



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

Youth Crisis Center

3015 Parental Home Road
Jacksonville, FL 32216

May 7-8, 2025

Compliance Monitoring Services Provided by



EXECUTIVE SUMMARY

Forefront LLC conducted a Quality Improvement (QI) monitoring visit on behalf of the Florida Network of Youth and Family Services (FNYFS) for the Youth Crisis Center for the FY 2024-2025 at its program office located at 3015 Parental Home Road Jacksonville, Florida 32216. 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. Youth Crisis Center is contracted with the Florida Network of Youth and Family Services (FNYFS) to provide direct services to Children/Families in Need of Services (CINS/FINS). The services to be provided are identified in Contract Section A - Descriptions and Specifications and Section B - Delivery and Performance, and are funded with General Revenue Funds effective from July 2024 through June 30, 2025.

The compliance monitoring review was conducted by Andrea Haugabook, Consultant for Forefront LLC. Agency representatives from Youth Crisis Center present for the entrance interview were: Logan Farrelly/ COO, Clarissa Benitez, Rhode Meone, Avinia Castro/ HR Generalist, Kallissa Watson/ Compliance. The last onsite QI visit was conducted on May 15-16, 2024.

In general, the Reviewer found that Youth Crisis Center is in compliance with specific contract requirements. **Youth Crisis Center received an overall compliance rating of 100% for achieving full compliance with 12 indicators** of the CINS/FINS Monitoring Tool. 1) There were no recommendations and no corrective action 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 05-07-08-2025

Agency Name: Youth Crisis Center					Monitor Name: Andrea Haugabook, Lead Reviewer		
Contract Type : CINS/FINS					Region/Office: 3015 Parental Home Road, Jacksonville, FL 32216		
Service Description: Comprehensive Onsite Compliance Monitoring					Site Visit Date(s): May 7-8, 2025		
Major Programmatic Requirements	Explain Rating					Ratings Based Upon: I = Interview O = Observation D = Documentation PTV = Submitted Prior To Visit (List Who and What)	Notes Explain Unacceptable or Conditionally Acceptable:
	Unacceptable	Conditionally Acceptable	Fully Met	Exceeded	Not Applicable		
I. Administrative and Fiscal							
DJJ Quality Improvement Peer Reviewer a. Provider shall demonstrate that a minimum of two (2) staff members have been trained to be certified as DJJ QI Peer reviewers. Provider shall participate in a minimum of one (1) on-site quality assurance review of a similar type of program in another judicial circuit during each 12-month period of the contract, if requested.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	The agency currently has one peer reviewer, Logan Farrley, COO. There were two additional peer reviewers who exited the agency recently. One of the previous peer reviewers did complete a review of a similar type in another judicial circuit during this contract's 12-month period. At the time of this review, there was still time remaining this fiscal year for the provider to complete a second review. The program is prepared to send additional staff members to the next available peer training.	
Additional Contracts a. Provider shall provide a listing of all current federal, state, or local government contracts, as well as other contracts entered into with for profit and not-for-profit organizations. Such a listing shall identify the awarding entity and contract start & end dates. PTV	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	The following is the list of additional contracts provided by the agency: Florida Network of Youth and Family Services, Department of Children and Families, Family Support Services, Baptist Hospital, Kids Hope Alliance, Kids, United Way of NE FL, Community Development Block Grant (Duval), Moran Foundation, Jaguars	

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						Foundation, Everbank, and Hume Foundation.	
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"/>	The agency has a current certificate of insurance from Arthur J. Gallagher Risk Management Services, LLC which shows the following coverages from 07/01/2024-07/1/2025 (except where indicated): Worker's Compensation and Employer's liability insurance as required by Chapter 440, F.S. with a limit of \$500,000 per accident, \$500,000 per person and \$500,000 policy aggregate; Commercial General Liability, damage to rented property, personal and advance injury, each with a limit of \$1,000,000, general aggregate and products liability with a limit of \$3,000,000 each, and medical expense (any one person) \$20,000. Automobile Liability Insurance, which includes a combined single limit of 1,000,000. Additional coverage includes student accident for medical expenses of \$25,000 (10/31/202, professional liability and sexual abuse and molestation with a limit of \$1,000,000 each claim and	

