>Exterior roof edges and siding on exterior requiring cleaning and repair. Gutters need to be adjusted and or repaired to prevent excessive water from spilling over and pooling in areas leading to increase moisture and mildew accumulation. Shower heads in bathrooms are showing evidence of light rusting.</p>

<p>Facility Inspection: a. All agency and staff vehicles are locked. b. Agency vehicles are equipped with major safety equipment including first aid kit, (all items in the first aid kit are current and do not have expired items; all expired items should be replaced regularly), fire extinguisher, flashlight, glass breaker and, seat belt cutter.</p>	<p>Compliance</p>	<p>The facility has one transportation van 2024 Ford Transit 12 passenger vehicle. The van is equipped with a first aid kit, flashlight , glass breaker & seat beat cutter.</p>	
<p>Facility Inspection: All chemicals are listed, approved for use, inventoried weekly and perpetually, stored securely and Material Safety Data Sheets (MSDS) are maintained on each item (minimum 1 time per week or per agency policy). A perpetual inventory will be the primary means of maintaining a current and real-time inventory. The weekly inventory will be conducted weekly at a minimum to ensure that a perpetual inventory is being maintained consistently and accurately. If more than one location is used to store chemicals, there is an inventory wherever chemicals are stored that is current and well maintained unless previously approved by the Network.</p>	<p>Compliance</p>	<p>The chemicals are located in the laundry room. Material Safety Data Sheets (MSDS) were accurate and complete. There was evidence of a perpetual tracking of all chemicals inventory being utilized to track chemicals in real-time. The agency has a process to check the inventory</p>	
<p>Facility Inspection: Washer/dryer are operational & general area/lint collectors are clean. Agency has a current DCF Child Care License which is displayed in the facility. Each youth has own individual bed with clean covered mattress, pillow, sufficient linens and blanket. Youth have a safe, lockable place to keep personal belongings, if requested.</p>	<p>Compliance</p>	<p>Facility washer and dryer is located in the laundry room and the dryer's lint catcher is lint free. The DCF Child Care License is displayed in the front lobby. All youth have individual beds and linens are clean. Each youth has a safe storage container for personal belongings.</p>	
<p>Additional Facility Inspection Narrative (if applicable)</p>			

<p>Fire and Safety Health Hazards: a. Annual facility fire inspection was conducted, and the facility is in compliance with local fire marshal and fire safety code within jurisdiction. b. Agency completes a minimum of 1 fire drill on each shift monthly (within 2 minutes or less). c. Completes 1 mock emergency drill per shift per quarter. d. All annual fire safety equipment inspections are valid and up to date (extinguishers, sprinklers, alarm system and kitchen overhead hood, including fire extinguishers in all vehicles).</p>	<p>Compliance</p>	<p>The shelter's current fire inspection was conducted on 3/24/25 . Fire Drills were conducted on all three work shifts. First shift : 10/1,11/2,12/2,1/8,2/7,3/9. Second shift : 10/3,11/8,12/8,1/1,2/2,3/2. Third shift : 10/9,11/15,12/9,1/7,2/6. The shelter Mock drills was conducted on each shift per quarter on First shift : 10/3/, 1/7. Second shift : 10/15, 1/18. Third shift :10/29, 1/29. All Fire safety equipment has an updated inspection: Overhead hood: 10/24, Sprinkler System: Shelter under 12occupants are not required per interview with the Program Director by the Fire Marshall, Fire Alarm: 6/24. The most recent fire extinguishers inspection was conducted on 10/24.</p>	
<p>Fire and Safety Health Hazards: a. Agency has a current Satisfactory Residential Group Care inspection report from the Department of Health.b. Agency has a current Satisfactory Food Service inspection report from the Department of Health and food menus are posted, current and signed by Licensed Dietician annually.c. All cold food is properly stored, marked and labeled and dry storage/pantry area is clean and food is properly stored.d. Refrigerators/Freezers are clean and maintained at required temperatures and all small and medium sized appliances are operable and clean for use as needed.</p>	<p>Compliance</p>	<p>The agency Satisfactory Residential Group Care inspection /Satisfactory Food Service was conducted 12/10/24. A copy of the inspection was in the front lobby. All food was properly stored in the freezer, refrigerator and pantry. At the time of this onsite program review, all areas were found to be clean and organized. Freezer temp was 29 and Fridge temp was 36.</p>	
<p>Additional Fire and Safety Health Hazards Narrative (if applicable)</p>			

