



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

Family Resources, Inc. - Manatee (Bradenton)

1001 9th Avenue West
Bradenton, FL 34205

May 7–8, 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 Family Resources Manatee (Bradenton) for the FY 2024-2025 at its program office located at 1001 9th Avenue West, Bradenton, Florida. Forefront LLC (Forefront) is an independent compliance monitoring firm that is contracted by FNYFS to perform onsite program reviews to assess the agency's adherence to fiscal, programmatic and overall contract requirements. Family Resources Manatee 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 Marcia Tavares, Consultant for Forefront LLC. Agency representatives from Family Resources Manatee present for the entrance interview were: Lisa Davis, CEO; Andrew Coble, COO; Nicole Leslie, Vice President of Impact; Cassie Hefner, Director of Data Integrity; Mandi Cordero, Director of Community Programs; Christina Blanchard, Clinical Supervisor; Lashawna Randall, Residential Supervisor; Brigette Pagano, SNAP Supervisor; and Gordon Park, ICM Case Manager. The last onsite QI visit was conducted on May 15, 2024.

In general, the Reviewer found that Family Resources Manatee is in compliance with specific contract requirements. Family Resources Manatee **received an overall compliance rating of 100% for achieving full compliance with 11 of the 11 applicable indicators** of the CINS/FINS Monitoring Tool. There are no corrective actions cited; however, one recommendation is made as a result of the contract monitoring visit.

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

2024-2025 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 05-07-2024-2025

Agency Name: Family Resources Manatee (Bradenton)					Monitor Name: Marcia Tavares, Lead Reviewer		
Contract Type : CINS/FINS					Region/Office: 1001 9th Avenue West, Bradenton, FL 34205		
Service Description: Comprehensive Onsite Compliance Monitoring					Site Visit Date(s): May 7-8, 2025		
Major Programmatic Requirements	Explain Rating					Ratings Based Upon: I = Interview O = Observation D = Documentation PTV = Submitted Prior To Visit (List Who and What)	Notes Explain Unacceptable or Conditionally Acceptable:
	Unacceptable	Conditionally Acceptable	Fully Met	Exceeded	Not Applicable		
I. Administrative and Fiscal							
DJJ Quality Improvement Peer Reviewer a. Provider shall demonstrate that a minimum of two (2) staff members have been trained to be certified as DJJ QI Peer reviewers. Provider shall participate in a minimum of one (1) on-site quality assurance review of a similar type of program in another judicial circuit during each 12-month period of the contract, if requested.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Documentation The agency currently has a total of three peer reviewers who have participated in peer reviews for the current FY. Two former peer reviewers, Mackenzie Tomasik and Kelli Yeazell, resigned in December 2024 and January 2025, respectively.	Recommendation 1): The agency is currently short of meeting its requirement of two staff members per contract (6 total) and must ensure appropriate staff are scheduled to be trained at the next available QI Peer Training offered.
Additional Contracts a. Provider shall provide a listing of all current federal, state, or local government contracts, as well as other contracts entered into with for profit and not-for-profit organizations. Such a listing shall identify the awarding entity and contract start & end dates. PTV	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Documentation A list of four additional contracts for FY 2024-2025 was provided by the provider including funding sources and contract term dates for the following agencies: Florida Department of Health (2), and Manatee County, School District of Manatee County (2).	No recommendation or Corrective Action
Limits of Coverage a. Provider shall provide and maintain during this contract, the following minimum kinds of insurance: Worker's Compensation and Employer's liability insurance as required by Chapter 440, F.S. with a minimum of \$100,000 per accident, \$100,000 per person and \$500,000 policy aggregate. Commercial General Liability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Documentation The agency has a certificate of insurance with Wallace Welch & Willingham, Inc., which provides the following insurance coverages: Worker's Compensation through Florida Insurance Trust (06/01/2024-06/01/2025) with limits of \$2,000,000	No recommendation or Corrective Action

2024-2025 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
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with a limit of \$500,000 per occurrence, and \$1,000,000 policy aggregate. Automobile Liability Insurance shall be required and shall provide bodily injury and property damage liability covering the operation of all vehicles used in conjunction with performance of this contract, with a minimum limit for bodily injury of \$250,000 per person; with a minimum limit for bodily injury of \$500,000 per accident; with a minimum limit for property damage of \$100,000 per accident and with a minimum limit for medical payments or \$5,000-\$10,000 per person. Florida Network is listed as payee or co-payee. PTV						per accident, \$2,000,000 each employee. Commercial General Liability (06/01/2024-06/01/2025) with a limit of \$1,000,000 per occurrence, and \$3,000,000 policy aggregate, \$500,000 damage to rented premises. Automobile Liability Insurance (06/01/2024-06/01/2025), with a combined single limit for each accident of \$1,000,000. The Florida Network of Youth and Family Services is listed as a certificate holder on the certificate of insurance reviewed on-site.	
External/Outside Contract Compliance a. Provider has corrective action item(s) cited by an external funding source (Fiscal or Non-Fiscal). ON SITE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Interview The Chief Operating Officer currently reports no corrective action items cited by any external funders.	No recommendation or Corrective Action
Fiscal Practice a. Agency must have employee and fiscal policy/procedures manuals that are in compliance with GAAP and provide sound internal controls. Agency maintains fiscal files that are audit ready. PTV	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Documentation Agency maintains a Fiscal Policies and Procedures Manual that is consistent with GAAP and provides for limited internal controls. Policies and procedures were last reviewed in June 2024. Various policies were reviewed	No recommendation or Corrective Action

2024-2025 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
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						that cover the agency's accounting standards, budget process, capital assets, petty cash, required vendor information, cost allocation, bank reconciliation, general ledger, internal controls, and purchasing.	
b. Agency maintains a general ledger and the corresponding source documents. A general ledger must be set up to track the activity of the grant separately (standard account numbers / separate funds for each revenue source, etc.). PTV	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Documentation A review of the agency's general ledger for October 2024 to March 2025 confirmed the agency's general ledger is set up to track the activity of the Florida Network of Youth and Family Services grant separately from all other revenue sources.	No recommendation or Corrective Action
c. Petty cash ledger system is balanced and all cash disbursements are compliant with financial policies and allowable under the contract. (Disbursements/invoices are approved & monitored by management.) -ON SITE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Interview: The agency does not use petty cash. The residential supervisor has an agency credit card for purchases. The policy states supervisors have a spending limit of up to \$500 on agency cards. Receipts for purchases are submitted to the accounting/finance department for reconciliation with the credit card statements. Credit card statements are paid monthly by the accounting/ finance department.	No recommendation or Corrective Action

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d. Financial records and reports are current. Includes bank statements reconciled within 6 weeks of receipt. Vendor invoices past 6 months. Invoices are submitted on a monthly basis with supporting documentation and documentation provided contained 2 signatures. (Disbursements/invoices are approved & monitored by management). ON SITE	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Documentation The agency provided bank reconciliation reports for operating account held with Truist bank for the period October 2024-March 2025. All reconciliation reports were completed within ten days of the close of the preceding monthly bank period. Checks are cut weekly to pay vendor invoices. Disbursements and invoices are reported to the CEO for a monthly signature by the Director of Finance.	No recommendation or Corrective Action
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. PTV/ON SITE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	The agency reports that there is no inventory purchased with funds from the FNYFS.	No recommendation or Corrective Action
f. Agency submits payroll taxes and deposits (and retirement deposits as applicable), <u>Employee</u> IRS Form W-2 and <u>Independent Contractors</u> IRS Form 1099 forms prior to federal requirements. ON SITE	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	The agency uses Dominion payroll services to submit payroll taxes and deposits. Documentation supporting biweekly payroll tax deposit recap and quarterly 941 Federal Tax Returns for the 4th quarter 2024 and 1 st quarter 2025 were reviewed.	No recommendation or Corrective Action

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g. Budget to actual reports prepared and reviewed by appropriate management. Variance from the budget are investigated and explained. PTV/ON SITE	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Documentation Budget to Actual report for the current fiscal year, as of 3/31/2025 for the CINS/FINS Program was reviewed. The report captures the variance for each budget item on a monthly and year-to-date basis. The provider has a monthly process of reviewing financial statements at Board meetings, and revisions based on variances are analyzed and shared with appropriate individuals.	No recommendation or Corrective Action
h. A Single Audit is performed as part of the annual audit if expenses are greater than \$750,000. The agency must submit a Corrective Action Plan for findings cited in the management letter and single audit. An annual financial audit was completed within 120 days after the previous fiscal year/calendar year and that a copy was provided to the Network unless and extension has been requested and approved in writing. Copy of Audit is submitted to the FNYFS by December 31st. Can obtain from FNYFS	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Documentation A Single Audit was completed for the period ending June 30, 2024, and 2023. The audit was completed by Assurance Dimensions, Certified Public Accountants and was dated October 17, 2024. There were no findings requiring corrective action reported in the audit. A copy of the audit was submitted to the FNYFS by December 31st.	No recommendation or Corrective Action

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i. Agency maintains confidentiality policy with written policies and procedures to ensure the security and privacy of all employee and client data. Personal information is not easily accessible. Agency maintains a backup system in case of accidental loss of financial information. Security procedures are in place to protect laptops. Obsolete documents are shredded, and computer hard drives are wiped prior to discarding. ON SITE	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	The documentation reviewed included policies and procedures to ensure the security and privacy of all employee and client data. Policies reviewed included the following: confidentiality – release of information; record retention; case record management and electronic records security; system monitoring; protection from viruses; system back-up; and disaster preparedness.	No recommendation or Corrective Action
j. Agency provided evidence that every direct care staff employee, as of October 1, 2023, is being paid at least \$19.00 per hour. This also includes funding for additional staff as approved by the Department. ON SITE	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Documentation: A salary list of all direct care staff was provided showing the name of staff, position title, cost center, and pay rate. All direct care staff listed were observed to be paid at least \$19 per hour.	No recommendation or Corrective Action

2024-2025 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
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CONCLUSION

Family Resources Manatee has met the requirements for the CINS/FINS contract as a result of full compliance with 11 of the 11 applicable indicators of the Administrative and Fiscal Contract Monitoring Tool. Three indicators were not applicable because: 1) the program does not have any corrective action items cited by an external funder, 2) petty cash is not used in the shelter program, and 3) no equipment was purchased with Florida Network funds requiring an Information Resources Request. Consequently, the overall compliance rate for this contract monitoring visit is 100%. There are no corrective actions cited; however, one recommendation is made 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 conducted in a manner which meets the standard described in the report's findings.

SUMMARY OF CORRECTIVE ACTIONS or RECOMMENDATIONS

Recommendation (1)

The agency is short of meeting its requirement of two staff members per contract (6 total) and must ensure appropriate staff is scheduled to be trained at the next available QI Peer Training offered.

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



Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Family Resources, Inc. - Bradenton (Manatee)
CINS/FINS Program

May 7- 8, 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	Limited
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: 85.71 %
Percent of Indicators rated Limited: 14.29 %
Percent of Indicators rated Failed: 0 %

Standard 2: Intervention and Case Management

2.01 Screening and Intake	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	Limited
2.09 Stop Now and Plan (SNAP)	Satisfactory

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

Standard 3: Shelter Care & Special Populations

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

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

Standard 4: Mental Health/Health Services

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

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

Overall Rating Summary

Percent of indicators rated Satisfactory: 89.29 %
Percent of indicators rated Limited: 10.71 %
Percent of indicators rated Failed: 0 %

Rating Definitions

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

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

Reviewers

Members

MarciaTavares - Lead Reviewer Consultant-Forefront LLC/Florida Network of Youth and Family Services
 Justin Terziu – Regional Monitor, Department of Juvenile Justice
 Carla Baity-Lisbon - Bethel Community Foundation
 Shelley Gress - Youth and Family Alternative GWH
 Samuel Laguerre - Lutheran Services Florida Oasis

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 checked="" type="checkbox"/> Counselor Non-Licensed	<input type="checkbox"/> Nurse – Part time
<input checked="" type="checkbox"/> Chief Operating Officer	<input type="checkbox"/> Advocate	<input type="checkbox"/> # Case Managers
<input type="checkbox"/> Executive Director	<input checked="" type="checkbox"/> Direct – Care Full time	<input type="checkbox"/> 1 # Program Supervisors
<input type="checkbox"/> Program Director	<input type="checkbox"/> Direct – Part time	<input type="checkbox"/> # 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 checked="" type="checkbox"/> Clinical Director	<input type="checkbox"/> Volunteer	<input type="checkbox"/> 2 # Other (Vice President Impact & Data Integrity Officer __)
<input type="checkbox"/> Counselor Licensed	<input checked="" type="checkbox"/> Human Resources	

