



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

**Children's Home Society of Florida (WaveCREST)**

4520 Selvitz Road  
Fort Pierce, FL 34981

**April 2-3, 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 Children's Home Society of Florida (WaveCREST) for the FY 2024-2025 at its program office located at 4520 Selviz Road, Fort Pierce, Florida 34981. 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. Children's Home Society of Florida (WaveCREST) is contracted with the Florida Network of Youth and Family Services (FNYFS) to provide direct services to Children/Families in Need of Services (CINS/FINS). The services to be provided are identified in Contract Section A - Descriptions and Specifications and Section B - Delivery and Performance and are funded with General Revenue Funds effective from July 2024 through June 30, 2025.

The compliance monitoring review was conducted by Andrea Haugabook, Consultant for Forefront LLC. Agency representatives from Children's Home Society of Florida (WaveCREST) present for the entrance interview were: Duane Gross (Residential Program Manager), Esther Samuelson (Residential Counselor), Lauren Fuentes (Vice President of Child Family Well Being), Tracy Avant (Residential Supervisor), Laura Zamjahn (Sr. Director of Out of Home Programs), Loni Lauer (Talent Service Manager), Jessica Stark (Sr. Manager of Quality Child and Family Well-Being), and Kristie Walsh (Program Manager). The last onsite QI visit was conducted on May 8-9, 2024.

In general, the Reviewer found that the Children's Home Society of Florida (WaveCREST) is in compliance with specific contract requirements. **Children's Home Society of Florida (WaveCREST) received an overall compliance rating of 100% for achieving full compliance with 12 indicators** of the CINS/FINS Monitoring Tool. 1) There were no recommendations or corrective 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](mailto:keithcarr@forefrontllc.com)

**2024-2025 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL**  
**Report Number: CM 04-02-03-2025**

<b>Agency Name:</b> Children’s Home Society of Florida (WaveCREST)			<b>Monitor Name:</b> Andrea Haugabook, Lead Reviewer					
<b>Contract Type :</b> CINS/FINS			<b>Region/Office:</b> 4520 Selvitz Road, Fort Pierce, FL 34981					
<b>Service Description:</b> Comprehensive Onsite Compliance Monitoring			<b>Site Visit Date(s):</b> April 2-3, 2025					
<b>Major Programmatic Requirements</b>	<b>Explain Rating</b>					<b>Ratings Based Upon:</b> <b>I = Interview</b> <b>O = Observation</b> <b>D = Documentation</b> <b>PTV = Submitted Prior To Visit</b> <b>(List Who and What)</b>	<b>Notes</b>  <b>Explain Unacceptable or Conditionally Acceptable:</b>	
	<b>Unacceptable</b>	<b>Conditionally Acceptable</b>	<b>Fully Met</b>	<b>Exceeded</b>	<b>Not Applicable</b>			
<b>I. Administrative and Fiscal</b>								
<b>DJJ Quality Improvement Peer Reviewer</b> a. Provider shall demonstrate that a minimum of two (2) staff members have been trained to be certified as DJJ QI Peer reviewers. Provider shall participate in a minimum of one (1) on-site quality assurance review of a similar type of program in another judicial circuit during each 12-month period of the contract, if requested.			<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	The agency has a total of five certified peer reviewers. Duane Gross and Kristi Walsh, Cynthia Muniz, Carlene Pierre and Jean Christiansen Goggin. Mrs. Pierre and Mrs. Goggin are the designated peers for this location, and both have completed reviews this fiscal year.
<b>Additional Contracts</b> a. Provider shall provide a listing of all current federal, state, or local government contracts, as well as other contracts entered into with for profit and not-for-profit organizations. Such a listing shall identify the awarding entity and contract start & end dates. <b>PTV</b>			<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	One additional contract was reported by the agency for FY 2024-2025: Administration for Children and Families/Health and Human Services-Basic Center - 9/2023 through 9/2026 for emergency shelter for runaway and homeless youth.
<b>Limits of Coverage</b> a. Provider shall provide and maintain during this contract, the following minimum kinds of insurance: Worker's Compensation and Employer's liability insurance as required by Chapter 440, F.S. with a minimum of \$100,000 per accident, \$100,000 per person and \$500,000 policy aggregate. Commercial General Liability with a limit of \$500,000 per occurrence, and \$1,000,000 policy aggregate. Automobile Liability Insurance shall be			<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	A certificate of insurance was provided with Combs Insurance Services, LLC listed as the producer. The following companies are listed as insurers affording coverage: Alliance of Nonprofits for Ins. And AmTrust Insurance Company. General Liability coverage from 07/01/2024-07/1/2025, for limits of coverage \$1,000,000 each \$3,000,000 aggregate and medical

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	<b>Unacceptable</b>	<b>Conditionally Acceptable</b>	<b>Fully Met</b>	<b>Exceeded</b>	<b>Not Applicable</b>		
required and shall provide bodily injury and property damage liability covering the operation of all vehicles used in conjunction with performance of this contract, with a minimum limit for bodily injury of \$250,000 per person; with a minimum limit for bodily injury of \$500,000 per accident; with a minimum limit for property damage of \$100,000 per accident and with a minimum limit for medical payments or \$5,000-\$10,000 per person. Florida Network is listed as payee or co-payee. <b>PTV</b>						payments for \$5000 was listed. Automobile coverage with combined single limit coverage for \$1,000,000, effective 7/01/24-7/1/25. Workers Compensation with limits of \$1,000,000 for each incident and \$1,000,000 policy limit, effective 7/01/24-7/01/25. Directors and Officers liability policy with limits of \$1,000,000, per occurrence, effective 7/01/24-7/1/25. Umbrella liability coverage with limits of \$2,000,000, each and aggregate, effective 7/01/24-7/1/25. The Florida Network of Youth and Family Services, Inc. is listed as certificate holder on the certificate of coverage.	
<b>External/Outside Contract Compliance</b> a. Provider has corrective action item(s) cited by an external funding source (Fiscal or Non-Fiscal). <b>ON SITE</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	The agency reports no external corrective action items cited by an external funding source.	
<b>Fiscal Practice</b> 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"/>	The agency has fiscal policies and procedures which were provided from the agency’s Accounting Policies and Procedures Manual. The Accounting	

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	Unacceptable	Conditionally Acceptable	Fully Met	Exceeded	Not Applicable		
GAAP and provide sound internal controls. Agency maintains fiscal files that are audit ready. <b>PTV</b>						Policies and Procedures were last reviewed on December 1, 2019, and are in progress of review effective 4/18/2024. The procedures reviewed appear to be consistent with GAAP and provide for limited internal controls. Procedures are included for accounts receivable, accounts payable, cash management, contributions, purchasing, travel, and Payroll. Fiscal files are located in the agency’s corporate office.	
b. Agency maintains a general ledger and the corresponding source documents. A general ledger must be set up to track the activity of the grant separately (standard account numbers / separate funds for each revenue source, etc.). <b>PTV</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	The general ledger from July 2024 – February 2025 for both CHS WaveCREST and CHS Non-residential programs was provided for review. The agency’s general ledger is detailed and set up to track all funding sources and there is a separate GL for each program.	
c. Petty cash ledger system is balanced and all cash disbursements are compliant with financial policies and allowable under the contract. (Disbursements/invoices are approved & monitored by management.) – <b>ON SITE</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	No change in practice was reported for the agency since the last on-site program review. Petty cash is maintained and reconciled by the Secretary monthly or as needed. The reconciliation is accompanied by a log	

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						including the date, vendor, amount, account, and sub-account for each activity.  Policies and procedures are maintained in the Fiscal Manual under the Cash Management section.  The maximum petty cash account for WaveCREST shelter is \$400. The funds are kept locked up in the Administrative Secretary’s office. Requests for petty cash are informal but are accompanied by an up-to-date log of activities and receipts that are maintained by the custodian.	
d. Financial records and reports are current. Includes bank statements reconciled within 6 weeks of receipt. Vendor invoices past 6 months. Invoices are submitted on a monthly basis with supporting documentation and documentation provided contained 2 signatures. (Disbursements/invoices are approved & monitored by management). <b>ON SITE</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bank Statements from August 2024 to February 2025 for accounts with Fifth Third Bank were submitted for review. Accompanying reconciliation statements and corresponding general ledger entries for accounts payable and payroll accounts show that all statements were reconciled by the Accounting Analyst and reviewed/ approved by the Accounting Manager.	

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	Unacceptable	Conditionally Acceptable	Fully Met	Exceeded	Not Applicable		
						Bank reconciliations are conducted within six weeks of receipt, and all supporting documentation contained two signatures.	
e. Agency maintains inventory in accordance with a written policy and FNYFS contractual requirements. If over \$1,000 inventory has DJJ Property Inventory Number/Tag. In the event the provider has purchased computer equipment an Informational Resources Request (IRR) has been submitted to DJJ. <b>PTV/ON SITE</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	No purchases over \$1000 were made for the review period.	
f. Agency submits payroll taxes and deposits (and retirement deposits as applicable), <u>Employee</u> IRS Form W-2 and <u>Independent Contractors</u> IRS Form 1099 forms prior to federal requirements. <b>ON SITE</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Biweekly payroll summaries from the last quarter ending December 31, 2024 through February 2025 were reviewed and show submission of payroll taxes and deposits biweekly.	
g. Budget to actual reports prepared and reviewed by appropriate management. Variance from the budget are investigated and explained. <b>PTV/ON SITE</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Budget to Actual reports for July 1, 2024-February 2025 for the CINS/FINS CHS Non-residential Program and CHS WaveCREST were reviewed. The report captures the monthly variance, year-to-date, and annual budget. The provider has a monthly process for reviewing and explaining variances.	
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	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	The provider submitted a copy of the Financial audit completed December 13, 2024 for fiscal year ending June 30,	

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management letter and single audit. An annual financial audit was completed within 120 days after the previous fiscal year/calendar year and that a copy was provided to the Network unless and extension has been requested and approved in writing. Copy of Audit is submitted to the FNYFS by December 31st. <b>Can obtain from FNYFS</b>						2024. The audit was completed by RSM US, LLP. There was no management letter or deficiencies in internal controls identified.	
i. Agency maintains confidentiality policy with written policies and procedures to ensure the security and privacy of all employee and client data. Personal information is not easily accessible. Agency maintains a backup system in case of accidental loss of financial information. Security procedures are in place to protect laptops. Obsolete documents are shredded and computer hard drives are wiped prior to discarding. <b>ON SITE</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	The agency has policies and procedures regarding the following: CHS1017/Confidentiality and Access to Client Information and Records; CHS1032/Board Member Confidentiality; CHS5100/Cyber Security and Awareness Training Practice; CHS5002/Password Utilization; CHS5004/Equipment and Property Assignment Policy; CHS5105/Business Continuity and Disaster Recovery Plan; CHS5007/Electronic Document Retention Practice; and Accounting Manual/Record Retention Policy.	

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j. Agency provided evidence that every direct care staff employee, as of October 1, 2023, is being paid at least \$19.00 per hour. This also includes funding for additional staff as approved by the Department. <b>ON SITE</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	A current payroll detail of all CINS/FINS staff was provided, showing position title, annual salary, and pay rate. All direct care staff was observed to be paid at least \$19 per hour.	

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

Children’s Home Society of Florida (WaveCREST) has met the requirements for the CINS/FINS contract as a result of full compliance with 12 applicable indicators of the Administrative and Fiscal Contract Monitoring Tool. Two of the fourteen indicators were not applicable because the agency has no corrective action items from any external funding sources and the agency has not purchased anything over \$1000 with funds from the Florida Network. Consequently, **the overall compliance rate for this contract monitoring visit is 100%**. There are no recommendations or corrective action required as a result of the contract monitoring visit. Overall, the provider is performing satisfactorily in meeting the fiscal and administrative terms of its contract. In addition, the majority of indicators reviewed were carried out in a manner which meets the standard described in the report findings.

**SUMMARY OF CORRECTIVE ACTIONS or RECOMMENDATIONS**

**Corrective Action (1)**

None

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



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

Review of Children's Home Society - WaveCREST  
CINS/FINS Program

Date: April 2-3, 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)	Not Applicable

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

### Standard 3: Shelter Care & Special Populations

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

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

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### Rating Definitions

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

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

### Reviewers

#### Members

- Andrea Haugabook - Lead Reviewer Consultant-Forefront LLC/Florida Network of Youth and Family Services
- Shakela Minns – Regional Monitor, Department of Juvenile Justice
- Kevin Lee – CDS Family and Behavioral Health Services, Inc.
- Samantha Roberts – LSF Miami Bridge

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

### Documents Reviewed

<input type="checkbox"/> Accreditation Reports	<input checked="" type="checkbox"/> Table of Organization	<input type="checkbox"/> Visitation Logs
<input checked="" type="checkbox"/> Affidavit of Good Moral Character	<input type="checkbox"/> Fire Prevention Plan	<input checked="" type="checkbox"/> Youth Handbook
<input checked="" type="checkbox"/> CCC Reports	<input checked="" type="checkbox"/> Grievance Process/Records	<input type="checkbox"/> # Health Records
<input checked="" type="checkbox"/> Logbooks	<input type="checkbox"/> Key Control Log	<input type="checkbox"/> # MH/SA Records
<input type="checkbox"/> Continuity of Operation Plan	<input type="checkbox"/> Fire Drill Log	<input type="checkbox"/> # Personnel /Volunteer Records
<input checked="" type="checkbox"/> Contract Monitoring Reports	<input checked="" type="checkbox"/> Medical and Mental Health Alerts	<input type="checkbox"/> # Training Records
<input type="checkbox"/> Contract Scope of Services	<input checked="" type="checkbox"/> Precautionary Observation Logs	<input type="checkbox"/> # Youth Records (Closed)
<input checked="" type="checkbox"/> Egress Plans	<input checked="" type="checkbox"/> Program Schedules	<input type="checkbox"/> # Youth Records (Open)
<input checked="" type="checkbox"/> Fire Inspection Report	<input checked="" type="checkbox"/> List of Supplemental Contracts	<input type="checkbox"/> # Other: ____
<input type="checkbox"/> Exposure Control Plan	<input checked="" 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 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 checked="" 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"/> 8 # of Youth	<input type="checkbox"/> 11 # of Direct Staff	<input type="checkbox"/> # of Other	<input type="checkbox"/>
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## Comments

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

### Monitoring Purpose

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

### Narrative Summary

Children's Home Society WaveCREST (CHS WaveCREST) located at 4520 Selvitz Road, Fort Pierce, FL 34981 is contracted with the Florida Network of Youth and Family Services to provide Child in Need of Services and Family in Need of Services (CINS/FINS) programs in Fort Pierce, Florida. CINS/FINS funding allows the agency to offer residential, community counseling, and case management services in Florida's Judicial Circuit 19. WaveCREST is currently licensed by the Department of Children and Families (DCF) for 12 beds. The agency also provides services to youth who meet the criteria under other specialized populations.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Indicator 2.09 Stop Now and Plan (SNAP) was rated **Not Applicable**.

