



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



Lutheran Services Florida NW – Currie House

4610 Fairfield Drive Pensacola, FL 32506

March 5-6, 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 Lutheran Services Florida NW Currie House (LSF NW Currie House) for the FY 2024-2025 at its program office located at 4610 Fairfield Drive Pensacola, FL 32506. Forefront LLC (Forefront) is an independent compliance monitoring firm that is contracted by the FNYFS to perform onsite program reviews to assess the agency's adherence to fiscal, programmatic and overall contract requirements. LSF NW Currie House 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 Keith Carr, Consultant for Forefront LLC. Agency representatives from LSF NW Currie House present for the entrance interview were Jamilyn Newton, Regional Director, and LSF NW Currie House Residential, Clinical, Community Counseling and Administrative staff members. The last onsite QI visit was conducted on March 20-21, 2024.

In general, the Reviewer found that LSF Currie House is in compliance with specific contract requirements. LSF NW Currie House **received an overall compliance rating of 100% for achieving full compliance with 11 of the 12 applicable compliance indicators** of the CINS/FINS Monitoring Tool. There was one corrective action item cited as a result of the monitoring visit.

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

2024-2025 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 3-5-6-2024-2025

Agency Name: Lutheran Services Florida (Currie House)					Monitor Name: Keith Carr, Lead Reviewer		
Contract Type: CINS/FINS					Region/Office: 4610 W. Fairfield Dr., Pensacola FL		
Service Description: Comprehensive Onsite Compliance Monitoring					Site Visit Date(s): March 5-6, 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"/>	Interview/Documentation: The program currently does not have two staff members certified as DJJ QI Peer reviewers for this location that covers the LSF NW Currie House programs: One staff person Christina Baker, is currently assigned and scheduled to participate in all peer reviews for this site this fiscal year until additional staff can attend future QI Peer Review certification training. The agency has requested to be notified when the next Quality Improvement (QI) Peer Reviewer training is announced.	Recommendation 1): The agency must register and have a minimum of two qualified staff members complete new QI Peer Reviewer training. Contact the FNYFS training department to submit this request and provide proof of submitting this request to Forefront once completed.
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 type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Documentation: A list of additional grant contracts for FY 2024-2025 was provided by the Agency. The list includes fund identification number, program name, funding source name, contract period start and end dates and contract amount. Further the agency has numerous grants providing various services including SAMH, Head Start, Food Programs, Case Management, Emergency Shelter, Immigration-	No Recommendation or Corrective Action.

2024-2025 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
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						Refugee Services, Guardianship and others.	
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 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	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Documentation: The provider has a policy with Market Global Reinsurance Company for General Liability insurance with limits of coverage of \$1,000,000 each/\$3,000,000 aggregate and \$10,000 each for medical expenses. Additional policies with this carrier include Professional Liability insurance provides limits of coverage of \$1,000,000 each/\$3,000,000 aggregate and Abuse/Molestation insurance provides limits of coverage of \$1,000,000 each/\$3,000,000 aggregate. The provider has a policy with Florida Insurance Trust for Automobile insurance that provides limits of coverage of \$1,000,000 combined for each accident. The provider has a policy with Century Surety Company for Excess/Umbrella Liability insurance which provides limits of coverage of \$1,000,000 ach/aggregate.	No Recommendation or Corrective Action.

2024-2025 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
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						Coverage for the above policies is in effect for the current FY 6/01/2024-6/01/2025. The certificate does list the Florida Network on the consolidate certificate of liability as a certificate holder.	
External/Outside Contract Compliance a. Provider has corrective action item(s) cited by an external funding source (Fiscal or Non-Fiscal). ON SITE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Documentation/Interview: N/A – Regional Director indicated that there are no outstanding corrective action item(s) cited by an external funding source.	Not Applicable.
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: The provider has existing policies which address general accounting practices which are maintained by the Chief Financial Officer for the agency. Fiscal policies and procedures are contained in the agency’s Financial Services Policy and Procedures Manual. The procedures appear to be consistent with GAAP and provide for limited internal controls. Provider provided 45 policies which include procedures for general ledger, cost accounting, payroll, petty cash, computer backup, and other relevant financial processes.	No Recommendation or Corrective Action.

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b. Agency maintains a general ledger and the corresponding source documents. A general ledger must be set up to track the activity of the grant separately (standard account numbers / separate funds for each revenue source, etc.). PTV	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Documentation: Detailed General Ledger for the current FY2024-2025 for July 2024 – February 2025. Provider maintains a detailed general ledger that includes breakdown of GL code, GL title, effective date, Doc number, ID number, Name of funding source, transaction description, fund code, year code, program code, location code, and debit and credit columns. Ledgers included current balances and differences.	No Recommendation or Corrective Action.
c. Petty cash ledger system is balanced and all cash disbursements are compliant with financial policies and allowable under the contract. (Disbursements/invoices are approved & monitored by management.) – ON SITE	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Observation/Documentation: The agency utilizes a system of managing petty cash. The agency has not implemented any revisions to the existing petty cash system since the last onsite program review. Petty cash is stored in a secure locked location and must be verified and approved monthly by management. At the time of this program review, the agency's Residential Supervisor is responsible for the petty cash. The agency's Regional Director is the only other staff member with access to petty cash. The petty cash on hand, checks, and receipts were	No Recommendation or Corrective Action.

2024-2025 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL

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						reconciled on day two during the onsite program review and was verified to be consistent with March 2025 cash reconciliation documentation onsite.	
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: Reviewed Bank Statements and Bank Reconciliations for months August 2024-January 2025 for one account with Ameris Bank. Bank reconciliations are conducted each month for the activities and bank statements for the preceding month and are reviewed by two parties. Invoices are submitted on a monthly basis with supporting Documentation.	No Recommendation or Corrective Action.
e. Agency maintains inventory in accordance with a written policy and FNYFS contractual requirements. If over \$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"/>	Documentation/Interview: N/A – The agency has not purchased any items with FNYFS funds since the last time on-site.	Not Applicable.
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"/>	Documentation: Provider submitted evidence of payroll taxes and deposits for third and fourth quarters for calendar year 2024. A formal list of agency bank deposits	No Recommendation or Corrective Action.

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						report showed being deposited via electronic funds transfer or check payments.	
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: Agency provided a detailed CINS/ FINS Budget Report which included months including March 2024 through August 2024. The report tracks all budget categories by current period actual and current period contract separately. Variances if applicable are identified.	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: Financial audit included consolidate statement of the agency's financial position for the period June 20, 2024, and 2023. The financial audit work was conducted and reported by RSM US LLP. A letter dated February 18, 2025, also stated no corrective action was needed. A copy was submitted directly to the Florida Network of Youth and Family Services.	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"/>	Documentation: The agency maintains a procedure manual with several sections (Information Technology, Risk Prevention and Management) to address security and privacy of employee and client data. The agency provided 7 Policies and Procedures for review including: Confidentiality of	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: The agency provided documented evidence of staff members' hourly pay rate being a minimum of \$19.	No Recommendation or Corrective Action.

2024-2025 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
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CONCLUSION

Lutheran Services Florida NW Currie House has met the requirements for the CINS/FINS contract as a result of full compliance with 12 applicable indicators of the Administrative and Fiscal Contract Monitoring Tool. Two of fourteen indicators were not applicable because 1) the provider does not have any outstanding corrective action item(s) cited by an external funding source, and 2) does not have any current inventory purchased with DJJ/FN Funds. Consequently, **the overall compliance rate for this contract monitoring visit is 100%**. One corrective action item is cited as a result of the contract monitoring visit. Overall, the provider is performing satisfactorily in meeting the fiscal and administrative terms of its contract. In addition, the majority of indicators reviewed were carried out in a manner which meets the standard described in the report findings.

SUMMARY OF CORRECTIVE ACTIONS or RECOMMENDATIONS

Recommendation (1):

When future New QI Peer Reviewer training dates are made available, the agency must register and have a minimum of two qualified staff members complete this required training. Contact the FNYFS training department to submit this request and provide proof of submitting this request and being placed on the New Peer Reviewer Training waitlist to Forefront once completed.

If required, the agency 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 Forefront within fourteen (14) working days of receipt of this report (See Forefront File Invite OBCAP link). The Forefront Reviewer 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(s) to address the item(s) cited in the report. If the corrective action is successful in resolving the items cited in the report the Forefront Reviewer will notify the agency in writing that the desired resolution has been achieved. Your agency will receive an automated link to address the corrective action item cited in this report for your agency to address via an online platform.



Florida Network of Youth and Family Services Quality Improvement Program Report

Lutheran Services Florida NW - Currie House
CINS/FINS Program

March 5-6, 2025

Compliance Monitoring Services Provided by



CINS/FINS Rating Profile

Standard 1: Management Accountability

1.01 Background Screening of Employees/Volunteers	Satisfactory
1.02 Provision of an Abuse Free Environment	Satisfactory
1.03 Incident Reporting	Satisfactory
1.04 Training Requirements	Limited
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	Satisfactory
2.09 Stop Now and Plan (SNAP)	Satisfactory

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

Standard 3: Shelter Care & Special Populations

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

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

Rating Definitions

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

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

Reviewers

Members

Keith Carr - Lead Reviewer Consultant-Forefront LLC/Florida Network of Youth and Family Services
 Kayshala K.Patterson, M.S., Operations Coordinator – Regional Monitor, Department of Juvenile Justice
 Naret Morales, Clinical Director, LMHC, Anchorage Children's Home of Bay County
 Laura Moneyham, QI & Compliance Manager, Florida Network of Youth and Family Services
 Regina Flowers, M.ED, Residential Program Director, CCYS

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 type="checkbox"/> Case Manager	<input type="checkbox"/> Nurse – Full time
<input type="checkbox"/> Chief Financial Officer	<input checked="" type="checkbox"/> Counselor Non-Licensed	<input checked="" type="checkbox"/> Nurse – Part time
<input type="checkbox"/> Chief Operating Officer	<input type="checkbox"/> Advocate	<input type="checkbox"/> # Case Managers
<input checked="" type="checkbox"/> Executive Director	<input checked="" type="checkbox"/> Direct – Care Full time	<input type="checkbox"/> 3 # Program Supervisors
<input type="checkbox"/> Program Director	<input type="checkbox"/> Direct – Part time	<input type="checkbox"/> # Food Service Personnel
<input type="checkbox"/> Program Manager	<input type="checkbox"/> Direct – Care On-Call	<input type="checkbox"/> 1 # 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 (listed Outreach and Maintenance staff)
<input type="checkbox"/> Counselor Licensed	<input type="checkbox"/> Human Resources	