Documents Reviewed

<input type="checkbox"/> Accreditation Reports	<input checked="" type="checkbox"/> Table of Organization	<input type="checkbox"/> Visitation Logs
<input checked="" type="checkbox"/> Affidavit of Good Moral Character	<input type="checkbox"/> Fire Prevention Plan	<input checked="" type="checkbox"/> Youth Handbook
<input checked="" type="checkbox"/> CCC Reports	<input checked="" type="checkbox"/> Grievance Process/Records	<input type="checkbox"/> 5 # Health Records
<input type="checkbox"/> Logbooks	<input type="checkbox"/> Key Control Log	<input type="checkbox"/> 6 # MH/SA Records
<input type="checkbox"/> Continuity of Operation Plan	<input checked="" type="checkbox"/> Fire Drill Log	<input type="checkbox"/> 5 # Personnel /Volunteer Records
<input checked="" type="checkbox"/> Contract Monitoring Reports	<input checked="" type="checkbox"/> Medical and Mental Health Alerts	<input type="checkbox"/> 8 # Training Records
<input type="checkbox"/> Contract Scope of Services	<input checked="" type="checkbox"/> Precautionary Observation Logs	<input type="checkbox"/> 20 # Youth Records (Closed)
<input checked="" type="checkbox"/> Egress Plans	<input checked="" type="checkbox"/> Program Schedules	<input type="checkbox"/> 11 # 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	<input type="checkbox"/> __

Observations During Review

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

Surveys

<input type="checkbox"/> 5 # of Youth	<input type="checkbox"/> 5 # of Direct Staff	<input type="checkbox"/> # of Other	<input type="checkbox"/>
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May 7-8, 2025

Comments

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

Monitoring Purpose

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

Narrative Summary

Family Resources Inc. is sub-contracted with the Florida Network of Youth and Family Services (Florida Network) to provide temporary residential and non-residential services to youth and families through the Children In Need of Services/Families In Need of Services (CINS/FINS) program. The central office is located in Pinellas Park, Florida and CINS/FINS SafePlace2B has three shelters located in Clearwater, St. Petersburg, and Bradenton, Florida. Family Resources, Inc. Safe Place 2B (Bradenton - Manatee shelter) is located at 1001 9th Avenue West, Bradenton, Florida 34205. Family Resources, Inc. serves both male and female youth between the ages of ten to seventeen years that are locked out, runaway, ungovernable and/or truant, homeless, abuse, neglected, or at-risk. The program is also contracted to provide services for Staff Secure Shelter and is a provider for youth referred through the Juvenile Justice Court System for domestic violence, probation respite, domestic minor sex trafficking, and Family/Youth Respite Aftercare Services (FYRAC). The Bradenton program is also contracted to provide Intensive Case Management (ICM) and SNAP Under 12, Clinical Group, and SNAP in School services for youth 12-17 years of age. The program is designated by the National Safe Place Program as a Safe Place provider who is responsible for building a network of safe place sites in the community to provide help and access to run away and homeless youth. The shelter holds a license from the Department of Children and Families, which is effective July 2024. The agency is currently accredited by the Council of Accreditation (COA) effective through December 31, 2028.

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 **Limited**.

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

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

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

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

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

Standard 2: There are nine indicators for Standard 2.

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

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

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

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

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

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 **Limited**.

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

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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 with Exception**.

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

Indicator 3.04 Log Books was rated **Satisfactory**.

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

Indicator 3.06 Staffing and Youth Supervision was rated **Limited**.

Indicator 3.07 Video Surveillance System was rated **Satisfactory with Exception**.

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 with Exception**.

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

Standard 1:

Indicator 1.02 - Limited

1) The facility was unable to provide any other grievances prior to March 2025. During the randomly selected weeks for logbook review, Reviewer observed one grievance that was not present for the review, verifying the absence of most likely more grievances that could not be reviewed.

2) All six of the two week periods that were reviewed did not have grievance box checks completed Monday-Friday as required. There was no indication the grievance boxes were checked on the following dates: 11/13 and 11/14/2024; 12/17 and 12/18/2024; 1/23, 1/24, 1/29, 1/30/2025; 2/21/2025; 3/5 and 3/14/2025; and 4/21/2025.

3) Two of the three grievances reviewed were not resolved within 72 hours.

Standard 2:

Indicator 2.08 - Limited

Six of the 8 case plans reviewed across DV Respite, Probation Respite, and ICM did not demonstrate all counseling needs were addressed and that case plans focused on behavioral issues and/or strength-based trauma-informed care.

Standard 3:

Indicator 3.06 - Limited

On the overnight shift the schedule shows one staff on duty on numerous shifts during the review period. Based on the schedule, 81 shifts had only one staff scheduled. On November 10, 2024 staff missed bed checks from 1:00 - 1:30 A.M.

CINS/FINS QUALITY IMPROVEMENT TOOL			
Quality Improvement Indicators and Results: Please select the appropriate outcome for each indicator for each item within the indicator.	Summary/Narrative Findings: The narrative write-up is a thorough summary of each assigned QI indicator, explaining how finding(s) are determined.	Deficiencies/Exceptions: Please add additional detailed explanations for any items that have any deficiencies or exceptions.	
Standard One – Management Accountability			
1.01: Background Screening of Employees, Contractors and Volunteers			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 1.01	YES		
	If NO, explain here:		
	The provider has the required policy and procedure, 1.01 Background Screening of Employees and Volunteers, that was approved by the Chief Operating Officer (COO) July 2024.		
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.	Compliance	The program uses the Berke pre-employment assessment tool. The tool was administered prior to offer of employment for five new direct care staff who were hired during the review period. All five staff obtained passing scores of medium to high on the Berke.	
For any applicant that did not pass the initial suitability assessment, there was evidence that the applicant retook the assessment and passed within five (5) business days of the initial attempt, not exceeding three (3) attempts within thirty (30) days.	No eligible items for review	All five new hires passed the pre-employment 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.	No eligible items for review	None of the five new hires were re-hired by the agency.	
Background screening completed prior to hire/start date (or exemption obtained prior to working with youth if rated ineligible) for new hires, volunteers/interns, and contractors. <i>(Employees who have had a break in service and are in good standing may be reemployed with the same agency without background screening if the break is less than 90 days.)</i>	Compliance	Background screenings for all five new hires were initiated prior to hire dates with eligibility documented on the DJJ background screening results with no exemptions required. The program has not utilized any applicable volunteers or interns during the review period.	

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	Per interview with COO, Family Resources Bradenton did not have any staff who met the requirement for background re-screening since the last onsite QI review.	
Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?	Compliance	The program emailed its Annual Affidavit of Compliance with Level 2 Screening Standards to the Background Screening Unit January 14, 2025 prior to the January 31st deadline. An email from DJJ on 1/15/25 confirmed receipt of the information.	
Proof of E-Verify for all new employees obtained from the Department of Homeland Security	Compliance	Proof of employment authorization from the Department of Homeland Security was obtained through E-verify and maintained on file for all five new hires.	
Additional Comments: There are no additional comments for this indicator.			
1.02: Provision of an Abuse Free Environment			Limited
Provider has a written policy and procedure that meets the requirement for Indicator 1.02	YES		
	If NO, explain here:		
	The provider has the required policy and procedure, 1.02 - Provision of an Abuse Free Environment, that was approved by the COO July 2024.		
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 all staff sign, prohibiting the use of physical abuse, profanity, and threats. Per interview with the clinical supervisor, the agency required all staff to review the newest employee handbook on February 5th, where staff acknowledged the Code of Conduct in their online payroll system.	
The agency has a process in place for reporting and documenting child abuse hotline calls.	Compliance	The agency has a process in place for reporting and documenting abuse hotline calls. The process includes a tracker that is formulated using their online platform in which seven abuse calls were documented over the last 6 months.	
Youth were informed of the Abuse and Contact Number	Compliance	Youth informally interviewed were able to indicate they are able to contact the abuse hotline, and pointed to the number hanging on the wall. Youth are also informed of the abuse hotline during orientation. Postings of the Abuse Hotline number were observed in all common areas of the facility.	
Grievance			
The program(s) have an accessible and responsive grievance process for youth to provide feedback and address complaints. Program director/ supervisor has access to and can manage grievances unless it is towards themselves.	Compliance	The program's grievance procedures include clear instructions for filing and resolution of grievances. Two locked grievance boxes were observed in areas accessible to the youth. Only the residential supervisor has access to the grievance boxes.	

<p><u>Shelter only:</u> Grievances are maintained on file at minimum for 1 year.</p>	<p>Exception</p>	<p>The facility was only able to furnish three grievances from the month of March 2025. It appears there were additional grievances, but the residential supervisor had misplaced the file, and it was not recovered during the course of the review. During the review of the logbook, reviewer observed reference to an additional grievance that had occurred; however, no written documentation of the grievance was on file.</p>	<p>The facility was unable to demonstrate grievances are maintained for one year as grievances prior to March 2025 were misplaced.</p>
<p><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.</p>	<p>Compliance</p>	<p>The facility has two grievance box locations, both in common areas, along with grievance forms that are easily accessible to youth. Youth are informed of the grievance process during program orientation.</p>	
<p><u>Shelter only:</u> There is evidence that grievance boxes are checked by management or a designated supervisor at least daily (excluding weekends and holidays) and documented in the program logbook.</p>	<p>Exception</p>	<p>The program only has one supervisor that has access to the grievance boxes. She checks it daily when she is working; however, the boxes do not appear to be checked when the supervisor is not on duty. Grievance box checks were conducted for the following dates: 11/4-11/15/2024; 12/9-12/20/2024; 1/21-1/31/2025; 2/17-2/28/2025; 3/1-3/14/2025; and 4/14-4/25/2025.</p>	<p>All six of the two week periods that were reviewed did not have grievance box checks completed Monday-Friday as required. There was no indication the grievance boxes were checked on the following dates: 11/13 and 11/14/2024; 12/17 and 12/18/2024; 1/23, 1/24, 1/29, 1/30/2025; 2/21/2025; 3/5 and 3/14/2025; and 4/21/2025.</p>
<p><u>Shelter only:</u> Grievances are resolved within 72 hours of being submitted or there was documentation explaining the cause for the delay in providing a resolution.</p>	<p>Exception</p>	<p>One of the three grievances received and reviewed could not be resolved due to the youth discharging, but an attempt was made by the supervisor.</p>	<p>Two of the three grievances reviewed were not resolved within 72 hours.</p>
<p>Additional Comments: There are no additional comments for this indicator.</p>			

1.03: Incident Reporting		Satisfactory with Exception	
Provider has a written policy and procedure that meets the requirement for Indicator 1.03	YES		
	If NO, explain here:		
	The provider has the required policy and procedure, 1.03 -CCC Incident Reporting, that was approved by the COO July 2024.		
During the past 6 months, the program notified the Department's CCC (Central Communication Center) no later than two hours after any reportable incident occurred or within two hours of the program learning of the incident	Compliance	In the last six months a total of 17 incidents were reported to and accepted by the CCC. All 17 of the incidents were reported within the two hour time frame.	
The program completes follow-up communication tasks/special instructions as required by the CCC	Exception	Twelve of the 17 CCC incidents reviewed on the CCC Daily Report pulled for this review were closed by the CCC and no further follow ups were required.	Five of the CCC incident reports are showing as still pending follow up based on the CCC Daily Report. The program was not able to provide communication with CCC regarding the closure of these incidents. The dates of the CCC incident reports are: 1/18/2025; 3/2/2025; 3/5/2025; 3/13/2025; and 4/27/2025.
Agency internal incidents are documented on incident reporting forms and all CCC reportable incidents were consistently reported to CCC as required.	Compliance	The agency has a incident report form in their online platform for all incidents which organizes them based on contract and incident type. The agency was able to show evidence of both CCC reportable incidents as well as non-reportable incidents.	
Incidents are documented in the program logs and on incident reporting forms	Compliance	Incidents are documented in both the logbook as well as in the online incident report platform.	
All incident reports are reviewed and signed by program supervisors/ directors	Compliance	There were a total of 17 incident reports, with the following types: four program disruptions, eight mental health incidents, four medical incidents, and one complaint against a staff. All 17 reports were reviewed by residential supervisor and risk manager.	
Additional Comments: There are no additional comments for this indicator.			
1.04: Training Requirements (Staff receives training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions)		Satisfactory with Exception	
Provider has a written policy and procedure that meets the requirement for Indicator 1.04	YES		
	If NO, explain here:		
	The provider has the required policy and procedure 1.04 - Training Requirements that was most recently reviewed October 2024 and approved by the COO.		