**Standard 3:** There are seven indicators for Standard 3.

Indicator 3.01 Shelter Environment was rated **Satisfactory with Exception**

Indicator 3.02 Program Orientation was rated **Satisfactory**

Indicator 3.03 Youth Room Assignment was rated **Satisfactory**

Indicator 3.04 Log Books was rated **Satisfactory with Exception**

Indicator 3.05 Behavior Management Strategies was rated **Satisfactory**

Indicator 3.06 Staffing and Youth Supervision was rated **Satisfactory**

Indicator 3.07 Video Surveillance System was rated **Satisfactory**

**Standard 4:** There are five indicators for Standard 4.

Indicator 4.01 Healthcare Admission Screening was rated **Satisfactory**.

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

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

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

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

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

There were no indicators rated Limited or Failed ratings at the time of this review.

<b>CINS/FINS QUALITY IMPROVEMENT TOOL</b>			
<b>Quality Improvement Indicators and Results:</b> Please select the appropriate outcome for each indicator for each item within the indicator.		<b>Summary/Narrative Findings:</b> The narrative write-up is a thorough summary of each assigned QI indicator, explaining how finding(s) are determined.	
		<b>Deficiencies/Exceptions:</b> Please add additional detailed explanations for any items that have any deficiencies or exceptions.	
<b>Standard One – Management Accountability</b>			
<b>1.01: Background Screening of Employees, Contractors and Volunteers</b>			<b>Satisfactory</b>
<b>Provider has a written policy and procedure that meets the requirement for Indicator 1.01</b>		<b>YES</b>	
		If NO, explain here:	
		The program has a policy and procedure CHS/7101 - Background Screening of Employees/ Volunteers, Annual Affidavit of Compliance with Good Moral Character & Annual Abuse Registry Clearance last reviewed 2/5/2025 by the Director of Out of Home Programs (DOHP).	
All positions providing direct services to youth have successfully passed the pre-employment suitability assessment on the initial attempt prior to an offer of employment.	<b>Compliance</b>	Eight of eight new hire employee files reviewed contained evidence of successfully passing a pre-employment suitability assessment on the initial attempt prior to an offer of employment.	
For any applicant that did not pass the initial suitability assessment, there was evidence that the applicant retook the assessment and passed within five (5) business days of the initial attempt, not exceeding three (3) attempts within thirty (30) days.	<b>No eligible items for review</b>	All new-hire employees passed the suitability assessment on the initial attempt.	
Agency has evidence for employees who have had a break in service for 18 months or more, and/or when the agency had a change or update in the suitability assessment tool used was different from the employee's original assessment, that a new suitability assessment and background screening was completed as required.	<b>No eligible items for review</b>	There were no new-hire employees who had a break in service for 18 months or longer.	
Background screening completed prior to hire/start date (or exemption obtained prior to working with youth if rated ineligible) for new hires, volunteers/interns, and contractors. <i>(Employees who have had a break in service and are in good standing may be reemployed with the same agency without background screening if the break is less than 90 days.)</i>	<b>Compliance</b>	An eligible background screen completed prior to the start date was observed in each of the eight new hire files reviewed.	

Five-year re-screening is completed every 5 years from the date of the last screening for all applicable employees and volunteers.	No eligible items for review	Since the date of the last on-site QI review, the program had no employees due for five year rescreening as observed on the staff verification system roster.	
Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?	Compliance	Observation of an Annual Affidavit of Compliance with Level 2 Screening Standards was completed December 17, 2024 by Director of Out of Home Programs and emailed to the Background Screening Unit on December 19, 2024.	
Proof of E-Verify for all new employees obtained from the Department of Homeland Security	Compliance	Proof of E-Verify completion from the Department of Homeland Security was observed in eight new hire employee files reviewed.	
<b>Additional Comments: There are no additional comments for this indicator.</b>			
<b>1.02: Provision of an Abuse Free Environment</b>			<b>Satisfactory</b>
Provider has a written policy and procedure that meets the requirement for Indicator 1.02	YES		
	If NO, explain here:		
	The program has a policy and procedures CHS/7102 - Providing an Abuse Free Environment, last reviewed 2/5/2025 by the Director of Out of Home Programs (DOHP).		
Agency has a code of conduct of policy and there is evidence that staff are aware of agency's code of conduct.	Compliance	The agency has a code of conduct that each employee receives in the CHS Employee Handbook at the time of hire. Each employee signs an acknowledgement of receipt of the agency's code of conduct which prohibits the use of physical abuse, intimidation of any kind, profanity, threats, and/or excessive use of force and states youth are not deprived of basic needs, such as food, clothing, shelter, medical care and security.□	
The agency has a process in place for reporting and documenting child abuse hotline calls.	Compliance	The residential supervisor reports there have been no calls to the abuse hotline in the past six months. The program does have a process in place for reporting and documenting child abuse hotline calls. All allegations are reported directly to the abuse hotline, documented on the agency's incident report form, and entered into the agency's online database.	
Youth were informed of the Abuse and Contact Number	Compliance	The program has the Florida Abuse Hotline number posted throughout the shelter for youth to be informed. Additionally, youth are informed of the abuse hotline and telephone number during orientation and are required to initial receipt of the information on the orientation checklist which was observed in each file reviewed.	

<b>Grievance</b>			
The program(s) have an accessible and responsive grievance process for youth to provide feedback and address complaints. Program director/ supervisor has access to and can manage grievances unless it is towards themselves.	<b>Compliance</b>	The program provides an accessible, as well as responsive grievance process for youth to provide feedback and address complaints. The grievance policy is outlined in the resident handbook. The Residential Supervisor is the only one that manages grievances unless it is towards themself.	
<u>Shelter only:</u> Grievances are maintained on file at minimum for 1 year.	<b>Compliance</b>	The program maintains copies of all grievances filed for a minimum of one year.	
<u>Shelter only:</u> There are formal grievance procedures for youth, including grievance forms, and a locked box which are easily accessible to youth in a common area.	<b>Compliance</b>	Youth are informed of the grievance procedures and are required to initial receipt of the information on the orientation checklist and information in the youth handbook. The locked grievance box and grievance forms are available to youth in the common area. The program recorded four grievances filed in the last six months.	
<u>Shelter only:</u> There is evidence that grievance boxes are checked by management or a designated supervisor at least daily (excluding weekends and holidays) and documented in the program logbook.	<b>Compliance</b>	A review of the program's logbook from October 2024 through March 2025 showed entries where the supervisor logged grievance box checks were completed at least daily (excluding weekends and holidays).	
<u>Shelter only:</u> Grievances are resolved within 72 hours of being submitted or there was documentation explaining the cause for the delay in providing a resolution.	<b>Compliance</b>	The program had four documented grievances filed and resolved on the following dates: filed 03/07/2025, resolved 03/10/2025, filed 12/17/2024, resolved 12/17/2024, filed 06/17/2024, resolved 06/20/2024, and filed 08/20/2024 resolved 08/22/2024. All filed grievances were addressed and resolved by the Residential Supervisor.	
<b>Additional Comments: There are no additional comments for this indicator.</b>			
<b>1.03: Incident Reporting</b>			<b>Satisfactory</b>
<b>Provider has a written policy and procedure that meets the requirement for Indicator 1.03</b>	<b>YES</b>		
	If NO, explain here:		
	The program has a policy and procedures CHS/7103 - Incident Reporting, approved 2/5/2025 by the Director of Out of Home Programs (DOHP).		
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	<b>Compliance</b>	During the past six months (October 2024 - March 2025) there were no occurrences of the program notifying the CCC no later than two hours after the occurrence of any reportable incident or within two hours of the program learning of the incident.	

The program completes follow-up communication tasks/special instructions as required by the CCC	<b>Compliance</b>	The program completes follow-up communication tasks/ special instructions as required by the CCC.	
Agency internal incidents are documented on incident reporting forms and all CCC reportable incidents were consistently reported to CCC as required.	<b>Compliance</b>	A total of fifteen internal incident reports were reviewed from October 2024 to March 2025. Observation of internal incidents occurred on the following dates: 03/7/2025, 03/01/2025*, 02/25/2025*, 02/17/2025*, 02/16/2025, 01/22/2025*, 12/31/2024, 12/21/2024*, 12/16/2024, 12/04/2024, 11/27/2024*, 10/26/2024, 10/16/2024, 10/12/2024*, 10/08/2024*. All CCC reportable* incidents were documented on internal incident reporting forms and consistently reported to the CCC as required.	
Incidents are documented in the program logs and on incident reporting forms	<b>Compliance</b>	Fifteen total incidents were documented and observed in the program log books from October 2024 to March 2025. Each incident was documented in the agency's internal incident reporting system. All CCC reportable incidents were included and the following types of CCC incidents were noted: Medical (3), Youth Behavior Incidents (1), Program Disruption (3), and Mental Health/ Substance Abuse (3).	
All incident reports are reviewed and signed by program supervisors/ directors	<b>Compliance</b>	All incident reports reviewed were signed by the program supervisors and directors.	
<b>Additional Comments: There are no additional comments for this indicator.</b>			
<b>1.04: Training Requirements</b> (Staff receives training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions )			<b>Satisfactory with Exception</b>
<b>Provider has a written policy and procedure that meets the requirement for Indicator 1.04</b>	<b>YES</b>		
	If NO, explain here:		
	The provider has a policy and procedures CHS/7104- Training Requirements last reviewed 2/5/2025 by the Director of Out of Home Programs (DOHP).		

<b>First Year Direct Care Staff</b>			
<p>All direct care staff have completed a new hire pre-service training provider orientation before they work independently. At a minimum, the orientation included the following:</p> <ul style="list-style-type: none"> <li>• Agency policies and procedures</li> <li>• Behavior Management (Shelter Only)</li> <li>• Building/Facility layout</li> <li>• File Documentation/development of paperwork requirements and confidentiality</li> <li>• CCC &amp; Incident Reporting</li> <li>• Child Abuse Reporting</li> <li>• Client Intake &amp; Screening</li> <li>• Client Orientation (direct care staff training on delivering new client orientation)</li> <li>• Fire Equipment Safety</li> <li>• Medical and Mental Health Alert System (Shelter)</li> <li>• Risk Management--Including but not limited to the following:                             <ul style="list-style-type: none"> <li>- Disaster Preparedness and Emergency Response</li> <li>- First Aid/CPR</li> <li>- Universal Precautions</li> </ul> </li> <li>• Video Camera Surveillance &amp; Equipment</li> <li>• All other necessary information to orient a new hire to perform their job role and duties.</li> </ul>	<p><b>Compliance</b></p>	<p>Two of two new-hire employees training files reviewed contained evidence of completion of all required pre-service training before they worked independently. Provider orientation included:</p> <ul style="list-style-type: none"> <li>• Agency policies and procedures</li> <li>• Behavior Management (Shelter Only)</li> <li>• Building/Facility layout</li> <li>• File Documentation/development of paperwork requirements and confidentiality</li> <li>• CCC &amp; Incident Reporting</li> <li>• Child Abuse Reporting</li> <li>• Client Intake &amp; Screening</li> <li>• Client Orientation (direct care staff training on delivering new client orientation)</li> <li>• Fire Equipment Safety</li> <li>• Medical and Mental Health Alert System (Shelter)</li> <li>• Risk Management--Including but not limited to the following:                             <ul style="list-style-type: none"> <li>- Disaster Preparedness and Emergency Response</li> <li>- First Aid/CPR</li> <li>- Universal Precautions</li> </ul> </li> <li>• Video Camera Surveillance &amp; Equipment</li> <li>• All other necessary information to orient a new hire to perform their job role and duties.</li> </ul>	
<p>All staff completed the United States Department of Justice (DOJ) Civil Rights &amp; Federal Funds training within 30 days from date of hire.</p>	<p><b>Compliance</b></p>	<p>Two of two new-hire employees training files reviewed contained evidence of completion of the United States Department of Justice (DOJ) Civil Rights &amp; Federal Funds Training within 30 days from the date of hire.</p>	
<p>All direct care CINS/FINS staff for shelter and community counseling services, including independent contractors (full-time, part-time, and on-call) and interns met the minimum requirement of 80 hours of training for the first full year of employment.</p>	<p><b>Compliance</b></p>	<p>Both direct care CINS/FINS staff for shelter met the required minimum 80 hours of training for the first full year of employment.</p>	
<p>All staff receives all mandatory training during the first 90 days of employment from date of hire.</p>	<p><b>Exception</b></p>	<p>One of two new-hire employees received all mandatory training during the first 90 days of employment from the date of hire.</p>	<p>One of two new-hire employees did not received all mandatory training during the first 90 days of employment from the date of hire. The training for Adverse Childhood Experiences (ACE) was completed after the first 90 days of employment.</p>

<b>Non Licensed Staff Assisting with Medication Distribution</b>			
Any staff without a medical license that assists with Medication Distribution received in-person training from a Registered Nurse prior to administering medication to a shelter youth.	<b>Compliance</b>	Two of two new-hire employee files contained evidence of completion of training for medication distribution from a Registered Nurse prior to administering medication to youth at the shelter.	
<b>Staff that are Utilizing NETMIS</b>			
Any staff that is utilizing NETMIS has evidence of completing NetMIS Training in their training file.	<b>No eligible items for review</b>	Two staff files reviewed do not utilize NetMIS.	
<b>Staff Participating in Case Staffing &amp; CINS Petitions (within the first year of employment BUT no later 7/1/24 for previous staff)</b>			
Documentation of instructor-led FL Statute 984 CINS Petition Training by a local DJJ Attorney <u>within 1 year of employment or no later than 7/1/24 if hired before 7/1/23.</u> (Policy went into effect 7/1/23).	<b>No eligible items for review</b>	Two staff files reviewed do not participate in Case Staffing and CINS Petitions.	
<b>Non-licensed Mental Health Clinical Shelter Staff (within first year of employment)</b>			
Documentation of non-licensed mental health clinical staff person's training in Assessment of Suicide Risk form or written confirmation by a licensed mental health professional of training (includes date, signature and license number of the licensed mental health professional supervisor).	<b>No eligible items for review</b>	Two staff files reviewed are not non-licensed mental health clinical staff.	
<b>In-Service Direct Care Staff</b>			
In-service staff completes all of the required annual or 2-year mandatory refresher Florida Network, SkillPro, or other job-related trainings within the required timeframe.	<b>Compliance</b>	Four of four in-service training files reviewed contained evidence of all required annual training or two-year refresher FN, SkillPro, or other job-related trainings within the required time-frame.	