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						\$3,000,000 aggregate. The Florida Network of Youth and Family Services is listed on the COI 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"/>	The agency reports there are no corrective action items cited by external funding sources.	
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"/>	The agency has employee and fiscal policies and procedure manuals that comply with GAPP and the agency's partnership and practice with the finance team at Klasfeld (3 rd party bookkeeper) provide sound internal controls. All fiscal processes are performed in-house and sent to Klasfeld for review, sent back to the CEO of approval of payment/ authorization and then paid by Klasfeld electronically or a check is issued and sent to the CEO for signature and disbursement. The agency The fiscal policies were last reviewed by the CEO January 2023. The agency	

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						maintains fiscal files that are audit ready.	
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"/>	A review of the agency's general ledger from July 1, 2024 – March 31, 2025 with corresponding source documents shows the general ledger is set up to track the activity of the grant separately for each revenue source.	
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"/>	The COO maintains the petty cash fund. Receipts are submitted to the Chief Development Officer for reconciliation and replenishing as needed. The designated amount of the petty cash fund is \$400. Staff make requests for petty cash for various youth activities and bring back a receipt for the funds used. Activities typically include outings, clothing, and anything pertaining to the youth's needs in shelter. The petty cash was observed to be maintained in a locked	

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						cash box. The petty cash was reconciled on-site and all cash on hand and receipts on hand balanced out to the designated fund amount of \$400.	
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"/>	<p>The agency has two operating accounts with two banks. Monthly bank statements and corresponding reconciliation reports from October 2024 – March 2025 were reviewed for each account. An interview with the Chief Development Officer indicates that bank statements are pulled on the 1st of the month and reconciled by Klasfeld. The reconciliations are sent to the CEO and Chief Development Officer for review and approval.</p> <p>The Chief Development Officer prepares and sends an accounts payable schedule to Klasfeld twice monthly to prepare payments for invoices/ bills. The bookkeeper then</p>	

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						prepares a report for the CEO to approve payments. Payments are made by Klasfeld electronically or printed checks are sent to the CEO and COO for signature and disbursement.	
e. Agency maintains inventory in accordance with a written policy and FNYFS contractual requirements. If over \$1,000 inventory has DJJ Property Inventory Number/Tag. In the event the provider has purchased computer equipment an Informational Resources Request (IRR) has been submitted to DJJ. PTV/ON SITE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	The agency currently has no assets purchased with Florida Network funds.	
f. Agency submits payroll taxes and deposits (and retirement deposits as applicable), <u>Employee</u> IRS Form W-2 and <u>Independent Contractors</u> IRS Form 1099 forms prior to federal requirements. ON SITE	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	The agency prepares and approves payroll reports in-house and submits it twice monthly to the Klasfeld for review, verification and submission to ADP for processing. Payroll taxes, deposits, IRS forms and retirement deposits are all processed through ADP. Completed 941 reports were observed for the periods ending December 2024 and March 2025. An	

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						annual 940 for year ending December 2024 was reviewed.	
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"/>	An agency budget to actual report was reviewed from July 2024 to present. Budget reports are prepared by the Chief Development Director with 29 cost centers. The CEO reviews each of those cost centers. Monthly finance packets (profits and loss statements and balance sheets) are prepared by Klasfeld and sent to the CEO for review and approval. The CEO, Chief Development Officer and Klasfeld report all budget information to the finance committee of the board monthly.	
h. A Single Audit is performed as part of the annual audit if expenses are greater than \$750,000. The agency must submit a Corrective Action Plan for findings cited in the management letter and single audit. An annual financial audit was completed within 120 days after the previous fiscal year/calendar year and that a copy was provided to the Network unless and extension has been requested	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	The agency presented an audit report completed on December 13, 2024, by Neville Waino, CPA's. The report is a combined financial statement for the years ended June 30, 2024, and 2023. There is no management letter.	