First Year Direct Care Staff			
<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"> • Agency policies and procedures • Behavior Management (Shelter Only) • Building/Facility layout • File Documentation/development of paperwork requirements and confidentiality • CCC & Incident Reporting • Child Abuse Reporting • Client Intake & Screening • Client Orientation (direct care staff training on delivering new client orientation) • Fire Equipment Safety • Medical and Mental Health Alert System (Shelter) • Risk Management--Including but not limited to the following: <ul style="list-style-type: none"> - Disaster Preparedness and Emergency Response - First Aid/CPR - Universal Precautions • Video Camera Surveillance & Equipment • All other necessary information to orient a new hire to perform their job role and duties. 	<p>Exception</p>	<p>Four first year training files were reviewed for one residential staff and three SNAP staff. Three of the four staff were within the first year of hire and one had recently completed the first full year. In three of the four training files reviewed, the employee orientation was completed timely.</p>	<p>One of the training files (SNAP) did not demonstrate the staff completed all orientation training topics which cover Confidentiality, Risk Management, and Building Layout during the 90 day timeframe as required. All three trainings were completed a day later than the cut-off date.</p>
<p>All staff completed the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days from date of hire.</p>	<p>Compliance</p>	<p>All four staff completed the DOJ Civil Rights training within 30 days 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>Compliance</p>	<p>All four of the staff reviewed exceeded the required 80 hours of training with training hours ranging from 94.5-153.5 hours.</p>	
<p>All staff receives all mandatory training during the first 90 days of employment from date of hire.</p>	<p>Compliance</p>	<p>One of the reviewed staff completed all required training within the first 90 days. The three SNAP Staff had not yet completed Naloxone training; however, one has one week remaining to complete the training and the other two staff have until June 30, 2025.</p>	

Non Licensed Staff Assisting with Medication Distribution			
Any staff without a medical license that assists with Medication Distribution received in-person training from a Registered Nurse prior to administering medication to a shelter youth.	Compliance	Medication training is only applicable to residential staff, and the one residential staff file reviewed completed medication training with a registered nurse within their 90 days.	
Staff that are Utilizing NETMIS			
Any staff that is utilizing NETMIS has evidence of completing NetMIS Training in their training file.	Compliance	Three applicable staff who are required to have Netmis training completed the training timely.	
Staff Participating in Case Staffing & CINS Petitions (within the first year of employment BUT no later 7/1/24 for previous staff)			
Documentation of instructor-led FL Statute 984 CINS Petition Training by a local DJJ Attorney <u>within 1 year of employment or no later than 7/1/24 if hired before 7/1/23. (Policy went into effect 7/1/23).</u>	No eligible items for review	None of the staff reviewed are required to complete the CINS Petition Training.	
Non-licensed Mental Health Clinical Shelter Staff (within first year of employment)			
Documentation of non-licensed mental health clinical staff person's training in Assessment of Suicide Risk form or written confirmation by a licensed mental health professional of training (includes date, signature and license number of the licensed mental health professional supervisor).	No eligible items for review	No new non-licensed mental health clinical shelter staff was hired during the annual review.	
In-Service Direct Care Staff			
In-service staff completes all of the required annual or 2-year mandatory refresher Florida Network, SkillPro, or other job-related trainings within the required timeframe.	Compliance	There were four annual training files reviewed for three residential staff and one community counseling staff. The only pending training is for the community counseling staff who has until June 30, 2025 to complete Naloxone training.	

Community Counseling Direct Care staff completes 24 hours of mandatory refresher Florida Network, SkillPro, and job-related training annually.	Exception	One of the four in-service training records reviewed is applicable for community counseling.	One applicable staff completed 20 training hours, and did not meet the required 24 hours annually. □
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>).	Compliance	The three residential training files demonstrated staff completed more than the required 40 hours of training annually.	
Required Training Documentation			
The agency has a training plan that includes all of the required training topics including the pre-service and in-service.	Compliance	The program uses an online training platform called SmartSheets that includes training plans for each staff documents the hours, trainings topics, and compliance with required completion dates for each staff.	
The agency has a designated staff member responsible to manage all employee's individual training files and completes routine tracking and reviews of staff files to ensure compliance.	Compliance	The Director of Data Integrity is responsible for tracking and following up with all staff that have pending training.	
The program maintains an individual training file or employee file AND a FLN Training Log (or similar document that includes all requirements) for each staff, which includes an annual employee training hours tracking form and related documentation, such as electronic record/transcript, training certificates, sign-in sheets, and agendas for each training attended.	Compliance	The program's electronic training record in SmartSheets is created to calculate the hours, trainings and compliance with required completion dates for each staff. Training documentation is maintained in the database for each staff.	
All Staff have completed the Naloxone Training as required within 90 days of hire or 1 year from the policy effective date 7/1/24:		Four of the eight reviewed training files had not completed Naloxone training. Three of the four staff have until June 30, 2025 to complete the training. One staff needs to complete prior to May 26, 2025 to complete it within 90 days of hire.	
Additional Comments: There are no additional comments for this indicator.			

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 the required policy and procedure, 1.05 Analyzing and Reporting Information, that was approved by the COO July 2024.	
Case record review reports demonstrate reviews are conducted quarterly, at a minimum. <i>(A summary report of case record reviews, identifying compliance with the CINS/FINS requirements, which is reviewed by management and communicated with staff on a quarterly basis at minimum.)</i>	Compliance	Case record reviews are conducted on a quarterly basis using a comprehensive 2-page checklist and summary page. Each designated program staff completes the respective peer review form and submits them to their direct supervisor by the 15th of the designated month. The Supervisor ensures all peer review forms, along with their summary, are scanned to the designated OneDrive folder, or email, as requested by VP of Impact. Following the completion of the reviews, the VP of Impact analyzes the data to identify trends, successes, and areas for improvement. Supervisors and directors share any important findings or trends during their monthly meetings including strengths, areas needing improvement, action plans, and status of prior action plans. The most recent case record reviews were conducted for the residential and community counseling programs for a total of 22 case records in quarter 2 on 11/7/24, and quarter 3, on 2/6/2025 for a total of 19 case records.
The program conducts reviews of incidents, accidents, and grievances quarterly, at a minimum	Compliance	The agency's Risk Management Committee tracks and monitors incidents, accidents, and grievances quarterly. The Risk Management Committee convenes each month following the conclusion of each quarter to facilitate a comprehensive review of incidents from the preceding quarter. An additional review is held annually in July at the end of the fiscal year. Program staff enters incidents, accidents, and grievances into the agency's SharePoint portal. Data is aggregated in terms of incident total by program, agency-wide incident totals by type, and incident type by program. The report also aggregates data for grievances. This information is published quarterly in the CQI Analysis report that is presented during directors and supervisory meetings and shared with staff during staff meetings. The quarterly Risk Management Committee meetings were held 10/29/24, 1/2/25, and 4/15/25.

<p>The program conducts an annual review of customer satisfaction data</p>	<p>Compliance</p>	<p>The agency uses Smartsheet for data tracking and benchmark reporting including client satisfaction surveys. Survey results are tracked monthly for the shelter and community counseling clients separately and compiled into quarterly and annually, in July, on the CQI Analysis report that is presented during directors and supervisory meetings and shared with staff during staff meetings.</p>	
<p>The program demonstrates a monthly review of the statewide End-of-Month ("EOM") report generated by the Florida Network Office. This includes monthly data, fiscal year to date data, benchmarks for residential and community counseling, screening data, report card measures, follow-up reporting measures.</p>	<p>Compliance</p>	<p>EOM reports are emailed to the COO and VP Impact and disseminated to supervisors to discuss with staff at the monthly staff meetings. Monthly staff meeting agendas and minutes for the review period validates program review of the EOM reports on a regular basis with staff. The Vice President of Impact reports findings for all benchmarks and CINS/ FINS compliance at each meeting. Meeting minutes for the following dates were observed: 4/1/25, 3/4/25, 2/11/25, 1/14/25, 12/3/24, and 11/25/24. Smart Sheet Dashboard for the agency also includes the EOM report.</p>	
<p>The program has a process in place to review and improve accuracy of data entry & collection</p>	<p>Compliance</p>	<p>The Director of Data Integrity performs data reconciliation every two weeks across all agency and external databases. A report is sent to all data entry staff and program leaders, allowing staff two business days to make necessary corrections. Emails titled 'Shelter Active' as well as 'Intakes and Discharges' were observed as part of this process. Examples of email communication between the Florida Network and the DDI demonstrates practice.</p>	
<p>There is documentation that findings are regularly reviewed by management and communicated to staff and stakeholders.</p>	<p>Compliance</p>	<p>Emails, CQI Analysis Reports, and meeting minutes were provided as evidence by the Vice President of Impact that findings are regularly reviewed by management and communicated to the staff and stakeholders. The program holds monthly, quarterly, and annual meetings to address continuous quality improvement.</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>Compliance</p>	<p>Final reports with limited or failed submissions are provided to the executive committee and included in the board packets. The Continuous Quality Improvement Analysis report has section titled 'Licensing/Accreditation/Audits,' which details information regarding licensing and audit results. Audit reports and board packets are uploaded to the board portal on SharePoint. Overall program performance is regularly discussed in board meetings.</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>Compliance</p>	<p>The agency has a VP Impact who oversees the development, implementation, documentation, evaluation, and promotion of continuous improvement practices and systems. Should a program fall below expectations in meeting an outcome or objective, action steps for immediate and sustained improvement are completed by program leadership and reviewed during monthly supervisor meetings, the CQI committee quarterly, and within executive leadership meetings when needed.</p>	
<p>Additional Comments: There are no additional comments for this indicator.</p>			
<p>1.06: Client Transportation</p>			<p>Satisfactory</p>
<p>Provider has a written policy and procedure that meets the requirement for Indicator 1.06</p>	<p>YES</p>		
	<p>If NO, explain here:</p>		
	<p>The provider has the required policy and procedure, 1.08 Agency Vehicles and 1.10 Transportation Policy that was approved by the COO July 2024.</p>		
<p>Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle</p>	<p>Compliance</p>	<p>The facility has an approved drivers list that is verified by human resources. If a staff is not located on the approved list, they are not allowed to drive the youth.</p>	
<p>Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy</p>	<p>Compliance</p>	<p>The insurance policy covers any approved employees of the company as well as passengers in the vehicle. All drivers on the current approved driver list have valid drivers licenses as confirmed on the Florida Department of 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 3rd party is NOT present in the vehicle while transporting</p>	<p>Compliance</p>	<p>The agency's policy prohibits transporting a youth without another passenger in the vehicle. There are provisions in place in case a 3rd party is not present in the vehicle. The policy notes if a driver is transporting a single client in a vehicle, there is evidence that the program supervisor is aware (prior to the transportation) and consent is documented accordingly.</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	Compliance	The agency's policy states in the event that a 3rd party cannot be obtained for transport, the agency's supervisor or managerial personnel considers the clients' history, evaluation and recent behavior when approving single youth transport.	
The 3 rd party is an approved volunteer, intern, agency staff, or other youth	Compliance	The program policy requires that a 3rd party used during transports are approved agency personnel or volunteers. All non-single transports reviewed had a staff or youth listed as 3rd party.	
The agency demonstrated evidence via logbook or other written verification that supervisor approval was obtained prior to all single youth transports.	Compliance	Transportation logs for the agency's van were reviewed by selection of 10 random single transport events during the review period. All 10 single transports received prior consent by a supervisor for the transport.	
When transporting a single client in a vehicle, there was documentation of the following: a. the transporting employee completed check-in by phone at agreed-upon intervals with the senior program leader, or designee, upon departure and arrival. b. the employee check-ins were documented by the manager or designee receiving the call.	Compliance	The program documented the start and end of each single transport, as well as the start of the open phone line with the staff completing the transport and a staff at the facility in each instance reviewed. The program highlights the information in orange in the logbook. The transporting employee shall check-in by phone at agreed upon intervals with the program supervisor, or designee, upon arrival and departure. Employee check-ins must be documented by manager or designee receiving the call.	
There is documentation of use of vehicle that notes name or initials of driver, date and time, mileage, number of passengers, purpose of travel and location.	Compliance	The trip log used for every transport the facility makes includes the date and time, the name of the staff and youth being transported, the purpose for the transport, and the milage.	
Additional Comments: There are no additional comments for this indicator.			
1.07 - Outreach Services			Satisfactory with Exception
Provider has a written policy and procedure that meets the requirement for Indicator 1.07	YES		
	If NO, explain here:		
	The provider has the required policy and procedure, 1.11 Outreach Services that was approved by the COO in July 2024.		
The program has a lead staff member designated to participate in local DJJ board, Circuit and Council meetings with evidence that includes minutes of the event or other verification of staff participation.	Compliance	The COO or the Residential Supervisor are the designees for participation and attendance to the DJJ Board, Circuit and Council meetings. Evidence of meeting minutes and staff participation (sign in sheets, emails and screen shots of virtual meetings demonstrate staff participation.	
The program maintains written agreements with other community partners which include services provided and a comprehensive referral process.	Compliance	The program was able to show evidence of 16 different interagency agreements covering topics such as mental health, truancy, and educational agreements, as well as agreements with law enforcement, and DJJ.	