Youth Engagement			
<p>a. Youth are engaged in meaningful, structured activities (e.g., education, recreation, counseling services, life and social skill training) seven days a week during awake hours. Idle time is minimal.</p> <p>b. At least one hour of physical activity is provided daily.</p> <p>c. Youth are provided the opportunity to participate in a variety of faith-based activities. Non-punitive structured activities are offered to youth who do not choose to participate in faith-based activities.</p> <p>d. Daily programming includes opportunities for youth to complete homework and access a variety of age appropriate, program approved books for reading. Youth are allowed quiet time to read.</p> <p>e. Daily programming schedule is publicly posted and accessible to both staff and youth.</p>	Compliance	<p>Youth have a daily activity schedule for 7 days a week which is posted in the common areas. Included in the schedule is physical activity, meditation, & study hall time. An interview was conducted with the Program Director and it was reported that currently there is a search for a minister to visit the shelter once a week.</p>	
Additional Comments: There are no additional comments for this indicator.			
3.02 - Program Orientation			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 3.02	YES		
	If NO, explain here:		
	Policy # P1114 Reviewed last 7/14 . The policy was reviewed and signed/approved by the COO on 1/10/25.		
Youth received a comprehensive orientation and handbook provided within 24 hours	Compliance	All files reviewed had a orientation packet that was signed within 24 hours.	
<p>Orientation includes the following:</p> <p>a. Youth is given a list of contraband items</p> <p>b. Disciplinary action is explained</p> <p>c. Dress code explained</p> <p>d. Review of access to medical and mental health services</p> <p>e. Procedures for visitation, mail and telephone</p> <p>f. Grievance procedure</p> <p>g. Disaster preparedness instructions</p> <p>h. Physical layout of the facility</p> <p>i. Sleeping room assignment and introductions</p> <p>j. Suicide prevention- alerting staff of feelings or awareness of others having suicidal thoughts</p>	Compliance	<p>Review of seven files revealed that all youth files included documentation of the following :</p> <p>a. Youth is given a list of contraband items</p> <p>b. Disciplinary action is explained</p> <p>c. Dress code explained</p> <p>d. Review of access to medical and mental health services</p> <p>e. Procedures for visitation, mail and telephone</p> <p>f. Grievance procedure</p> <p>g. Disaster preparedness instructions</p> <p>h. Physical layout of the facility</p> <p>i. Sleeping room assignment and introductions</p> <p>j. Suicide prevention- alerting staff of feelings or awareness of others having suicidal thoughts</p>	

Documentation of each component of orientation, including orientation topics and dates of presentation, as well as signatures of the youth and staff involved is maintained in the individual youth record	Compliance	Evidence of documentation was noted in all client files reviewed. All files evidence of reviewing each component of orientation which included orientation topics, dates of presentation as well as signatures of youth and staff embers involved.	
3.03 - Youth Room Assignment			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 3.03	YES		
	If NO, explain here:		
	The agency Policy # P-1116 and is 3.03 Sleeping Arrangements. The policy was reviewed on January 11, 2024and signed / approved by Chief Operations Officer on 1/10/25.		
A process is in place that includes an initial classification of the youths, to include:			
<ul style="list-style-type: none"> a. Review of available information about the youth’s history, status and exposure to trauma b. Initial collateral contacts, c. Initial interactions with and observations or the youth d. Separation of younger youth from older youth, e. Separation of violent youth from non-violent youth f. Identification of youth susceptible to victimization g. Presence of medical, mental or physical disabilities h. Suicide risk i. Sexual aggression and predatory behavior j. Acute health symptoms requiring quarantine or isolation 	Compliance	A total of seven youth files were reviewed and all records included evidence of documentation of all youth room assignment information collected during the residential intake process.	
An alert is immediately entered into the program’s alert system when a youth is admitted with special needs and risks such as risk of suicide, mental health, substance abuse, physical health or security risk factors	Compliance	The shelter has a alert board that is located in the youth care worker office. The board consist of special needs and risks such as risk of suicide, mental health, substance abuse, physical health or security risk factors.	
Additional Comments: There are no additional comments for this indicator.			
3.04 - Log Books			Satisfactory with Exception
Provider has a written policy and procedure that meets the requirement for Indicator 3.04	YES		
	If NO, explain here:		
	Indicate policy number, authorized signee, date(s) of last review/revision/approval: Policy # P-1149 Program Log Book Reviewed 7/24. The policy was reviewed and signed / approved on 1/10/25 by the chief operations officer.		