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and approved in writing. Copy of Audit is submitted to the FNYFS by December 31st. Can obtain from FNYFS										
i. Agency maintains confidentiality policy with written policies and procedures to ensure the security and privacy of all employee and client data. Personal information is not easily accessible. Agency maintains a backup system in case of accidental loss of financial information. Security procedures are in place to protect laptops. Obsolete documents are shredded, and computer hard drives are wiped prior to discarding. ON SITE					<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	The agency has a confidentiality policy pertaining to confidentiality of medical information, outlined in the Employee Handbook last revised February 1, 2023. There is additional language in the 2023-2024 YCC Operations Manual, included in 1.01 Program Description and Mission Statement, which discusses client confidentiality.
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"/>	The agency provided a report of all direct care staff with titles, pay rate, and hire date. All direct care staff are currently being paid at least \$19.00 per hour.

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CONCLUSION

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

SUMMARY OF CORRECTIVE ACTIONS or RECOMMENDATIONS

Corrective Action (1)

NONE

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



Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Youth Crisis Center
CINS/FINS Program

Date: May 7-8, 2025

Compliance Monitoring Services Provided by



CINS/FINS Rating Profile

Standard 1: Management Accountability

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

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

Standard 2: Intervention and Case Management

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

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

Standard 3: Shelter Care & Special Populations

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

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

Standard 4: Mental Health/Health Services

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

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

Overall Rating Summary

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

Rating Definitions

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

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

Reviewers

Members

- Andrea Haugabook - Lead Reviewer Consultant-Forefront LLC/Florida Network of Youth and Family Services
- Meghan Thrasher – Regional Monitor, Department of Juvenile Justice
- Lori Bright – Regional Monitor, Department of Juvenile Justice
- Cyntoria Thomas – Thaise Educational and Exposure Tours
- Pamela Washington – Arnette House
- Jennifer Erfurth – Crosswinds

Methodology

This review was conducted in accordance with FDJJ-2000 (Quality Assurance Policy and Procedures), and focused on the areas of (1) Management Accountability, (2) Intervention and Case Management, (3) Shelter Care/Health Services, and (4) Mental Health/Health Services, which are included in the Children/Families in Need of Services (CINS/FINS) Standards (Effective July 1, 2024).

Persons Interviewed

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

Documents Reviewed

- | | | |
|---|--|--|
| <input type="checkbox"/> Accreditation Reports | <input checked="" type="checkbox"/> Table of Organization | <input type="checkbox"/> Visitation Logs |
| <input checked="" type="checkbox"/> Affidavit of Good Moral Character | <input type="checkbox"/> Fire Prevention Plan | <input checked="" type="checkbox"/> Youth Handbook |
| <input checked="" type="checkbox"/> CCC Reports | <input checked="" type="checkbox"/> Grievance Process/Records | 5 # Health Records |
| <input checked="" type="checkbox"/> Logbooks | <input checked="" type="checkbox"/> Key Control Log | 10 # MH/SA Records |
| <input type="checkbox"/> Continuity of Operation Plan | <input checked="" type="checkbox"/> Fire Drill Log | 23 # Personnel /Volunteer Records |
| <input checked="" type="checkbox"/> Contract Monitoring Reports | <input checked="" type="checkbox"/> Medical and Mental Health Alerts | 8 # Training Records |
| <input type="checkbox"/> Contract Scope of Services | <input checked="" type="checkbox"/> Precautionary Observation Logs | 8 # Youth Records (Closed) |
| <input checked="" type="checkbox"/> Egress Plans | <input checked="" type="checkbox"/> Program Schedules | 9 # Youth Records (Open) |
| <input checked="" type="checkbox"/> Fire Inspection Report | <input checked="" type="checkbox"/> List of Supplemental Contracts | <input type="checkbox"/> # Other: __ |
| <input type="checkbox"/> Exposure Control Plan | <input checked="" type="checkbox"/> Vehicle Inspection Reports | __ |

Observations During Review

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

Surveys

- | | | | |
|---------------|---------------------|------------|--------------------------|
| 15 # of Youth | 9 # of Direct Staff | # of Other | <input type="checkbox"/> |
|---------------|---------------------|------------|--------------------------|

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

Youth Crisis Center (YCC) is located at 3015 Parental Home Road, Jacksonville, FL 32216. The agency operates Residential, SNAP, and Family Link Services under a contract with the Florida Network of Youth and Family Services for Children In Need of Services/ Families In Need of Services (CINS/ FINS). CINS/ FINS programs provide temporary shelter care and crisis counseling services for runaways, ungovernable, troubled and/or habitually truant youth (ages 10-17) and their families. The intent of CINS/FINS is to divert children who commit status offenses from entering the child welfare or juvenile justice systems. YCC serves the following Florida judicial circuits: 07, 04, and 08 throughout Nassau, Saint Johns, Baker Duval, and Clay counties.