<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>Exception</p>	<p>The program was able to show evidence of 36 events entered into NetMIS for outreach that occurred within the last 6 months for the entire agency.</p>	<p>All of the outreach events occurred in Pinellas County with no documentation of events that have been attended/held in Bradenton/Manatee County to show local community engagement.</p>
<p>The program has designated staff that conducts outreach which is defined in their job description.</p>	<p>Compliance</p>	<p>The program has a designated position that conducts outreach Community Liaison. However, the program's expectation is that all staff are required to complete outreach activities for the agency.</p>	
<p>Additional Comments: There are no additional comments for this indicator.</p>			
<p>Standard Two – Intervention and Case Management</p>			
<p>2.01 - Screening and Intake</p>			<p>Satisfactory</p>
<p>Provider has a written policy and procedure that meets the requirement for Indicator 2.01</p>	<p>YES</p>		
	<p>If NO, explain here:</p>		
	<p>The provider has the required policy and procedure, 2.0, Screening for CINS/FINS eligibility, most recently approved July 2024 by COO.</p>		
<p>Shelter youth: Eligibility screening form is completed immediately for all shelter placement inquiries.</p>	<p>Compliance</p>	<p>Five shelter youth files were reviewed, two open and three discharged. All five files were found to be compliant as the screenings were completed immediately for shelter placement.</p>	
<p>Community counseling: Eligibility screening form is completed within 3 business days of referral by a trained staff using the Florida Network screening form.</p>	<p>Compliance</p>	<p>Five community counseling case files were reviewed, two open and three discharged. All five community counseling case files demonstrated screening form was completed by a trained staff within three business days using the Florida Network screening form.</p>	
<p>There is evidence all referrals for service is screened for eligibility and is logged in NetMIS within 72 hours of screening completion.</p>	<p>Compliance</p>	<p>All ten files reviewed included evidence that the referrals for service, with dates of the referrals noted in the files, were screened for eligibility and logged in NetMIS within seventy-two hours of 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>Compliance</p>	<p>All ten files reviewed showed evidence that youth and parents received available service options and rights and responsibilities of youth and parents/guardians. The documents were dated and signed by youth and parents during intakes.</p>	

<p>The following is also available to the youth and parents/guardians: a. Possible actions occurring through involvement with CINS/FINS services (case staffing committee, CINS petition, CINS adjudication) b. Grievance procedures</p>	<p>Compliance</p>	<p>All ten files reviewed showed evidence that youth and parents were advised of possible action through involvement in the CINS/FINS program and grievance procedures. Documents were noted in the file of the possible actions.</p>	
<p>During intake, all youth were screened for suicidality and correctly assessed as required if needed.</p>	<p>Compliance</p>	<p>All ten files reviewed were screened for suicidality and correctly assessed as required. Documentations in the files and any follow up needed was present, signed and dated by staff.</p>	
<p>Additional Comments: There are no additional comments for this indicator.</p>			
<p>2.02 - Needs Assessment</p>			<p>Satisfactory with Exception</p>
<p>Provider has a written policy and procedure that meets the requirement for Indicator 2.02</p>	<p>YES</p>		
	<p>If NO, explain here:</p>		
	<p>The provider has the required policy and procedure, 3.03, Network Inventory of Risks, Victories and Needs Assessment, most recently approved July 2024 by COO.</p>		
<p>Shelter Youth: NIRVANA is initiated within 72 hours of admission</p>	<p>Compliance</p>	<p>All five residential files reviewed showed evidence of NIRVANA initiated within seventy-two hours of admission. Evidence of a completed NIRVANA was found in the youth files and noted in NetMIS.</p>	
<p>Non-Residential youth: NIRVANA is initiated at intake and completed within 2 to 3 face-to-face contacts after the initial intake OR updated, if most recent assessment is over 6 months old</p>	<p>Compliance</p>	<p>All five community counseling youth files reviewed showed evidence of NIRVANA initiated during intake and completed within two to three face to face contact.</p>	
<p>Supervisor signatures is documented for all completed NIRVANA assessments and/or the chronological note and/or interview guide that is located in the youths' file.</p>	<p>Exception</p>	<p>Nine of the ten files reviewed included a supervisor's signature on the completed NIRVANA assessments.</p>	<p>One of the ten files reviewed did not include a supervisor's signature on the completed NIRVANA assessment. The supervisor signature was added during the review.</p>
<p>(Shelter Only) NIRVANA Self-Assessment (NSR) is completed within 24 hours of youth being admitted into shelter. If unable to complete, there must be documentation in NetMIS and the youth's file explaining the barriers to completion.</p>	<p>Compliance</p>	<p>The five residential records reviewed included a NIRVANA Self-Assessment (NSR) that were completed within 24 hours of youth being admitted into shelter.</p>	
<p>A NIRVANA Post-Assessment is completed at discharge for all youth who have a length of stay that is greater than 30 days.</p>	<p>Compliance</p>	<p>Three of the ten files reviewed were applicable for NIRVANA Post Assessments. Post Assessments were completed in two of the three files. One youth voluntarily withdrew from the program; therefore, the staff was unable to complete the Post-Assessment and this was documented in the case notes of the file.</p>	

A NIRVANA Re-Assessment is completed every 90 days excluding files for youth receiving SNAP services.	No eligible items for review	None of the ten files reviewed were in care for over 90 days.	
All files include the interview guide and/or printed NIRVANA.	Compliance	All ten files reviewed showed evidence of a printed NIRVANA in the file..	
Additional Comments: There are no additional comments for this indicator.			
2.03 - Case/Service Plan			Satisfactory with Exception
Provider has a written policy and procedure that meets the requirement for Indicator 2.03	YES		
	If NO, explain here:		
	The provider has the required policy and procedure, 4.03, Case/Service Plan, most recently revised July 2024 by the COO.		
The case/service plan is developed on a local provider-approved form or through NETMIS and is based on information gathered during the initial screening, intake, and NIRVANA.	Compliance	All ten files reviewed had service plans developed from information gathered during initial screening and assessment. The documents were placed in the youth's files, dated and signed by the staff.	
Case/Service plan is developed within 7 working days of NIRVANA	Compliance	All ten case/service plans provided implementation dates that fell on or within the seven working days of the NIRVANA assessment date.	
Case plan/service plan includes: 1. Individualized and prioritized need(s) and goal(s) identified by the NIRVANA 2. Service type, frequency, location 3. Person(s) responsible 4. Target date(s) for completion and actual completion date(s) 5. Signature of youth, parent/guardian, counselor, and supervisor 6. Date the plan was initiated	Exception	All ten case/service plans reviewed contained individualized and prioritized goals identified by the NIRVANA and date plan was initiated; service type, frequency, location, person(s) responsible for completing goals; and target and completed dates for completion of goals. Signatures of youth, parent/ guardian, counselor, and supervisor were observed in nine of the ten plans.	The signature of the parent/guardian was not captured on one (residential youth) of the nine case/service plan reviewed.
Case/service plans are reviewed for progress/revised by counselor and parent (if available) every 30 days for the first three months and every 6 months after	Compliance	Five of the youth files reviewed provided evidence that the case/service plans were reviewed for progress by the counselor and parent. Due to the completion of target goals before the 30 day review, five charts were not applicable.	
Additional Comments: There are no additional comments for this indicator.			

2.04 - Case Management and Service Delivery		Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 2.04	YES	
	If NO, explain here:	
	The provider has the required policy and procedure, 2.04, Case Management and Service Delivery, that was approved July 2024 by the COO.	
Counselor/Case Manager is assigned	Compliance	Each of the ten files demonstrated a counselor/case manager was assigned to work with the youth/family from case assignment to termination.
The Counselor/Case Manager completes the following as applicable: 1. Establishes referral needs and coordinates referrals to services based upon the on-going assessment of the youth's/family's problems and needs 2. Coordinates service plan implementation 3. Monitors youth's/family's progress in services 4. Provides support for families 5. Monitoring progress of court ordered youth in shelter 6. Makes referrals to the case staffing to address problems and needs of the youth/family 7. Accompanies youth and parent/guardian to court hearings and related appointments 8. Refers the youth/family for additional services when appropriate 9. Provides case monitoring and reviews court orders 10. Provides case termination notes 11. Provides follow-up after 30 days post discharge 12. Provides follow-up after 60 days post discharge	Compliance	As applicable, all 10 records were observed to demonstrate coordination of service plans, monitor progress in services, and provision of various types of support for youth and family. Eight applicable records demonstrated referrals for needed services. None of the ten records reviewed were court ordered or referred to the case staffing committee or required judicial/adjudication services.
The program maintains written agreements with other community partners that include services provided and a comprehensive referral process	Compliance	The program has a list of community partners and a referral process. The agreements are held with a variety of community partners to provide a comprehensive referral process including mental health, substance abuse, medical services, and support services. Total of 14 MOU's - 3 - District (Educational), 3 - Police Departments, 2 - Healthy Teams (Life Skills/Educational), 1 - State Attorney's Office Circuit 12, 1 - Insight (Mental Health/Counseling), 1 - Manatee School For The Arts (Arts and Leisure), 1- Horizons Academy (Educational), 1 - BAYS - Bay Area Youth Services (Substance Abuse), 1- Starting Right Now - Human Trafficking.
Additional Comments: There are no additional comments for this indicator.		

2.05 - Counseling Services		Satisfactory	
Provider has a written policy and procedure that meets the requirement for Indicator 2.05	YES		
	If NO, explain here:		
	The provider has the required policy and procedure, 2.05 Counseling Services, that was approved by the COO July 2024.		
Shelter Program			
Shelter programs provides individual and family counseling	Compliance	All ten files reviewed showed evidence individual and family counseling was provided.	
Group counseling sessions held a minimum of five days per week	Compliance	The program's group sign in sheets for the review period were reviewed. It was evident from the documents presented the program is conducting groups five days per week consistently.	
Groups are conducted by staff, youth, or guests and group counseling sessions consist of : 1. A clear leader or facilitator 2. Relevant topic - educational/informational or developmental 3. Opportunity for youth to participate 4. 30 minutes or longer	Compliance	The program provided group notes that indicated the date, time of start and ending of group, topic, and the names of youth in attendance. The group notes indicated that groups are typically 45 minutes to an hour long. On May 8th the reviewer observed a group session and noted that all six youths were active participants. The group topic: Handling Stress was facilitated by a community partner.	
Documentation of groups must include date and time, a list of participants, length of time, and topic.	Compliance	Group notes between the months of November 2024 and April 2025 were reviewed. All notes were found to include the date and time, a list of participants, length of time and the topic.	
Community Counseling			
Community counseling programs provide therapeutic community-based services designed to provide the intervention necessary to stabilize the family. Services are provided in the youth's home, a community location, the local provider's counseling office or virtually if written documentation is provided in the youth's file for reasons why it is in the best interest of the youth and family.	Compliance	There was evidence that the community counseling program provides therapeutic community-based services designed to provide the intervention necessary to stabilize the family whenever needed. Services are provided in the youth's home, a community location, or the local provider's counseling office. None of the records indicated services were provided virtually.	
Counseling Services			
There is evidence the program completes review of all case files for coordination between presenting problem(s), psychosocial assessment, case/service plan, case/service plan reviews, case management, and follow-up.	Compliance	The program has an internal process that ensures clinical reviews of case records and staff performance. Interview with the Clinical Director supported practice of reviewing all open cases to provide oversight on coordination of services.	
Maintain individual case files on all youth and adhere to all laws regarding confidentiality.	Compliance	All ten youth records were maintained in individual case files with adherence to all laws regarding confidentiality.	

Case notes maintained for all counseling services provided and documents youth's progress.	Compliance	All ten files reviewed had evidence in the case notes of maintaining counseling services and documents of the youth's progress.	
On-going internal process that ensures clinical reviews of case records and staff performance.	Compliance	Treatment team meets weekly and includes the Clinical Director. The team discuss progress of youth, and case files are reviewed and documented. Reviewer observed case review documents in the youth's record.	
When an intake is conducted through virtual means, consent is confirmed by the counselor, documented in the file, and reviewed with the supervisor during supervision/case review. There is written documentation provided in the youths file for reasons why virtual sessions are in the best interest of the youth and family.	No eligible items for review	None of the ten files reviewed had a virtual intake.	
Additional Comments: There are no additional comments for this indicator.			
2.06 - Adjudication/Petition Process			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 2.06	YES		
	If NO, explain here:		
	The provider has the required policy and procedure, 4.05 CINS Adjudication Services, revised July 2024, and Policy 4.06 CINS Petition Process, reviewed July 2024 by COO.		
Must include: a. DJJ rep. or CINS/FINS provider b. Local school district representative	Compliance	Case staffing sign in sheet for the two files reviewed included Department of Juvenile Justice or Children In Need of Service/Families in Need of Services provider and a local school district representative present.	
Other members may include: a. State Attorney's Office b. Others requested by youth/ family c. Substance abuse representative d. Law enforcement representative e. DCF representative f. Mental health representative	Compliance	The two case staffings included a mental health representative. Other members requested by the youth/family are encouraged.	
The program has an established case staffing committee, and has regular communication with committee members	Compliance	The program had evidence of an established case staffing committee and regular communication with committee members. The evidence included letters, minutes, time and dates of the program case staffing in the two files reviewed. The committee members were identified.	
The program has an internal procedure for the case staffing process, including a schedule for committee meetings	Compliance	The case staffing meetings occur monthly and additional meetings may be held if, requested, including emergency case staffing. Members of the committee are notified via email when a case staffing is scheduled to be convened.	