Documents Reviewed

<input checked="" 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 checked="" type="checkbox"/> Fire Prevention Plan	<input checked="" type="checkbox"/> Youth Handbook
<input checked="" type="checkbox"/> CCC Reports	<input checked="" type="checkbox"/> Grievance Process/Records	<input type="checkbox"/> 6 # Health Records
<input checked="" type="checkbox"/> Logbooks	<input checked="" type="checkbox"/> Key Control Log	<input type="checkbox"/> 5 # MH/SA Records
<input checked="" type="checkbox"/> Continuity of Operation Plan	<input checked="" type="checkbox"/> Fire Drill Log	<input type="checkbox"/> # Personnel /Volunteer Records
<input checked="" type="checkbox"/> Contract Monitoring Reports	<input checked="" type="checkbox"/> Medical and Mental Health Alerts	<input type="checkbox"/> 9 # Training Records
<input checked="" type="checkbox"/> Contract Scope of Services	<input checked="" type="checkbox"/> Precautionary Observation Logs	<input type="checkbox"/> 13 # Youth Records (Closed)
<input checked="" type="checkbox"/> Egress Plans	<input checked="" type="checkbox"/> Program Schedules	<input type="checkbox"/> 5 # Youth Records (Open)
<input checked="" type="checkbox"/> Fire Inspection Report	<input checked="" type="checkbox"/> List of Supplemental Contracts	<input type="checkbox"/> # Other: ____
<input type="checkbox"/> Exposure Control Plan	<input checked="" type="checkbox"/> Vehicle Inspection Reports	

Observations During Review

<input type="checkbox"/> Intake	<input checked="" type="checkbox"/> Posting of Abuse Hotline	<input checked="" type="checkbox"/> Staff Supervision of Youth
<input checked="" type="checkbox"/> Program Activities	<input 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 checked="" type="checkbox"/> Meals
<input checked="" type="checkbox"/> Social Skill Modeling by Staff	<input checked="" type="checkbox"/> Youth Movement and Counts	<input checked="" type="checkbox"/> Signage that all youth welcome
<input checked="" type="checkbox"/> Medication Administration	<input checked="" type="checkbox"/> Staff Interactions with Youth	<input checked="" type="checkbox"/> Census Board

Surveys

<input type="checkbox"/> 8 # of Youth	<input type="checkbox"/> 16 # of Direct Staff	<input type="checkbox"/> # of Other	<input type="checkbox"/>
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March 5-6, 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

Lutheran Services Florida Inc. (LSF) operates six crisis shelters in the State of Florida that are contracted with Florida Network of Youth & Family Services, Inc. The Currie House and community counseling programs primarily provides service in Escambia, Santa Rosa, Walton and Okaloosa Counties (2 sites-Pensacola and Crestview). The shelter is licensed for 12 beds and offers 24-hour availability, youth supervision, food and clothing, life skills education, crisis counseling, individual and family counseling, recreation and leisure activities, and case management services. Educational services are provided by the local school district, in the county in which the shelter is located. The Community Counseling services team for CINS/FINS also serves youth and families in the aforementioned counties and coordinate the delivery of community services to families and children in care. Funding through CINS/FINS allows the agency to serve both male and female youth up to seventeen years old that are locked out, runaway, ungovernable and/or truant, homeless, abuse, neglected, or at-risk. The agency also provides specialized services to youth who meet the criteria for Staff Secure shelter, Domestic Minor Sex Trafficking, and youth referred by the Juvenile Justice Court System for domestic violence, probation respite, and limited Intensive Case Management (ICM) cases. LSF-NW is currently accredited by the Council of Accreditation (COA) and was recently re-accredited through February 28, 2026.

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

Standard 1: There are seven indicators for Standard 1.

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

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

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

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

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

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

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

Standard 2: There are nine indicators for Standard 2.

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

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

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

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

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

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

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

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

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

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Standard 3: There are seven indicators for Standard 3.

Indicator 3.01 Shelter Environment was rated **Limited**.

Indicator 3.02 Program Orientation was rated **Satisfactory**.

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

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

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

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

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

Standard 4: There are five indicators for Standard 4.

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

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

Indicator 4.03 Medications was rated **Satisfactory**.

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

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

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

Standard 1: There are seven indicators for Standard 1.

Indicator 1.04 Training Requirements was rated Limited. One of the counselor files did not include evidence of completion for the DOJ Civil Rights & Federal Funds training. One YCS staff did not complete Adolescent Development training, and one YCS staff did not complete MAB training. The Shelter Manager reported that the staff member would be scheduled for MAB training within the month. Four of four YCS files were missing child Abuse Recognition, Reporting and Prevention, three of four were missing Human Trafficking Intervention, three of four were missing Information Security, one of four was missing PREA Parts I & II, and Sexual Harassment training. One of four was missing Suicide Prevention, and two of four were missing Fire Safety Equipment. None of the four YCS files reviewed contained a training log that tracks the cumulative number of training hours completed after the first year of employment. At the time of this review, the agency did not have a designated staff member responsible for managing all employees' individual training files, complete routine tracking and review of staff files to ensure compliance.

Standard 3: There are seven indicators for Standard 3.

Indicator 3.01 Shelter Environment was rated Limited. One of the two lights were completely out. Room two was missing a curtain rod. There was a magnet boken off the back of the door and a couple broken blinds. The blinds are getting replaced in the bedrooms along with with door handles. In room five the wall is getting repaired due to a youth punching a hole in the wall. In bedroom number one the magnet that holds the door open is hanging from the wall. It appears to be in the works of being repaired. Waiting on the plature to dry. There were missing signatures for the weekly count of the inventory. The only dates that had signatures at the top were 9/14/2024,9/21/2024, 9/28/2024,10/05/2024, 10/12/2024 and 10/19/2024. The perpetual inventory only shows the use of tide pods being used on a consistent basis. There are other items being used to clean but they are not getting logged on the perpetual inventory sheet.

CINS/FINS QUALITY IMPROVEMENT TOOL			
Quality Improvement Indicators and Results: Please select the appropriate outcome for each indicator for each item within the indicator.		Summary/Narrative Findings: The narrative write-up is a thorough summary of each assigned QI indicator, explaining how finding(s) are determined.	
		Deficiencies/Exceptions: Please add additional detailed explanations for any items that have any deficiencies or exceptions.	
Standard One – Management Accountability			
1.01: Background Screening of Employees, Contractors and Volunteers			Satisfactory with Exception
Provider has a written policy and procedure that meets the requirement for Indicator 1.01	YES		
	If NO, explain here:		
	The agency has a policy titled 1.01- Background Screening of Employees and Volunteers that was reviewed by the Regional Director on July 31, 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.	Exception	The agency utilized the Predictive Index (PI) or screening all possible candidates prior to hire until 12/31/2024. Twelve new hire staff members files were reviewed. Eight were applicable for successful completion of the pre-employment suitability assessment. Six staff members successfully passed the pre-employment suitability assessment prior to an offer of employment.	The remaining two staff members were offered employment prior to completing the pre-employment suitability assessment.
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	The agency reported they did not have any applicants that were hired that did not pass the suitability assessment on the first attempt. During an interview with the Regional Director, it was explained that any staff members who do not pass the suitability assessment on the first attempt are not considered for employment.	
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	The agency did not have any employees with a break in service during this review period.	
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>	Exception	Twelve new hire files were reviewed. Eleven staff members completed background screening prior to hire/start date.	The remaining staff did not complete background screening prior to hire/start date.
Five-year re-screening is completed every 5 years from the date of the last screening for all applicable employees and volunteers.	Exception	Four staff members were eligible for five-year rescreening. The five-year rescreening's were completed every five years based upon the Clearinghouse Prints Expiration Date for three staff.	The remaining staff member's five year rescreening was completed 47 days late.

Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?	Exception	The agency provided a copy of the Annual Affidavit of Compliance to the reviewer to determine if the document was submitted within the required timeframe.	The Affidavit of Annual Compliance with Level 2 Screening Standard was not completed by January 31st. Specifically, it was completed and sent to Blackground Screening Unit (BSU) on February 24, 2025.
Proof of E-Verify for all new employees obtained from the Department of Homeland Security	Compliance	Fourteen files contained evidence the E-Verify was verified from the Department of Homeland Security.	
Additional Comments: There are no additional comments for this indicator.			
1.02: Provision of an Abuse Free Environment			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 1.02	YES		
	If NO, explain here:		
	The agency has a policy titled 1.02- Provision of an Abuse Free Environment that was reviewed by the Regional Director on 07/31/2024.		
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 is outlined in the Lutheran Services Florida Personnel Policies and Procedures Manual, Section 1.0-Statements of Mission and Philosophy. Employees sign forms acknowledging they will comply with the expectations. The signed forms are located in the employee's personnel file.	

The agency has a process in place for reporting and documenting child abuse hotline calls.	Compliance	Staff members are trained to report allegations of child abuse or suspected abuse to the Florida Abuse Hotline. Abuse reports are documented in the electronic logbook and client files. A review of the documentation provided by the agency indicated there have been a total of five abuse reports in the past six months.	
Youth were informed of the Abuse and Contact Number	Compliance	The Florida Abuse Hotline contact number was observed as posted throughout the facility.	
Grievance			
The program(s) have an accessible and responsive grievance process for youth to provide feedback and address complaints. Program director/ supervisor has access to and can manage grievances unless it is towards themselves.	Compliance	The agency has a policy and procedures for the grievance process. The program's grievance process includes an informal, supervisor, and program director phase.	
<u>Shelter only:</u> Grievances are maintained on file at minimum for 1 year.	Compliance	Grievances are maintained as required. Additionally, the agency provided grievance documentation for the six month review period.	
<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.	Compliance	The secure grievance box and blank forms were observed in the common/living area of the shelter. The grievance box and forms are accessible to youth and the grievance procedures are posted for client view.	
<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.	Compliance	A review of the past six months documentation from the electronic logbook indicated notations of some checks for grievances being documented during the required timeframe (as allowed per policy and the indicator).	
<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.	Compliance	The program had three grievances during the annual compliance review period. A review of the three grievances revealed they were resolved within the required timeframes and signed/dated accordingly by the youth and staff.	
Additional Comments: There are no additional comments for this indicator.			

1.03: Incident Reporting		Satisfactory	
Provider has a written policy and procedure that meets the requirement for Indicator 1.03		YES	
		If NO, explain here:	
		The agency has a policy titled 1.03- Incident Reporting/Risk Management that was reviewed by the Regional Director on 07/31/2024.	
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	The agency had a total of twelve incidents reported to the Central Communications Center (CCC) during the annual compliance review period. Five of the twelve incidents were reviewed. All five of the incidents were reported within two hours and documented in the program logbook.	
The program completes follow-up communication tasks/special instructions as required by the CCC	Compliance	The program provided documentation of electronic communications with the CCC as it relates to follow-up communication and tasks/special instructions.	
Agency internal incidents are documented on incident reporting forms and all CCC reportable incidents were consistently reported to CCC as required.	Compliance	Incidents were documented on the Contract Provider Incident Report Form and were consistently reported to the CCC.	
Incidents are documented in the program logs and on incident reporting forms	Compliance	A review of the agency's electronic logbooks indicated incidents were documented. Additionally, incidents were documented via the agency's Contract Provider Incident Report Forms.	
All incident reports are reviewed and signed by program supervisors/ directors	Compliance	For the annual compliance review period, the agency had eight program disruption incidents; one medical incident; one mental health and substance abuse incident; two complaints against staff. All incident reports observed were signed by the supervisor/director.	
Additional Comments: There are no additional comments for this indicator.			
1.04: Training Requirements (<i>Staff receives training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions</i>)		Limited	
Provider has a written policy and procedure that meets the requirement for Indicator 1.04		YES	
		If NO, explain here:	
		Policy #1.04 Training Requirements reviewed and signed 7/31/2024 by the Regional Director.	