<p>Community Counseling Direct Care staff completes 24 hours of mandatory refresher Florida Network, SkillPro, and job-related training annually.</p>	<p><b>Compliance</b></p>	<p>Three of three Community Counseling Direct Care staff files reviewed contained evidence of completion of 24 hours of mandatory refresher Florida Network, SkillPro, and job-related training for the past fiscal year.</p>	
<p>Shelter Program Direct Care staff completes 40 hours of mandatory refresher Florida Network, SkillPro, and job-related training annually (<i>E.g. the program has a DCF child caring license</i>).</p>	<p><b>Compliance</b></p>	<p>One of one Shelter Program Direct Care staff file reviewed contained evidence of completion of 40 hours of mandatory refresher Florida Network, SkillPro, and job-related training annually.</p>	
<p><b>Required Training Documentation</b></p>			
<p>The agency has a training plan that includes all of the required training topics including the pre-service and in-service.</p>	<p><b>Compliance</b></p>	<p>Each of the six training files reviewed contained a training plan that has all required training topics including pre-service and in-service.</p>	
<p>The agency has a designated staff member responsible to manage all employee's individual training files and completes routine tracking and reviews of staff files to ensure compliance.</p>	<p><b>Compliance</b></p>	<p>The Program Manager is the designated staff member responsible for managing all employee's individual training files and completes routine tracking and reviews of staff files to ensure compliance.</p>	
<p>The program maintains an individual training file or employee file AND a FLN Training Log (or similar document that includes all requirements) for each staff, which includes an annual employee training hours tracking form and related documentation, such as electronic record/transcript, training certificates, sign-in sheets, and agendas for each training attended.</p>	<p><b>Compliance</b></p>	<p>Evidence of and individual training file was observed for each employee reviewed. Each file contained a training log which was similar to the FLN training log. The program's training log tracks the employee training hours and related documentation for each training completed.</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>Four of four in-service training files reviewed contained evidence of completion of Naloxone training.</p>	
<p><b>Additional Comments: There are no additional comments for this indicator.</b></p>			

1.05 - Analyzing and Reporting Information		Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 1.05	YES	
	If NO, explain here:	
	The provider has a policy and procedure CHS/7105- Reporting and Analyzing Data/Information, last reviewed 2/5/2025 by the Director of Out of Home Programs (DOHP).	
Case record review reports demonstrate reviews are conducted quarterly, at a minimum. <i>(A summary report of case record reviews, identifying compliance with the CINS/FINS requirements, which is reviewed by management and communicated with staff on a quarterly basis at minimum.)</i>	Compliance	Evidence of case record reviews conducted for both the shelter and community counseling programs from October 2024 to March 2025 were reviewed were observed as being completed at least quarterly.
The program conducts reviews of incidents, accidents, and grievances quarterly, at a minimum	Compliance	The program has evidence, as observed in Prevention Services Team Meeting minutes from June 2024 - March 2025, that reviews of incidents accidents, and grievances are conducted at least quarterly.
The program conducts an annual review of customer satisfaction data	Compliance	Surveys are monitored by quality management staff who generate reports that are discussed at monthly program meetings, and quarterly quality council meetings. Evidence of consumer survey results is reported on quarterly program performance review reports. Consumer surveys are collected submitted through the agency's website.
The program demonstrates a monthly review of the statewide End-of-Month ("EOM") report generated by the Florida Network Office. This includes monthly data, fiscal year to date data, benchmarks for residential and community counseling, screening data, report card measures, follow-up reporting measures.	Compliance	EOM reports are emailed to the Program Director and disseminated to the management team. Data from the EOM report is reviewed at the monthly staff meetings. Prevention Services Team Meetings reviewed for March 13, 2025, February 13, 2025, December 12, 2024, November 13, 2024, October 17, 2024, September 12, 2024, August 8, 2024, July 18, 2024, and June 13, 2024 validates program review of the EOM reports on a regular basis.
The program has a process in place to review and improve accuracy of data entry & collection	Compliance	The program has a process in place to review and improve accuracy of data entry & collection through their quality management process and data collection system.

<p>There is documentation that findings are regularly reviewed by management and communicated to staff and stakeholders.</p>	<p><b>Compliance</b></p>	<p>Data collected is maintained on a dashboard accessible to the quality management team and findings are regularly reported and reviewed with staff and stakeholders. Evidence of quarterly quality council meetings, executive leadership meetings, and staff meeting minutes support regular communication to stakeholders.</p>	
<p>There is evidence the program demonstrates that program performance is routinely reviewed with the Board of Directors. All final reports that include a Limited or Failed score is submitted electronically or by mail to the providers Executive Committee on the Board of Directors.</p>	<p><b>Compliance</b></p>	<p>All final QI reports that include a limited or failed score are submitted electronically to the executive committee of the Board of Directors.</p>	
<p>There is evidence that strengths and weaknesses are identified, improvements are implemented or modified, and staff are informed and involved throughout the process.</p>	<p><b>Compliance</b></p>	<p>A review of the quality management team meeting minutes for the past six months show evidence the program reviews identified strengths and weaknesses, implement improvements or modifications, and inform and involve staff throughout the process.</p>	
<p><b>Additional Comments: There are no additional comments for this indicator.</b></p>			
<p><b>1.06: Client Transportation</b></p>			<p><b>Satisfactory</b></p>
<p><b>Provider has a written policy and procedure that meets the requirement for Indicator 1.06</b></p>	<p><b>YES</b> If NO, explain here: The provider has a policy and procedures CHS/7106- Client transportation last reviewed 2/5/2025 by the Director of Out of Home Programs (DOHP).</p>		
<p>Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle</p>	<p><b>Compliance</b></p>	<p>The program has a current list of 15 authorized drivers, who are approved by administration and are covered under the agency's insurance policy to drive agency vehicles.</p>	
<p>Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy</p>	<p><b>Compliance</b></p>	<p>All 15 approved drivers are covered under the agency's automobile insurance and have valid driver's license according to the agency's check with the Florida Department of Highway Safety and Motor Vehicles.</p>	

<p>Agency's Transportation policy prohibit transporting a client without maintaining at least one other passenger in the vehicle during the trip and include exceptions in the event that a 3<sup>rd</sup> party is NOT present in the vehicle while transporting</p>	<p><b>Compliance</b></p>	<p>Per the program's transportation policy, the best practice to prevent situations that put youth or staff in danger of real or perceived harm, or allegations of inappropriate conduct by either staff or youth is to have a 3rd party present in the vehicle while transporting a client. The policy also states, however, in the event a 3rd party cannot be present, the policy includes exceptions and guidelines for staff to follow.</p>	
<p>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</p>	<p><b>Compliance</b></p>	<p>The agency's policy provides provision in the event a 3rd party cannot be obtained for the transport for the consideration of the client's history, evaluation and recent behavior.</p>	
<p>The 3<sup>rd</sup> party is an approved volunteer, intern, agency staff, or other youth</p>	<p><b>Compliance</b></p>	<p>The agency's policy does require the 3rd party to be an approved volunteer, intern, agency staff or other youth.</p>	
<p>The agency demonstrated evidence via logbook or other written verification that supervisor approval was obtained prior to all single youth transports.</p>	<p><b>Compliance</b></p>	<p>The program conducted 70 single transports from September 2024 to March 2025. Evidence of supervisor's approval was documented in the program logbook for all single transportation events entered on the following dates: 3/3/25, 3/4/25, 3/10/25, 3/13/25, 2/25/25, 2/5/25, 2/13/25, 2/10/25, 2/4/25, 12/29/24.</p>	
<p>When transporting a single client in a vehicle, there was documentation of the following: a. the transporting employee completed check-in by phone at agreed-upon intervals with the senior program leader, or designee, upon departure and arrival. b. the employee check-ins were documented by the manager or designee receiving the call.</p>	<p><b>Compliance</b></p>	<p>All single transport entries observed in the program's logbook documented when the transporting employee completed check-in by phone at agreed-upon intervals and were documented by the designee receiving the call.</p>	
<p>There is documentation of use of vehicle that notes name or initials of driver, date and time, mileage, number of passengers, purpose of travel and location.</p>	<p><b>Compliance</b></p>	<p>The program uses a log which has the name/ initials of the driver, date and time of the transport event, mileage, number of passengers, purpose of travel and location.</p>	

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

<p><b>1.07 - Outreach Services</b></p>	<p><b>Satisfactory</b></p>	
<p><b>Provider has a written policy and procedure that meets the requirement for Indicator 1.07</b></p>	<p><b>YES</b></p>	
	<p>If NO, explain here:</p>	
	<p>The program has a policy and procedures CHS/7107- Outreach and Interagency Agreements, last reviewed 2/5/2025 by the Director of Out of Home Programs (DOHP).</p>	

<p>The program has a lead staff member designated to participate in local DJJ board, Circuit and Council meetings with evidence that includes minutes of the event or other verification of staff participation.</p>	<p><b>Compliance</b></p>	<p>The Community Counseling Program Manager, Kristie Walsh is the designated staff member who attends and participates in the local DJJ board, Circuit and Council meetings. Evidence of meeting minutes were reviewed and maintained by the Community Counseling Program Manager.</p>	
<p>The program maintains written agreements with other community partners which include services provided and a comprehensive referral process.</p>	<p><b>Compliance</b></p>	<p>The program maintains written agreements that have a comprehensive referral process with other community partners which include: Fort Pierce Police Department, Hibiscus Children's Center, Hope for Families Homeless Family Center, Inc. St. Lucie County Sheriff's Department, Indian River County Sheriff's Department, Martin County Sheriff's Department, Okeechobee County Police and Sheriff's Department, Pace Center for Girls, Sebastian and Stuart Police Departments, Substance Abuse Council of Indian River, Treasure Coast Homeless Services Council, Unites Way of Martin County Vero Beach Police Department, St. Lucie, MArith and Okeechobee Health Departments, Florida Department of Health, Teen Choices, Behavioral Health Center at Indian River Medical Center, DATA Hayslip Treatment Center, Helping People Succeed, New Horizons, Inc., Suncoast Mental Health, Tykes and Teens, Treasure Coast Food Bank, United Against Poverty. DJJ comprehensive Agreement with DJJ Circuit Court , School Supt, State Attorney, Sheriff, Local Police Chiefs, Public Safety Departments, District Administrators and DCF.</p>	
<p>The program will maintain documentation of outreach activities and enter into NetMIS the title, date, duration (hours), zip code, location description, estimated number of people reached, modality, target audience and topic.</p>	<p><b>Compliance</b></p>	<p>A review of the program's outreach documentation showed a total of 61 outreach events in NetMIS from September 2024 through March 2025. Each entry contained the title, date, duration, zip code, location, description, estimated number of people reached, modality, target audience and topic.</p>	
<p>The program has designated staff that conducts outreach which is defined in their job description.</p>	<p><b>Compliance</b></p>	<p>The Community Counseling Program Manager is the designated staff member who conducts outreach.</p>	
<p><b>Additional Comments:</b> There are no additional comments for this indicator.</p>			

Standard Two – Intervention and Case Management		
2.01 - Screening and Intake		Satisfactory
<p><b>Provider has a written policy and procedure that meets the requirement for Indicator 2.01</b></p>		<p><b>YES</b></p> <p style="background-color: #FFF9C4;">If NO, explain here:</p> <p>The agency has a policy CHS7201/Screening Eligibility for Services and Intake Assessment last reviewed 2/5/25 by the Director of Out of Home Programs.</p>
<p><b>Shelter youth:</b> Eligibility screening form is completed immediately for all shelter placement inquiries.</p>	<p><b>Compliance</b></p>	<p>A review of three closed and two open residential case management records found the program completed the shelter screening form immediately for all shelter placement inquiries.</p>
<p><b>Community counseling:</b> Eligibility screening form is completed within 3 business days of referral by a trained staff using the Florida Network screening form.</p>	<p><b>Compliance</b></p>	<p>The program has written policy and procedure which indicates an initial screening must be completed within three business days of the youth being referred for services. A review of five case management records were reviewed for screening. Five youth records found each initial screening was completed within the required timeframe.</p> <p>Observation: Upon initial review of documentation, two community counseling youth files did not contain an eligibility screening form completed within three business days of referral. Two records reviewed found the youth were initially screened for shelter. Due to not participating in the shelter, the youth were referred to community counseling (CC). After a search in NetMIS, evidence of a new screening was observed as being completed by the CC staff within the required timeframe.</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><b>Compliance</b></p>	<p>A review of ten case management records found the referrals for service was screened for eligibility and logged within seventy-two hours of the screening completion.</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><b>Compliance</b></p>	<p>A review of ten case management records found the youth and parents/guardians received and signed the youth handbook. The youth's handbook included available service options and 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><b>Compliance</b></p>	<p>A review of ten case management records found the youth and parents/guardians received and signed the youth handbook. The youth's handbook included possible actions occurring through involvement with CINS/FINS services case staffing committee, CINS petition, CINS adjudication, and grievance procedures.</p>

During intake, all youth were screened for suicidality and correctly assessed as required if needed.	<b>Compliance</b>	A review of ten case management records found each reviewed youth was screened during the initial intake process for suicidality and assessed accordingly.	
<b>Additional Comments: There are no additional comments for this indicator.</b>			
<b>2.02 - Needs Assessment</b>			<b>Satisfactory</b>
<b>Provider has a written policy and procedure that meets the requirement for Indicator 2.02</b>	<b>YES</b>		
	If NO, explain here:		
	The program has a policy CHS7202-Network Inventory of Risks, Victories and Needs Assessment (NIRVANA) and CHS Needs Assessment last reviewed 02/05/2025 by the Director of Out of Home Programs.		
Shelter Youth: NIRVANA is initiated within 72 hours of admission	<b>Compliance</b>	A review of five residential youth case management records found a NIRVANA was commenced within the required timeframe.	
Non-Residential youth: NIRVANA is initiated at intake and completed within 2 to 3 face-to-face contacts after the initial intake <b>OR</b> updated, if most recent assessment is over 6 months old	<b>Compliance</b>	A review of five community case management records included documentation to confirm the NIRVANA was commenced during the initial intake and completed within the required timeframe.	
Supervisor signatures is documented for all completed NIRVANA assessments and/or the chronological note and/or interview guide that is located in the youths' file.	<b>Compliance</b>	A review of ten case management records found the supervisor signed each NIRVANA assessment and the NIRVANA was located in each youth's record.	
(Shelter Only) NIRVANA Self-Assessment (NSR) is completed within 24 hours of youth being admitted into shelter. If unable to complete, there must be documentation in NetMIS and the youth's file explaining the barriers to completion.	<b>Compliance</b>	A review of five residential youth case management records found the NIRVANA was completed within twenty-four hours.	