The youth and family are provided a new or revised plan for services	Compliance	Evidence supported the youth and family for the two records reviewed were provided a new or revised plan for services as a result of the case staffing.	
Written report is provided to the parent/guardian within 7 days of the case staffing meeting, outlining recommendations and reasons behind the recommendations	Compliance	A review of the two case staffing records revealed a report was provided immediately after the case staffing to the youth/family outlining the recommendations of the committee.	
If applicable, the program works with the circuit court for judicial intervention for the youth/family	No eligible items for review	None of the two records reviewed required court/judicial intervention.	
Case Manager/Counselor completes a review summary prior to the court hearing	No eligible items for review	None of the two records reviewed required court/judicial intervention.	
Additional Comments: There are no additional comments for this indicator.			
2.07 - Youth Records			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 2.07	YES		
	If NO, explain here:		
	The provider has the required policy and procedure, 2.07 Youth Records, that was approved by the COO July 2024.		
All records are clearly marked 'confidential'.	Compliance	All ten case files were completed electronically and accessed only by eligible program administration or staff with secure passwords.	
All records are kept in a secure room or locked in a file cabinet that is marked "confidential"	Compliance	All medication administration records are kept in a secure room and locked in a file cabinet that is marked "confidential. Evidence of the secured files was provided and viewed by the Peer Reviewer. All other client files are stored electronically.	
When in transport, all records are locked in an opaque container marked "confidential"	Compliance	The program has a locked container to transport records offsite. The container is black and has a combination lock for secure transport of the records and is marked confidential.	
All records are maintained in a neat and orderly manner	Compliance	All client files are stored electronically.	

<p>SHELTER FILES contain the following: Table of Contents that outlines documents in each section:</p> <ul style="list-style-type: none"> •Screening •Informed Consent • Photograph of the youth • Shelter Intake Form • Suicide Assessment (if needed) • NIRVANA Self Report (NSR) • NIRVANA full Assessment • Plan of Service • Chronological Notes • Medication Inventory Form • Approved contact list • Copies of referrals made & Follow-Up (if needed) • Discharge summary once case is closed 	<p>Compliance</p>	<p>Verification of all content related documents were found in five electronic shelter files.</p>	
<p>COMMUNITY COUNSELING FILES contain the following: Table of Contents that outlines documents in each section:</p> <ul style="list-style-type: none"> • Screening • Informed Consent • Community Counseling Intake Form • Suicide Assessment (if needed) • NIRVANA full Assessment • Plan of Service • Chronological case notes • Copies of referrals made & Follow-Up (if needed) • Discharge summary once the case is closed 	<p>Compliance</p>	<p>Verification of all content related documents were found in all five electronic community counseling files.</p>	
<p>All records kept electronically, are maintained securely and can be made immediately available upon request for audit purposes.</p>	<p>Compliance</p>	<p>Records are maintained in an electronic platform that provides secure access by requiring username and passwords. Access is limited to program approved staff.</p>	
<p>Records are retained for the duration of the time specified by the contract.</p>	<p>Compliance</p>	<p>The Clinical Supervisor verified that all records are retained for the duration of the time specified by the contract.</p>	
<p>Additional Comments: There are no additional comments for this indicator.</p>			

2.08 - Specialized Additional Program Services		Limited	
Provider has a written policy and procedure that meets the requirement for Indicator 2.08	YES		
	If NO, explain here:		
	The provider has the required policies and procedures, 2.08/Specialized Additional Program Services, 2.09a Special Populations, and 2.09b FYRAC, that were approved by the COO July 2024.		
Staff Secure			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	No eligible items for review	The agency has not served any youth who meet the criteria for staff secure in the last 6 months or since the last onsite QI review	
Staff Secure policy and procedure outlines the following: a. In-depth orientation on admission b. Assessment and service planning c. Enhanced supervision and security with emphasis on control and appropriate level of physical intervention d. Parental involvement e. Collaborative aftercare	Compliance	A review of the current staff secure policy and procedures indicate protocols are in place to provide the following as required: In-depth orientation on admission; assessment and service planning; enhanced supervision and security with emphasis on control and appropriate level of physical intervention; parental involvement; and collaborative aftercare.	
Program only accept youth that meet legal requirements of F.S. 984 for being formally court ordered in to Staff Secure Services	No eligible items for review	No eligible youth were served during the annual review period.	
Staff Assigned: a. One staff secure bed and assigned staff supervision to one staff secure youth at any given time b. Program assign specific staff during each shift to monitor location/ movement of staff secure youth c. Agency clearly documents the specific staff person assigned to the staff secure youth in the logbook or any other means on each shift	No eligible items for review		
Agency provides a written report for any court proceedings regarding the youth's progress	No eligible items for review		
Domestic Minor Sex Trafficking (DMST)			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	No eligible items for review	The agency has not served any youth who meet the criteria for Domestic Minor Sex Trafficking (DMST) in the last 6 months or since the last onsite QI review.	

Agency has evidence that the FNYFS was contacted for approval prior to admission for all Domestic Minor Sex Trafficking (DMST) placements.	No eligible items for review		
There is evidence the youth was entered into NetMIS as a Special Populations youth at admission and a Human Trafficking Screening Tool (HTST) was completed.	No eligible items for review		
Services provided to these youth specifically designated services designed to serve DMST youth	No eligible items for review		
Did the placement of DMST youth require additional supervision for the safety of the youth or the program? If so, did the agency provide the appropriate level of supervision and safety measures?	No eligible items for review		
Length of Stay: a. Youth in program do not have length of stay in DMST placement that exceeds seven (7) days b. Agency has approval for stays and support beyond seven (7) days for DMST placements that are obtained on a case-by-case basis? (If applicable.)	No eligible items for review		
Agency has evidence that staff assigned to DMST youth under this provision are to enhance the regular services available through direct engagement in positive activities designed to encourage the youth to remain in shelter	No eligible items for review		
All other services provided to DMST youth are consistent with all other general CINS/FINS program requirements	No eligible items for review		
Domestic Violence <input type="checkbox"/>			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	Yes	Three youth records were reviewed, one open and two closed.	
Youth admitted to DV Respite placement have evidence in the file of a pending DV charge	Compliance	Three youth records all had indications that the placement was being sought out due to need for DV respite pending charges.	
Data entry into NetMIS within (3) business days of intake and discharge	Compliance	All three youth charts reviewed demonstrated data entry was entered into NetMIS timely.	
Youth length of stay in DV Respite placement does not exceed 21 days. If more than 21 days, documentation exists in youth file of transition to CINS/FINS or Probation Respite placement, if applicable.	Compliance	None of the three DV youth placement exceeded 21 days.	

Case plan in file reflects goals for aggression management, family coping skills, or other intervention designed to reduce propensity for violence in the home	Exception	Two of the three youth charts and service plans reviewed indicated goals that focused on the following areas: plans for managing emotions, family coping skills, and/or other interventions to reduce the propensity for violence in the homes.	The case plan for one of the youth did not address youth behavioral issues or anger management as required to assist reduce youth's propensity for violence.
All other services provided to Domestic Violence Respite youth are consistent with all other general CINS/FINS program requirements	Compliance	Services documented in the three youth charts reviewed were found to be consistent with other general CINS/FINS program requirements.	
Probation Respite			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	Yes	Two closed youth records were reviewed	
All probation respite referrals are submitted to the Florida Network.	Compliance	Documentation supported the program submitted both probation respite referrals to the Florida Network.	
All Probation Respite Referral come from DJJ Probation and there is evidence that the youth is on Probation regardless of adjudication status.	Compliance	The two case records reviewed included evidence of referral by DJJ Probation and the Face Sheets for both records documented the youths' probation status.	
Data entry into NetMIS and JJIS within (3) business days of intake and discharge	Compliance	Both youth charts reviewed demonstrated data entry was entered into NetMIS timely.	
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.	Compliance	Length of stay for the two youth did not exceed 30 days.	
All case management and counseling needs have been considered and addressed	Exception	Two case plans reviewed indicated goals to address compliance with shelter rules only and not the issues related to youth's referral and issues presented.	None of the two case plans reviewed included goals or case management services to address the youth's behavioral issues.
All other services provided to Probation Respite youth are consistent with all other general CINS/FINS program requirements	Compliance	Services documented in the two youth charts reviewed were found to be consistent with other general CINS/FINS program requirements.	
Intensive Case Management (ICM)			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	Yes	Three cases, one open and two closed, were reviewed for ICM services.	

<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>Compliance</p>	<p>All three youth were referred due to truancy.</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>Compliance</p>	<p>All three records reviewed documented two direct contacts each month and two collateral contacts per week. The program documents contacts on a form and provided a description of the contact event.</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>Compliance</p>	<p>Three youth records reviewed had NIRVANA completed at intake. Two closed youth charts reviewed had applicable post discharge NIRVANA completed.</p>	
<p>Service/case plan demonstrates a strength-based, trauma-informed focus</p>	<p>Exception</p>	<p>All three ICM records reviewed each had one goal related to school attendance. Other needs identified for skills that are lacking were identified but were not addressed.</p>	<p>Other needs identified on the NIRVANA assessment for all three youth were not discussed and included on the service plans.</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>No eligible items for review</p>	<p>Virtual services were not indicated or provided for the youth records reviewed.</p>	
<p>Family and Youth Respite Aftercare Services (FYRAC)</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>No eligible items for review</p>	<p>The agency has not served any youth who met the criteria for Family and Youth Respite Aftercare Services (FYRAC) in the last 6 months or since the last onsite QI review.</p>	
<p>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.</p>	<p>No eligible items for review</p>		
<p>Agency has evidence that all FYRAC referrals have documented approval from the Florida Network office</p>	<p>No eligible items for review</p>		

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

There is evidence of completed 30 and/or 60 day follow-ups and is documented in NetMIS following case discharge.	No eligible items for review		
Youth and family participate in services for thirteen (13) sessions or ninety (90) consecutive days of services, or there is evidence in the youth's file that an extension is granted by DJJ circuit Probation staff	No eligible items for review		
Any service that is offered virtually, is documented in the youth's file why it was in the youth and families best interest.	No eligible items for review		
All data entry in NetMIS is completed within 3 business days as required.	No eligible items for review		
Additional Comments: There are no additional comments for this indicator.			
2.09- Stop Now and Plan (SNAP)			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 2.09	YES		
	If NO, explain here:		
	The provider has the required policies and procedures, 2.09 Stop Now and Plan (SNAP), 2.09a SNAP Group Delivery, 2.09b SNAP Fidelity Monitoring, 2.09c SNAP Discharge Requirements, and SNAP for Schools and Communities. The policies were approved by the COO in July 2024.		
SNAP Clinical Groups Under 12			
Youth are screened to determine eligibility of services with the required documents: a. Florida Network Youth Screening Form b. SNAP® Brief Intake Screening Checklist	Compliance	Two open youth records were reviewed. Both youth were screened using NetMIS and the Brief SNAP screening forms to determine eligibility.	
All files contain each of the required documents below: a. SNAP Child Screening Interview Report b. Florida Network Community Counseling Intake Form c. Reinforcement Trap/Coercive Cycle Diagram d. Consent to Treatment and Participation in Research Form	Compliance	Each of the two records reviewed contained a SNAP Child Screening Interview Report, Florida Network Community Counseling Intake Form, Reinforcement Trap/Coercive Cycle Diagram, and Consent to Treatment and Participation in Research Form.	
The NIRVANA was completed at initial intake, or within two sessions.	Compliance	Each youth record contained a printed NIRVANA assessment that was completed at intake.	

There is evidence of the completed the Pre - Child Behavior Checklist (CBCL) by the caregiver and is located within the file.	Compliance	The pre-CBCL forms were completed and contained in the two youth records.	
There is evidence of the completed Pre - TOPSE is completed by the caregiver and is located within the file.	Compliance	Each record contained a completed pre-TOPSE form completed by the parent/guardian.	
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>	Not Applicable	The two records reviewed were open at the time of the review. .	
SNAP Clinical Groups Under 12 - Discharge			
There is evidence of the completed the Post - Child Behavior Checklist (CBCL) by the caregiver and is located within the file.	Not Applicable	The two records reviewed were open at the time of the review. .	
There is evidence of the completed Post - TOPSE is completed by the caregiver and is located within the file.	Not Applicable		
There is evidence of the completed SNAP Discharge Report located within the file for any discharged youth.	Not Applicable		
There is evidence of the SNAP Boys/SNAP Girls Child Group Evaluation Form located in the file.	Not Applicable		
There is evidence of the SNAP Boys/SNAP Girls Parent Group Evaluation Form located in the file.	Not Applicable		
SNAP Clinical Groups for Youth 12-17			
Youth are screened to determine eligibility of services using the Florida Network Youth Screening Form.	Compliance	Three closed youth records were reviewed. All three youth were screened using the Florida Network Youth Screening Form to determine eligibility.	
The file contains the completed Florida Network Community Counseling Intake Form and is located within the file.	Compliance	Each youth record contained a Florida Network Community Counseling Intake Form.	