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>Compliance</p>	<p>Three training files for YCS staff hired since the last review date were reviewed. All three staff completed the following minimum pre-service training in orientation, prior to working independently with youth:</p> <ul style="list-style-type: none"> • Agency policies and procedures • Behavior Management • 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 <p>The Shelter Manager reported that only she and the Regional Director review the video surveillance equipment, so that is NA.</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>Exception</p>	<p>Three YCS and two Counselor new hire files were reviewed. All except one counselor staff received the DOJ Civil Rights training within 30 days of hire.</p>	<p>One of the counselor files did not include evidence of completion for the DOJ Civil Rights & Federal Funds training.</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 five newly hired staff are within their first year of employment have either exceeded the 80 hour minimum requirement or have time remaining within their first year of employment to complete it.</p>	
<p>All staff receives all mandatory training during the first 90 days of employment from date of hire.</p>	<p>Exception</p>	<p>Three YCS staff members and two counselor new hire training files were reviewed. For the YCS staff, one of three completed all mandatory training and two of three were missing one training each.</p>	<p>One YCS staff member did not complete Adolescent Development training and one YCS staff did not complete MAB training. The Shelter Manager reported that the staff member would be scheduled for Managing Aggressive Behavior (MAB) training within the month. One counselor staff did not complete Sexual Harassment training and a second counselor did not complete CCC Incident reporting or Cultural Humility.</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	Three training files for YCS staff hired since the last review date were reviewed. All three staff completed the Medication Administration training provided by the RN and were certified as competent.	
Staff that are Utilizing NETMIS			
Any staff that is utilizing NETMIS has evidence of completing NetMIS Training in their training file.	Exception	Two Counselor new hire files were reviewed and one of two completed the NetMIS training.	One counselor did not complete the NetMIS training.
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>	Compliance	Two Counselor new hire files were reviewed and both completed the FS 984 training within the required timeframe.	
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 eligible files for the period under 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.	Exception	Four YCS staff files were reviewed. One of four completed Human Trafficking Intervention and Information Security. Three of four completed PREA Parts I & II and Sexual Harassment training. Three of four completed Suicide Prevention and two of four completed Fire Safety Equipment.	Four of four YCS files were missing child Abuse Recognition, Reporting and Prevention, three of four were missing Human Trafficking Intervention, three of four were missing Information Security, one of four was missing PREA Parts I & II and Sexual Harassment training. One of four was missing Suicide Prevention and two of four were missing Fire Safety Equipment.

Community Counseling Direct Care staff completes 24 hours of mandatory refresher Florida Network, SkillPro, and job-related training annually.	Not Applicable	No annual Community counselor files were reviewed.	
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>).	Exception	Four YCS files were reviewed.	None of the four YCS files reviewed contained a contained a training log that tracks the cumulative number of training hours completed after the first year of employment.
Required Training Documentation			
The agency has a training plan that includes all of the required training topics including the pre-service and in-service.	Exception	Applicable to the file sample reviewed.	None of the four YCS files reviewed contained a contained a training log that tracks the cumulative number of training hours completed after the first year of employment.
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.	Exception	No one was designated to track reviews.	At the time of this review, the agency did not have a designated staff member responsible to manage all employee's individual training files, complete routine tracking and review of staff files to ensure compliance.
The program maintains an individual training file or employee file AND a FLN Training Log (or similar document that includes all requirements) for each staff, which includes an annual employee training hours tracking form and related documentation, such as electronic record/transcript, training certificates, sign-in sheets, and agendas for each training attended.	Exception	Applicable to the file sample reviewed.	None of the four YCS files reviewed contained a training log that tracks the cumulative number of training hours completed after the first year of employment.
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:		Three of the five newly hired staff have completed Naloxone Training and the remaining two staff have June 30, 2025 to complete the training. Four of the four annual staff files reviewed indicate that all four have completed the Naloxone training.	
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 agency has a policy called 1.05 Analyzing and Reporting. The policy contains provisions to address all the requirements of the indicator. The policy was reviewed and approved by the Regional Director on August 1, 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	A review of the agency's quarterly client case record review practice was conducted. The Currie House and Hope House Quality Assurance File review charts for September 2024 were reviewed. Additionally, case file review documents covering cases in October 2024 through January 2025 were also provided to be assessed by the monitor.
The program conducts reviews of incidents, accidents, and grievances quarterly, at a minimum	Compliance	The agency utilizes the Cycle Quality Improvement (CQI) monthly reports to keep track of incidents, accidents, grievances, customer satisfaction and other program and services delivery data sets. The aforementioned monthly reports for the period of Aug 2024 - February 2025 were provided for review to demonstrate data sources that the agency uses to assess the past and current status of its performance. The Plan, Do, Study, Act (PDSA) Worksheet is completed weekly for tracking specific initiatives and maintaining updates to agency goals.
The program conducts an annual review of customer satisfaction data	Compliance	The agency reviews monthly reports focused on the agency's client satisfaction, incidents, accidents, and grievance reports. These reports are reviewed on a monthly basis during monthly meetings. Satisfaction data from August 2024 - February 2025 was provided to assess the current and past status of the agency's performance.
The program demonstrates a monthly review of the statewide End-of-Month ("EOM") report generated by the Florida Network Office. This includes monthly data, fiscal year to date data, benchmarks for residential and community counseling, screening data, report card measures, follow-up reporting measures.	Compliance	The agency receives FNYFS data extracts on numerous performance indicators. The agency reviews these measures with designated staff members to ensure the agency meets minimum requirements at least once a month during Cycle Quality Improvement (CQI) meetings. If performance is detected to be below the standard, the agency implements a corrective action or intervention plan to address the performance issue on the PDSA worksheet. The PDSA worksheet is tracked weekly until the matter is corrected.

The program has a process in place to review and improve accuracy of data entry & collection	Compliance	The agency has a process in place to review and improve accuracy of data entry, timeliness and accuracy of collection. Agency has dedicated staff members to enter data and assesses this process to ensure that there is minimal to no data entry lag time.	
There is documentation that findings are regularly reviewed by management and communicated to staff and stakeholders.	Compliance	The agency provided documentation of monthly meetings. The agency addresses identified program performance issues through meeting minutes. All findings are shared with key staff members and stakeholders.	
There is evidence the program demonstrates that program performance is routinely reviewed with the Board of Directors. All final reports that include a Limited or Failed score is submitted electronically or by mail to the providers Executive Committee on the Board of Directors.	Compliance	The agency has a process in which all agency performance reports are submitted to regional and headquarters leadership and governance boards. All Executive Committee members are provided with annual performance reports on an ongoing basis.	
There is evidence that strengths and weaknesses are identified, improvements are implemented or modified, and staff are informed and involved throughout the process.	Compliance	There is evidence that monthly residential and community counseling monthly meeting minutes are routinely shared across all supervisors, managers and leadership staff. All major strengths and weaknesses are identified and interventions are planned and implemented to address specific issues. Staff members are involved in all action plans and intervention efforts from the start of the process to its conclusion.	
Additional Comments: There are no additional comments for this indicator.			
1.06: Client Transportation			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 1.06	YES		
	If NO, explain here:		
	The agency has a policy titled 1.06- Client Transportation. The policy was reviewed by the Regional Director on 07/31/2024.		
Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	Compliance	The agency's Human Resources (HR) provided a list of 26 staff members approved by administrative personnel to transport clients in agency vehicles.	
Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	Compliance	All of the approved driver's currently have a valid driver's license. Additionally, proof of insurance was provided by the agency.	
Agency's Transportation policy prohibit transporting a client without maintaining at least one other passenger in the vehicle during the trip and include exceptions in the event that a 3 rd party is NOT present in the vehicle while transporting	Compliance	The agency's transportation policy prohibits transporting a client without at least another passenger and includes exceptions when a 3 rd party is not present. The agency is in compliance with this requirement.	

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	Per the agency's policy, the supervisor or shelter manager considers the client's history, evaluation, and recent behavior for single transports.	
The 3 rd party is an approved volunteer, intern, agency staff, or other youth	Compliance	The agency's policy is in compliance with the indicator and utilizes a 3rd party who is an approved volunteer, intern, agency staff, or other youth.	
The agency demonstrated evidence via logbook or other written verification that supervisor approval was obtained prior to all single youth transports.	Compliance	Transportation logs from September 2024-February 2025 were reviewed for this indicator. The program was in compliance 100% of the time by obtaining 10 supervisor approvals for 10 single transports.	
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 agency provided documentation which indicated the required elements for a single transport were adhered to as per the program's policy.	
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	A review of the agency's vehicle usage logs for the annual compliance review period noted the name or initials of the driver, date and time, mileage, number of passengers, purpose of travel and location for each transport.	
Additional Comments: There are no additional comments for this indicator.			
1.07 - Outreach Services			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 1.07	YES		
	If NO, explain here:		
	The agency has a policy titled 1.07- Outreach Services that was reviewed by the Regional Director on 07/31/2024.		
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 agency has a Community Outreach Coordinator designated to participate in the local Department of Juvenile Justice (DJJ) Council meetings. Documentation of attendance at various community meetings and events was provided by the agency. This information was entered also entered into NETMIS.	
The program maintains written agreements with other community partners which include services provided and a comprehensive referral process.	Compliance	The agency has written interagency agreements and maintains partnerships with local organizations including schools, law enforcement, hospitals, the local Continuum of Care, etc. These agreements enable referral submissions in and out of the program.	

<p>The program will maintain documentation of outreach activities and enter into NetMIS the title, date, duration (hours), zip code, location description, estimated number of people reached, modality, target audience and topic.</p>	<p>Compliance</p>	<p>The NETMIS Outreach Report indicated 85 outreach events during the annual compliance review period. The report contained the required elements. Examples of meetings included Community Networking, Achieve Orientation, PYP Mix & Mingle, NW Florida Prevention Coalition, Human Trafficking Summit and Housing for Homeless Families with Children.</p>	
<p>The program has designated staff that conducts outreach which is defined in their job description.</p>	<p>Compliance</p>	<p>Program Director; Community Outreach Coordinator have position description duties. Also, other staff members are all designated to conduct outreach.</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 with Exception</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>Policy 2.01: Screening and Intake was approved by Regional Director on 7/31/24.</p>		
<p>Shelter youth: Eligibility screening form is completed immediately for all shelter placement inquiries.</p>	<p>Compliance</p>	<p>All six files had eligibility screening forms which contained evidence of being completed immediately for all shelter placement inquiries.</p>	
<p>Community counseling: Eligibility screening form is completed within 3 business days of referral by a trained staff using the Florida Network screening form.</p>	<p>Compliance</p>	<p>All four files had eligibility screening forms completed within three business days of referral by trained staff 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 10 files had evidence that all referrals for service have evidence of screening for eligibility and are logged in NetMIS within 72 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>Exception</p>	<p>All 10 files had received available service options available and rights and responsibilities of youth and parents/guardians in writing.</p>	<p>All 10 files did not have a receipt of Notice of Privacy Practices.</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 10 files had evidence that youth and parent/guardian received information regarding possible actions occurring through involvement with CINS/FINS services and Grievance Procedures.</p>	
<p>During intake, all youth were screened for suicidality and correctly assessed as required if needed.</p>	<p>Compliance</p>	<p>All 10 files reviewed, all youth were screened for suicidality and if needed were correctly assessed as required.</p>	
<p>Additional Comments: There are no additional comments for this indicator.</p>			