Log book entries that could impact the security and safety of the youth and/or program are highlighted	Compliance	Evidence shows that log book entries are well highlighted to impact the security and safety of the youth.	
All entries are brief, legibly written in ink and include: • Date and time of the incident, event or activity • Names of youth and staff involved • Brief statement providing pertinent information • Name and signature of person making the entry	Compliance	Evidence shows that log book entries have dates, time, activity, youth names, info, and staff signatures.	
Recording errors are struck through with a single line. The staff person must initial and date the correction. The use of whiteout and erasures is prohibited.	Compliance	A random review of the log logbook was conducted. The review of logbooks over the last six months found staff members struck out words. Stricken words in most cases were initialed, but some were not dated. Interview with the Program Director revealed that the agency is working on a training for all staff to adopt the policy	Staff members struck out a word, initialed it, but did not date the logged entry.
The program director or designee reviews the facility logbook(s) every week and makes a note chronologically in the logbook indicating the dates reviewed and if any correction, recommendations and follow-up are required and sign/date the entry	Compliance	Evidence shows in the logbook the Program Director reviews the logbook daily 12/1/24-4/4/25, which indicated reviews included the last three shifts over the review period.	
All staff review the logbook of the previous two shifts and makes an entry signed and dated into the logbook indicating the dates reviewed	Compliance	Evidence shows from the logbook that staff members review the past three shifts upon beginning their work shift.	
At the beginning of their shift, oncoming supervisor and shelter counselor reviews the logbook of all shifts since their last log entry and makes a signed and dated entry and into log book indicating the dates reviewed.	Compliance	Evidence shows from the supervisor reviews the log book prior to their work shift back to the dates of their last know entry.	
Logbook entries include: a. Supervision and resident counts b. Visitation and home visits	Compliance	Evidence shows in the logbook from 11/2024-3/2025 of resident counts & youth outside visits over the review period.	
Additional Comments: There are no additional comments for this indicator.			
3.05 - Behavior Management Strategies			Limited
Provider has a written policy and procedure that meets the requirement for Indicator 3.05	YES		
	If NO, explain here:		
	The agency has a policy and procedures titled P-1123 Behavior Management Strategies. The policy was last reviewed on 1/10/2025 by the Chief Operations Officer.		

<p>The program has a detailed written description of the BMS and it is explained during program orientation</p>	<p>Compliance</p>	<p>A review and observations of the current behavior management plan was conducted. The program utilizes the "FACEBOOK"-Facilitating Activity and Communication Effectively model. Per policy and interview with Shelter Director, A "FACEBOOK" is provided to each youth upon admission.</p>	
<p>Behavior Management Strategies must include:</p>			
<p>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</p>	<p>Exception</p>	<p>The agency's FACE Behavior Management System is designed to introduce and teach youth prosocial behaviors and to help them understand their behavior and consequences of their actions. The agency addresses behavioral interventions which are applied immediately. The interventions are applied according to severity of the youth's behavior. The Behavior Management System uses a variety of incentives to encourage participation such as utilizing points that they have earned to purchase items from the program's Achievement Store. Appropriate consequences and sanctions are required to be used by all staff members. The agency also incorporates counseling, verbal interventions and de-escalation as techniques used prior to any physical intervention being implemented. Group discipline is not imposed and room restriction is not a part of the Behavior Management System. Youth are not denied their basic rights or any services they are required to receive during their shelter stay.</p>	<p>Four residents do not have completed FACEBOOK Assessments that capture status of Targeting Skills, Assessment Level and Daily Skills Reviewed. Six of the seven clients files reflect intermittent occurrences of inconsistent documentation of specific behavior, YCW initials and daily points tally across some work shifts (8-4 and 4-12).</p>
<p>Program's use of the BMS</p>			
<p>All staff are trained in the theory and practice of administering BMS rewards and consequences</p>	<p>Compliance</p>	<p>Staff are trained during their initial on the job training session Training includes staff members understanding and the utilization of applying the Behavior Management System rewards and consequences.</p>	
<p>There is a protocol for providing feedback and evaluation of staff regarding their use of BMS rewards and consequences</p>	<p>Exception</p>	<p>Feedback and evaluation is provided to staff members regarding their use of the Behavior Management Systems rewards and consequences.</p>	<p>Interviews with both staff members and supervisors indicate inconsistent understanding and application and consistency in the use of the current behavior management system.</p>

Supervisors are trained to monitor the use of rewards and consequences by their staff	Exception	Supervisors are trained to monitor the use of consequences and rewards by their staff.	Proof of reviews of staff member application of the Behavior Management System and provide detailed use of all staff members proficiency in the use the awards system are vague and inconsistent across staff members.
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Additional Comments: There are no additional comments for this indicator.