The Consent to Treatment and Participation in Research Form is completed, signed by the parent/guardian before receiving services, and located within the file.	Compliance	Each youth record contained a printed Consent to Treatment and Participation signed by the parent/guardian prior to receiving services.	
The NIRVANA was completed at initial intake, or within two sessions.	Compliance	A printed copy of the NIRVANA completed at intake was present in the three files reviewed.	
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.	Compliance	HIT forms were completed and contained in all three youth records.	
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.	Compliance	There is evidence the Social Skills Improvement System (SSIS) Student forms were completed and contained in all three youth records.	
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.	Compliance	Social Skills Improvement System (SSIS) Teacher/Adult forms were completed and contained in all three youth records.	
All closed files contained evidence in the file a NIRVANA was completed at discharge.	Compliance	One of the three closed youth records contained a completed NIRVANA at discharge. The other two youth/family voluntarily withdrew from services prior to discharge.	
SNAP for Schools & Communities			
The program demonstrated all of the required weekly attendance sheets that included youth names and/or identifying numbers completed with the teacher and trained SNAP Facilitator signatures. <i>(This must include a total of 13 attendance sheets for a full cycle)</i>	Compliance	The program completed on SNAP in Schools session during the review period. All thirteen weekly attendance sheets that included the names of youth participating were present for the class.	
The program maintained evidence of a completed 'Way to Go Goal' Sheet within the file.	Compliance	There is documentation of a completed 'Way to Go Goal' Sheet within the file for the class.	
The program maintained evidence of both pre AND post Measure of Classroom Environment (MoCE) completed documents for the class reviewed.	Compliance	Evidence of completed pre and post Measure of Classroom Environment (MoCE) was observed for the class reviewed.	
The program maintained evidence of completed pre and post evaluation documents for the class reviewed.	Compliance	The class reviewed contained evidence of pre and post evaluations completed by the youth.	

<p>There is evidence of the SNAP® for Schools & Communities Feedback Form completed by the supervisory adult responsible for the support of the youth receiving services and entered into NetMIS.</p>	<p>Compliance</p>	<p>Documentation supported the SNAP® for Schools & Communities Feedback Form was completed for and entered into NetMIS.</p>	
<p>There is evidence of one (1) Fidelity Adherence Checklist completed per classroom for the 13-week classroom sessions which is located in the file.</p>	<p>Compliance</p>	<p>The class reviewed contained evidence of one Fidelity Adherence Checklist completed for the 13-week classroom sessions held.</p>	
<p>Additional Comments: There are no additional comments for this indicator.</p>			
<p>Standard Three – Shelter Care</p>			
<p>3.01 - Shelter Environment</p>			<p>Satisfactory with Exception</p>
<p>Provider has a written policy and procedure that meets the requirement for Indicator 3.01</p>	<p>YES</p>		
	<p>If NO, explain here:</p>		
	<p>The provider has the required policy and procedure, 3.01 Shelter Environment, that was approved by the COO July 2024.</p>		
<p>Facility Inspection: a. Furnishings are in good repair. b. The program is free of insect infestation. c. Bathrooms and shower areas are clean and functional, free of foul odors, leaks, dust, and mildew and in good working order. d. There is no graffiti on walls, doors, or windows. e. Lighting is adequate for tasks performed there. f. Exterior areas are free of debris; grounds are free of hazards. g. Dumpster and garbage can(s) are covered. h. All doors are secure, in and out access is limited to staff members and key control is in compliance. i. Detailed map and egress plans of the facility, general client rules, grievance forms, abuse hotline information, DJJ Incident Reporting Number and other related notices are posted. j. Interior areas (bedrooms, bathrooms, common areas) do not contain contraband and are free from hazardous unauthorized metal/foreign objects.</p>	<p>Compliance</p>	<p>A tour of the facility was conducted with the program's Residential Supervisor. During the tour it was observed all furnishings were well maintained. The program is bug free, has sufficient lighting throughout, and graffiti free on furniture and walls. Exterior areas are well-kept, free of debris, and grounds are free of hazards. A total of eight restrooms were observed and all are free of foul odors, leaks, dust, and mildew, and in good working order. Each of the six dorm rooms has a full bathroom with shower stall and/or a tub. All four of the garbage cans on the exterior had lids that were closed properly. Reviewer confirmed all doors were secured, in and out access is limited to staff members, and key control is monitored. The program had detailed maps and egress plans of the facility, general client rules, grievance forms, abuse hotline information, DJJ Incident Reporting number and other related notices posted. All interior areas (bedrooms, bathrooms, and common areas) do not contain contraband and are free from hazardous unauthorized metal/foreign objects</p>	
<p>Facility Inspection: a. All agency and staff vehicles are locked. b. Agency vehicles are equipped with major safety equipment including first aid kit, (all items in the first aid kit are current and do not have expired items; all expired items should be replaced regularly), fire extinguisher, flashlight, glass breaker and, seat belt cutter.</p>	<p>Compliance</p>	<p>During the tour of the facility, all agency and staff vehicles were locked. The program has one vehicle used to transport youth, a 2022 gray Honda Odyssey. The vehicle was equipped with all major safety equipment such as a valid fire extinguisher, and all in one (flashlight, glass breaker and, seat belt cutter). The first aid kit had evidence of current medical supplies and had no expired items.</p>	

<p>Facility Inspection:</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>Compliance</p>	<p>Reviewed weekly chemical inventory November 2024 - April 2025 and found all chemicals were inventoried weekly and a perpetual inventory was conducted after each chemical use. MSDS sheets were present for each chemical in use.</p>	
<p>Facility Inspection:</p> <p>Washer/dryer are operational & 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>Compliance</p>	<p>Both sets of washers and dryers were operational and both dryer vents were lint free. Signage is hanging in laundry room reminding staff and youth to clean after each use. The agency has evidence of a current DCF license that is effective July 2024. Each bedroom has a nice decorative theme. Staff secures youth belongings in closest called confidential closet near dining area.</p>	
<p>Additional Facility Inspection Narrative (if applicable)</p>			

<p>Fire and Safety Health Hazards:</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>Exception</p>	<p>The Fire Department completed its annual inspection 5/15/24 at 15:52 and reported two indicators violations, the fire alarm panel and fire sprinkler system. A successful re-inspection was scheduled completed. Kitchen overhead hood and fire extinguishers all updated and inspected February 5, 2024. Logbook and fire drill logs confirmed fire drills as follows: 1st Shift : 11/05/2024, 11/22/2024, 12/04/2024, 01/14/2025, 02/04/2025, 03/11/2025, (Missing April 2025); 2nd Shift: 11/06/2024, 12/05/2024, 01/17/2025, 02/04/2025, 03/06/2025, 04/28/2025; and 3rd Shift: 11/22/2024, 12/23/2024, 01/30/2025, 02/28/2025, 03/05/2025, 04/25/2025. Mock emergency drills were completed as follows: 1st Shift: 11/13/2024, 12/11/2024, 01/08/2025, 02/07/2025, 03/12/2025, 04/07/2025; 2nd Shift: 12/23/2024, 01/10/2025, 02/10/2025, 04/14/2025; and 3rd Shift: 11/07/2024, 12/09/2024, 01/29/2025, 02/28/2025, 04/30/2025.</p>	<p>Fire drill was not completed on the 1st shift in the month of April 2025.</p>
<p>Fire and Safety Health Hazards:</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>Compliance</p>	<p>Agency has a current Satisfactory Food Service inspection report from the Department of Health effective July 1, 2024 and food menus are posted in dining hall area and signed by Licensed Dietician . The Department of Health conducted a successful group care inspection on May 16, 2024. The kitchen is well maintained and all cold food was properly stored, leftovers marked and labeled, and dry storage area was clean. Refrigerators/Freezers were clean and maintained optimal temperatures with thermometers to monitor temperature. All small appliances appeared operable and clean.</p>	
<p>Additional Fire and Safety Health Hazards Narrative (if applicable)</p>			

Youth Engagement			
<p>a. Youth are engaged in meaningful, structured activities (e.g., education, recreation, counseling services, life and social skill training) seven days a week during awake hours. Idle time is minimal.</p> <p>b. At least one hour of physical activity is provided daily.</p> <p>c. Youth are provided the opportunity to participate in a variety of faith-based activities. Non-punitive structured activities are offered to youth who do not choose to participate in faith-based activities.</p> <p>d. Daily programming includes opportunities for youth to complete homework and access a variety of age appropriate, program approved books for reading. Youth are allowed quiet time to read.</p> <p>e. Daily programming schedule is publicly posted and accessible to both staff and youth.</p>	Compliance	<p>Youth 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. Daily programming activity calendar is posted in the common area dining hall on a bulletin board. At least one hour of physical activity (titled fitness group) is provided daily at 4pm. The schedule is Included in youth handbook and posted on the weekly activity bulletin board. Youth are provided the opportunity to participate in a variety of faith-based activities. Daily programming includes opportunities for youth to complete homework and access program approved books for reading. Youth are allowed quiet time to read.</p>	
Additional Comments: There are no additional comments for this indicator.			
3.02 - Program Orientation			Satisfactory with Exception
Provider has a written policy and procedure that meets the requirement for Indicator 3.02	YES		
	If NO, explain here:		
	The provider has the required policy and procedure, 3.02 Program Orientation, that was approved by the COO July 2024.		
Youth received a comprehensive orientation and handbook provided within 24 hours	Compliance	Five youth records reviewed and it was confirmed that each youth received a comprehensive orientation and handbook within twenty-four hour of admission.	
<p>Orientation includes the following:</p> <p>a. Youth is given a list of contraband items</p> <p>b. Disciplinary action is explained</p> <p>c. Dress code explained</p> <p>d. Review of access to medical and mental health services</p> <p>e. Procedures for visitation, mail and telephone</p> <p>f. Grievance procedure</p> <p>g. Disaster preparedness instructions</p> <p>h. Physical layout of the facility</p> <p>i. Sleeping room assignment and introductions</p> <p>j. Suicide prevention- alerting staff of feelings or awareness of others having suicidal thoughts</p>	Exception	<p>Four of the five youth record reviewed included an orientation checklist that included items/topics reviewed with the youth such as list of contraband items, disciplinary actions, dress code, review of access to medical and mental health services, procedures for visitation, mail, telephone, grievance procedure, disaster preparedness instructions, physical layout of the facility, sleeping room assignments and introductions, and suicide prevention.</p>	<p>One youth record was missing the orientation checklist and evidence of it was conducted with the youth.</p>

Documentation of each component of orientation, including orientation topics and dates of presentation, as well as signatures of the youth and staff involved is maintained in the individual youth record	Compliance	Documentation of each component of orientation which included orientation topics and dates of presentation, as well as signatures of the youth and staff involved was present in the four files that contained the orientation checklist.	
Additional Comments: There are no additional comments for this indicator.			
3.03 - Youth Room Assignment			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 3.03	YES		
	If NO, explain here:		
	The provider has the required policy and procedure, 3.03 Youth Room Assignment, that was approved by the COO July 2024.		
A process is in place that includes an initial classification of the youths, to include:			
<ul style="list-style-type: none"> a. Review of available information about the youth's history, status and exposure to trauma b. Initial collateral contacts, c. Initial interactions with and observations or the youth d. Separation of younger youth from older youth, e. Separation of violent youth from non-violent youth f. Identification of youth susceptible to victimization g. Presence of medical, mental or physical disabilities h. Suicide risk i. Sexual aggression and predatory behavior j. Acute health symptoms requiring quarantine or isolation 	Compliance	A review of all five records indicated there is a process currently in place that includes a review of available information about the youth's history, status and exposure to trauma, Initial collateral contacts, Initial interactions with and observations or the youth. All youth files contained a collateral contact for youth with the name, phone number and relationship to the youth. Program practice is to place youth within the same age range no more than two years apart. Any youth place on suicide watch is place in a designated area until youth is seen by a counselor. All present issues, medical and mental health are listed in youth's intake.	
An alert is immediately entered into the program's alert system when a youth is admitted with special needs and risks such as risk of suicide, mental health, substance abuse, physical health or security risk factors	Compliance	A review of all five records indicated 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.	
Additional Comments: There are no additional comments for this indicator.			

3.04 - Log Books		Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 3.04	YES	
	If NO, explain here:	
	The provider has the required policy and procedure, 3.04 Log Book, that was approved by the COO July 2024.	
Log book entries that could impact the security and safety of the youth and/or program are highlighted	Compliance	A random selection of logbook entries for 12 weeks during the review period was conducted. Entries that impact the security and safety of the youth/program were highlighted throughout the log entries.
All entries are brief, legibly written in ink and include: • Date and time of the incident, event or activity • Names of youth and staff involved • Brief statement providing pertinent information • Name and signature of person making the entry	Compliance	All entries were brief, legibly written in ink and include the date and time of the event, names of youth and staff involved, brief statement providing vital information and 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.	Compliance	All overwriting and recording errors were struck through with a single line, signed by staff with initials and included dates of correction. The staff person initials and date the correction. No use of whiteout was found.
The program director or designee reviews the facility logbook(s) every week and makes a note chronologically in the logbook indicating the dates reviewed and if any correction, recommendations and follow-up are required and sign/date the entry	Compliance	The shelter supervisor reviewed log book entries weekly and document with the date which the log book was reviewed.
All staff review the logbook of the previous two shifts and makes an entry signed and dated into the logbook indicating the dates reviewed	Compliance	Each incoming staff reviewed the log book and document they have reviewed the last two shift with their signature.
At the beginning of their shift, oncoming supervisor and shelter counselor reviews the logbook of all shifts since their last log entry and makes a signed and dated entry and into log book indicating the dates reviewed.	Compliance	Incoming supervisor and shelter counselor reviewed the log book entries at the beginning of their shift and document it with a signature, indicating the dates reviewed to their last log entry.
Logbook entries include: a. Supervision and resident counts b. Visitation and home visits	Compliance	Staff documents on each shift the youth count in the shelter. All visitations are documented in the log book.
Additional Comments: There are no additional comments for this indicator.		
3.05 - Behavior Management Strategies		Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 3.05	YES	
	If NO, explain here:	
	The provider has the required policy and procedure, 3.05 Behavior Management Strategies, that was approved by the COO July 2024.	