A NIRVANA Post-Assessment is completed at discharge for all youth who have a length of stay that is greater than 30 days.	<b>Compliance</b>	A review of five youth case management records found three youth were applicable for a NIRVANA Post Assessment. Reviewed documentation reflected all three youth's records included a NIRVANA Post Assessment completed at discharge.	
A NIRVANA Re-Assessment is completed every 90 days excluding files for youth receiving SNAP services.	<b>No eligible items for review</b>	There were no youth exceeding 90 days of service in need of a NIRVANA Re-Assessment.	
All files include the interview guide and/or printed NIRVANA.	<b>Compliance</b>	A review of ten youth case management records included an interview guide and/or printed NIRVANA.	
<b>Additional Comments: There are no additional comments for this indicator.</b>			
<b>2.03 - Case/Service Plan</b>			<b>Satisfactory</b>
<b>Provider has a written policy and procedure that meets the requirement for Indicator 2.03</b>	<b>YES</b>		
	If NO, explain here:		
	The program has a policy CHS7203/Service/Case Plans Implementation last reviewed 2/5/25 by the Director of Out of Home Programs.		
The case/service plan is developed on a local provider-approved form or through NETMIS and is based on information gathered during the initial screening, intake, and NIRVANA.	<b>Compliance</b>	A review of ten case management records included a case/service plan developed on a provider- approved form.	
Case/Service plan is developed within 7 working days of NIRVANA	<b>Compliance</b>	A review of ten case management records found that the case/service plan was developed within the seven-day timeframe.	
<b>Case plan/service plan includes:</b> 1. Individualized and prioritized need(s) and goal(s) identified by the NIRVANA 2. Service type, frequency, location 3. Person(s) responsible 4. Target date(s) for completion and actual completion date(s) 5. Signature of youth, parent/guardian, counselor, and supervisor 6. Date the plan was initiated	<b>Compliance</b>	A review of ten case plans/service plans included the required elements outlined in the program's policy: 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	

<p>Case/service plans are reviewed for progress/revised by counselor and parent (if available) every 30 days for the first three months and every 6 months after</p>	<p><b>Compliance</b></p>	<p>A review of five residential case plans/service plans found a formal review to assess progress was made within the required timeframe when applicable. Each plan was signed by the required parties.</p> <p>A review of five community counseling case plans/service plans found a formal review to assess progress was made within the required timeframe when applicable. Each plan was signed by the required parties.</p>	
<p><b>Additional Comments:</b> There are no additional comments for this indicator.</p>			
<p><b>2.04 - Case Management and Service Delivery</b></p>			<p><b>Satisfactory</b></p>
<p><b>Provider has a written policy and procedure that meets the requirement for Indicator 2.04</b></p>	<p><b>YES</b></p> <p>If NO, explain here:</p> <p>The program has a policy CHS7204/Case management and Service Delivery/Family Involvement last reviewed 2/6/2025 by the Director of Out of Home Programs.</p>		
<p>Counselor/Case Manager is assigned</p>	<p><b>Compliance</b></p>	<p>A review of ten youth case management records included documentation to confirm the youth was assigned to a counselor or case manager.</p>	

<p>The Counselor/Case Manager completes the following as applicable:</p> <ol style="list-style-type: none"> <li>1. Establishes referral needs and coordinates referrals to services based upon the on-going assessment of the youth's/family's problems and needs</li> <li>2. Coordinates service plan implementation</li> <li>3. Monitors youth's/family's progress in services</li> <li>4. Provides support for families</li> <li>5. Monitoring progress of court ordered youth in shelter</li> <li>6. Makes referrals to the case staffing to address problems and needs of the youth/family</li> <li>7. Accompanies youth and parent/guardian to court hearings and related appointments</li> <li>8. Refers the youth/family for additional services when appropriate</li> <li>9. Provides case monitoring and reviews court orders</li> <li>10. Provides case termination notes</li> <li>11. Provides follow-up after 30 days post discharge</li> <li>12. Provides follow-up after 60 days post discharge</li> </ol>	<p><b>Compliance</b></p>	<p>A review of ten case management records found documentation the counselor/ case manager completes the required elements when applicable:</p> <ol style="list-style-type: none"> <li>1. Establishes referral needs and coordinates referrals to services based upon the on-going assessment of the youth's/family's problems and needs</li> <li>2. Coordinates service plan implementation</li> <li>3. Monitors youth's/family's progress in services</li> <li>4. Provides support for families</li> <li>5. Monitoring progress of court ordered youth in shelter</li> <li>6. Makes referrals to the case staffing to address problems and needs of the youth/family</li> <li>7. Accompanies youth and parent/guardian to court hearings and related appointments</li> <li>8. Refers the youth/family for additional services when appropriate</li> <li>9. Provides case monitoring and reviews court orders</li> <li>10. Provides case termination notes</li> <li>11. Provides follow-up after 30 days post discharge</li> <li>12. Provides follow-up after 60 days post discharge.</li> </ol>	
<p>The program maintains written agreements with other community partners that include services provided and a comprehensive referral process</p>	<p><b>Compliance</b></p>	<p>A review of the program's interagency agreements confirmed the program has agreements with community partners which include services provided and a comprehensive referral process.</p>	
<p><b>Additional Comments: There are no additional comments for this indicator.</b></p>			
<p><b>2.05 - Counseling Services</b></p>			<p><b>Satisfactory</b></p>
<p><b>Provider has a written policy and procedure that meets the requirement for Indicator 2.05</b></p>	<p><b>YES</b></p>		
	<p>If NO, explain here:</p>		
	<p>The program has a policy CHS725/Counseling Services last reviewed 2/6/2025 by the Director of Out of Home Programs.</p>		
<p><b>Shelter Program</b></p>			
<p>Shelter programs provides individual and family counseling</p>	<p><b>Compliance</b></p>	<p>A review of five residential youth's case notes in comparison with case plans found the program offers youth individual and family counseling.</p>	

<p>Group counseling sessions held a minimum of five days per week</p>	<p><b>Compliance</b></p>	<p>A review of five residential youth's case notes in comparison with group sign-in sheets confirmed group counseling sessions are held at a minimum of five days per week.</p>	
<p>Groups are conducted by staff, youth, or guests and group counseling sessions consist of :</p> <ol style="list-style-type: none"> <li>1. A clear leader or facilitator</li> <li>2. Relevant topic - educational/informational or developmental</li> <li>3. Opportunity for youth to participate</li> <li>4. 30 minutes or longer</li> </ol>	<p><b>Compliance</b></p>	<p>A review of the program's group binder for the past six months found documentation to confirm group counseling sessions included a clear leader or facilitator, relevant topics (educational or developmental), opportunity for youth to participate, and was conducted thirty minutes or longer.</p>	
<p>Documentation of groups must include date and time, a list of participants, length of time, and topic.</p>	<p><b>Compliance</b></p>	<p>A review of the program's group binder found documentation of groups included the date and time, a list of participants, length of time, and topic.</p>	
<p><b>Community Counseling</b></p>			
<p>Community counseling programs provide therapeutic community-based services designed to provide the intervention necessary to stabilize the family. Services are provided in the youth's home, a community location, the local provider's counseling office or virtually if written documentation is provided in the youth's file for reasons why it is in the best interest of the youth and family.</p>	<p><b>Compliance</b></p>	<p>A review of each youth's case notes found the program provides community counseling services designed to provide the intervention necessary to stabilize the family. Services are provided in the community.</p>	
<p><b>Counseling Services</b></p>			
<p>There is evidence the program completes review of all case files for coordination between presenting problem(s), psychosocial assessment, case/service plan, case/service plan reviews, case management, and follow-up.</p>	<p><b>Compliance</b></p>	<p>A review of each youth's case management records found the program completes review of each youth's record for coordination between presenting problems, psychosocial assessment, case/service plan, case/service plan reviews, case management, and follow-up.</p>	
<p>Maintain individual case files on all youth and adhere to all laws regarding confidentiality.</p>	<p><b>Compliance</b></p>	<p>A reviewed of each youth's record confirmed it was maintained in accordance to laws regarding confidentiality.</p>	
<p>Case notes maintained for all counseling services provided and documents youth's progress.</p>	<p><b>Compliance</b></p>	<p>A review of each youth's case management records found case notes documenting youth progress and services provided.</p>	
<p>On-going internal process that ensures clinical reviews of case records and staff performance.</p>	<p><b>Compliance</b></p>	<p>A review of youth records found the supervisor has an internal process for completing case reviews and reviewing staff performance, as required.</p>	

<p>When an intake is conducted through virtual means, consent is confirmed by the counselor, documented in the file, and reviewed with the supervisor during supervision/case review. There is written documentation provided in the youths file for reasons why virtual sessions are in the best interest of the youth and family.</p>	<p><b>Not Applicable</b></p>	<p>The program has not conducted intakes through virtual means.</p>	
<p><b>Additional Comments: There are no additional comments for this indicator.</b></p>			
<p><b>2.06 - Adjudication/Petition Process</b></p>			<p><b>Satisfactory</b></p>
<p><b>Provider has a written policy and procedure that meets the requirement for Indicator 2.06</b></p>	<p><b>YES</b></p>		
	<p>If NO, explain here:</p>		
	<p>The agency has a policy CHS/7206 Adjudication/ Petition Process last reviewed 2/5/2025 by the Director of Out of Home Programs.</p>		
<p>Must include: a. DJJ rep. or CINS/FINS provider b. Local school district representative</p>	<p><b>Compliance</b></p>	<p>The program had one applicable case staffing that was held during the review period. Documentation in the file indicated a DJJ representative, CINS/FINS provider, and local school district representative was present at the staffing.</p>	
<p>Other members may include: a. State Attorney's Office b. Others requested by youth/ family c. Substance abuse representative d. Law enforcement representative e. DCF representative f. Mental health representative</p>	<p><b>Compliance</b></p>	<p>The file reviewed listed other members that were present for the staffing. The program's policy indicates other members of the committee may include: State Attorney's Office; others requested by youth/ family; substance abuse representative; law enforcement representative; DCF representative; and mental health representative.</p>	
<p>The program has an established case staffing committee, and has regular communication with committee members</p>	<p><b>Compliance</b></p>	<p>The program has an established case staffing committee, and has regular communication with committee members.</p>	
<p>The program has an internal procedure for the case staffing process, including a schedule for committee meetings</p>	<p><b>Compliance</b></p>	<p>The program has an internal procedure for the case staffing process, including a schedule for committee meetings</p>	
<p>The youth and family are provided a new or revised plan for services</p>	<p><b>Compliance</b></p>	<p>One youth file reviewed contained a completed plan for services.</p>	

Written report is provided to the parent/guardian within 7 days of the case staffing meeting, outlining recommendations and reasons behind the recommendations	<b>Compliance</b>	Evidence of a written report (dated 10/04/2024) was provided to the parent/guardian within seven days of the case staffing meeting, outlining recommendations and reasons behind the recommendations as documented in one youth case file reviewed.	
If applicable, the program works with the circuit court for judicial intervention for the youth/family	<b>Compliance</b>	Documentation in the youth case file verifies the program works with the circuit court for judicial intervention for the youth/family.	
Case Manager/Counselor completes a review summary prior to the court hearing	<b>Compliance</b>	Evidence of a completed review by the Case Manager/Counselor was present in the youth file reviewed.	
<b>Additional Comments: There are no additional comments for this indicator.</b>			
<b>2.07 - Youth Records</b>			<b>Satisfactory</b>
<b>Provider has a written policy and procedure that meets the requirement for Indicator 2.07</b>	<b>YES</b>		
	If NO, explain here:		
	The agency has a policy CHS7207/Youth Records and Case Management Services last reviewed 2/6/2025 by the Director of Out of Home Programs.		
All records are clearly marked 'confidential'.	<b>Compliance</b>	A review of ten youth records found each record was clearly marked as confidential.	
All records are kept in a secure room or locked in a file cabinet that is marked "confidential"	<b>Compliance</b>	Observations made during the review found the records are kept in a locked file cabinet that is marked "confidential"	
When in transport, all records are locked in an opaque container marked "confidential"	<b>Compliance</b>	An informal interview with the program staff in comparison to an observation found community staff transport all records in a locked opaque container marked "confidential. Staff reported residential staff are not allowed to take records off-site.	
All records are maintained in a neat and orderly manner	<b>Compliance</b>	A review of ten youth records found they were maintained in a neat and orderly manner.	

<p>SHELTER FILES contain the following:                  Table of Contents that outlines documents in each section:</p> <ul style="list-style-type: none"> <li>•Screening</li> <li>•Informed Consent</li> <li>• Photograph of the youth</li> <li>• Shelter Intake Form</li> <li>• Suicide Assessment (if needed)</li> <li>• NIRVANA Self Report (NSR)</li> <li>• NIRVANA full Assessment</li> <li>• Plan of Service</li> <li>• Chronological Notes</li> <li>• Medication Inventory Form</li> <li>• Approved contact list</li> <li>• Copies of referrals made &amp; Follow-Up (if needed)</li> <li>• Discharge summary once case is closed</li> </ul>	<p><b>Compliance</b></p>	<p>A review of five shelter records found the records contained all required elements:</p> <ul style="list-style-type: none"> <li>•Screening</li> <li>•Informed Consent</li> <li>• Photograph of the youth</li> <li>• Shelter Intake Form</li> <li>• Suicide Assessment (if needed)</li> <li>• NIRVANA Self Report (NSR)</li> <li>• NIRVANA full Assessment</li> <li>• Plan of Service</li> <li>• Chronological Notes</li> <li>• Medication Inventory Form</li> <li>• Approved contact list</li> <li>• Copies of referrals made &amp; Follow-Up (if needed)</li> <li>• Discharge summary once case is closed</li> </ul>	
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<p>COMMUNITY COUNSELING FILES contain the following: Table of Contents that outlines documents in each section:</p> <ul style="list-style-type: none"> <li>• Screening</li> <li>• Informed Consent</li> <li>• Community Counseling Intake Form</li> <li>• Suicide Assessment (if needed)</li> <li>• NIRVANA full Assessment</li> <li>• Plan of Service</li> <li>• Chronological case notes</li> <li>• Copies of referrals made &amp; Follow-Up (if needed)</li> <li>• Discharge summary once the case is closed</li> </ul>	<p><b>Compliance</b></p>	<p>A review of five community records found each reviewed record contained all required elements:</p> <ul style="list-style-type: none"> <li>• Screening</li> <li>• Informed Consent</li> <li>• Community Counseling Intake Form</li> <li>• Suicide Assessment (if needed)</li> <li>• NIRVANA full Assessment</li> <li>• Plan of Service</li> <li>• Chronological case notes</li> <li>• Copies of referrals made &amp; Follow-Up (if needed)</li> <li>• Discharge summary once the case is closed</li> </ul>	
<p>All records kept electronically, are maintained securely and can be made immediately available upon request for audit purposes.</p>	<p><b>Not Applicable</b></p>	<p>The program does not maintain electronic records.</p>	
<p>Records are retained for the duration of the time specified by the contract.</p>	<p><b>Compliance</b></p>	<p>Observations made during the review found the records are retained as required per the contract.</p>	
<p><b>Additional Comments: There are no additional comments for this indicator.</b></p>			
<p><b>2.08 - Specialized Additional Program Services</b></p>			<p><b>Satisfactory</b></p>
<p><b>Provider has a written policy and procedure that meets the requirement for Indicator 2.08</b></p>	<p><b>YES</b></p>		
	<p>If NO, explain here:</p>		
	<p>The agency has a policy, CHS 7211 Specialized Additional Program Services, last updated 02/5/2025 by the Director of Out Home Services.</p>		
<p><b>Staff Secure</b></p>			
<p>Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? <b>(If no, select rating "No eligible items for review")</b></p>	<p><b>No eligible items for review</b></p>	<p>The Program Manager indicated that the program did not have any staff secure cases in the last six months or since the date of the last QI review.</p>	
<p>Staff Secure policy and procedure outlines the following:</p> <ol style="list-style-type: none"> <li>a. In-depth orientation on admission</li> <li>b. Assessment and service planning</li> <li>c. Enhanced supervision and security with emphasis on control and appropriate level of physical intervention</li> <li>d. Parental involvement</li> <li>e. Collaborative aftercare</li> </ol>	<p><b>Compliance</b></p>	<p>The program's policies and procedures pertaining to staff secure youth that outline:</p> <ol style="list-style-type: none"> <li>a. In-depth orientation on admission</li> <li>b. Assessment and service planning</li> <li>c. Enhanced supervision and security with emphasis on control and appropriate level of physical intervention</li> <li>d. Parental involvement</li> <li>e. Collaborative aftercare</li> </ol>	