3.06 - Staffing and Youth Supervision	Satisfactory
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Provider has a written policy and procedure that meets the requirement for Indicator 3.06	YES		
	If NO, explain here:		
		Policy # P-1121 Supervision & Staffing Ratio/ Scheduling . Reviewed 12/24. The policy was last reviewed on 1/10/2025 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	Compliance	Reviewed in the log book during the day and night hours, there's a staff to youth ratio. During the day it's 1:6 and at night 1:12 - sleeping . Two staff members are always on overnights.	
All shifts must always provide a minimum of two direct care staff present that have met the minimum training requirements	Compliance	Direct staff members files reviewed have evidence present indicating that they have met the minimum training requirements.	
Program staff included in staff-to-youth ratio includes only staff that are background screened and properly trained youth care workers, supervision staff, and treatment staff	Compliance	Total of seven staff members were properly trained & had background screening.	
The staff schedule is provided to staff or posted in a place visible to staff	Compliance	Staff member schedules are observed in the employee only office	
There is a holdover or overtime rotation roster which includes the telephone numbers of staff who may be accessed when additional coverage is needed	Compliance	All staff members contact information is located in the employee only office .	
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	Compliance	A review of the video was reviewed on dates 3/24,3/29,4/1,4/8,4/10 from the hours of 1 am - 6am. Staff members observed youth while sleeping every 15 minutes. It was documented in the log book & bed scanner.	

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

3.07 - Video Surveillance System	Satisfactory
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Provider has a written policy and procedure that meets the requirement for Indicator 3.07	YES	
	If NO, explain here:	

Surveillance System			
<p>The agency, at a minimum, shall demonstrate:</p> <ul style="list-style-type: none"> a. A written notice that is conspicuously posted on the premises for the purpose of security b. System can capture and retain video photographic images which must be stored for a minimum of 30 days c. System can record date, time, and location; maintain resolution that enables facial recognition d. Back-up capabilities consist of cameras' ability to operate during a power outage e. Have cameras placed in interior (e.g. intake office, counseling office, cafeteria, day room) and exterior (e.g. entrance/exit, recreation area, parking lot) general locations of the shelter where youth and staff congregate and where visitors enter and exit; to include locations where youth searches are conducted. Cameras are never placed in bathrooms or sleeping quarters. f. All cameras are visible 	<p>Compliance</p>	<p>The following observations of the youth shelter included the fa sign in Lobby stating Video Surveillance in progress. Additional observations included:</p> <ul style="list-style-type: none"> a. written notice that is conspicuously posted on the premises for the purpose of security b. System can capture and retain video photographic images which must be stored for a minimum of 30 days c. System can record date, time, and location; maintain resolution that enables facial recognition d. Back-up capabilities consist of cameras' ability to operate during a power outage e. Have cameras placed in interior (e.g. intake office, counseling office, cafeteria, day room) and exterior (e.g. entrance/exit, recreation area, parking lot) general locations of the shelter where youth and staff congregate and where visitors enter and exit; to include locations where youth searches are conducted. Cameras are never placed in bathrooms or sleeping quarters. f. All cameras are visible 	
<p>A list of designated personnel who can access the video surveillance system is maintained (includes off-site capability per personnel)?</p>	<p>Compliance</p>	<p>A list of staff members is located in the office of those individuals that have access to the video surveillance system.</p>	
<p>Supervisory review of video is conducted a minimum of once every 14 days and timeframes reviewed are noted in the logbook.</p>	<p>Compliance</p>	<p>During Observation & interview with PD -it's noticed that the dates in the surveillance review binder are different then dates in the logbook. However observation of video dates in the log book indicates that review is every seven days.</p>	
<p>The reviews assess the activities of the facility and include a review of random sample of overnight shifts</p>	<p>Compliance</p>	<p>The agency provided proof of camera reviews and assesses general activities of the facility and includes a review of random sample of overnights shifts.</p>	
<p>Grant the requesting of video recordings to yield a result within 24-72 hours from program quality improvement visits and when an investigation is pursued after an allegation of an incident</p>	<p>Compliance</p>	<p>Observation of the agency's camera system shows that video recordings can be produced upon request for all official need to know parties.</p>	
<p>Camera service order/requests will be made within 24 hours of discovery of camera malfunctioning or being inoperable. All efforts made to obtain repairs are documented and maintained</p>	<p>Compliance</p>	<p>Interview with the agency program director indicated that any malfunction of cameras will be reported immediately.</p>	
<p>Additional Comments: There are no additional comments for this indicator.</p>			