<p>The program has a detailed written description of the BMS and it is explained during program orientation</p>	<p>Compliance</p>	<p>The agency has a process which includes providing documentation and full explanation of its Behavior Management System (BMS). The plan has a detailed written description of the BMS and it is explained to the youth during program orientation process and is in the client handbook.</p>	
<p>Behavior Management Strategies must include:</p>			
<p>a. BMS is designed to teach youth new behaviors and help youth understand the natural consequences for their actions b. Behavioral interventions are applied immediately, with certainty, and reflect the severity of the behavior c. BMS uses a wide variety of awards/incentives to encourage participation and completion of the program d. Appropriate consequences and sanctions are used by the program and consequences for behavior are logical and designed to promote skill-building for the youth e. Counseling, verbal intervention and de-escalation techniques are used prior to physical intervention (Only techniques approved by the Florida Network and DJJ are used if physical intervention is required) f. Only staff discipline youth. Group discipline is not imposed g. Room restriction is not used as part of the system or for youth who are physically and/or emotionally out of control h. Youth should never be denied basic rights such as meals, clothing, sleep, services, exercise, or correspondence privileges</p>	<p>Compliance</p>	<p>Behavior management is designed to assist youth with growth and promote positive behavior in the shelter. Behavior interventions are stated in the behavior management system. Consequences are also listed in the behavior management policy. Youth has a wide variety of incentives available and displayed to them in the common area. The three levels are Orientation 24 hours, Citizenship 48 hours, and Leadership which is the highest level. In the event a youth display any inappropriate behavior, youth will be placed on Ownership level for 24 hours. Youth will get the opportunity to regain and get back on higher levels. Only staff discipline youth and group discipline is not imposed. Room restriction is not used as part of the system or for youth who are physically and/or emotionally out of control. Youth are never be denied basic rights such as meals, clothing, sleep, services, exercise, or correspondence privileges.</p>	

Program's use of the BMS			
All staff are trained in the theory and practice of administering BMS rewards and consequences	Compliance	All staff are trained on the behavior management system during their OJT (On Job Training). Staff also gets to observe the practice while job shadowing.	
There is a protocol for providing feedback and evaluation of staff regarding their use of BMS rewards and consequences	Compliance	The residential supervisor monitors BMS and provides feedback and evaluation of staff regarding their use of BMS rewards and consequences at staff meetings.	
Supervisors are trained to monitor the use of rewards and consequences by their staff	Compliance	The program reported residential supervisor monitors behavior grading sheets to evaluate all staff regarding their use of BMS rewards and consequences.	
Additional Comments: There are no additional comments for this indicator.			
3.06 - Staffing and Youth Supervision			Limited
Provider has a written policy and procedure that meets the requirement for Indicator 3.06	YES		
	If NO, explain here:		
	The provider has the required policy and procedure, 3.06 Staffing And Youth Supervision, that was approved by the COO July 2024.		
The program maintains minimum staffing ratios as required by Florida Administrative Code and contract. • 1 staff to 6 youth during awake hours and community activities • 1 staff to 12 youth during the sleep period	Compliance	A review of staff schedules and youth census for November 2024 through April 2025 confirmed that the agency scheduled the minimum staff members required to the ratios for each work shift.	
All shifts must always provide a minimum of two direct care staff present that have met the minimum training requirements	Exception	The staff schedules reviewed for the period November 2024 through April 2025 revealed that the agency does not consistently provide a minimum of two direct care staff on each shift as required.	For the overnight shift the schedule shows one staff on duty on numerous shifts. Based on the schedule 81 shifts had only one staff scheduled.
Program staff included in staff-to-youth ratio includes only staff that are background screened and properly trained youth care workers, supervision staff, and treatment staff	Compliance	A review of the documentation confirmed all direct care workers, supervisors, and clinical staff members working in the shelter are background screened. A review of training files indicated staff were generally provided all pre-service required trainings.	
The staff schedule is provided to staff or posted in a place visible to staff	Compliance	During the tour of the facility, it was observed that the staff schedule is posted on staff YDS workstation visible to staff.	
There is a holdover or overtime rotation roster which includes the telephone numbers of staff who may be accessed when additional coverage is needed	Compliance	Staff list is posted in staff area with phone number and staff names printed.	

<p>Staff observe youth at least every 15 minutes while they are in their sleeping room, either during the sleep period or at other times, such as during illness or room restriction</p>	<p>Exception</p>	<p>Program documentation of bed checks in the logbook and video review of randomly selected bed check dates and times was conducted to assess 15-minute bed checks were completed as required. The following dates and times were reviewed: April 11th, 12am-2am; April 16th, 2am-4am; April 19th 4am-6am; April 21st, 1am-3am; and May 4th, 3am-5am. All five selected dates were reviewed and staff were observed conducting bed checks in 15 minutes increments with the exception of one date/time.</p>	<p>On November 10, 2024 staff missed bed checks from 1:00 - 1:30 A.M.</p>
<p>Additional Comments: There are no additional comments for this indicator.</p>			
<p>3.07 - Video Surveillance System</p>			<p>Satisfactory with Exception</p>
<p>Provider has a written policy and procedure that meets the requirement for Indicator 3.07</p>	<p>YES If NO, explain here: The provider has the required policy and procedure, 3.07 Video Surveillance System, that was approved by the COO July 2024.</p>		
<p>Surveillance System</p>			
<p>The agency, at a minimum, shall demonstrate: a. A written notice that is conspicuously posted on the premises for the purpose of security b. System can capture and retain video photographic images which must be stored for a minimum of 30 days c. System can record date, time, and location; maintain resolution that enables facial recognition d. Back-up capabilities consist of cameras' ability to operate during a power outage e. Have cameras placed in interior (e.g. intake office, counseling office, cafeteria, day room) and exterior (e.g. entrance/exit, recreation area, parking lot) general locations of the shelter where youth and staff congregate and where visitors enter and exit; to include locations where youth searches are conducted. Cameras are never placed in bathrooms or sleeping quarters. f. All cameras are visible</p>	<p>Exception</p>	<p>During the tour it was observed that the program has a written notice that is posted around the campus for the purpose of security. The Residential Supervisor confirmed during video review that the video surveillance system can capture and retain video photographic images. It was observed the program's video surveillance system can record date, time, and location, and maintain resolution that enables facial recognition. In addition, the back-up battery capabilities consist of cameras' ability to operate during a power outage. All 27 cameras are positioned in interior and exterior common locations of the shelter where youth and staff congregate and where visitors enter and exit, including locations where youth searches are conducted. No cameras were placed in bathrooms or dorms.</p>	<p>During the review of the surveillance camera, it showed a capacity for 28 days. COO contacted the provider and was informed they are not able to identify when the camera system issue began. The surveillance camera had a high tech recording issue which was adjusted by the tech support provider. On Wednesday, May 7th camera had 28 days of recording but as of May 8th the camera is at 29 days of recording which is still less than the 30 days minimum required.</p>
<p>A list of designated personnel who can access the video surveillance system is maintained (includes off-site capability per personnel)?</p>	<p>Compliance</p>	<p>The program maintains a list of designated management who can access the video surveillance system. In addition, the program has the capability off-site for designated management.</p>	

Supervisory review of video is conducted a minimum of once every 14 days and timeframes reviewed are noted in the logbook.	Compliance	In reviewing the logbook for supervisory review of the camera it confirmed a minimum of once every 14 days and timeframes reviewed are noted in the logbook (not counting holidays).	
The reviews assess the activities of the facility and include a review of random sample of overnight shifts	Compliance	A review of five selected dates determined the agency's protocol of the requirements of this indicator. All dates revealed the reviews assess the activities of the facility and include overnight shifts.	
Grant the requesting of video recordings to yield a result within 24-72 hours from program quality improvement visits and when an investigation is pursued after an allegation of an incident	Compliance	The agency has a policy and process for providing requested video recordings when an investigation is pursued after an allegation of an incident within 24-72 hours of request by respectful party.	
Camera service order/requests will be made within 24 hours of discovery of camera malfunctioning or being inoperable. All efforts made to obtain repairs are documented and maintained	Compliance	Management documents via email to Iron Shield Security any camera service order/requests within 24 hours of discovery of camera malfunctioning or being inoperable. All efforts made to obtain repairs are documented and maintained.	

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

Standard Four – Mental Health/Health Services

4.01 - Healthcare Admission Screening

Satisfactory

Provider has a written policy and procedure that meets the requirement for Indicator 4.01	YES	
	If NO, explain here:	
	The provider has an approved policy and procedure, 4.01 Healthcare Admission Screening, which was authorized by the COO in July 2024.	

Preliminary Healthcare Screening

Screening includes : a. Current medications b. Existing (acute and chronic) medical conditions c. Allergies d. Recent injuries or illnesses e. Presence of pain or other physical distress f. Observation for evidence of illness, injury, physical distress, difficulty moving, etc. g. Observation for presence of scars, tattoos, or other skin markings h. Acute health symptoms requiring quarantine or isolation	Compliance	The Residential Intake Screening form, reviewed across all five records, included documentation of current medications, existing acute and chronic medical conditions (One Youth), observations of scars, tattoos, or other skin markings, and any acute health symptoms requiring quarantine or isolation. None of the five youth records reviewed had any injuries to be documented.	
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Referral and Follow-Up

Youth with chronic medical conditions have a referral to ensure medical care (e.g. diabetes, pregnancy, seizure disorder, cardiac disorders, asthma, tuberculosis, hemophilia, head injuries, etc.)	Compliance	One of five youth records reviewed indicated youth having a chronic medical condition that required follow up care. The youth's asthma condition is already under the care of a physician.	
When needed, the parent is involved with the coordination and scheduling of follow-up medical appointments	Compliance	The reviewed policy outlines the process for involving parents in the coordination and scheduling of follow-up medical appointments. The Residential Manager interview confirmed the policy by describing the current practice for addressing any medical conditions presented by the youth.	
All medical referrals are documented on a daily log.	Compliance	The reviewed policy states that all medical referrals, follow-up care, and related documentation are recorded in both the logbook and the youth case file.	
The program has a thorough referral process and a mechanism for necessary follow-up medical care as required and/or needed	Compliance	The program has a comprehensive referral process in place, along with an established mechanism to ensure that necessary follow-up medical care is provided as required.	
Additional Comments: There are no additional comments for this indicator.			
4.02 - Suicide Prevention			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 4.02	YES		
	If NO, explain here:		
	The provider has the required policy and procedure, 4.02 Suicide Prevention, that was approved by the COO in July 2024.		
Suicide Risk Screening and Approval (Residential and Community Counseling)			
Suicide risk screening occurred during the initial intake and screening process. Suicide screening results reviewed and signed by the supervisor and documented in the youth's case file.	Compliance	All six youth records reviewed confirmed that a suicide risk screening was completed at the time of intake, with all questions asked and properly documented. Suicide Risk Assessments were conducted as part of the initial intake and screening process. The screening results were reviewed and signed by a supervisor and appropriately documented in each youth's case file.	
The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	Compliance	The program utilizes the Assessment of Suicide Risk tool, which has been approved by the Florida Network of Youth and Family Services.	
Supervision of Youth with Suicide Risk (Shelter Only)			
Youth are placed on the appropriate level of supervision based on the results of the suicide risk assessment.	Compliance	All three residential records reviewed indicated that youth were assigned the appropriate level of supervision based on the results of their suicide risk assessments.	