<p>Program only accept youth that meet legal requirements of F.S. 984 for being formally court ordered in to Staff Secure Services</p>	<p><b>Compliance</b></p>	<p>The program's policies and procedures pertaining to staff secure youth indicate: the program only accepts youth that meet legal requirements of F.S. 984 for being formally court ordered in to Staff Secure Services.</p>	
<p>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</p>	<p><b>No eligible items for review</b></p>	<p>The program did not have any staff secure cases in the last six months or since the date of the last QI review.</p>	
<p>Agency provides a written report for any court proceedings regarding the youth's progress</p>	<p><b>No eligible items for review</b></p>	<p>The program did not have any staff secure cases in the last six months or since the date of the last QI review.</p>	
<p><b>Domestic Minor Sex Trafficking (DMST)</b></p>			
<p>Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")</p>	<p><b>No eligible items for review</b></p>	<p>The Program Manager indicated that the program did not have any Domestic Minor Sex Trafficking cases in the last six months or since the date of the last QI review.</p>	
<p>Agency has evidence that the FNYFS was contacted for approval prior to admission for all Domestic Minor Sex Trafficking (DMST) placements.</p>	<p><b>No eligible items for review</b></p>		
<p>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.</p>	<p><b>No eligible items for review</b></p>		
<p>Services provided to these youth specifically designated services designed to serve DMST youth</p>	<p><b>No eligible items for review</b></p>		
<p>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?</p>	<p><b>No eligible items for review</b></p>		
<p>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.)</p>	<p><b>No eligible items for review</b></p>		

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		
<b>Domestic Violence</b> ☐			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	No eligible items for review	The Program Manager indicated that the program did not have any Domestic Violence cases in the last six months or since the date of the last QI review.	
Youth admitted to DV Respite placement have evidence in the file of a pending DV charge	No eligible items for review		
Data entry into NetMIS within (3) business days of intake and discharge	No eligible items for review		
Youth length of stay in DV Respite placement does not exceed 21 days. If more than 21 days, documentation exists in youth file of transition to CINS/FINS or Probation Respite placement, if applicable.	No eligible items for review		
Case plan in file reflects goals for aggression management, family coping skills, or other intervention designed to reduce propensity for violence in the home	No eligible items for review		
All other services provided to Domestic Violence Respite youth are consistent with all other general CINS/FINS program requirements	No eligible items for review		
<b>Probation Respite</b>			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	Yes	The program did have one Probation Respite case in the last six months.	
All probation respite referrals are submitted to the Florida Network.	Compliance	Evidence of a referral submitted to the Florida Network was observed for the one Probation Respite case reviewed.	
All Probation Respite Referral come from DJJ Probation and there is evidence that the youth is on Probation regardless of adjudication status.	Compliance	Observation of documentation in the youth record indicate the referral for services came from DJJ and the youth is currently on probation.	
Data entry into NetMIS and JJIS within (3) business days of intake and discharge	Compliance	The file contained evidence of data entry into NetMIS within the required 3 business days of intake and discharge.	

<p>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.</p>	<p><b>Compliance</b></p>	<p>The one youth Probation Respite file reviewed did not have a stay greater than 30 days.</p>	
<p>All case management and counseling needs have been considered and addressed</p>	<p><b>Compliance</b></p>	<p>Evidence of all case management and counseling needs being considered and addressed was documented in the youth service plan and case notes.</p>	
<p>All other services provided to Probation Respite youth are consistent with all other general CINS/FINS program requirements</p>	<p><b>Compliance</b></p>	<p>The Probation Respite case received all other services consistent with the general CINS/ FINS program requirements.</p>	
<p><b>Intensive Case Management (ICM)</b></p>			
<p>Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")</p>	<p><b>No eligible items for review</b></p>	<p>The Program Manager indicated that the program did not have any Intensive Case Management cases in the last six months or since the date of the last QI review.</p>	
<p>Youth receiving services were deemed chronically truant and/or runaway and require more intensive and lengthy services. The youth was determined to be eligible because they have gone through petition and/or case staffing and was in need of case management services.</p>	<p><b>No eligible items for review</b></p>		
<p>Services for youth and family include: a. Two (2) direct contacts per month b. Two (2) collateral contacts per week c. Direct and collateral contacts not obtained must have documentation to support attempts made to obtain them. All reasonable attempts (at minimum of three) must be made to reach all contacts (direct and collateral) and documented in the case file and NetMIS.</p>	<p><b>No eligible items for review</b></p>		
<p>Assessments include a. NIRVANA at intake b. NIRVANA Re-Assessment every 90 days c. Post NIRVANA at discharge as aligned with timeframe requirements</p>	<p><b>No eligible items for review</b></p>		
<p>Service/case plan demonstrates a strength-based, trauma-informed focus</p>	<p><b>No eligible items for review</b></p>		
<p>For any virtual services provided, there is written documentation in the youths' file as to why virtual contact is in the best interest of the youth and family</p>	<p><b>No eligible items for review</b></p>		

<b>Family and Youth Respite Aftercare Services (FYRAC)</b>			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	<b>No eligible items for review</b>	The Program Manager indicated that the program did not have any Family and Youth Respite Aftercare Services (FYRAC) cases in the last six months or since the date of the last QI review.	
Youth is referred by DJJ for a domestic violence arrest on a household member, and/or the youth is on probation regardless of adjudication status and at risk of violating.	<b>No eligible items for review</b>		
Agency has evidence that all FYRAC referrals have documented approval from the Florida Network office	<b>No eligible items for review</b>		
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.	<b>No eligible items for review</b>		
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.	<b>No eligible items for review</b>		

<p>Individual Sessions: a. The program conducted sessions with the youth and family to focus on work to engage the parties and identify strengths and needs of each member that help to improve family functioning. b. Issues to be covered through each session include but are not limited to: Identifying emotional triggers; body cues; healthy coping strategies through individual, group and family counseling; understanding the cycle of violence and the physical and emotional symptoms of anger; developing safety plans; and educating families on the legal process and rights.</p>	<p><b>No eligible items for review</b></p>		
<p>Group Sessions: a. Focus on the same issues as individual/family sessions with application to youth pulling on similar experiences with other group members with the overall goal of strengthening relationships and prevention of domestic violence. b. Shall be no more than eight (8) youth at one (1) time and shall be for a minimum of sixty (60) minutes per session</p>	<p><b>No eligible items for review</b></p>		
<p>There is evidence of completed 30 and/or 60 day follow-ups and is documented in NetMIS following case discharge.</p>	<p><b>No eligible items for review</b></p>		
<p>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</p>	<p><b>No eligible items for review</b></p>		
<p>Any service that is offered virtually, is documented in the youth's file why it was in the youth and families best interest.</p>	<p><b>No eligible items for review</b></p>		
<p>All data entry in NetMIS is completed within 3 business days as required.</p>	<p><b>No eligible items for review</b></p>		

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

<b>2.09- Stop Now and Plan (SNAP)</b>		<b>Not Applicable</b>	
<b>Provider has a written policy and procedure that meets the requirement for Indicator 2.09</b>	N/A		
	If NO, explain here:		
	N/A		
<b>SNAP Clinical Groups Under 12</b>			
Youth are screened to determine eligibility of services with the required documents: a. Florida Network Youth Screening Form b. SNAP® Brief Intake Screening Checklist	<b>Not Applicable</b>	The program is not contracted to perform SNAP services.	
All files contain <b>each</b> of the required documents below: a. SNAP Child Screening Interview Report b. Florida Network Community Counseling Intake Form c. Reinforcement Trap/Coercive Cycle Diagram d. Consent to Treatment and Participation in Research Form	<b>Not Applicable</b>		
The NIRVANA was completed at initial intake, or within two sessions.	<b>Not Applicable</b>		
There is evidence of the completed the Pre - Child Behavior Checklist (CBCL) by the caregiver and is located within the file.	<b>Not Applicable</b>		
There is evidence of the completed Pre - TOPSE is completed by the caregiver and is located within the file.	<b>Not Applicable</b>		
There is evidence of the following documents located within the file: a. SNAP® Parent Goal Sheet b. Child Way To Go Goal Sheet <i>(This may be in progress for open files but is required for all closed files.)</i>	<b>Not Applicable</b>		
<b>SNAP Clinical Groups Under 12 - Discharge</b>			
There is evidence of the completed the Post - Child Behavior Checklist (CBCL) by the caregiver and is located within the file.	<b>Not Applicable</b>	The program is not contracted to perform SNAP services.	

There is evidence of the completed Post - TOPSE is completed by the caregiver and is located within the file.	<b>Not Applicable</b>		
There is evidence of the completed SNAP Discharge Report located within the file for any discharged youth.	<b>Not Applicable</b>		
There is evidence of the SNAP Boys/SNAP Girls Child Group Evaluation Form located in the file.	<b>Not Applicable</b>		
There is evidence of the SNAP Boys/SNAP Girls Parent Group Evaluation Form located in the file.	<b>Not Applicable</b>		
<b>SNAP Clinical Groups for Youth 12-17</b>			
Youth are screened to determine eligibility of services using the Florida Network Youth Screening Form.	<b>Not Applicable</b>	The program is not contracted to perform SNAP services.	
The file contains the completed Florida Network Community Counseling Intake Form and is located within the file.	<b>Not Applicable</b>		
The Consent to Treatment and Participation in Research Form is completed, signed by the parent/guardian before receiving services, and located within the file.	<b>Not Applicable</b>		
The NIRVANA was completed at initial intake, or within two sessions.	<b>Not Applicable</b>		
There is evidence of the completed 'How I Think Questionnaire' (HIT) form located within the file or evidence of at least three (3) documented attempts in the youths' file to obtain this information.	<b>Not Applicable</b>		
There is evidence of the completed Social Skills Improvement System (SSIS) Student form located within the file or evidence of at least three (3) documented attempts in the youths' file to obtain this information.	<b>Not Applicable</b>		
There is evidence of the completed Social Skills Improvement System (SSIS) Teacher/Adult form located within the file or evidence of at least three (3) documented attempts in the youths' file to obtain this information.	<b>Not Applicable</b>		

All closed files contained evidence in the file a NIRVANA was completed at discharge.	<b>Not Applicable</b>		
<b>SNAP for Schools &amp; Communities</b>			
The program demonstrated all of the required weekly attendance sheets that included youth names and/or identifying numbers completed with the teacher and trained SNAP Facilitator signatures. <i>(This must include a total of 13 attendance sheets for a full cycle)</i>	<b>Not Applicable</b>	The program is not contracted to perform SNAP services.	
The program maintained evidence of a completed 'Way to Go Goal' Sheet within the file.	<b>Not Applicable</b>		
The program maintained evidence of both pre AND post Measure of Classroom Environment (MoCE) completed documents for the class reviewed.	<b>Not Applicable</b>		
The program maintained evidence of completed pre and post evaluation documents for the class reviewed.	<b>Not Applicable</b>		
There is evidence of the SNAP® for Schools & Communities Feedback Form completed by the supervisory adult responsible for the support of the youth receiving services and entered into NetMIS.	<b>Not Applicable</b>		
There is evidence of one (1) Fidelity Adherence Checklist completed per classroom for the 13-week classroom sessions which is located in the file.	<b>Not Applicable</b>		
<b>Additional Comments: There are no additional comments for this indicator.</b>			
<b>Standard Three – Shelter Care</b>			
<b>3.01 - Shelter Environment</b>			<b>Satisfactory with Exception</b>
<b>Provider has a written policy and procedure that meets the requirement for Indicator 3.01</b>	<b>YES</b>		
	If NO, explain here:		
	The agency has a policy and procedure CHS/7301 Shelter Environment last reviewed 4/29/24 by the Director of Our of Home Care Programs.□		

<p><b>Facility Inspection:</b></p> <ul style="list-style-type: none"> <li>a. Furnishings are in good repair.</li> <li>b. The program is free of insect infestation.</li> <li>c. Bathrooms and shower areas are clean and functional, free of foul odors, leaks, dust, and mildew and in good working order.</li> <li>d. There is no graffiti on walls, doors, or windows.</li> <li>e. Lighting is adequate for tasks performed there.</li> <li>f. Exterior areas are free of debris; grounds are free of hazards.</li> <li>g. Dumpster and garbage can(s) are covered.</li> <li>h. All doors are secure, in and out access is limited to staff members and key control is in compliance.</li> <li>i. Detailed map and egress plans of the facility, general client rules, grievance forms, abuse hotline information, DJJ Incident Reporting Number and other related notices are posted.</li> <li>j. Interior areas (bedrooms, bathrooms, common areas) do not contain contraband and are free from hazardous unauthorized metal/foreign objects.</li> </ul>	<p><b>Compliance</b></p>	<p>One dumpster is located outside on the front east side of the shelter. Dumpster and garbage cans were observed both days of the audit to be covered at all times and free from debris. The exterior grounds were kept well landscaped and free of trash/debris. The program is free of insect infestation and receives pest services. In and out access is limited to staff members. Shelter keys are locked in the "mail room". Observations from the logbook September 2024 to March 2025 showed consistent entries of staff signing shelter keys in and out at the beginning/end of shifts. In the lobby area, there is a visitor log that visitors must sign when they enter the building. No graffiti observed on the walls, doors, or windows throughout the shelter. All areas and furnishings throughout the shelter were kept clean and in good condition. there are bright walls and colorful motivational posters in the dayroom area, creating a warm and comfortable environment. No contraband or hazardous objects were observed throughout the shelter. There are two functional bathrooms for the youth to use, one in the boys wing with two toilet stalls, and one in the girls wing with two toilet stalls. Two sinks are located in the bathrooms of each wing. All bathrooms and shower areas were free of foul odors and mildew. The grievance box was observed to be easily accessible and located in the dining room. Blank grievance forms were readily available for the youth, located next to the grievance box. The grievance form policy was posted next to the grievance box as well as in all of the youth bedrooms. The DJJ incident reporting number is posted in the Youth Care Specialist office. The abuse hotline number is posted in the YCS office and on the bulletin board across from the nurse/intake office. Detailed maps and egress plans are posted throughout the facility at the following locations: one in the dining room area, one in the back staff hallway, two in the boys dorm hallway, and one in the boys dorm hallway.</p>	
<p><b>Facility Inspection:</b></p> <ul style="list-style-type: none"> <li>a. All agency and staff vehicles are locked.</li> <li>b. Agency vehicles are equipped with major safety equipment including first aid kit, (all items in the first aid kit are current and do not have expired items; all expired items should be replaced regularly), fire extinguisher, flashlight, glass breaker and, seat belt cutter.</li> </ul>	<p><b>Compliance</b></p>	<p>The agency has one vehicle which was locked both days while on-site. The vehicle is a 2020 Ford Transit. Extremely clean and appeared to be in great condition. The vehicle was equipped with two fire extinguishers, a first aid kit (with no expired items), a flashlight, a glass breaker, and a seat belt cutter. All staff vehicles were observed to be locked on both days.</p>	