Standard Four – Mental Health/Health Services			
4.01 - Healthcare Admission Screening		Satisfactory with Exception	
Provider has a written policy and procedure that meets the requirement for Indicator 4.01	YES		
	If NO, explain here:		
	The agency has a policy P-1117. Preliminary Physical Health Screening. The policy was last reviewed on 1/10/2025 by the Chief Operations Officer.		
Preliminary Healthcare Screening			
Screening includes : a. Current medications b. Existing (acute and chronic) medical conditions c. Allergies d. Recent injuries or illnesses e. Presence of pain or other physical distress f. Observation for evidence of illness, injury, physical distress, difficulty moving, etc. g. Observation for presence of scars, tattoos, or other skin markings h. Acute health symptoms requiring quarantine or isolation	Exception	The agency has policy regarding the healthcare admission screening requirements. A total of seven youth records were reviewed for primary healthcare screenings and observations documented for each youth admitted to the program which included current medications, existing medical conditions, allergies, recent injuries and illnesses, presence of pain or other physical distress, observations for evidence of illness, injury, pain or physical distress, difficulty moving, presence of scars, tattoos, or other skin markings and acute healthcare symptoms requiring quarantine or isolation.	Two resident files do not have evidence of review by the RN. An additional resident file has evidence that the file was reviewed, but there is no date documented.
Referral and Follow-Up			
Youth with chronic medical conditions have a referral to ensure medical care (e.g. diabetes, pregnancy, seizure disorder, cardiac disorders, asthma, tuberculosis, hemophilia, head injuries, etc.)	Compliance	The program has policy and procedures to ensure youth with chronic medication conditions have a referral for medical care, as required. A review of seven client files was conducted. None of the youth reviewed were applicable to requiring a referral for medical care for chronic conditions.	
When needed, the parent is involved with the coordination and scheduling of follow-up medical appointments	Compliance	A review of seven client files was conducted. None of client files reviewed were applicable to requiring a parent referral for medical care appointments.	
All medical referrals are documented on a daily log.	Compliance	None of client files reviewed were applicable for requiring a medical referral in a medical log.	
The program has a thorough referral process and a mechanism for necessary follow-up medical care as required and/or needed	Compliance	The agency has procedures that include addressing referrals for necessary follow-up medical care for youth admitted with chronic medical conditions. This process includes contacting the parent/guardian, youth's physician if the parent/guardian is unavailable, or 9-1-1 if an emergency, and documenting the Medical Health Follow-Up Form if applicable.	
Additional Comments: There are no additional comments for this indicator.			

4.02 - Suicide Prevention		Satisfactory	
Provider has a written policy and procedure that meets the requirement for Indicator 4.02	YES		
	If NO, explain here:		
	The agency has a policy P-1247. Suicide Prevention. The policy was last reviewed on 1/10/2025 by the Chief Operations Officer.		
Suicide Risk Screening and Approval (Residential and Community Counseling)			
Suicide risk screening occurred during the initial intake and screening process. Suicide screening results reviewed and signed by the supervisor and documented in the youth's case file.	Compliance	The agency has a process in place which includes prevention, observation and assessment of suicide risk during the intake and screening process. Five client files were reviewed. All five youth had a suicide risk screening occur during the initial intake and screening process. Suicide screening results were reviewed and signed by the supervisor and documented in the youth's case file in all five records reviewed.	
The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	Compliance	The agency's suicide risk assessment process has been approved by the Florida Network of youth and Family Services. The agency has made no changes to the process since the last onsite program review.	
Supervision of Youth with Suicide Risk (Shelter Only)			
Youth are placed on the appropriate level of supervision based on the results of the suicide risk assessment.	Compliance	All five residential client files were reviewed and all five contained evidence of each file being assessed by a licensed professional licensed professional within twenty-four hours from the suicide risk screening results, or the morning of the first business day. All five residential youth files were placed on the appropriate level of supervision based on the results of the suicide risk assessment.	
Staff person assigned to monitor youth maintained one-to-one supervision or constant supervision and documented his/her observations of the youth's behavior at 30 minute or less intervals	Compliance	The agency requires a designated staff member conduct rounds on each work shift to monitor the status of the youths' behavior at 30 minute, or less, intervals and included the time of day, behavioral observations, any warning signs observed, and the initials of the staff member conducting rounds in the residential client record.	