<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>Compliance</p>	<p>All applicable reviewed records demonstrated that a staff member was assigned to monitor the youth, maintained one-to-one supervision, and documented observations of the youth's behavior at intervals of 30 minutes 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>Compliance</p>	<p>The program uses a separate sight and sound supervision sheet, distinct from the daily communication log, which includes the time of day, behavioral observations, any warning signs observed, and the initials of the staff member conducting the observation. This documentation is maintained in either the observation log or the shelter's daily log.</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>Compliance</p>	<p>All applicable reviewed records indicated that the level of supervision was not modified or reduced until a further assessment was completed by a licensed professional, or by a non-licensed mental health professional under the supervision of a licensed professional, or following the initiation of a Baker Act by local law enforcement.</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>Compliance</p>	<p>All records reviewed contained evidence that supervisory staff reviewed the documentation during each shift. Completed observation logs were properly maintained in the youth's case files.</p>	

Youth with Suicide Risk (Community Counseling Only)			
<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>Compliance</p>	<p>Three community counseling records were reviewed, all of which showed that youth identified as at risk for suicide during intake were immediately assessed by a licensed professional or a non-licensed professional under the direct supervision of a licensed mental health professional. Both the parents and the supervisor were promptly notified of the assessment results.</p>	
<p>During the intake, if the appropriate staff is unavailable, youth identified for suicide risk was immediately referred by the provider and the parent/guardian is notified of the suicide risk findings disclosed and advised that an Assessment of Suicide Risk should be completed ASAP by a licensed professional.</p>	<p>Compliance</p>	<p>All applicable youth records identified as at risk for suicide were immediately referred by the provider, and the parent or guardian was notified of the findings. An Assessment of Suicide Risk was subsequently completed by a licensed professional.</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>Compliance</p>	<p>Three community counseling records were reviewed and information on resources available in the community for further assessment was provided to the parent/guardian and documented in the youth's records.</p>	
<p>If the parent/guardian cannot be contacted, all efforts to contact them are documented in the case file.</p>	<p>Compliance</p>	<p>Three community counseling records reviewed showed evidence in the notes of attempts to contact parent/guardians. All efforts to contact parent/guardians were documented in the case files.</p>	
<p>When the screening was completed during school hours on school property, the appropriate school authorities were notified.</p>	<p>No eligible items for review</p>	<p>Three community counseling records were reviewed and none of the suicide screenings were completed during school hours or on school property.</p>	
<p>Additional Comments: There are no additional comments for this indicator.</p>			

4.03 - Medications		Satisfactory with Exception	
<p>Provider has a written policy and procedure that meets the requirement for Indicator 4.03</p>		YES	
		If NO, explain here:	
		The provider has the required policy and procedure, 4.03 Medications, that was approved by the Chief Operation Officer(COO)in July 2024	
<p>The agency has a Registered Nurse (RN) and/or a Licensed Practical Nurse (LPN) that is being supervised by RN and all of their credentials have been verified.</p>	Compliance	<p>This program location does not currently have a nurse on staff; however, access to a nurse from another program location is available to assist with training needs as required.</p>	
<p>The agency has evidence of the following for all non-nursing shelter staff designated to assist with the self-administration of medication:</p> <p>a. Documentation of in-person self-administration of medication distribution training provided by a Registered Nurse</p> <p>b. Evidence demonstrating their competency to assist with self-administration of medication distribution</p> <p>c. Maintenance of their annual medication training re-certification</p>	Compliance	<p>Staff training records for all non-nursing staff designated to assist with the self-administration of medication were reviewed. Documentation included in-person training on self-administration of medication distribution provided by a registered nurse, staff competency in assisting with medication distribution, and proof of annual medication training re-certification, all of which were available for review by the Residential Supervisor.</p>	
<p>The agency held at least quarterly staff meetings conducted by RN and/or Shelter Manager to review and assess:</p> <p>a. strategies implemented to reduce medication errors shelter wide</p> <p>b. analyze factors that contributed to medication errors</p> <p>c. allow staff the opportunity to practice and role-play solutions</p>	Compliance	<p>Monthly staff meetings were conducted by the RN and/or Shelter Manager to review and assess strategies aimed at reducing medication errors across the shelter, analyze factors contributing to medication errors, and provide staff with the opportunity to practice and role-play potential solutions. Sign-in sheets for these monthly meetings were reviewed.</p>	
<p>The agency has strategies implemented to ensure medications are provided within the 2-hour time frame.</p>	Compliance	<p>Upon reviewing the program process and conducting an interview with the Residential Supervisor, it was confirmed that staff use alarms on their phones for all medication times to ensure that medications are administered within the 2-hour window.</p>	
<p>All non-licensed staff members are clearly identified and designated on the staff schedule and shift change report/shift responsibility form for assisting with the self-administration of medications on each shift</p>	Compliance	<p>The monthly staff schedule clearly identified staff responsible for medication distribution.</p>	
<p>The agency has clear methods of communicating which youth are on medications with the times and dosage easily discernable by all staff on each shift.</p>	Compliance	<p>The agency has a census board in the staff office which documents specific medications with times and dosage each youth are on medication, if applicable.</p>	

<p>The delivery process of medications is consistent with the FNYFS Medication Management and Distribution Policy and the agency has an internal quality assurance process to include the following:</p> <ul style="list-style-type: none"> 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>Compliance</p>	<p>Reviewer observed video footage review of medication pass. Interview with the Residential Supervisor validated the medication delivery process is consistent with the FNYFS medication management and distribution policy. The program utilizes staff meetings and shift change briefings to disseminate any changes or reminders needed on the medication process.</p>	
<p>Admission/Intake of Youth</p>			
<ul style="list-style-type: none"> a. Upon admission, the youth and parent/guardian (if available) were interviewed by the Registered Nurse (when on-site) about the youth's current medications as part of the Medical and Mental Health Assessment screening process and/or an interview was conducted by the RN within three (3) business days if the RN was not on the premise at admission. <i>*If the agency does not have an RN, there was a medication review conducted by an LPN or certified Leadership position.</i> b. Upon intake/admission, there is evidence that the on-shift certified supervisor of higher level staff did review all medication forms by the next business day. 	<p>Compliance</p>	<p>The program does not currently have a registered nurse; however, they utilize a form titled Nurse Review of the Healthcare Admission Screening, which is reviewed by one of the program supervisors within the three-day window. Additionally, medication forms are reviewed by the Residential Supervisor by the next business day.</p>	

Medication Storage			
<p>a. All medications are stored in a Pyxis ES Medication Cabinet that is inaccessible to youth (when unaccompanied by authorized staff)</p> <p>b. Pyxis machine is stored in accordance with guidelines in FS 499.0121 and policy section in Medication Management</p> <p>c. Oral medications are stored separately from injectable epi-pen and topical medications</p> <p>d. Medications requiring refrigeration are stored in a secure refrigerator that is used only for this purpose, at temperature range 2-8 degrees C or 36-46 degrees F. (If the refrigerator is not secure, the room is secure and inaccessible to youth.)</p> <p>e. Narcotics and controlled medications are stored in the Pyxis ES Station</p> <p>f. Pyxis keys with the following labels are accessible to staff in the event they need to access medications if there is a Pyxis malfunction: a TOP COVER b BACK PANEL-LEFT TALL CABINET LOCK- LEFT, c BACK PANEL-RIGHT TALL CABINET LOCK- RIGHT</p>	<p>Compliance</p>	<p>The agency stores all medications in the Pyxis medication cabinet, which is kept behind a locked door in the staff office. At the time of the review, the program did not have any topical or epinephrine (epi-pen) medications; however, their policy and practice require these to be stored in a separate section of the Pyxis. The program also maintains a locked medication refrigerator in the same room, which was checked and found to be in compliance with the correct temperature range. At the time of the review, there were no medications requiring refrigeration. The keys to the Pyxis are labeled and securely stored in the supervisor's office.</p>	
Medication Distribution			
<p>a. Agency maintains a minimum of 2 site-specific System Managers for the Pyxis ES Station</p> <p>b. Only designated staff delineated in User Permissions have access to secured medications, with limited access to controlled substances (narcotics)</p> <p>c. A Medication Distribution Log shall be used for distribution of medication by non-licensed and licensed staff</p> <p>d. Agency verifies medication using one of three methods listed in the FNYFS Policies & Procedures Manual</p> <p>e. When nurse is on duty, medication processes are ALWAYS conducted by the nurse or when the nurse is not onsite, then the designated staff who has been trained by a licensed Registered Nurse provides the medication.</p> <p>f. Agency does not accept youth currently prescribed injectable medications, except for epi-pens</p> <p>h. Non-licensed staff have received training in the use of epinephrine auto-injectors provided by a registered nurse</p>	<p>Compliance</p>	<p>The program maintains a minimum of two site-specific System Managers for the Pyxis ES Station. A list of trained staff is kept in a binder and corresponds with those authorized to access the Pyxis. Only designated staff with appropriate user permissions are granted access to secured medications, with restricted access to controlled substances (narcotics). A Medication Distribution Log is utilized for the distribution of medications by both licensed and non-licensed staff. The agency does not currently have a nurse and they do not accept youth with injectable medications except for epi-pens.</p>	

<p>The medication distribution log documentation includes: a. the time of medication administration b. evidence of youth initials that the dosage was given <input type="checkbox"/> c. evidence of staff initials that the dosage was given <input type="checkbox"/></p>	<p>Compliance</p>	<p>A review of the medication distribution log for the applicable youth on medication showed the time of medication administration, along with evidence of the youth's initials confirming the dosage was received, and staff initials verifying that the dosage was administered.</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>Compliance</p>	<p>Medication distribution log for one open and two closed records reviewed showed compliance with the required timeframes for medication distribution.</p>	
<p>During the review period, there were no instances where youth missed their medication due to failure to open the pyxis machine.</p>	<p>Compliance</p>	<p>During the review period there were no instances where the pyxis machine failed to open.</p>	
<p>If applicable: Any staff member deemed responsible for a medication error, there was evidence that the staff member received refresher training from an RN and demonstrated competency prior to being assigned future medication administration responsibilities. There is evidence that any staff member deemed responsible for 3 errors within a 1-year time frame, had their certification suspended and was not recertified until the completion of the full in-person medication administration training, demonstrating competency and re-certification from an RN.</p>	<p>Compliance</p>	<p>Program had one staff responsible for a medication error. The staff was provided refresher training on March 25, 2025. There were no staff responsible for 3 errors within 1 year timeframe.</p>	
<p>Medication Inventory</p>			
<p>a. For controlled substances, a perpetual inventory with running balances is maintained as well as a shift-to shift count verified by a witness and documented b. Over-the-counter medications that are accessed regularly and inventoried weekly c. Syringes and sharps (needles, scissors, etc.) are secured, and counted and documented weekly</p>	<p>Compliance</p>	<p>Documentation reviewed indicated a perpetual count that is completed by staff on each shift to document the running balances of the medication and shift-to-shift counts verified by a witness. Over the counter medications are inventoried on a weekly basis. The program does not use syringes or medical sharps.</p>	

There are monthly reviews of the Pyxis reports to monitor medication management practice.	Exception	The program supervisor was interviewed about the practice of running and reviewing Pyxis reports monthly to monitor medication management practice. The COO provided Pyxis reports that were run for February-April 2025; however, they were all generated with a stamped date of 5/8/2025 post review, and therefore not accepted as real time monthly reports.	No documentation of monthly Pyxis reports were provided to establish on ongoing practice of medication management.
Medication discrepancies are cleared after each shift.	Compliance	The program provided documentation of shift meeting notes of shift to shift clearance of medication discrepancies.	
Additional Comments: There are no additional comments for this indicator.			
4.04 - Medical/Mental Health Alert Process			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 4.04	YES		
	If NO, explain here:		
	The provider has the required policy and procedure, 4.04 Medical / Mental Health, that was approved by the Chief Operation Officer (COO) on July 2024		
Youth with a medical, mental health, or food allergy was appropriately placed on the program's alert system	Compliance	Documentation reviewed showed evidence of alerts being documented for each youth that is maintained in the youth's electronic record. The program utilizes an alert board for active youth.	
Alert system includes precautions concerning prescribed medications, medical/mental health conditions	Compliance	The alert system uses color codes which are notated on the second page of the Residential Intake Form. There are specific alerts for medications and medical/mental health conditions.	
Staff are provided sufficient training, information and instructions to recognize/respond to the need for emergency care for medical/mental health problems	Compliance	Program provides staff sufficient training, information and instructions to recognize/respond to the need for emergency care for medical/mental health problems, during the orientation.	
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	The program notes any alerts on the Residential Intake Form and the file utilizing a color coding system. Documentation reviewed indicated alerts are 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.	
Additional Comments: There are no additional comments for this indicator.			

4.05 - Episodic/Emergency Care		Satisfactory with Exception	
Provider has a written policy and procedure that meets the requirement for Indicator 4.05	YES		
	If NO, explain here:		
	The provider has the required policy and procedure, 4.05 Episodic / Emergency Care, that was approved by the Chief Operation Officer(COO) on July 2024.		
Off Site Emergency Care			
a. If off-site emergency medical or dental care was provided, an incident report was submitted for the medical or dental care b. Upon youth return, there is a verification receipt of medical clearance via discharge instructions with follow-up is present in file c. Youth's parent/guardian was notified d. A daily log is maintained for emergency care provided	Exception	The program does not utilize an Episodic Emergency Care Log For Off-Site Emergencies; however, every episodic/emergency is documented in the youths personal file. Three of three records reviewed, indicated youth were taken off-site for a medical emergency. Upon return of the youth, verification of medical clearance via discharge instructions with follow-up was present in the youth records only for two youth. The youth parent / guardian were notified.	Program was unable to provide documentation of clearance via discharge instruction for one youth who was transported off-site for emergency medical care.
All staff are trained on emergency medical procedures	Compliance	All staff records reviewed reflects staff have been trained on emergency medical procedures.	
The program has a Knife-for-life and wire cutters accessible to staff in a secure location(s)	Compliance	The program maintains the Knife-for-Life and wire cutters in a case inside the office located near the common area.	
Additional Comments: There are no additional comments for this indicator.			