2.02 - Needs Assessment		Satisfactory with Exception	
Provider has a written policy and procedure that meets the requirement for Indicator 2.02		YES	
		If NO, explain here:	
		Policy 2.02: Needs Assessment was approved by Regional Director on 7/31/24.	
Shelter Youth: NIRVANA is initiated within 72 hours of admission	Exception	Five of the six residential files reviewed had NIRVANA initiated within 72 hours of admission.	One of the six residential files initiated the NIRVANA after 72 hours of admission.
Non-Residential youth: NIRVANA is initiated at intake and completed within 2 to 3 face-to-face contacts after the initial intake OR updated, if most recent assessment is over 6 months old	Compliance	All non-residential files had NIRVANA initiated at intake and completed within 2 to 3 face to face contacts.	
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.	Exception	Eight of the client files had supervisor signatures documented for all completed Nirvana assessments. One of 10 files did not have a completed NIRVANA assessment due to discharge within 24 hours.	One of 10 files did not have a supervisor's signature documented on the completed NIRVANA Assessment.
(Shelter Only) NIRVANA Self-Assessment (NSR) is completed within 24 hours of youth being admitted into shelter. If unable to complete, there must be documentation in NetMIS and the youth's file explaining the barriers to completion.	Exception	Five out of 6 residential client files have NIRVANA Self-Assessment completed within 24 hours of youth being admitted to shelter.	One out of 6 residential files did not have NIRVANA Self-Assessment completed within 24 hours of youth being admitted to shelter.
A NIRVANA Post-Assessment is completed at discharge for all youth who have a length of stay that is greater than 30 days.	Compliance	A total of three client files are applicable for this indicator. Three of 10 files eligible had completed NIRVANA Post-Assessments.	
A NIRVANA Re-Assessment is completed every 90 days excluding files for youth receiving SNAP services.	Exception	Three out of 4 non-residential files had NIRVANA Re-Assessment completed.	One out of 4 non-residential files did not have a NIRVANA Re-Assessment completed.
All files include the interview guide and/or printed NIRVANA.	Compliance	Nine out of 10 files included the interview guide and/or printed NIRVANA. One of 10 files did not have a NIRVANA due to the client being discharged within 24 hours.	
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:	
		Policy 2.03: Case/Service Plan was approved by Regional Director on 7/31/24.	
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	Nine out of 10 client files had case/service plans developed on a local provider approved form or through NetMIS and is based on information gathered during the initial screening, intake, and NIRVANA. One of 10 did not have a case/service plan due to discharge within 24 hours.	
Case/Service plan is developed within 7 working days of NIRVANA	Compliance	Nine out of 10 client files had case/service plans developed within 7 working days of NIRVANA. One of 10 did not have a case/service plan due to discharge within 24 hours.	
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	A total of nine out of 10 files had individualized and prioritized needs and goals identified by the NIRVANA. Nine of 10 files included service type, frequency, and location. Nine of 10 files included person(s) responsible. Eight of 10 files included target dates. Three of 8 closed files included completion dates. Nine of 10 files had signatures of youth, parent/guardian, counselor, and supervisor. Nine of 10 files included the date the plan was initiated. One of 10 files did not have a case/service plan due to discharge within 24 hours.	One of 10 files did not include target dates on the case/service plan. Five of 8 closed files did not include completion dates on case/service plan.
Case/service plans are reviewed for progress/revised by counselor and parent (if available) every 30 days for the first three months and every 6 months after	Exception	Four of 5 files with services over 30 days had 30 day reviews for the first 3 months and every 6 months after.	One of five files with services over 30 days had a 30 day review 5 days late.
Additional Comments: There are no additional comments for this indicator.			
2.04 - Case Management and Service Delivery		Satisfactory with Exception	
Provider has a written policy and procedure that meets the requirement for Indicator 2.04		YES	
		If NO, explain here:	
		Policy 2.04: Case Management and Service Delivery was approved by Regional Director on 7/31/24.	
Counselor/Case Manager is assigned	Compliance	All 10 client files have evidence of the client being assigned a counselor.	

<p>The Counselor/Case Manager completes the following as applicable: 1. Establishes referral needs and coordinates referrals to services based upon the on-going assessment of the youth's/family's problems and needs 2. Coordinates service plan implementation 3. Monitors youth's/family's progress in services 4. Provides support for families 5. Monitoring progress of court ordered youth in shelter 6. Makes referrals to the case staffing to address problems and needs of the youth/family 7. Accompanies youth and parent/guardian to court hearings and related appointments 8. Refers the youth/family for additional services when appropriate 9. Provides case monitoring and reviews court orders 10. Provides case termination notes 11. Provides follow-up after 30 days post discharge 12. Provides follow-up after 60 days post discharge</p>	<p>Compliance</p>	<p>Ten of 10 files established referral needs and coordinated referrals to services based upon the ongoing assessment of the youth's/family's problems and needs. Nine of 10 files coordinated service plan implementation. Nine of 10 files monitored youth's/family's progress in services. Ten of 10 files provided support for families. Four of 4 court ordered files were monitoring progress of court ordered youth in shelter. N/A there were no files for case staffings. One of one court hearing appointments file was accompanied to court hearings and related appointments. All files referred the youth /family for additional services when appropriate. All files provided case monitoring and reviews of court orders. All closed files provided case termination notes. All files that needed 30 day follow-ups were completed. All files that needed 60 day follow-ups were completed.</p>	
<p>The program maintains written agreements with other community partners that include services provided and a comprehensive referral process</p>	<p>Exception</p>	<p>The agency reported that they do not have a formal referral process in place with detailed agreements that include comprehensive service provision.</p>	<p>Clinical supervisor reports they do not have a formal referral process, but invite outside providers to clinical meetings to discuss appropriate referrals.</p>
<p>Additional Comments: There are no additional comments for this indicator.</p>			
<p>2.05 - Counseling Services</p>			<p>Satisfactory with Exception</p>
<p>Provider has a written policy and procedure that meets the requirement for Indicator 2.05</p>	<p>YES If NO, explain here: Policy 2.05: Counseling Services was approved by Regional Director on 7/31/24.</p>		
<p>Shelter Program</p>			
<p>Shelter programs provides individual and family counseling</p>	<p>Compliance</p>	<p>All client files have evidence of providing individual and family counseling.</p>	
<p>Group counseling sessions held a minimum of five days per week</p>	<p>Exception</p>	<p>Three of six residential files provided a minimum of five group counseling sessions per week. One of six files the youth discharged within 24 hours.</p>	<p>Two of six residential files did not provide a minimum of five group counseling sessions per week.</p>

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	All group counseling sessions were conducted by staff, youth, or guest and documented to include a clear leader or facilitator, relevant topic (educational/informational or developmental), opportunity for youth to participate, and were 30 minutes or longer.	
Documentation of groups must include date and time, a list of participants, length of time, and topic.	Compliance	All documentation included date and time, a list of participants, length of time, and topic.	
Community Counseling			
Community counseling programs provide therapeutic community-based services designed to provide the intervention necessary to stabilize the family. Services are provided in the youth’s home, a community location, the local provider’s counseling office or virtually if written documentation is provided in the youth's file for reasons why it is in the best interest of the youth and family.	Compliance	All client files provided therapeutic community-based services designed to provide the intervention necessary to stabilize the family. Services are provided by the agency 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.	
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	All files have evidence the program completing a review of all case files for coordination between presenting problem(s), psychosocial assessment, case/service plan reviews, case management, and follow-up.	
Maintain individual case files on all youth and adhere to all laws regarding confidentiality.	Compliance	All files maintained individual case files on all youth and adhere to all laws regarding confidentiality.	
Case notes maintained for all counseling services provided and documents youth’s progress.	Compliance	All files contained case notes maintained for all counseling services provided and documents of youth's progress.	
On-going internal process that ensures clinical reviews of case records and staff performance.	Compliance	All files contained an on-going internal process that ensures clinical reviews of case records and staff performance.	
When an intake is conducted through virtual means, consent is confirmed by the counselor, documented in the file, and reviewed with the supervisor during supervision/case review. There is written documentation provided in the youths file for reasons why virtual sessions are in the best interest of the youth and family.	No eligible items for review	The agency reported that no clients received virtual communication platforms.	
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:	
	Policy 2.06: Adjudication/Petition Process was approved by Regional Director on 7/31/24.	
Must include: a. DJJ rep. or CINS/FINS provider b. Local school district representative	Compliance	The agency has a comprehensive process for operating the CINS/FINS staff and petition process to serve children and families. The agency's current process includes DJJ, and other local area system partners.
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 agency's current process includes DJJ, local school representatives as needed and several area system partners.
The program has an established case staffing committee, and has regular communication with committee members	Compliance	The agency has a comprehensive process for operating the CINS/FINS staff and petition process to serve children and families. At the time of this onsite program review, there were no samples available for review.
The program has an internal procedure for the case staffing process, including a schedule for committee meetings	Compliance	The agency has a comprehensive process for operating the CINS/FINS staff and petition process to serve children and families. At the time of this onsite program review, there were no samples available for review.
The youth and family are provided a new or revised plan for services	No eligible items for review	The agency has a comprehensive process for operating the CINS/FINS staff and petition process to serve children and families. At the time of this onsite program review, there were no samples available for review.
Written report is provided to the parent/guardian within 7 days of the case staffing meeting, outlining recommendations and reasons behind the recommendations	No eligible items for review	The agency has a comprehensive process for operating the CINS/FINS staff and petition process to serve children and families. At the time of this onsite program review, there were no samples available for review.
If applicable, the program works with the circuit court for judicial intervention for the youth/family	No eligible items for review	The agency has a comprehensive process for operating the CINS/FINS staff and petition process to serve children and families. At the time of this onsite program review, there were no samples available for review.
Case Manager/Counselor completes a review summary prior to the court hearing	No eligible items for review	The agency has a comprehensive process for operating the CINS/FINS staff and petition process to serve children and families. At the time of this onsite program review, there were no samples available for review.