Documentation includes the time of day, behavioral observations, any warning signs observed, and the observers' initials and was maintained in either an observation log or in the shelter daily log.	Compliance	All elevated supervision rounds on suicide prevention checks include proof of the staff member documenting warning signs and overall status of youth. The agency documents placing youth on, ongoing status checks and youth being removed from elevated supervision status in the program log book as required.	
Supervision level was not changed/reduced until a licensed professional or a non-licensed mental health professional under the supervision of a licensed professional completed a further assessment OR Baker Act by local law enforcement	Compliance	All client records document all status movements of youth which include placement, sustainment and removal until approved by the agency's licensed professional.	
There was evidence that documentation was reviewed by supervisory staff each shift. If program uses an observation log, completed logs are maintained in the youth's file.	Compliance	There agency provided proof of documenting all supervision round being documented by supervisory staff on work shift, and the completed observation log forms were maintained in the resident's file in all five client file records.	
Youth with Suicide Risk (Community Counseling Only)			
Youth identified for suicide risk during intake was immediately assessed by a licensed professional or non-licensed professional (under the direct supervision of a licensed mental health professional) and the parents and supervisor were both notified of the results.	Compliance	The agency reported that one Community Counseling youth client record was screened for suicide risk responded with a positive response on one of the five suicide risk screening questions. The agency's clinician is documented as completing and overseeing the assessment. A parent was notified and onsite.	
During the intake, if the appropriate staff is unavailable, youth identified for suicide risk was immediately referred by the provider and the parent/guardian is notified of the suicide risk findings disclosed and advised that an Assessment of Suicide Risk should be completed ASAP by a licensed professional.	Compliance	The agency provided the youth and family with all information for local referral sources tor further assessment as required.	
Information on resources available in the community for further assessment was provided to the parent/guardian and is documented in the youth's file and signed by the parent/guardian OR a written follow-up notification was sent by certified mail if the parent/guardian was not present during the screening and was notified by telephone.	Compliance	The agency provided safety plan information to the parent/guardian and this is documented in the youth's file and signed by the parent/guardian onsite.	
If the parent/guardian cannot be contacted, all efforts to contact them are documented in the case file.	Compliance	The parent was documented as being onsite during the intake and assessment process.	
When the screening was completed during school hours on school property, the appropriate school authorities were notified.	Not Applicable	Youth intake and assessment was conducted onsite at the agency.	
Additional Comments: There are no additional comments for this indicator.			

4.03 - Medications		Satisfactory with Exception	
<p>Provider has a written policy and procedure that meets the requirement for Indicator 4.03</p>		<p>YES</p>	
		<p>If NO, explain here:</p>	
		<p>Agency policy and procedures P-1120 Medication Provision, Storage, Access, Inventory and Disposal (1/2024), P-1200 Medication-Training and Education (1/2024), P-1306 Naloxone Policy (8/2024) meet the requirements of this indicator. Each policy was reviewed and approved on 1/10/2025 by the Chief Operations Officer.</p>	
<p>The agency has a Registered Nurse (RN) and/or a Licensed Practical Nurse (LPN) that is being supervised by RN and all of their credentials have been verified.</p>	<p>Compliance</p>	<p>The agency RN has a valid and clear license.</p>	
<p>The agency has evidence of the following for all non-nursing shelter staff designated to assist with the self-administration of medication: a. Documentation of in-person self-administration of medication distribution training provided by a Registered Nurse b. Evidence demonstrating their competency to assist with self-administration of medication distribution c. Maintenance of their annual medication training re-certification</p>	<p>Exception</p>	<p>The RN reported and a review of training files confirmed that staff initially receive a 4 part-training (detailed medication Training, Pyxis Training, Epi-Pen training and observation of medication administration).</p>	<p>The RN reported and a review of training files confirmed that after the initial training, the current practice is the provision of re-fresher trainings annually in a group setting that do not individually assess each person's competency to continue the function of administering medications. The training documents do not explicitly document the staff member's competency and certification. The RN reported that this practice will be changed immediately to reflect the assessment of competency and re-certification requirements.</p>
<p>The agency held at least quarterly staff meetings conducted by RN and/or Shelter Manager to review and assess: a. strategies implemented to reduce medication errors shelter wide b. analyze factors that contributed to medication errors c. allow staff the opportunity to practice and role-play solutions</p>	<p>Compliance</p>	<p>The RN reported and a review of staff meeting minutes confirm that medication administration strategy/med training is incorporated in monthly staff meetings, rather than quarterly. RN reported the following strategies are utilized to ensure medications are given within the 2 hour time frame: Alarm clock, documenting in log book or providing verbal reminders during shift change if there is atypical med time, RN texts or calls staff on weekends to remind and ensure meds are given timely. Review of log book indicates that staff notate in logbook after medication passes are completed.</p>	
<p>The agency has strategies implemented to ensure medications are provided within the 2-hour time frame.</p>	<p>Compliance</p>	<p>RN reported the following strategies are utilized to ensure medications are given within the 2 hour time frame: Alarm clock, documenting in log book or providing verbal reminders during shift change if there is atypical med time, RN texts or calls staff on weekends to remind and ensure meds are given timely.</p>	