<p><b>Facility Inspection:</b></p> <p>All chemicals are listed, approved for use, inventoried weekly and perpetually, stored securely and Material Safety Data Sheets (MSDS) are maintained on each item (minimum 1 time per week or per agency policy).</p> <p>A perpetual inventory will be the primary means of maintaining a current and real-time inventory.</p> <p>The weekly inventory will be conducted weekly at a minimum to ensure that a perpetual inventory is being maintained consistently and accurately. If more than one location is used to store chemicals, there is an inventory wherever chemicals are stored that is current and well maintained unless previously approved by the Network.</p>	<p><b>Compliance</b></p>	<p>Chemical inventory logs were observed starting in September 2024 until March 2025. Chemicals were observed to be secured safely and locked in a cabinet located in the laundry room. Residential supervisor states that inventory of chemicals is conducted every 6-7 days by the overnight shift staff, which was consistent with the reviewed sample documentation. During the tour, the chemical inventory binder was observed to be located in the Youth Care Specialist office. The MSDS binder was also located in the Youth Care Specialist office, and was up to date with all present chemicals in the cabinet of the laundry room having a corresponding safety data sheet.</p>	
<p><b>Facility Inspection:</b></p> <p>Washer/dryer are operational &amp; general area/lint collectors are clean.</p> <p>Agency has a current DCF Child Care License which is displayed in the facility.</p> <p>Each youth has own individual bed with clean covered mattress, pillow, sufficient linens and blanket.</p> <p>Youth have a safe, lockable place to keep personal belongings, if requested.</p>	<p><b>Compliance</b></p>	<p>The facility has one washer and one dryer in the laundry room. Both appliances are operational and the lint collectors were observed to be clean during the walk-through on both days of the audit. Each youth had their own bed, mattress cover, pillows, linens, and blankets. All items appeared to be clean and neat. All youth are able to store their personal items in a safe lockable place if requested. That safe is located in the pantry. Only staff are able to access the pantry, and only staff have keys to open the safe. Items observed in the safe were: client cell-phones (which staff store there due to cell-phones not permitted/allowed into the shelter).</p>	
<p><b>Additional Facility Inspection Narrative (if applicable)</b></p>			

<p><b>Fire and Safety Health Hazards:</b></p> <p>a. Annual facility fire inspection was conducted, and the facility is in compliance with local fire marshal and fire safety code within jurisdiction.</p> <p>b. Agency completes a minimum of 1 fire drill on each shift monthly (within 2 minutes or less).</p> <p>c. Completes 1 mock emergency drill per shift per quarter.</p> <p>d. All annual fire safety equipment inspections are valid and up to date (extinguishers, sprinklers, alarm system and kitchen overhead hood, including fire extinguishers in all vehicles).</p>	<p><b>Exception</b></p>	<p>The annual facility fire inspection was last completed on February 20th, 2025. No notes or violations noted in the fire inspection. Fire drills were confirmed with paperwork and the logbook on the following dates: First shift: 3/4/25, 2/2/25, 1/3/25, 12/1/24, 11/01/24, 11/3/24, 10/2/24, 9/5/24, Second Shift: 3/10/25, 2/9/25, 1/8/25, 12/3/24, 10/1/24, 9/1/24 Third Shift: 3/9/25, 2/8/25, 1/2/25, 12/8/24, 11/2/24, 10/6/24, 9/6/24.</p> <p>Mock emergency drills were completed at least one per quarter. Emergency drills were conducted for first shift: 3/19/25, 3/6/25, 2/19/25, 1/10/25, 1/3/25, 12/6/24, 12/1/24, 11/6/24, 11/3/24, 11/1/24, 10/13/24, 10/3/24, 9/9/24, 9/7/24, second shift: 3/10/25, 2/9/25, 2/2/25, 1/13/25, 12/3/24, 10/7/24, 9/1/24. All fire extinguishers in the facility were last inspected on October 17th 2024. All 10 fire extinguishers were located throughout the shelter and observed to be easily accessible in the event of an emergency, not locked away. The building fire alarm system inspection was last completed on January 25th, 2024. The most recent kitchen hood inspection was completed on December 2nd, 2024, and no deficiencies were noted.</p>	<p>Fire drill for the second shift was not conducted in November 2024.</p>
<p><b>Fire and Safety Health Hazards:</b></p> <p>a. Agency has a current Satisfactory Residential Group Care inspection report from the Department of Health.</p> <p>b. Agency has a current Satisfactory Food Service inspection report from the Department of Health and food menus are posted, current and signed by Licensed Dietician annually.</p> <p>c. All cold food is properly stored, marked and labeled and dry storage/pantry area is clean and food is properly stored.</p> <p>d. Refrigerators/Freezers are clean and maintained at required temperatures and all small and medium sized appliances are operable and clean for use as needed.</p>	<p><b>Exception</b></p>	<p>The most recent Group Care inspection was up to date and completed on January 8th, 2025. There was a violation for a broken plastic drawer in the refrigerator located next to the Youth Care Specialist office in the kitchen. The inspection noted that this must be corrected before the next Group Care inspection. The violation item was observed to still be broken during the walk-through both days of the audit. Freezer one maintained a temperature of -5, freezer two maintained a temperature of -3, fridge one maintained a temperature of 29 degrees, and fridge three maintained a temperature of 30 degrees. All refrigerators and freezers were are very clean and operable. Some moisture and water was observed to collect on the bottom level of one of the refrigerators (under the plastic drawers). The Shelter Director stated that they have been in contact with companies to get that moisture fixed and consistent documentation was provided showing that correspondence.</p>	<p>Fourteen food items were observed to not have expiration dates or labels on them. Two were already previously opened, and the remaining twelve items were unopened but still had no expiration date.</p>
<p><b>Additional Fire and Safety Health Hazards Narrative (if applicable)</b></p>			

<b>Youth Engagement</b>			
<p>a. Youth are engaged in meaningful, structured activities (e.g., education, recreation, counseling services, life and social skill training) seven days a week during awake hours. Idle time is minimal.</p> <p>b. At least one hour of physical activity is provided daily.</p> <p>c. Youth are provided the opportunity to participate in a variety of faith-based activities. Non-punitive structured activities are offered to youth who do not choose to participate in faith-based activities.</p> <p>d. Daily programming includes opportunities for youth to complete homework and access a variety of age appropriate, program approved books for reading. Youth are allowed quiet time to read.</p> <p>e. Daily programming schedule is publicly posted and accessible to both staff and youth.</p>	<b>Compliance</b>	<p>Youth are engaged in meaningful structured activities throughout the day. The program has a monthly recreational schedule in addition to the daily program schedule. The program also has a weekly counseling group schedule that includes a variety of topics such as substance abuse &amp; hygiene from the health department. Youth participate in one hour of physical activity on a daily basis. This was observed to be written on the daily programming schedule and was consistently documented daily in the logbook from September 2024 to March 2025. Youth are provided to participate in faith-based activities aligned with their spiritual beliefs if they prefer such as church services online and in person that is available once a week. The daily program schedule includes homework time from 3:00pm-5:00pm during the week. Observed a bookshelf located in the day/living room for all youth to access age appropriate books at any time. On the weekends, there is a designated time in the schedule for journaling and reading. The daily programming schedule is posted publicly for all staff to see in the hallway across from the medical office. The programming schedule is also posted in all youth bedrooms.</p>	
<b>Additional Comments:</b> There are no additional comments for this indicator.			
<b>3.02 - Program Orientation</b>			<b>Satisfactory</b>
<b>Provider has a written policy and procedure that meets the requirement for Indicator 3.02</b>	<b>YES</b>		
	If NO, explain here:		
	The agency has a policy and procedure CHS/7302 Program Orientation last reviewed 12/03/2021 by the Director of Program Operations.		
Youth received a comprehensive orientation and handbook provided within 24 hours	<b>Compliance</b>	All five of the sampled youth files showed that they received a comprehensive orientation and provided a handbook within 24 hours of admission into the shelter.	

<p>Orientation includes the following:                  a. Youth is given a list of contraband items                  b. Disciplinary action is explained                  c. Dress code explained                  d. Review of access to medical and mental health services                  e. Procedures for visitation, mail and telephone                  f. Grievance procedure                  g. Disaster preparedness instructions                  h. Physical layout of the facility                  i. Sleeping room assignment and introductions                  j. Suicide prevention- alerting staff of feelings or awareness of others having suicidal thoughts</p>	<p><b>Compliance</b></p>	<p>The orientation handbook includes which items are considered contraband, the disciplinary action procedures along with the behavior management system, the dress code, grievance box location and procedures, visitation and contact approval lists, a physical map of the facility, disaster preparedness instructions, room assignments and expectations, and suicide prevention questions are asked.</p>	
<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</p>	<p><b>Compliance</b></p>	<p>Each component of the client orientation indicates the signature of the youth and the staff who were conducting the orientation, as well as the dates. This documentation is located in each individual youth record.</p>	
<p><b>Additional Comments: There are no additional comments for this indicator.</b></p>			
<p><b>3.03 - Youth Room Assignment</b></p>			<p><b>Satisfactory</b></p>
<p><b>Provider has a written policy and procedure that meets the requirement for Indicator 3.03</b></p>	<p><b>YES</b></p>		
	<p>If NO, explain here:</p>		
	<p>The agency has a policy and procedure CHS/7303 Youth room Assignment last reviewed 4/29/24 by the Director of Our of Home Care Programs. <input type="checkbox"/></p>		
<p><b>A process is in place that includes an initial classification of the youths, to include:</b></p>			
<p>a. Review of available information about the youth's history, status and exposure to trauma                  b. Initial collateral contacts,                  c. Initial interactions with and observations 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</p>	<p><b>Compliance</b></p>	<p>All five of the sampled youth files showed that they were evaluated according to their policy and assigned in rooms/beds accordingly. All applicable criteria was followed: history of the youth's trauma, initial interactions/observations of the youth were documented, suicide risk assessments conducted, predatory behavior/sexual aggression is evaluated, evaluated if acute health symptoms evaluated or any other medical/physical disabilities detected, separation of younger youth from older youth was observed, and separation of violent youth from non-violent youth was observed.</p>	

An alert is immediately entered into the program's alert system when a youth is admitted with special needs and risks such as risk of suicide, mental health, substance abuse, physical health or security risk factors	<b>Compliance</b>	All five of the sampled youth showed that an alert was immediately entered into the program's alert system when there were special needs indicated such as suicide risk, mental health, substance abuse, physical health issues, and security risk factors.	
<b>Additional Comments: There are no additional comments for this indicator.</b>			
<b>3.04 - Log Books</b>			<b>Satisfactory with Exception</b>
<b>Provider has a written policy and procedure that meets the requirement for Indicator 3.04</b>	<b>YES</b>		
	If NO, explain here:		
	The agency has a policy and procedure CHS/7304, Log Books last reviewed 4/29/24 by the Director of Out of Home Programs.		
Log book entries that could impact the security and safety of the youth and/or program are highlighted	<b>Compliance</b>	Safety and security issues that could impact the youth & program are highlighted in red and yellow throughout the sample timeframe reviewed September 2024-March 2025.	
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	<b>Compliance</b>	All entries in the logbook are brief and legibly written in ink throughout the timeframe of September 2024-March 2025. All logbook entries include the date and time of incidents/events, names of staff/youth involved, brief statements providing pertinent information, name and signature of person making the entry.	
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.	<b>Compliance</b>	All errors observed within the sample timeframe of September 2024-March 2025 were struck through with a clear line and initialed and dated by the staff. No white-out or erasing was evident in the paper logbooks throughout September 2024-March 2025.	
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	<b>Exception</b>	The Program Director/designee reviews the logbook as observed from September 2024 - March 2025.	The review of the logbook does not indicate the dates that were reviewed by the Program Director.
All staff review the logbook of the previous two shifts and makes an entry signed and dated into the logbook indicating the dates reviewed	<b>Exception</b>	A review of the logbooks from September 2024 - March 2025 contained entries for all staff review of the previous two shifts.	A direct care staff on shift did not sign in or review the previous two shift notes as required according to the logbook on 11/18/24 for the overnight shift.

<p>At the beginning of their shift, oncoming supervisor and shelter counselor reviews the logbook of all shifts since their last log entry and makes a signed and dated entry and into log book indicating the dates reviewed.</p>	<p><b>Exception</b></p>	<p>The oncoming supervisor reviewed the logbook of all shifts since their last logbook entry.</p>	<p>The residential counselor did not consistently review the logbook of all shifts since their last logbook entry. The counselor stated the number of previous shifts reviewed in the logbook entry, which does not satisfy the indicator as the specific dates reviewed must be stated. Examples noted: 11/18/24 at 8:00am states "reviewed previous two shifts", 11/22/24 at 7:00am states "reviewed previous two shifts", 11/21/24 at 8:30am "reviewed two shifts", 11/22/24 does not state which shifts or dates were reviewed, 11/25/24 states "six prior shift notes reviewed".</p>
<p>Logbook entries include: a. Supervision and resident counts b. Visitation and home visits</p>	<p><b>Compliance</b></p>	<p>Supervision and resident counts are consistently documented in the logbook throughout the sample timeframe of September 2024-March 2025. Visitation and home visits are consistently documented in the logbook entries throughout the sample timeframe of September 2024-March 2025.</p>	

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

<p><b>3.05 - Behavior Management Strategies</b></p>		<p><b>Satisfactory</b></p>	
<p><b>Provider has a written policy and procedure that meets the requirement for Indicator 3.05</b></p>	<p><b>YES</b></p>		
	<p>If NO, explain here:</p>		
	<p>The agency has a policy and procedure CHS/7305 Behavior Management Systems Strategies last reviewed 04/09/24 by the Director of Out of Home Programs.</p>		
<p>The program has a detailed written description of the BMS and it is explained during program orientation</p>	<p><b>Compliance</b></p>	<p>The program has a detailed written description of the behavior management system and is explained during program orientation. There is a detailed description of the behavior management system included in the youth handbook.</p>	
<p><b>Behavior Management Strategies must include:</b></p>			