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:	
	2.07: Youth Records was approved by Regional Director on 7/31/24.	
All records are clearly marked 'confidential'.	Compliance	All file samples reviewed across standards two, three and four are clearly marked "confidential."
All records are kept in a secure room or locked in a file cabinet that is marked "confidential"	Compliance	All files were kept in a secure room and locked in a file cabinet that is marked "confidential."
When in transport, all records are locked in an opaque container marked "confidential"	Compliance	All files when in transport are locked in an non see-through container marked "confidential."
All records are maintained in a neat and orderly manner	Compliance	All files were maintained in a neat and orderly manner.
SHELTER FILES contain the following: Table of Contents that outlines documents in each section: <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 	Compliance	All residential files reviewed contained proof of the following in each file: The Table of Contents that outlines documents in each section: <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>COMMUNITY COUNSELING FILES contain the following: Table of Contents that outlines documents in each section: • Screening • Informed Consent • Community Counseling Intake Form • Suicide Assessment (if needed) • NIRVANA full Assessment • Plan of Service • Chronological case notes • Copies of referrals made & Follow-Up (if needed) • Discharge summary once the case is closed</p>	<p>Compliance</p>	<p>The sample of community counseling files reviewed contained proof of the following documents in each file. The Table of Contents outlines documents found in the corresponding section in each file. • 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>	
<p>All records kept electronically, are maintained securely and can be made immediately available upon request for audit purposes.</p>	<p>Not Applicable</p>	<p>The agency does not utilize electronic client files.</p>	
<p>Records are retained for the duration of the time specified by the contract.</p>	<p>Compliance</p>	<p>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>			
<p>2.08 - Specialized Additional Program Services</p>			<p>Satisfactory with Exception</p>
<p>Provider has a written policy and procedure that meets the requirement for Indicator 2.08</p>	<p>YES</p>		
	<p>If NO, explain here:</p>		
	<p>Policy 2.08: Specialized Additional Program Services was approved by Regional Director on 7/31/24.</p>		
<p>Staff Secure</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 staff secure in the last 6 months or since the last onsite QI review.</p>	
<p>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</p>	<p>No eligible items for review</p>	<p>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.</p>	

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	The agency policy, Specialized Additional Program Services, meets all the requirements of the indicator.	
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 met the criteria for Domestic Minor Sex Trafficking (DMST) in the last 6 months or since the last onsite QI review. There are no eligible cases to 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 ☐			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating “No eligible items for review”)	Yes	The agency provided a sample case to be reviewed for this measure.	
Youth admitted to DV Respite placement have evidence in the file of a pending DV charge	Compliance	One of one residential file admitted to DV Respite placement has evidence in the file of pending DV charges.	
Data entry into NetMIS within (3) business days of intake and discharge	Compliance	One of one residential file had data entry into NetMIS within three business days of intake and discharge.	
Youth length of stay in DV Respite placement does not exceed 21 days. If more than 21 days, documentation exists in youth file of transition to CINS/FINS or Probation Respite placement, if applicable.	No eligible items for review		
Case plan in file reflects goals for aggression management, family coping skills, or other intervention designed to reduce propensity for violence in the home	Compliance	One of one residential file was reviewed. The case plan reflects goals for aggression management, family coping skills, or other intervention designed to reduce propensity for violence in the home.	
All other services provided to Domestic Violence Respite youth are consistent with all other general CINS/FINS program requirements	Compliance	One of one residential file all other services provided to DV Respite youth are consistent with all other general CINS/FINS 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	One client case file was provided to be reviewed for this measure.	
All probation respite referrals are submitted to the Florida Network.	Compliance	One of one residential file referral was submitted 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	One of one residential file referrals came from DJJ probation and there is evidence that the youth is on probation regardless of adjudication status.	
Data entry into NetMIS and JJIS within (3) business days of intake and discharge	Compliance	One of one residential file has data entry into NetMIS and JJIS within three business days of intake and discharge.	

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.	Exception	The length of stay was reviewed to assess adherence to a stay of no more than 14 to 30 days was provided within the require timeframe.	One of one residential client file does not have evidence of the Juvenile Probation Officer approval for a stay longer than 30 days.
All case management and counseling needs have been considered and addressed	Compliance	One of one residential files has all case management and counseling needs which have been considered and addressed.	
All other services provided to Probation Respite youth are consistent with all other general CINS/FINS program requirements	Compliance	One of one residential file all other services provided to DV Respite youth are consistent with all other general CINS/FINS 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")	No eligible items for review	The agency has a contract to perform ICM services in specific areas of service region. At the time of the review, there were no eligible cases to review.	
Youth receiving services were deemed chronically truant and/or runaway and require more intensive and lengthy services. The youth was determined to be eligible because they have gone through petition and/or case staffing and was in need of case management services.	No eligible items for review		
Services for youth and family include: a. Two (2) direct contacts per month b. Two (2) collateral contacts per week c. Direct and collateral contacts not obtained must have documentation to support attempts made to obtain them. All reasonable attempts (at minimum of three) must be made to reach all contacts (direct and collateral) and documented in the case file and NetMIS.	No eligible items for review		
Assessments include a. NIRVANA at intake b. NIRVANA Re-Assessment every 90 days c. Post NIRVANA at discharge as aligned with timeframe requirements	No eligible items for review		
Service/case plan demonstrates a strength-based, trauma-informed focus	No eligible items for review		
For any virtual services provided, there is written documentation in the youths' file as to why virtual contact is in the best interest of the youth and family	No eligible items for review		

Family and Youth Respite Aftercare Services (FYRAC)			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	Yes	One client case file was provided to be reviewed for this measure.	
Youth is referred by DJJ for a domestic violence arrest on a household member, and/or the youth is on probation regardless of adjudication status and at risk of violating.	Compliance	One of one non-residential file youth was referred by DJJ for a domestic violence arrest on a household member and/or youth is on probation regardless of adjudication status and at risk of violating.	
Agency has evidence that all FYRAC referrals have documented approval from the Florida Network office	Exception	One of one non-residential file was reviewed to assess its adherence to this measure.	One of one non-residential file does not have evidence that FYRAC referral documented has approval from the Florida Network Office.
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.	Compliance	One of one non-residential file has Intake and initial assessment sessions which meet 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.	
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.	Compliance	One of one non-residential file has evidence of Life Management Sessions which has proof of meeting 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>Individual Sessions: a. The program conducted sessions with the youth and family to focus on work to engage the parties and identify strengths and needs of each member that help to improve family functioning. b. Issues to be covered through each session include but are not limited to: Identifying emotional triggers; body cues; healthy coping strategies through individual, group and family counseling; understanding the cycle of violence and the physical and emotional symptoms of anger; developing safety plans; and educating families on the legal process and rights.</p>	<p>Compliance</p>	<p>One of one non-residential file has evidence of Individual conducting sessions which have proof of the following: a. The program conducted sessions with the youth and family to focus on work to engage the parties and identify strengths and needs of each member that help to improve family functioning. b. Issues to be covered through each session include but are not limited to: Identifying emotional triggers; body cues; healthy coping strategies through individual, group and family counseling; understanding the cycle of violence and the physical and emotional symptoms of anger; developing safety plans; and educating families on the legal process and rights.</p>	
<p>Group Sessions: a. Focus on the same issues as individual/family sessions with application to youth pulling on similar experiences with other group members with the overall goal of strengthening relationships and prevention of domestic violence. b. Shall be no more than eight (8) youth at one (1) time and shall be for a minimum of sixty (60) minutes per session</p>	<p>Not Applicable</p>	<p>Not applicable for the sample reviewed.</p>	
<p>There is evidence of completed 30 and/or 60 day follow-ups and is documented in NetMIS following case discharge.</p>	<p>Compliance</p>	<p>One of one non-residential file has evidence of completed 30 and/or 60 day follow-ups and is documented in NetMIS following case discharge.</p>	
<p>Youth and family participate in services for thirteen (13) sessions or ninety (90) consecutive days of services, or there is evidence in the youth's file that an extension is granted by DJJ circuit Probation staff</p>	<p>Compliance</p>	<p>One of one non-residential file has youth and family participate in services for thirteen (13) sessions or ninety (90) consecutive days of services, or there is evidence in the youth's file that an extension is granted by DJJ circuit Probation staff.</p>	
<p>Any service that is offered virtually, is documented in the youth's file why it was in the youth and families best interest.</p>	<p>Not Applicable</p>	<p>The agency did not provide any virtual services.</p>	
<p>All data entry in NetMIS is completed within 3 business days as required.</p>	<p>Compliance</p>	<p>One of one non-residential file has data entry into NetMIS completed within 3 business days as required.</p>	
<p>Additional Comments: There are no additional comments for this indicator.</p>			

2.09- Stop Now and Plan (SNAP)		Satisfactory with Exception	
Provider has a written policy and procedure that meets the requirement for Indicator 2.09	YES		
	If NO, explain here:		
	Indicate policy number, authorized signee, date(s) of last review/revision/approval: Policy 2.09: Stop Now and Plan was approved by Regional Director on 7/31/24.		
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	All files had youth screened to determine eligibility of services with the required documents: Florida Network Youth Screening Form and SNAP Brief Intake Screening Checklist.	
All files contain each of the required documents below: a. SNAP Child Screening Interview Report b. Florida Network Community Counseling Intake Form c. Reinforcement Trap/Coercive Cycle Diagram d. Consent to Treatment and Participation in Research Form	Exception	Two of three SNAP files have evidence of the 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.	One of three SNAP files did not have the Florida Network Community Counseling Intake Form.
The NIRVANA was completed at initial intake, or within two sessions.	Compliance	All files had NIRVANA completed at initial intake or within two sessions.	
There is evidence of the completed the Pre - Child Behavior Checklist (CBCL) by the caregiver and is located within the file.	Compliance	All files had evidence of the completed Pre-Child Behavior Checklist by the caregiver and is located in the file.	
There is evidence of the completed Pre - TOPSE is completed by the caregiver and is located within the file.	Compliance	All files had evidence of the completed Pre-TOPSE by the caregiver and is located within the file.	
There is evidence of the following documents located within the file: a. SNAP® Parent Goal Sheet b. Child Way To Go Goal Sheet (This may be in progress for open files but is required for all closed files.)	Compliance	All files have evidence of the following documents located within the client file: a. SNAP® Parent Goal Sheet b. Child Way To Go Goal Sheet	
SNAP Clinical Groups Under 12 - Discharge			
There is evidence of the completed the Post - Child Behavior Checklist (CBCL) by the caregiver and is located within the file.	Compliance	All client files have evidence of the completed the Post - Child Behavior Checklist (CBCL) by the caregiver and is located within the file.	
There is evidence of the completed Post - TOPSE is completed by the caregiver and is located within the file.	Compliance	All files have evidence of the completed Post - TOPSE is completed by the caregiver and is located within the file.	
There is evidence of the completed SNAP Discharge Report located within the file for any discharged youth.	Exception	All files had evidence of the completed SNAP Discharge Report located within the file for any discharged youth.	One of one SNAP file did not have evidence of the required discharge date on the SNAP Discharge Report.
There is evidence of the SNAP Boys/SNAP Girls Child Group Evaluation Form located in the file.	Compliance	All files have evidence of the SNAP Boys/SNAP Girls Child Group Evaluation Form located in the file.	