<p>All non-licensed staff members are clearly identified and designated on the staff schedule and shift change report/shift responsibility form for assisting with the self-administration of medications on each shift</p>	<p>Compliance</p>	<p>The RN provides medications when she is on-site and trained/approved staff provide medications when she is not scheduled, confirmed by review of schedule.</p>	
<p>The agency has clear methods of communicating which youth are on medications with the times and dosage easily discernable by all staff on each shift.</p>	<p>Compliance</p>	<p>RN reported the following strategies are utilized to ensure medications are given within the 2 hour time frame: Alarm clock, documenting in log book or providing verbal reminders during shift change if there is atypical med time, RN texts or calls staff on weekends to remind and ensure meds are given timely.</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>Compliance</p>	<p>This reviewer observed the RN conducting a med pass it was consistent with the FN policy and procedure: The youth was asked his name and his identity was verified. The RN asked youth if he experienced any side effects. The RN reviewed MAR, opened Pyxis machine and compared prescription bottle with MAR, removed 1 pill, provided to youth and confirmed that pill was swallowed. RN asked youth to initial MDL and followed by initially. A review of the error reduction strategies reported above indicate that the program is able to identify systemic issues and implement effective mitigation strategies.</p>	
<p>Admission/Intake of Youth</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> 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>Compliance</p>	<p>Four shelter youth records were reviewed (2 open and 2 closed). All four youth's Health Screening documents were reviewed by the RN on the day of their admission.</p>	

Medication Storage			
<p>a. All medications are stored in a Pyxis ES Medication Cabinet that is inaccessible to youth (when unaccompanied by authorized staff)</p> <p>b. Pyxis machine is stored in accordance with guidelines in FS 499.0121 and policy section in Medication Management</p> <p>c. Oral medications are stored separately from injectable epi-pen and topical medications</p> <p>d. Medications requiring refrigeration are stored in a secure refrigerator that is used only for this purpose, at temperature range 2-8 degrees C or 36-46 degrees F. (If the refrigerator is not secure, the room is secure and inaccessible to youth.)</p> <p>e. Narcotics and controlled medications are stored in the Pyxis ES Station</p> <p>f. Pyxis keys with the following labels are accessible to staff in the event they need to access medications if there is a Pyxis malfunction: a TOP COVER b BACK PANEL- LEFT TALL CABINET LOCK- LEFT, c BACK PANEL- RIGHT TALL CABINET LOCK- RIGHT</p>	Compliance	<p>An observation of the RN office and administration of medication to one youth indicate that: all medications (including narcotics and controlled medication) are stored in the Pyxis machine, the Pyxis machine is stored in accordance with guidelines, oral medications are stored separately, the refrigerator is locked and is maintained at 40 degrees, and the Pyxis machine is accessible during power outages.</p>	
Medication Distribution			
<p>a. Agency maintains a minimum of 2 site-specific System Managers for the Pyxis ES Station</p> <p>b. Only designated staff delineated in User Permissions have access to secured medications, with limited access to controlled substances (narcotics)</p> <p>c. A Medication Distribution Log shall be used for distribution of medication by non-licensed and licensed staff</p> <p>d. Agency verifies medication using one of three methods listed in the FNYFS Policies & Procedures Manual</p> <p>e. When nurse is on duty, medication processes are ALWAYS conducted by the nurse or when the nurse is not onsite, then the designated staff who has been trained by a licensed Registered Nurse provides the medication.</p> <p>f. Agency does not accept youth currently prescribed injectable medications, except for epi-pens</p> <p>h. Non-licensed staff have received training in the use of epinephrine auto-injectors provided by a registered nurse</p>	Compliance	<p>The agency maintains a minimum of two System Managers for the Pyxis ES, only designated staff have access, perpetual inventory with running balances are maintained for controlled substances, shift-to shift counts with verification by a witness are conducted and documented, The RN verifies medications using drugs.com and comparing to prescription. The RN administers medications and conducts all medical screenings when she is scheduled to work. The agency does not accept youth on injectable medications, other than an Epi-pen. The RN reported that the program does not dispense OTC medications, if child needs OTC, the RN calls the parent to come in and provide OTC. If child needs OTC frequently, the RN asks parents to provide prescription from MD and meds are placed in Pyxis and inventoried.</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>Compliance</p>	<p>A review of the documentation indicates that the time of the administration is documented and the youth and staff initial when the administration is completed.</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>Exception</p>	<p>Upon review of the root-cause of the error, the RN and Shelter Manager made the decision to suspend the responsible staff member's certification. The root cause of the error was the staff member that was scheduled to provide medications called in did not communicate with RN or Shelter Manager. Staff member was not scheduled for further medication administration duties and program removed staff member from the list of staff authorized to provide medications.</p>	<p>CCC data indicates and RN reported that Program had one CCC incident in December 2024 resulting in two medication errors.</p>
<p>During the review period, there were no instances where youth missed their medication due to failure to open the pyxis machine.</p>	<p>Compliance</p>	<p>There were no errors associated with a failure to open the Pyxis ES.</p>	
<p>If applicable: Any staff member deemed responsible for a medication error, there was evidence that the staff member received refresher training from an RN and demonstrated competency prior to being assigned future medication administration responsibilities. There is evidence that any staff member deemed responsible for 3 errors within a 1-year time frame, had their certification suspended and was not recertified until the completion of the full in-person medication administration training, demonstrating competency and re-certification from an RN.</p>	<p>Compliance</p>	<p>The program had one error since the last review. Upon review of the root-cause of the error, the RN and Shelter Manager made the decision to suspend the responsible staff member's certification.</p>	
<p>Medication Inventory</p>			
<p>a. For controlled substances, a perpetual inventory with running balances is maintained as well as a shift-to shift count verified by a witness and documented b. Over-the-counter medications that are accessed regularly and inventoried weekly c. Syringes and sharps (needles, scissors, etc.) are secured, and counted and documented weekly</p>	<p>Compliance</p>	<p>Perpetual inventory with running balances are maintained for controlled substances, shift-to shift counts with verification by a witness are conducted and documented, The RN reported that the program does not dispense OTC medications, if child needs OTC, the RN calls the parent to come in and provide OTC. If child needs OTC frequently, the RN asks parents to provide prescription from MD and meds are placed in Pyxis and inventoried. Sharps are inventoried weekly.</p>	
<p>There are monthly reviews of the Pyxis reports to monitor medication management practice.</p>	<p>Compliance</p>	<p>Pyxis reports are reviewed at least monthly by the RN.</p>	