<p>a. BMS is designed to teach youth new behaviors and help youth understand the natural consequences for their actions</p> <p>b. Behavioral interventions are applied immediately, with certainty, and reflect the severity of the behavior</p> <p>c. BMS uses a wide variety of awards/incentives to encourage participation and completion of the program</p> <p>d. Appropriate consequences and sanctions are used by the program and consequences for behavior are logical and designed to promote skill-building for the youth</p> <p>e. Counseling, verbal intervention and de-escalation techniques are used prior to physical intervention (Only techniques approved by the Florida Network and DJJ are used if physical intervention is required)</p> <p>f. Only staff discipline youth. Group discipline is not imposed</p> <p>g. Room restriction is not used as part of the system or for youth who are physically and/or emotionally out of control</p> <p>h. Youth should never be denied basic rights such as meals, clothing, sleep, services, exercise, or correspondence privileges</p>	<p><b>Compliance</b></p>	<p>The program uses a variety of positive incentives including an incentive closet in which youth can "buy" special items with their earned points. Based on the amount of points the clients earn every week, they can save their points throughout their time at the shelter in their "point bank". The concept is similar to banking, earning and saving points similar to money, and choosing whether they want to use their points to save or use. For example, the items that cost more points are headphones, and items that cost less are nice hygiene sets, etc. Appropriate interventions are used by the program to teach youth new behaviors and help youth understand the natural consequences for their actions. Interventions are applied immediately, with certainty, and reflect the severity of the behavior. There are different levels of consequences such as going to bed earlier, loss of video game privilege, and loss of television time. Consequences for violation of program rules appear to be applied logically and consistently. Group discipline is never imposed, and youth are never denied basic rights in place of a consequence (clothing, meals, sleep, services, exercises, etc.). Counseling, verbal intervention, and de-escalation techniques are used prior to physical intervention by the shelter counselors and the youth care workers. The behavior management system appears to promote order, safety, security, respect, fairness, and protection of resident rights. The system provides positive reinforcement, constructive dialogue, and peaceful resolution, and minimizes separation of youth from the general population.</p>	
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Program's use of the BMS			
All staff are trained in the theory and practice of administering BMS rewards and consequences	<b>Compliance</b>	All staff are trained in the theory and practice of administering the behavior management system rewards and consequences during their youth care worker shadowing period. The staff also explain the rewards and consequences to all new youth during their orientation.	
There is a protocol for providing feedback and evaluation of staff regarding their use of BMS rewards and consequences	<b>Compliance</b>	There is a protocol for providing feedback and evaluation of staff regarding their use of positive and negative consequences during annual staff performance reviews and one-on-one conversations with the supervisor as needed based on observations.	
Supervisors are trained to monitor the use of rewards and consequences by their staff	<b>Compliance</b>	Yes, the supervisors are trained to monitor the use of rewards and consequences by the staff. The supervisor reviews the point papers in the client's file weekly. The supervisor also often observes the use of the incentive closet by the staff to ensure that it is being completed correctly.	
<b>Additional Comments:</b> There are no additional comments for this indicator.			
<b>3.06 - Staffing and Youth Supervision</b>			<b>Satisfactory</b>
<b>Provider has a written policy and procedure that meets the requirement for Indicator 3.06</b>	<b>YES</b>		
	If NO, explain here:		
	The agency has a policy and procedure CHS/7306 Staffing and Youth Supervision last reviewed 4/29/24 by the Director of Out of Home Programs.		
The program maintains minimum staffing ratios as required by Florida Administrative Code and contract. • 1 staff to 6 youth during awake hours and community activities • 1 staff to 12 youth during the sleep period	<b>Compliance</b>	A review of the program's staff schedules and logbooks for the past six months it is evident the program maintains the minimum staffing ratios as required by Florida Administrative code and contact.	
All shifts must always provide a minimum of two direct care staff present that have met the minimum training requirements	<b>Compliance</b>	All shifts consistently maintain a minimum of two staff present on each shift which was consistently observed throughout the logbook. The logbook documentation also corresponded with the staff schedules that were observed from September 2024-March 2025.	
Program staff included in staff-to-youth ratio includes only staff that are background screened and properly trained youth care workers, supervision staff, and treatment staff	<b>Compliance</b>	All program staff included in the staff-to-youth ratio only include staff that are properly background screened (youth care workers, supervision staff, and treatment staff).	

The staff schedule is provided to staff or posted in a place visible to staff	<b>Compliance</b>	Program staff schedule is posted to all staff in a visible place for staff in the Youth Care worker 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	<b>Compliance</b>	There is an "On-Call" directory that includes staff names, titles, and phone numbers to be contacted when additional coverage is needed.	
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	<b>Compliance</b>	<p>Staff observe youth at least every fifteen minutes as required while they are sleeping or any time they are in their rooms. All bed check documentation in the written logbook entries were observed to be consistently completed every 10 minutes, no inconsistencies noted in the timeframe reviewed (September 2024-March 2025). Video footage was reviewed for the time periods of March 4th: 9:00pm-11:00pm, March 7th: 1:00am-3:00am, March 9th: 6:00am-8:00am, March 13th: 2:00am-4:00am, March 27th: 1:00am-3:00pm. During these time frames, a staff member was observed to consistently conduct bed checks every fifteen minutes.</p> <p>Observation: During the video review on March 4th 9:00pm-11:00pm, a youth was observed to be awake speaking with staff by an office but was marked by staff in the logbook to have been sleeping in the dorm at that time.</p>	

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

<b>3.07 - Video Surveillance System</b>		<b>Satisfactory</b>
Provider has a written policy and procedure that meets the requirement for Indicator 3.07	<b>YES</b>	
	If NO, explain here:	
	The agency has a policy and procedure CHS/7307 Video Surveillance System last reviewed 4/29/2024 by the Director of Out of Home Programs.	
<b>Surveillance System</b>		

<p>The agency, at a minimum, shall demonstrate:</p> <ul style="list-style-type: none"> <li>a. A written notice that is conspicuously posted on the premises for the purpose of security</li> <li>b. System can capture and retain video photographic images which must be stored for a minimum of 30 days</li> <li>c. System can record date, time, and location; maintain resolution that enables facial recognition</li> <li>d. Back-up capabilities consist of cameras' ability to operate during a power outage</li> <li>e. Have cameras placed in interior (e.g. intake office, counseling office, cafeteria, day room) and exterior (e.g. entrance/exit, recreation area, parking lot) general locations of the shelter where youth and staff congregate and where visitors enter and exit; to include locations where youth searches are conducted. Cameras are never placed in bathrooms or sleeping quarters.</li> <li>f. All cameras are visible</li> </ul>	<p><b>Compliance</b></p>	<p>Written notices are posted throughout the shelter stating "Smile, you're on camera". Cameras are posted in all of the general locations of the shelter. Locations of cameras observed: one in the medical intake office, one in the lobby (entrance/exit), one in the girls dorm hallway, one in the boys dorm hallway, one in the back staff hallway, one in the day/common area, one in the dining area, one in the kitchen, one in the pantry, one exterior camera in the back of the shelter viewing the backyard area, one in the back porch/indoor patio area, one exterior camera on the front right side of the building, and one exterior camera on the left side of the building. All cameras are visible throughout the interior and exterior of the shelter. No cameras were observed in any bathrooms or sleeping areas throughout the shelter. System is able to capture and retain video photographic images and be stored for a minimum of 30 days. System is able to record the date, time, and location. Footage maintains resolution that enables facial recognition. The camera system is able to operate during a power outage with the battery backup.</p>	
<p>A list of designated personnel who can access the video surveillance system is maintained (includes off-site capability per personnel)?</p>	<p><b>Compliance</b></p>	<p>There is a list of designated personnel who can access the video surveillance system is maintained which is the program manager, shelter supervisor, director of program operations, and vice president of children &amp; family welfare.</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><b>Compliance</b></p>	<p>Supervisory review of video is conducted a minimum of once every 14 days and documented in the logbook consistently through the time period of September 2024-March 2025.</p>	
<p>The reviews assess the activities of the facility and include a review of random sample of overnight shifts</p>	<p><b>Compliance</b></p>	<p>The noted video system reviews completed by the supervisor include activities of the facility and overnight shifts. It was recommended to review random time frames instead of the same timeframes every two weeks.</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><b>Compliance</b></p>	<p>There is a process for third party review of video recordings after a request from program quality improvement visits and when an investigation is pursued after an allegation of an incident.</p>	

<p>Camera service order/requests will be made within 24 hours of discovery of camera malfunctioning or being inoperable. All efforts made to obtain repairs are documented and maintained</p>	<p><b>Compliance</b></p>	<p>No camera service order requests were made due to the supervisor saying she did not notice any camera malfunctions that were observed during prior to the audit up to the month of March 2025. While on-site, there was a work order requested on 4/3/25 after a malfunction was discovered during the video surveillance review on 4/3/25 of the skip/gap that occurs when staff walk down the girls wing hallway for approximately 10-20 seconds each time. The skip occurs after staff are observed walking into the hallway, it skips and only shows when they are walking out of the hallway. The 10-20 seconds timeframe that is missing is the time in which would allow us to observe with certainty that staff are checking the youth bedrooms. Request for service was made by the Residential Program Manager within the twenty-four hour required time-frame of discovery.</p>	
<p><b>Additional Comments:</b> There are no additional comments for this indicator.</p>			
<p><b>Standard Four – Mental Health/Health Services</b></p>			
<p><b>4.01 - Healthcare Admission Screening</b></p>			<p><b>Satisfactory</b></p>
<p><b>Provider has a written policy and procedure that meets the requirement for Indicator 4.01</b></p>	<p><b>YES</b></p>		
	<p>If NO, explain here:</p>		
	<p>The agency has a policy and a procedure Healthcare Admission Screening, Policy number: CHS/7401, last reviewed 04/29/2024 by the Director of home programs.</p>		
<p><b>Preliminary Healthcare Screening</b></p>			
<p>Screening includes :</p> <ul style="list-style-type: none"> <li>a. Current medications</li> <li>b. Existing (acute and chronic) medical conditions</li> <li>c. Allergies</li> <li>d. Recent injuries or illnesses</li> <li>e. Presence of pain or other physical distress</li> <li>f. Observation for evidence of illness, injury, physical distress, difficulty moving, etc.</li> <li>g. Observation for presence of scars, tattoos, or other skin markings</li> <li>h. Acute health symptoms requiring quarantine or isolation</li> </ul>	<p><b>Compliance</b></p>	<p>Five of five residential (three closed and two open) files reviewed contained evidence of a primary healthcare screening which included:</p> <ul style="list-style-type: none"> <li>a. Current medications</li> <li>b. Existing (acute and chronic) medical conditions</li> <li>c. Allergies</li> <li>d. Recent injuries or illnesses</li> <li>e. Presence of pain or other physical distress</li> <li>f. Observation for evidence of illness, injury, physical distress, difficulty moving, etc.</li> <li>g. Observation for presence of scars, tattoos, or other skin markings</li> <li>h. Acute health symptoms requiring quarantine or isolation</li> </ul>	
<p><b>Referral and Follow-Up</b></p>			

Youth with chronic medical conditions have a referral to ensure medical care (e.g. diabetes, pregnancy, seizure disorder, cardiac disorders, asthma, tuberculosis, hemophilia, head injuries, etc.)	<b>No eligible items for review</b>	Five of five residential (three closed and two open) files reviewed contained evidence that none of the participants needed any referral for medical care because of any chronic medical conditions.	
When needed, the parent is involved with the coordination and scheduling of follow-up medical appointments	<b>No eligible items for review</b>	Five of five residential (three closed and two open) files reviewed, and there wasn't any evidence showing a need for parent participating in the coordination or scheduling of follow up medical appointments.	
All medical referrals are documented on a daily log.	<b>No eligible items for review</b>	Five of five residential (three closed and two open) files, and there wasn't any medical referrals made. Therefore there isn't any evidence in their files notating the need for any medical logs.	
The program has a thorough referral process and a mechanism for necessary follow-up medical care as required and/or needed	<b>Compliance</b>	The program has a policy and procedure which addresses a thorough referral process and mechanism for necessary follow-up medical care as required or needed for all youth. After interviewing the Residential Supervisor, it was reported this agency has a thorough referral process, and mechanism for necessary follow-up medical care as required and/or needed.	
<b>Additional Comments: There are no additional comments for this indicator.</b>			
<b>4.02 - Suicide Prevention</b>			<b>Satisfactory</b>
<b>Provider has a written policy and procedure that meets the requirement for Indicator 4.02</b>	<b>YES</b>		
	If NO, explain here:		
	The agency has a policy and procedure titled: Suicide risk screening and referral for assessment, Policy number: CHS/7407, Last reviewed: 02/05/2025, by the Director of out of home programs.		
<b>Suicide Risk Screening and Approval (Residential and Community Counseling)</b>			
Suicide risk screening occurred during the initial intake and screening process. Suicide screening results reviewed and signed by the supervisor and documented in the youth's case file.	<b>Compliance</b>	Five of five residential (three closed and two open) files were reviewed. And all five files contained evidence that suicide risk screening occurred during each of their initial intake and signed by Residential Supervisor and is shown inside each of the youths case files.	
The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	<b>Compliance</b>	This program's suicide risk assessment policy has been approved by the Florida Network of Youth and Family Services, per the Children's Home Society of Florida Residential and Community Counseling Policy and Procedures which was last reviewed by the Director of Out of Home Programs on 02/05/2025.	

<b>Supervision of Youth with Suicide Risk (Shelter Only)</b>			
<p>Youth are placed on the appropriate level of supervision based on the results of the suicide risk assessment.</p>	<p><b>Compliance</b></p>	<p>Youth are placed on the appropriate level of supervision based on the results of the suicide risk assessment as observed in three closed residential files that were reviewed. Evidence youth were placed on the appropriate level of supervision, which was sight and sound was observed in the file as documented in each youth's suicide risk assessment and corresponding observation logs.</p>	
<p>Staff person assigned to monitor youth maintained one-to-one supervision or constant supervision and documented his/her observations of the youth's behavior at 30 minute or less intervals</p>	<p><b>Compliance</b></p>	<p>According to the three closed residential files reviewed that were placed on one-to-one supervision or constant supervision, the proper documentation on the observation logs was being documented at thirty-minute intervals or less.</p>	
<p>Documentation includes the time of day, behavioral observations, any warning signs observed, and the observers' initials and was maintained in either an observation log or in the shelter daily log.</p>	<p><b>Compliance</b></p>	<p>Documentation of observation logs in three youth records applicable for sight and sound included: the date, time, and all the behaviors being observed by staff, and the observer's initials.</p>	
<p>Supervision level was not changed/reduced until a licensed professional or a non-licensed mental health professional under the supervision of a licensed professional completed a further assessment OR Baker Act by local law enforcement</p>	<p><b>Compliance</b></p>	<p>A consistent level of supervision was maintained in three youth files reviewed who were applicable for supervision. Supervision level was only changed after a licensed professional completed a further assessment of the youth.</p>	
<p>There was evidence that documentation was reviewed by supervisory staff each shift. If program uses an observation log, completed logs are maintained in the youth's file.</p>	<p><b>Compliance</b></p>	<p>Evidence of completed observation logs were documented in the three youth records reviewed. Each observation log had a supervisor's signature indicating the document has been reviewed by the supervisory staff each shift.</p>	

<b>Youth with Suicide Risk (Community Counseling Only)</b>			
<p>Youth identified for suicide risk during intake was immediately assessed by a licensed professional or non-licensed professional (under the direct supervision of a licensed mental health professional) and the parents and supervisor were both notified of the results.</p>	<p><b>No eligible items for review</b></p>	<p>After reviewing five (community Counseling) files there were no cases where a youth was identified for suicide risk during the intake process being conducted.</p>	
<p>During the intake, if the appropriate staff is unavailable, youth identified for suicide risk was immediately referred by the provider and the parent/guardian is notified of the suicide risk findings disclosed and advised that an Assessment of Suicide Risk should be completed ASAP by a licensed professional.</p>	<p><b>Compliance</b></p>	<p>After reviewing five of five residential (three closed and two open) files. There was three (closed) files that show that the parent/guardian was notified and the assessment of suicide risk was completed within twenty four hours of being identified as a suicide risk.</p>	
<p>Information on resources available in the community for further assessment was provided to the parent/guardian and is documented in the youth's file and signed by the parent/guardian OR a written follow-up notification was sent by certified mail if the parent/guardian was not present during the screening and was notified by telephone.</p>	<p><b>Compliance</b></p>	<p>After reviewing five of five residential (three closed and two open) files, and the information in each file shows documentation that each parent/guardian received and signed for further resources that are available in the community.</p>	
<p>If the parent/guardian cannot be contacted, all efforts to contact them are documented in the case file.</p>	<p><b>Compliance</b></p>	<p>After reviewing five residential files, three closed, and two open. There was no cases where the parent/guardian was not contacted about the youths suicide screening assessment.</p>	
<p>When the screening was completed during school hours on school property, the appropriate school authorities were notified.</p>	<p><b>No eligible items for review</b></p>	<p>After interviewing the residential supervisor, the residential program manager. Five of five (three closed and two opened) files. There were no screenings completed during school hours on school property.</p>	
<p><b>Additional Comments:</b> There are no additional comments for this indicator.</p>			