There is evidence of the SNAP Boys/SNAP Girls Parent Group Evaluation Form located in the file.	Compliance	All files have evidence of the SNAP Boys/SNAP Girls Parent Group Evaluation Form located in the file.	
SNAP Clinical Groups for Youth 12-17			
Youth are screened to determine eligibility of services using the Florida Network Youth Screening Form.	Not Applicable	The SNAP program is not applicable to this program.	
The file contains the completed Florida Network Community Counseling Intake Form and is located within the file.	Not Applicable		
The Consent to Treatment and Participation in Research Form is completed, signed by the parent/guardian before receiving services, and located within the file.	Not Applicable		
The NIRVANA was completed at initial intake, or within two sessions.	Not Applicable		
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.	Not Applicable		
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.	Not Applicable		
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.	Not Applicable		
All closed files contained evidence in the file a NIRVANA was completed at discharge.	Not Applicable		
SNAP for Schools & Communities			

<p>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></p>	<p>Compliance</p>	<p>One cycle reviewed 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.</p>	
<p>The program maintained evidence of a completed 'Way to Go Goal' Sheet within the file.</p>	<p>Compliance</p>	<p>One cycle reviewed maintained evidence of a completed 'Way to Go Goal' Sheet within the file.</p>	
<p>The program maintained evidence of both pre AND post Measure of Classroom Environment (MoCE) completed documents for the class reviewed.</p>	<p>Compliance</p>	<p>One cycle reviewed maintained evidence of both pre AND post Measure of Classroom Environment (MoCE) completed documents for the class reviewed.</p>	
<p>The program maintained evidence of completed pre and post evaluation documents for the class reviewed.</p>	<p>Compliance</p>	<p>One cycle reviewed maintained evidence of completed pre and post evaluation documents for the class reviewed.</p>	
<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>One cycle reviewed has evidence of the SNAP® for Schools & Communities Feedback Form completed by the supervisory adult responsible for the support of the youth receiving services and entered into NetMIS.</p>	
<p>There is evidence of one (1) Fidelity Adherence Checklist completed per classroom for the 13-week classroom sessions which is located in the file.</p>	<p>Compliance</p>	<p>One cycle reviewed has evidence of one (1) Fidelity Adherence Checklist completed per classroom for the 13-week classroom sessions which is located in the file.</p>	
<p>Additional Comments: There are no additional comments for this indicator.</p>			
<p>Standard Three – Shelter Care</p>			

3.01 - Shelter Environment		Limited	
<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 agency has a policy titled 3.01- Shelter Environment that was approved by the Regional Director on 08/01/2024.</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>Exception</p>	<p>On day one of the tour it was observed to have normal wear and tear on the seating in the common area of the shelter. There were enough seating for the capacity of the youth and the staff. There are four sofas and one lounge chair in the dayroom. There are a total of six bedrooms with two beds in each room. Room six does have the ability to serve three youth if needed. All of the rooms have good lighting with exception of room number three. One of the two lights were completely out. Room two was missing a curtain rod, the magnet broken off the back of the door and with a couple broken blinds. The blinds are getting replaced in the bedrooms along with door handles. Room five the wall is getting repaired due to a youth punching a hole in the wall. All rooms are free of debris. The beds were made in most of the rooms with the exception of one bed in room five. The bathrooms are not numbered, but for reporting bathroom number one the door is being repaired. All of the bathrooms are clean; no broken items in the bathrooms, no mildew, no dust or foul odors. The water did take about minute and half to get warm. All of the bathrooms have adequate lighting and one of the bathrooms is wheel chair accessible. All doors are secure and locked from the outside in. The staff have color coded keys that are exchanged from one staff member to the next from shift to shift.</p>	<p>One of the two lights were completely out. Room two was missing a curtain rod. There was a magnet broken off the back of the door and a couple broken blinds. The blinds are getting replaced in the bedrooms along with door handles. In bedroom number one the magnet that holds the door open is hanging from the wall. It appears to be in the works of being repaired. Waiting on the plaster to dry.</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>This facility has two vehicles: 2016 Collins Bus and 2016 Honda Odessey. Both vehicles were locked as evidenced by engaging door handles. The safety equipment was put together to ensure it was operational. The flashlight is in working order, first aid kits are stocked with band aids, bandages, scissors, and alcohol wipes. The kit and its contents are up to date. The glass breaker and seat belt cutter were present. Both vehicles fire extinguishers were inspected in July 2024.</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>Exception</p>	<p>All chemicals that are being used in the facility do have MSDS sheets. The logs that were reviewed was 9/14/2024 to 3/1/2025. The weekly log is being completed at the minimum at least once a week.</p>	<p>There were missing signatures for the weekly count of the inventory. The only dates that had signatures at the top were 9/14/2024,9/21/2024, 9/28/2024,10/05/2024, 10/12/2024 and 10/19/2024. The perpetual inventory only shows the use of tide pods being used on a consistent basis. There are other items being used to clean but they are not getting logged on the perpetual inventory sheet.</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>The facility has two washers and two dryers. The washers were clean and one was in the process of being used. The two dryers were not in use, they were clean and lint free. The youth have lockers in their room along with dressers for their personal items. If the youth have any belongings that they want to secure in lock up, they are able to give to staff to they are locked in the office. Each youth has a clean mattress, pillow, linen and a blanket.</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 annual facility has completed and in compliance with the fire inspector that was completed on 8/14/2024. The agency is in compliance with completing fire drills on each shift within two minutes or less. The fire safety equipment is up to date as of July 2024.</p>	<p>The facility has completed emergency mock drills only the 1st shift only. The drill dates were 9/28/2024, 10/28/2024,12/29/2024 and 12/31/2024.</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>Exception</p>	<p>The Department of Health issued a satisfactory Food Service Inspection Report on 9/30/2024. This report is posted on the board located in the kitchen. Signed and approved menus by the dietician are also located on this board, the last date reviewed was 2023. This facility has two refrigerators and one freezer in the kitchen. The refrigerator temperatures are 40 degrees F and the freezer is -22 degrees F. In one of the refrigerators things are not labeled. The freezer has items inside without any organization without any labels of when things were opened. The other refrigerator that is attached to the freezer does have items with dates however things are just placed inside without any organization. The kitchen sink has running hot and cold water. The stove, oven, microwave, and toaster are in good working condition. The dishwasher is getting replaced. There was no posted Group Care Inspection received from DOH. The freezers are labeled with breakfast, bread, vegetables that are in the pantry. The logs have not been completed since Jan 11th for the vegetable freezer, the meat freezer is meat- there hasn't been a thermometer review notated since 1/20. There is a missing thermometer in the vegetable freezer. . The freezer food is appeared to have no organization. The items in the refrigerators and freezer in the kitchen are unorganized. On day two the vegetable freezer thermometer was missing and the logs were not still however everything else was corrected from the previous day.</p>	<p>The logs have not been completed since Jan 11, 2025, for the vegetable freezer. The meat freezer is neat and there has not been a thermometer review notated since January 20, 2025. There is a missing thermometer in the vegetable freezer. There is no organization of any sort in the fridge. Freezer Temperature: - The thermometer was not reading at 40 degrees. However everything was frozen in the freezer. There were no labels of when the food was placed inside the freezer. Freezer Temperature: The thermometer was not reading at 40 degrees. However everything was frozen in the freezer. There were no labels clearly documenting when the food was placed inside the freezer.</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>During the walkthrough of the facility. The youth were working on school items. One youth was working on the computer completing work and the other two youth were working on educational packets with the other staff. The room did have books, educational activities and the structured free time items. The schedule is posted in the day room and the youth also have a copy in the handbook that is provided to them. The parent/guardian also gets a copy of the schedule that the youth will follow. The youth do have the opportunity to participate in faith-based activities if they would like to. There is no punitive action for those who do not want to participate. The other youth will be involved in another activity during that time. During the time this peer spoke to one of the youth who was on the way to school. She was excited to go to school to be around her friends. This peer also spoke to another youth who was in the parking lot returning from school. This youth was very polite and respectful and offered to help put bags in the vehicle. The youth knew exactly where to go and the expectations of the searching procedure when arriving to the facility. On day two, the reviewer witnessed the youth eating lunch and going outside for physical activity.</p>
Additional Comments: There are no additional comments for this indicator.		
3.02 - Program Orientation		Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 3.02	YES	
	If NO, explain here:	
	The agency has a policy titled 3.02- Program Orientation that was approved by the Regional Director on 08/01/2024.	

<p>Youth received a comprehensive orientation and handbook provided within 24 hours</p>	<p>Compliance</p>	<p>Two closed files and two open files were reviewed. All files had evidence of showing that the youth received the orientation and handbook on intake day.</p>	
<p>Orientation includes the following: a. Youth is given a list of contraband items b. Disciplinary action is explained c. Dress code explained d. Review of access to medical and mental health services e. Procedures for visitation, mail and telephone f. Grievance procedure g. Disaster preparedness instructions h. Physical layout of the facility i. Sleeping room assignment and introductions j. Suicide prevention- alerting staff of feelings or awareness of others having suicidal thoughts</p>	<p>Compliance</p>	<p>During the intake process the youth receive a handbook that outlines the rules and expectations of the program. The youth walked through each part of the intake process. The staff member explains the dress code, mental health services that are provided, the grievance procedures, emergency disaster evacuation plans, the suicide prevention, dress code, the behavior management (Journey to Success) and the discipline actions. The youth is also made aware of the video surveillance and room assignment. The youth are introduced to the staff and other youth and then the youth is able to take a shower. Inside of the packet there is no layout but here are signs posted throughout the facility.</p>	
<p>Documentation of each component of orientation, including orientation topics and dates of presentation, as well as signatures of the youth and staff involved is maintained in the individual youth record</p>	<p>Compliance</p>	<p>All program orientation paperwork was signed by the youth and the staff.</p>	
<p>Additional Comments: There are no additional comments for this indicator.</p>			
<p>3.03 - Youth Room Assignment</p>			<p>Satisfactory</p>
<p>Provider has a written policy and procedure that meets the requirement for Indicator 3.03</p>	<p>YES</p>		
	<p>If NO, explain here:</p>		
	<p>The agency has a policy titled 3.03- Youth Room Assignment that was approved by the Regional Director on 08/01/2024.</p>		
<p>A process is in place that includes an initial classification of the youths, to include:</p>			
<p>a. Review of available information about the youth’s history, status and exposure to trauma b. Initial collateral contacts, c. Initial interactions with and observations or the youth d. Separation of younger youth from older youth, e. Separation of violent youth from non-violent youth f. Identification of youth susceptible to victimization g. Presence of medical, mental or physical disabilities h. Suicide risk i. Sexual aggression and predatory behavior j. Acute health symptoms requiring quarantine or isolation</p>	<p>Compliance</p>	<p>During that intake process the staff member will determine which room the youth will be placed. There are several factors that come into play when placing a youth such as age, aggression, sexual history, physical abilities, trauma, suicide risk and gender.</p>	

<p>An alert is immediately entered into the program's alert system when a youth is admitted with special needs and risks such as risk of suicide, mental health, substance abuse, physical health or security risk factors</p>	<p>Compliance</p>	<p>There is an alert system is in place to capture special needs. There are color coded dots that are on the file to indicate the alerts. The facility has an alert board in the kitchen for youth that have dietary or allergies concerns. An alert binder is in the medication room for youth that take medication and may have allergies. Suicide assessment forms are in the youth's file to assess suicide risk. The screening form along with the intake form will be evaluated to determine what alerts are to be presented for the youth.</p>	
<p>Additional Comments: There are no additional comments for this indicator.</p>			
<p>3.04 - Log Books</p>			<p>Limited</p>
<p>Provider has a written policy and procedure that meets the requirement for Indicator 3.04</p>	<p>YES If NO, explain here: The agency has a policy titled 3.04- Logbooks (Paper or Electronic) that was approved by the Regional Director on 08/01/2024.</p>		
<p>Log book entries that could impact the security and safety of the youth and/or program are highlighted</p>	<p>Compliance</p>	<p>The program has outlined the different highlights to alert the staff about what is happening through the shift.</p>	
<p>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</p>	<p>Compliance</p>	<p>Each entry that is used with an active note icon that is clearly identified. The date, time, incident, activity, staff member that is involved, youth and signature is noted. The icon will indicate what movement and or action is being held at the time of the entry.</p>	
<p>Recording errors are struck through with a single line. The staff person must initial and date the correction. The use of whiteout and erasures is prohibited.</p>	<p>Compliance</p>	<p>The electronic tablet does have the ability for the strikethrough feature.</p>	
<p>The program director or designee reviews the facility logbook(s) every week and makes a note chronologically in the logbook indicating the dates reviewed and if any correction, recommendations and follow-up are required and sign/date the entry</p>	<p>Exception</p>	<p>It is noted that the YCS III is reviewing the logbook daily on shift there is no clear date of what shifts are being reviewed.</p>	<p>The YCS III is not documenting notes related to recommendations or follow up of agency activities, events and general occurrences associated to what she is reviewing.</p>
<p>All staff review the logbook of the previous two shifts and makes an entry signed and dated into the logbook indicating the dates reviewed</p>	<p>Compliance</p>	<p>The staff members who sign on to the work shift indicate that they are reading the last two shifts.</p>	
<p>At the beginning of their shift, oncoming supervisor and shelter counselor reviews the logbook of all shifts since their last log entry and makes a signed and dated entry and into log book indicating the dates reviewed.</p>	<p>Exception</p>	<p>It is observed that the Clinical Director consistently reviews the logbook, but there are no dates indicated on the review period.</p>	<p>The review of the logbook does not indicate consistent documentation of the supervisor and counselor reviews of the logbook since the date of the last time they were on duty.</p>