Medication discrepancies are cleared after each shift.	Compliance	Any discrepancies are cleared after each shift.	
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Additional Comments: There are no additional comments for this indicator.			
4.04 - Medical/Mental Health Alert Process			Satisfactory with Exception
Provider has a written policy and procedure that meets the requirement for Indicator 4.04	YES		
	If NO, explain here:		
	The agency has a policy P-1119 Medical and Mental Health Alert Process. The policy was last reviewed on 1/10/2025 by the Chief Operations Officer.		
Youth with a medical, mental health, or food allergy was appropriately placed on the program's alert system	Exception	Six open youth files were reviewed, three were not applicable. One of three applicable files had documentation that the youth was appropriately placed on the alert system.	One youth was missing an alert for two medications and one youth was missing an alert for bed wetting.
Alert system includes precautions concerning prescribed medications, medical/mental health conditions	Compliance	The alert system includes precautions for prescribed medication and mental health/medical conditions.	
Staff are provided sufficient training, information and instructions to recognize/respond to the need for emergency care for medical/mental health problems	Compliance	A review of the training logs indicate that staff are provided sufficient training to recognize and respond to the need for emergency care.	
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	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,	
Additional Comments: There are no additional comments for this indicator.			
4.05 - Episodic/Emergency Care			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 4.05	YES		
	If NO, explain here:		
	The agency has a policy P-1166 Episodic Emergency Care. The policy was last reviewed on 1/10/2025 by the Chief Operations Officer.		
Off Site Emergency Care			
a. If off-site emergency medical or dental care was provided, an incident report was submitted for the medical or dental care b. Upon youth return, there is a verification receipt of medical clearance via discharge instructions with follow-up is present in file c. Youth's parent/guardian was notified d. A daily log is maintained for emergency care provided	Compliance	Three closed youth files were reviewed. Each youth required off-site emergency medical care (One for a bead lodged in the ear, one for abdominal pain, and one youth Baker acted). In each case, an incident report was completed, the parent or guardian was notified, and medical clearance and discharge instructions were verified upon their return to the shelter.	

All staff are trained on emergency medical procedures	Compliance	Staff received training on emergency procedures, including emergency drills.	
The program has a Knife-for-life and wire cutters accessible to staff in a secure location(s)	Compliance	The agency possessed emergency equipment which includes a knife for life and wire cutters as required.	
Additional Comments: There are no additional comments for this indicator.			