4.03 - Medications		Satisfactory with Exception	
Provider has a written policy and procedure that meets the requirement for Indicator 4.03	YES		
	If NO, explain here:		
	The agency has a policy and procedure: Suicide risk screening and referral for assessment, Policy number: CHS/7407, last reviewed: 02/05/2025, by the Director of Out of Home Programs.		
The agency has a Registered Nurse (RN) and/or a Licensed Practical Nurse (LPN) that is being supervised by RN and all of their credentials have been verified.	Compliance	Interview was conducted with the Residential Supervisor regarding the program's nurse. This agency does have a Registered Nurse with all of the required credentials at this time. The RN was hired 02/07/2025.	
The agency has evidence of the following for all non-nursing shelter staff designated to assist with the self-administration of medication: a. Documentation of in-person self-administration of medication distribution training provided by a Registered Nurse b. Evidence demonstrating their competency to assist with self-administration of medication distribution c. Maintenance of their annual medication training re-certification	Compliance	The agency has evidence of all the non-nursing shelter staff designated to assist with the self-administration of medication having received training by a Registered Nurse in the self-administration of medication distribution and demonstrating competency. Each of the non-nursing shelter staff designated to assist with the self-administration of medication received an annual medication re-certification.	
The agency held at least quarterly staff meetings conducted by RN and/or Shelter Manager to review and assess: a. strategies implemented to reduce medication errors shelter wide b. analyze factors that contributed to medication errors c. allow staff the opportunity to practice and role-play solutions	Compliance	After reviewing all of minutes from this agency staff meetings and interviewing the Residential Supervisor. I observed that they have placed strategies to refresh, and reduce medication errors and role playing solutions.	
The agency has strategies implemented to ensure medications are provided within the 2-hour time frame.	Compliance	After interviewing the Residential Supervisor, she informed me that they use different strategies to ensure the youths medications are provided within the two hour window. By placing alarms on their cellphones, and reminding one another on shift.	
All non-licensed staff members are clearly identified and designated on the staff schedule and shift change report/shift responsibility form for assisting with the self-administration of medications on each shift	Compliance	After reviewing the program's schedules all non-licensed staff members that was designated for the self-administration of medications to the youth on each shift was clearly identified.	

<p>The agency has clear methods of communicating which youth are on medications with the times and dosage easily discernable by all staff on each shift.</p>	<p><b>Compliance</b></p>	<p>After observation of the agency's practices and interview with the Residential Supervisor and the Residential Program Manager, it's evident they have clear methods of communicating which youth take medication along with the times, and dosage. On the medication board located the medication room along with the medication distribution log(s). This information is also located inside the files of every youth that receives medication(s).</p>	
<p>The delivery process of medications is consistent with the FNYFS Medication Management and Distribution Policy and the agency has an internal quality assurance process to include the following: a. to ensure appropriate medication management and distribution methods b. to track medication errors c. to identify systemic issues and implement mitigation strategies, as appropriate.</p>	<p><b>Compliance</b></p>	<p>After reviewing the medication logs, and interviewing both the Residential Supervisor, and the Residential Program Manager, it was observed the program follows the rules and guidelines per Florida network policy and procedures. This agency tracks the medication errors, and they identify systemic issues which they implement strategies to improve monthly during their staff meetings.</p>	
<p><b>Admission/Intake of Youth</b></p>			
<p>a. Upon admission, the youth and parent/guardian (if available) were interviewed by the Registered Nurse (when on-site) about the youth's current medications as part of the Medical and Mental Health Assessment screening process and/or an interview was conducted by the RN within three (3) business days if the RN was not on the premise at admission. <i>*If the agency does not have an RN, there was a medication review conducted by an LPN or certified Leadership position.</i></p> <p>b. Upon intake/admission, there is evidence that the on-shift certified supervisor of higher level staff did review all medication forms by the next business day.</p>	<p><b>Compliance</b></p>	<p>After reviewing five of five residential (three closed and two open) files. The two open files that had medication(s) during their intake process. The youth and parent/guardian were interviewed as part of the medical and mental health assessment screening or within three days. Each file was reviewed by the Residential Supervisor within twenty-four hours of the youths' admission into the program.</p>	

<p>a. All medications are stored in a Pyxis ES Medication Cabinet that is inaccessible to youth (when unaccompanied by authorized staff)</p> <p>b. Pyxis machine is stored in accordance with guidelines in FS 499.0121 and policy section in Medication Management</p> <p>c. Oral medications are stored separately from injectable epi-pen and topical medications</p> <p>d. Medications requiring refrigeration are stored in a secure refrigerator that is used only for this purpose, at temperature range 2-8 degrees C or 36-46 degrees F. (If the refrigerator is not secure, the room is secure and inaccessible to youth.)</p> <p>e. Narcotics and controlled medications are stored in the Pyxis ES Station</p> <p>f. Pyxis keys with the following labels are accessible to staff in the event they need to access medications if there is a Pyxis malfunction: a TOP COVER b BACK PANEL- LEFT TALL CABINET LOCK- LEFT, c BACK PANEL- RIGHT TALL CABINET LOCK- RIGHT</p>	<p><b>Compliance</b></p>	<p>After interviewing the Residential Supervisor and Residential Program Manager, as well as observing the med station, it was verified that all medications are being stored in the pyxis machine. This agency also have a small refrigerator with a lock on it, to store medications that require being kept at temperatures within thirty-six and forty-six degrees Fahrenheit. The medication refrigerator is housed in the pantry which is also locked. Epi-pen(s) and topical medications are housed separately. All medications are in a locked room. Where the youth are not allowed to enter at any time. Narcotics and controlled medications are stored in the Pyxis ES Station 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. The three pyxis keys are available in their medication room where staff have access as needed.</p>	
<p><b>Medication Distribution</b></p>			
<p>a. Agency maintains a minimum of 2 site-specific System Managers for the Pyxis ES Station</p> <p>b. Only designated staff delineated in User Permissions have access to secured medications, with limited access to controlled substances (narcotics)</p> <p>c. A Medication Distribution Log shall be used for distribution of medication by non-licensed and licensed staff</p> <p>d. Agency verifies medication using one of three methods listed in the FNYFS Policies &amp; Procedures Manual</p> <p>e. When nurse is on duty, medication processes are ALWAYS conducted by the nurse or when the nurse is not onsite, then the designated staff who has been trained by a licensed Registered Nurse provides the medication.</p> <p>f. Agency does not accept youth currently prescribed injectable medications, except for epi-pens</p> <p>h. Non-licensed staff have received training in the use of epinephrine auto-injectors provided by a registered nurse</p>	<p><b>Compliance</b></p>	<p>After reviewing the medication logs, interviewing the Residential Supervisor, and the Residential Program Manager concerning those designated to use the pyxis machine to pass medication(s). This agency has two super users for the pyxis machine. In the medication distribution logs for both male and female the names of the staff designated and/or licensed to issue medication to the youth are labeled in the front of both logs. This agency verifies the youths medication(s) by calling the local pharmacy. When the registered nurse is not on duty. Only those designated staff that has been trained by a registered nurse or licensed staff can distribute medication. This facility does not take youth who require injectors, except epi-pens. All of the required trainings needed to legally issue medications to the youth.</p>	

<p>The medication distribution log documentation includes: a. the time of medication administration b. evidence of youth initials that the dosage was given <input type="checkbox"/> c. evidence of staff initials that the dosage was given <input type="checkbox"/></p>	<p><b>Compliance</b></p>	<p>After reviewing the medication distribution logs from October 2024 - March 2025, documentation included showed medication(s) were issued within the one hour window allowed. Along with the evidence of the initials of the youth receiving the medication(s) and the staff issuing the medication(s).</p>	
<p>There is evidence that staff provide youth with medications within one hour of the scheduled time of delivery as ordered by the medication. Documentation is provided for instances this does not occur within the required timeframe.</p>	<p><b>Compliance</b></p>	<p>Medication logs reviewed provided evidence staff issues medications within the one hour window of the scheduled time of delivery as ordered by the medication(s). Documentation (i.e. incident reports, logbook entries, email communication) was observed for instances when this did not occur within the timeframe required.</p>	
<p>During the review period, there were no instances where youth missed their medication due to failure to open the pyxis machine.</p>	<p><b>Compliance</b></p>	<p>While reviewing the CCC reports for this agency. There was a case discovered with an issue with the pyxis machine not working properly. Staff was unable to issue morning medication to the youth(s) scheduled to take their medication(s). The pyxis machine wouldn't open. The staff had to trouble shoot the pyxis machine. Once staff was finally able to open the pyxis machine it was sixteen minutes outside of the one hour window allowed to pass medication(s). Therefore staff called in a CCC report, and completed an internal incident. The incident was well documented with steps that was taken to rectify the problem and youth did receive the prescribed medication.</p>	
<p><b><u>If applicable:</u></b> Any staff member deemed responsible for a medication error, there was evidence that the staff member received refresher training from an RN and demonstrated competency prior to being assigned future medication administration responsibilities. There is evidence that any staff member deemed responsible for 3 errors within a 1-year time frame, had their certification suspended and was not recertified until the completion of the full <b>in-person</b> medication administration training, demonstrating competency and re-certification from an RN.</p>	<p><b>Exception</b></p>	<p>From October 2024 to April 2025 there was observation of one medication error. The Residential Supervisor (RS) issued the wrong medication to a youth per CCC documentation on November 27, 2024. At the time of the incident the program did not have a RN and the agency's Regional Director reached out to the Florida Network for a recommendation of a RN who could facilitate a refresher training for the RS. The RS reached out to the Florida network RN on 12/05/2024. The RN wasn't able to give the RS a refresher until 01/02/2025 because she was out of the country.  The RD has since hired a RN on 2/7/2025 to prevent this incident from occurring again.</p>	<p>Evidence of the RS issuing medication to the youths was observed on youths medication distribution logs after November 27, 2024 and prior to the completion of refresher training on 01/02/2025 because there was no one else on shift that had been properly trained on the self-administration of medication.</p>

<b>Medication Inventory</b>			
<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</p> <p>b. Over-the-counter medications that are accessed regularly and inventoried weekly</p> <p>c. Syringes and sharps (needles, scissors, etc.) are secured, and counted and documented weekly</p>	<b>Compliance</b>	<p>After reviewing the medication inventory process and the medication log(s) the perpetual inventory for control medications is being kept and documented in the medication log. There is a control medication count conducted at the beginning of all three shifts, verified by a witness, and documented on the medication(s) log. Then a record of the count(s) is also documented in the shift log book. The over the counter medication(s), and the non-controlled medication(s) are counted and documented weekly. Although all medication(s) controlled, non-controlled, and over the counter medication(s) counts are recorded each time they are issued out. This agency does not accept any medication(s) that require syringes and sharps such as needles, scissors etc., therefore they do not house any syringes or sharps.</p>	
<p>There are monthly reviews of the Pyxis reports to monitor medication management practice.</p>	<b>Compliance</b>	<p>The Residential Supervisor, and the Registered Nurse have monthly reviews of the pyxis, monitoring the medication management practices.</p>	
<p>Medication discrepancies are cleared after each shift.</p>	<b>Compliance</b>	<p>The Residential Supervisor, provided information from the pyxis machine showing that all medication discrepancies were being cleared out after ever shift, as needed.</p>	
<p><b>Additional Comments:</b> Observation of the Residential Supervisor (RS) passing medication to a youth took place while on-site. The RS called the youth by name, cleaned the pill counter off with an alcohol pad, and pulled medication out of the pyxis machine, after verifying the name and dosage of the youth's medication, the RS then issued the assigned medication to the youth. The RS asked the youth to open their mouth and put their tongue out to verify that the youth had safely swallowed the medication. The RS then recleaned the pill counter. Recounted the medication, documented how many tablets were left, and the RS and youth initialed the medication distribution log in the appropriate places.</p>			

4.04 - Medical/Mental Health Alert Process		Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 4.04	YES	
	If NO, explain here:	
	The agency has a policy medical and mental health alert process number: CHS/7404, last updated: 07/01/2024 by the Sr. Director of Out of Home Programs.	
Youth with a medical, mental health, or food allergy was appropriately placed on the program's alert system	Compliance	After reviewing five of five residential (three closed and two open) files. The only youth that documented an allergy, was documented on the youth's medication board, inside the staff control room on a the youth's board, and in the youth's file.
Alert system includes precautions concerning prescribed medications, medical/mental health conditions	Compliance	After reviewing the five of five residential (three closed and two open) files. As well as interviewed the residential supervisor. The alert system includes precautions concerning prescribed medications, mental health conditions. Listed in the youth files, in the medical room, on the medication board, in the staff control room on the youth board.
Staff are provided sufficient training, information and instructions to recognize/respond to the need for emergency care for medical/mental health problems	Compliance	After interviewing the residential supervisor and the residential program manager. Reviewing the training logs, and the staff meeting minutes. Staff are provided sufficient training, information and instructions to recognize/respond to the need for emergency care for medical/mental health problems.
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	After interviewing the residential supervisor and the residential program manager. Reviewing five of five (three closed and two open) files. 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. Medical and mental health alerts are located in the medication room inside the medication distribution logs, the youth medication board, the youths file, the youth board inside the staff control room, and food allergies alerts can be found in the youths file, and in the kitchen.
<b>Additional Comments:</b> There are no additional comments for this indicator.		

<b>4.05 - Episodic/Emergency Care</b>		<b>Satisfactory</b>	
<b>Provider has a written policy and procedure that meets the requirement for Indicator 4.05</b>	<b>YES</b>		
	If NO, explain here:		
	The agency has a policy Episodic/emergency care The policy number is CHS/7405 and was last reviewed on 4/29/2024 by the Sr. Director of Out of Home Programs.		
<b>Off Site Emergency Care</b>			
a. If off-site emergency medical or dental care was provided, an incident report was submitted for the medical or dental care b. Upon youth return, there is a verification receipt of medical clearance via discharge instructions with follow-up is present in file c. Youth's parent/guardian was notified d. A daily log is maintained for emergency care provided	<b>No eligible items for review</b>	After interviewing the residential supervisor, the residential program manager, reviewing five (three closed and two opened) files and the program's emergency care log, it was determined there were no incidents of any off-site medical or dental emergencies in the past six months or back to the date of the last review.	
All staff are trained on emergency medical procedures	<b>Compliance</b>	After reviewing the staff training files and interviewing the residential supervisor it is evident each staff has been trained on emergency medical procedures.	
The program has a Knife-for-life and wire cutters accessible to staff in a secure location(s)	<b>Compliance</b>	This agency has a knife for life hanging on the wall in the staff control room. There is a bag in the staff control room with another knife for life and wire cutter, that they take with them whenever they are operating their agency van.	
<b>Additional Comments: There are no additional comments for this indicator.</b>			