<p>Logbook entries include: a. Supervision and resident counts b. Visitation and home visits</p>	<p>Exception</p>	<p>There is a shift note that is created at midnight for the day shift for resident counts. A review for consistent headcount was conducted.</p>	<p>On the sign in shift there is no consistent headcount for each shift.</p>
<p>Additional Comments: There are no additional comments for this indicator.</p>			
<p>3.05 - Behavior Management Strategies</p>			<p>Satisfactory</p>
<p>Provider has a written policy and procedure that meets the requirement for Indicator 3.05</p>	<p>YES</p>		
	<p>If NO, explain here:</p>		
	<p>The agency has a policy titled 3.05- Behavior Management Strategies that was approved by the Regional Director on 08/01/2024.</p>		
<p>The program has a detailed written description of the BMS and it is explained during program orientation</p>	<p>Compliance</p>	<p>The program has outlined a detail written description of the BMS and it is explained during orientation and given to the parents in the parent paperwork.</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>Journeys to success is a point system where the youth attain points for task completion or adherence to expectations. The system is not consequence based and relies on affirming and validating the youth for positive behaviors and maintaining compliance with rules and routines. There are a maximum number of points for the day and the week. The only time the youth are not able to get points is if they have any major incidents which are : youth arrest, destruction of property suspension from school, or aggression/assault. There are also levels to the BMS system which falls into four levels. Discovery, Achieve/Believe, Ownership, and Empowerment. The incentive options are determined based on the level of the youth. Journeys is a new program that has been implemented. The staff will meet with each youth to explain to them their points. Therapeutic approaches are always encouraged, and staff are to engage with youth immediately when negative behaviors arise. Youth are encouraged to use their coping skill to help deescalate their behavior or ask for assistance immediately from a preferred staff onsite. The staff are also MAB (Managing Aggressive Behavior) for physical interventions are used as a last resort and only when youth are bringing harm to themselves or someone else. Youth rights are not denied during the time of crisis but may be delayed if the youth behavior is not safe.</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 have been trained to use the Journeys to Success.	
There is a protocol for providing feedback and evaluation of staff regarding their use of BMS rewards and consequences	Compliance	The supervisor will informally remind the youth who have not completed accessing their points for the shift; to remember their goal/incentive to remind the youth.	
Supervisors are trained to monitor the use of rewards and consequences by their staff	Compliance	The supervisors monitor the BMS to ensure that point cards and rewards are being completed and fulfilled.	
Additional Comments: There are no additional comments for this indicator.			
3.06 - Staffing and Youth Supervision			Satisfactory with Exception
Provider has a written policy and procedure that meets the requirement for Indicator 3.06	YES		
	If NO, explain here:		
	The agency has a policy titled 3.06- Staffing and Youth Supervision that was approved by the Regional Director on 08/01/2024.		
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	The facility has a capacity of twelve (12) youth. There are six (6) bedrooms with two (2) beds in each. The ratio while the youth are awake is 6 to 1 within a minimum of two staff being present on the shift. During the video review the following the shifts were viewed 2/18/2025 and 3/05/2025 there were two to three staff present during the shift. The youth were actively engaged while being in the presence of staff.	
All shifts must always provide a minimum of two direct care staff present that have met the minimum training requirements	Exception	One of the three completed all the training required before working independently with youth.	The second of three completed all of the training required prior to working independently except MAB training. It was reported the Shelter Manager that she would be included in the next MAB session within the month. The third YC staff completed all of the required training except Adolescent Development.

<p>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</p>	<p>Exception</p>	<p>Four YCS Annual training files were reviewed.</p>	<p>Four of four were missing Skill Pro #168-Child Abuse Recognition, Reporting and Prevention; Three of four were missing Skill Pro #316 Human Trafficking Intervention for Direct Care Staff; Three of four were missing Skill Pro #45 Information Security Awareness; One of four was missing Skill Pro #1549 and 1546-PREA Parts one and two; one of four was missing the FNYFS Youth Suicide Prevention.</p>
<p>The staff schedule is provided to staff or posted in a place visible to staff</p>	<p>Compliance</p>	<p>Evidence of the staff schedule was provided. The schedule is posted in the staff office.</p>	
<p>There is a holdover or overtime rotation roster which includes the telephone numbers of staff who may be accessed when additional coverage is needed</p>	<p>Compliance</p>	<p>The list of staff who are able to assist with additional coverage is located in the staff office. There is also a board on in the office that shows who is on call for the time period,</p>	
<p>Staff observe youth at least every 15 minutes while they are in their sleeping room, either during the sleep period or at other times, such as during illness or room restriction</p>	<p>Compliance</p>	<p>The facility has a capacity of twelve (12) youth. There are six bedrooms with two beds in each room. The ratio during sleeping hours is 12 to one, with a minimum of two staff being present on the shift. During the video review, the following overnight shifts were viewed: 2/25/2025 and 2/28/2025. There were two staff present during the overnight shift. The staff were sitting in the middle of the hallway, able to see the open doors of the bedrooms as well as the exit doors. The staff would conduct the room checks every ten (10) minutes. The staff would pick up the tablet and scan the QR Code on the outside of the youth door. The tablet would record the time of the check-in in real time.</p>	
<p>Additional Comments: There are no additional comments for this indicator.</p>			
<p>3.07 - Video Surveillance System</p>			<p>Satisfactory</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 agency has a policy titled 3.07- Video Surveillance that was approved by the Regional Director on 08/01/2024.</p>		
<p>Surveillance System</p>			

<p>The agency, at a minimum, shall demonstrate:</p> <ul style="list-style-type: none"> a. A written notice that is conspicuously posted on the premises for the purpose of security b. System can capture and retain video photographic images which must be stored for a minimum of 30 days c. System can record date, time, and location; maintain resolution that enables facial recognition d. Back-up capabilities consist of cameras' ability to operate during a power outage e. Have cameras placed in interior (e.g. intake office, counseling office, cafeteria, day room) and exterior (e.g. entrance/exit, recreation area, parking lot) general locations of the shelter where youth and staff congregate and where visitors enter and exit; to include locations where youth searches are conducted. Cameras are never placed in bathrooms or sleeping quarters. f. All cameras are visible 	<p>Compliance</p>	<p>There was notice of surveillance on the entry way of the doors, parking lot and inside the admin building. The cameras are in visible spots. Inside the Youth Care Specialist office and the nurses office you can view live footage of the cameras. The cameras can retain the videos up to 30 days. There are no cameras in the bathrooms or bedrooms. There are a total of 27 cameras throughout the facility.</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 list of designated people who are able to access the cameras are as followed. The Shelter Manager, Youth Care Specialist III (supervisor) all of which who have onsite and offsite access.</p>	
<p>Supervisory review of video is conducted a minimum of once every 14 days and timeframes reviewed are noted in the logbook.</p>	<p>Compliance</p>	<p>The Shelter Manager does review the cameras as well and makes a notation.</p>	
<p>The reviews assess the activities of the facility and include a review of random sample of overnight shifts</p>	<p>Compliance</p>	<p>The Shelter Manager makes notes of when she reviews the cameras and findings.</p>	
<p>Grant the requesting of video recordings to yield a result within 24-72 hours from program quality improvement visits and when an investigation is pursued after an allegation of an incident</p>	<p>Compliance</p>	<p>The Shelter Manager and Youth Care Specialist III have the ability to download the footage if requested.</p>	
<p>Camera service order/requests will be made within 24 hours of discovery of camera malfunctioning or being inoperable. All efforts made to obtain repairs are documented and maintained</p>	<p>Not Applicable</p>	<p>During this review time there was no service review that was observed.</p>	

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 agency has a policy called 4.01 Health Care Admission Screening. The policy was reviewed and approved by the Regional Director on August 1, 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	A total of six client files were reviewed to determine their adherence to the requirements of this indicator. All client files contained the initial screening tool and a comprehensive client intake screening. The Intake form includes a series of health screening questions. All six client files had evidence of each client being properly screened for acute past and present medical and mental health issues as required. Each form was completed during the intake session and reviewed by the supervisors and nurse.	
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	All six client files have evidence of each file possessing a screening for a broad range of major chronic medical conditions. No major chronic medical issues were documented.	
When needed, the parent is involved with the coordination and scheduling of follow-up medical appointments	Compliance	Each client file indicated parents/guardians were notified as required. There were no requirements for clients to receive follow up medical appointments.	
All medical referrals are documented on a daily log.	Compliance	All reported incidents have been documented in the program's daily log as required.	
The program has a thorough referral process and a mechanism for necessary follow-up medical care as required and/or needed	Compliance	The agency has a process for ensuring that any required medical follow up for medical and health reasons are planned and scheduled as needed. The agency coordinates these planned events with parents/guardians.	
Additional Comments: There are no additional comments for this indicator.			

4.02 - Suicide Prevention		Satisfactory with Exception	
Provider has a written policy and procedure that meets the requirement for Indicator 4.02	YES		
	If NO, explain here:		
	The agency has a policy called 4.02 Suicide Prevention. The policy was reviewed and approved by the Regional Director on August 1, 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	A total of six randomly selected client files were selected to determine adherence to the requirements of this indicator (five residential and 1 non-residential). All six client files contained evidence of a completed suicide risk screening and the associated results documented in the file.	
The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	Compliance	There were no changes reported to the agency's existing suicide prevention policy since the last time it was approved by the Florida Network.	
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.	Exception	Five residential client files were screened for suicide risk and were placed on sight and sound elevated supervision status. Each youth had evidence of being placed on the correct level of supervision in a timely manner and with the level of supervision required based on the client's identified risk.	One out of three assessments was not found for one client placed on sight and sound supervision.
Staff person assigned to monitor youth maintained one-to-one supervision or constant supervision and documented his/her observations of the youth's behavior at 30 minute or less intervals	Compliance	All youth placed on the sight and sound supervision contained evidence of documented observation checks. Additionally, all notifications of initially placing youth on Sight and Sound status, remaining on the status and or being removed from the status were all documented in the electronic logbook. The observation checks were conducted in the 30 minute or less interval in each youth's file as required.	

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.	Exception	Entries of the status of the four out of the five residential client files indicate time, status of behavior, health and general conditions were documented for each youth in the agency's logbook or observation log.	A total of five out of five observations checks were not found in one out of five residential client files or the electronic log book.
Supervision level was not changed/reduced until a licensed professional or a non-licensed mental health professional under the supervision of a licensed professional completed a further assessment OR Baker Act by local law enforcement	Compliance	All five youth have documented evidence that their supervision level was not changed with out receiving official notification from the licensed professional.	
There was evidence that documentation was reviewed by supervisory staff each shift. If program uses an observation log, completed logs are maintained in the youth's file.	Compliance	All observations logs documenting the status of the youth placed on elevated supervision and all assessments included evidence of being signed and reviewed by the supervisory staff on each shift and assessments being reviewed by the licensed clinician.	
Youth with Suicide Risk (Community Counseling Only)			
Youth identified for suicide risk during intake was immediately assessed by a licensed professional or non-licensed professional (under the direct supervision of a licensed mental health professional) and the parents and supervisor were both notified of the results.	Compliance	One community counseling file identified youth being immediately assessed by the licensed clinician, as well as the parent being notified that the youth indicated positive on the agency's risk screening tool.	
During the intake, if the appropriate staff is unavailable, youth identified for suicide risk was immediately referred by the provider and the parent/guardian is notified of the suicide risk findings disclosed and advised that an Assessment of Suicide Risk should be completed ASAP by a licensed professional.	Compliance	The agency counselor consulted with the clinician at the time the risk was identified, notified parent as required and advised parent of potential need for additional assessment for risk.	
Information on resources available in the community for further assessment was provided to the parent/guardian and is documented in the youth's file and signed by the parent/guardian OR a written follow-up notification was sent by certified mail if the parent/guardian was not present during the screening and was notified by telephone.	Compliance	The agency file indicates that the parent was notified immediately during the intake process. Further, there is evidence that the parent/guardian received information and resources related to precautions, safety and risk planning and local facilities for additional assistance as needed.	
If the parent/guardian cannot be contacted, all efforts to contact them are documented in the case file.	Compliance	The agency file indicates that the parent was notified immediately during the intake process.	
When the screening was completed during school hours on school property, the appropriate school authorities were notified.	No eligible items for review	The screening was not conducted on school grounds. The intake session was conducted onsite at the agency administrative office.	
Additional Comments: There are no additional comments for this indicator.			

4.03 - Medications		Satisfactory	
<p>Provider has a written policy and procedure that meets the requirement for Indicator 4.03</p>		<p>YES</p>	
		<p>If NO, explain here:</p>	
		<p>The agency has a policy called 4.03 Medications. The policy has The policy was reviewed and approved by the Regional Director on August 1, 2024.</p>	
<p>The agency has a Registered Nurse (RN) and/or a Licensed Practical Nurse (LPN) that is being supervised by RN and all of their credentials have been verified.</p>	<p>Compliance</p>	<p>The agency reported that it has had Registered Nurse (RN) on duty since February 2022.</p>	
<p>The agency has evidence of the following for all non-nursing shelter staff designated to assist with the self-administration of medication: a. Documentation of in-person self-administration of medication distribution training provided by a Registered Nurse b. Evidence demonstrating their competency to assist with self-administration of medication distribution c. Maintenance of their annual medication training re-certification</p>	<p>Compliance</p>	<p>A review of the current practice and documentation/evidence resulted in the RN providing evidence of documentation of annual medication distribution training. In the last the year, the RN trained three new staff members for medication distribution training. The RN has evidence of providing nine in-service staff members. The training for staff members included intake through discharge and included review of medication count, verification with the guardian, uniformity of pills, directions on the bottle, and logging the initial time medication are received from the client. This step of receiving medication is documented in the electronic logbook platform under the Intake Process.</p>	
<p>The agency held at least quarterly staff meetings conducted by RN and/or Shelter Manager to review and assess: a. strategies implemented to reduce medication errors shelter wide b. analyze factors that contributed to medication errors c. allow staff the opportunity to practice and role-play solutions</p>	<p>Compliance</p>	<p>A review of medication practice included assessing date(s) of quarterly meetings held. The RN conducts monthly meetings with residential manager regarding medication errors on shift counts, weaknesses in intake, and with drawing medications. The RN conducts mock exercises on medication distribution during the on-boarding process. The RN identifies staff members with weaknesses and works directly with staff members to address on inventory versus the override process. The agency RN requires staff members to complete Medication Distribution policy test for medications. Staff members must score an minimum of 80 to pass.</p>	
<p>The agency has strategies implemented to ensure medications are provided within the 2-hour time frame.</p>	<p>Compliance</p>	<p>The agency informs the staff member that there is a 2 hour window in which to provide medications. Training involves informing staff that medication can be delivered one hour before or one hour after the prescribed medication distribution time. This training requires them to read the Medications policy prior to training and is covered during this training.</p>	
<p>All non-licensed staff members are clearly identified and designated on the staff schedule and shift change report/shift responsibility form for assisting with the self-administration of medications on each shift</p>	<p>Compliance</p>	<p>The agency designates the staff member assigned distribution of medication on each shift by highlighting their name on each work shift.</p>	

<p>The agency has clear methods of communicating which youth are on medications with the times and dosage easily discernable by all staff on each shift.</p>	<p>Compliance</p>	<p>The agency provides a green dot placed on each youth's file that are required to receive medication. The youth name is listed in the pass down shift log as requiring medications for all staff to know the medication and the time the medications are to be delivered. The agency also uses at laminated sheet that list the client's initials, time of distribution and number to be distributed to each client.</p>	
<p>The delivery process of medications is consistent with the FNYFS Medication Management and Distribution Policy and the agency has an internal quality assurance process to include the following: a. to ensure appropriate medication management and distribution methods b. to track medication errors c. to identify systemic issues and implement mitigation strategies, as appropriate.</p>	<p>Compliance</p>	<p>The RN tracks medication errors. The RN reviews the monthly log sheet to identify systemic issues through an audit of the practice process. The RN reviews what is supposed to be given and the times meds are distributed to assess errors. The agency also requires medication to be distributed at the top of the hour. Following the distribution of medications the staff member distributing the medication must call the manager and supervisor on duty to inform them that all medications are passed.</p>	
<p>Admission/Intake of Youth</p>			
<p>a. Upon admission, the youth and parent/guardian (if available) were interviewed by the Registered Nurse (when on-site) about the youth's current medications as part of the Medical and Mental Health Assessment screening process and/or an interview was conducted by the RN within three (3) business days if the RN was not on the premise at admission. <i>*If the agency does not have an RN, there was a medication review conducted by an LPN or certified Leadership position.</i> b. Upon intake/admission, there is evidence that the on-shift certified supervisor of higher level staff did review all medication forms by the next business day.</p>	<p>Compliance</p>	<p>The RN is required to interview the child coming into the shelter on medications. The RN has a three-day or less window in which to review the intake related to medical matters for each child. The YCS III Supervisor is designated to review all medication forms of all youth when the RN is not on duty.</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>All resident medications are stored in the Pyxis medication cabinet and when necessary the facility refrigerator. All medication is stored in its own self-contained closed pocket called a Cubi. The Pyxis keys are stored in a locked office in the same office space location.</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 agency has three site specific Pyxis managers onsite. All staff members trained and approved by the RN have access to prescribed and controlled medications. The RN distributes medications when on duty. The agency does not allow or accept youth requiring insulin. The agency does permit youth epi-pens that are provided by the client and their family. The RN trains all staff members on all epi-pens and auto-injectors.</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 current practice on these three measures resulted in the agency found to be compliant on all three medication distribution log requirements.</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>A review of the current practice related to distributing medication within the required timeframe found all medications are distributed within the required timeframe.</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>Review of practice indicated none documented for the review period.</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 recertification from an RN.</p>	<p>Compliance</p>	<p>The RN conducts retraining on an annual basis or after a medication monthly audit and review of practice. There has been training delivered as a result of a medication error.</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>The agency documents all controlled medication counts on all three work shifts. The agency documents these counts by utilizing the electronic logbook platform (Shift to Shift Control notation). Controlled counts are conducted on all shifts even if there are no controlled medication present in the shelter for good practice.</p>	
<p>There are monthly reviews of the Pyxis reports to monitor medication management practice.</p>	<p>Compliance</p>	<p>The RN conducts reviews of the following Pyxis Reports, which include all events, discrepancies, clients receiving meds, and the inventory weekly.</p>	
<p>Medication discrepancies are cleared after each shift.</p>	<p>Compliance</p>	<p>None documented. The agency must clear discrepancies prior to close of their work shift.</p>	
<p>Additional Comments: There are no additional comments for this indicator.</p>			

4.04 - Medical/Mental Health Alert Process		Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 4.04		YES
		If NO, explain here:
		The agency has a policy called 4.04 Medical / Mental Health Alert Process. The policy was reviewed and approved by the Regional Director on August 1, 2024.
Youth with a medical, mental health, or food allergy was appropriately placed on the program's alert system	Compliance	A total of six randomly selected residential client files were selected to determine adherence to the requirements of this indicator. All six client files contained evidence of a completed screening for all applicable alerts.
Alert system includes precautions concerning prescribed medications, medical/mental health conditions	Compliance	All six client files have evidence of each file possessing a screening for a broad range of major alerts included clients currently on medications or possessing mental health issues.
Staff are provided sufficient training, information and instructions to recognize/respond to the need for emergency care for medical/mental health problems	Compliance	A review of training curriculum provided to staff members indicate that staff members are provided signs and symptoms of mental health and or other medical issues.
A medical and mental health alert system is in place that ensures information concerning a youth's medical condition, allergies, common side effects of prescribed medications, foods and medications that are contraindicated, or other pertinent mental health treatment information, is communicated to all staff	Compliance	The agency has a medical and mental health alert system that identifies the appropriate alert for staff members to be informed of across each work shift to be aware of related to medical, mental health, allergies, behavior and other information related to specific treatment regimens a youth must receive during their shelter stay.
Additional Comments: There are no additional comments for this indicator.		

4.05 - Episodic/Emergency Care		Satisfactory	
Provider has a written policy and procedure that meets the requirement for Indicator 4.05		YES	
		If NO, explain here:	
		The agency has a policy called 4.05 Episodic / Emergency Care. The policy was reviewed and approved by the Regional Director on August 1, 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	No eligible items for review	The agency had no eligible items for review for this indicator. The agency reported two Mock Drills were performed related to injuries requiring medical care. One case occurred on October 28, 2024, (head injury - 2024-00000) and the second drill was performed on Jan 30, 2025, (slip and fall - 2025-00000) drills agency. The agency used simulated incidents cited in this write up.	
All staff are trained on emergency medical procedures	Compliance	A random sample of staff members training files indicate staff have evidence of first aid, Cardiopulmonary resuscitation (CPR), universal precautions, and other safety training courses.	
The program has a Knife-for-life and wire cutters accessible to staff in a secure location(s)	Compliance	The agency has emergency equipment onsite which includes a knife for life and wire cutters in case of an emergency. The emergency equipment is secured in a locked cabinet in the youth care work office and is not accessible to residents.	
Additional Comments: There are no additional comments for this indicator.			