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 with Exception**.

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

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**.

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

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

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

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

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

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

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

Standard 3: There are seven indicators for Standard 3.

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

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

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

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

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

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

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

Standard 4: There are five indicators for Standard 4.

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

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

Indicator 4.03 Medications was rated **Satisfactory.**

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

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

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

CINS/FINS QUALITY IMPROVEMENT TOOL			
Quality Improvement Indicators and Results: Please select the appropriate outcome for each indicator for each item within the indicator.		Summary/Narrative Findings: The narrative write-up is a thorough summary of each assigned QI indicator, explaining how finding(s) are determined.	
		Deficiencies/Exceptions: Please add additional detailed explanations for any items that have any deficiencies or exceptions.	
Standard One – Management Accountability			
1.01: Background Screening of Employees, Contractors and Volunteers			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 1.01		YES	
		If NO, explain here:	
		The agency has a policy 7.01 Background screening of employees and volunteers, last reviewed 07/01/2024 by the CEO.	
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	Six of twenty new-hire employees had evidence of successful completion of a pre-employment suitability assessment prior to an offer of employment.	<p>Fourteen of twenty new-hire employees providing direct services to youth did not successfully complete a suitability assessment prior to an offer of employment.</p> <p>Appeal Granted by the Florida Network - 1.01 previously rated Limited is changed to Satisfactory.</p> <p>Florida Network Response: Interviewed COO and reviewed a sample of suitability assessments and offer letters provided to prospective hires. The time stamps make it clear that the practice is to conduct the screenings prior to an offer of employment being offered, even if it is on the same day.</p>
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.	Compliance	Three of twenty new-hire employees did not pass the pre-employment assessment on the initial attempt. There was evidence that the three employees retook and passed the pre-employment suitability assessment within five days of the initial attempt and did not exceed three attempts within thirty days.	
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	There were no employees hired within the review period who have had a break in service for 18 months or more.	

<p>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></p>	<p>Compliance</p>	<p>Nineteen of twenty new-hire employees had evidence of an eligible background screening completed prior to hire/ start date. One new-hire employee hire date preceded the date of eligibility on the DJJ background screening. Interview with the HR Specialist confirmed and verified through time sheets and payroll records that the employee had only began training with the administration department and had no contact with youth or youth records prior to receipt of the background screening.</p>	
<p>Five-year re-screening is completed every 5 years from the date of the last screening for all applicable employees and volunteers.</p>	<p>Compliance</p>	<p>Three of three employees eligible for a five-year rescreen from the date of the last screening did receive a completed re-screen prior to the expiration of their retained fingerprints.</p>	
<p>Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?</p>	<p>Compliance</p>	<p>Emailed verification of an Annual Affidavit of Compliance with Level 2 Screening Standards completed January 13, 2025 was verified as being sent to BSU.</p>	
<p>Proof of E-Verify for all new employees obtained from the Department of Homeland Security</p>	<p>Compliance</p>	<p>All employees reviewed had evidence of a E-Verify obtained from the Department of Homeland Security.</p>	
<p>Additional Comments: There are no additional comments for this indicator.</p>			
<p>1.02: Provision of an Abuse Free Environment</p>			<p>Satisfactory</p>
<p>Provider has a written policy and procedure that meets the requirement for Indicator 1.02</p>	<p>YES</p>		
	<p>If NO, explain here:</p>		
	<p>The agency has a policy 5.02 Provision for abuse free environment, reviewed 7/01/2024 by CEO.</p>		
<p>Agency has a code of conduct of policy and there is evidence that staff are aware of agency's code of conduct.</p>	<p>Compliance</p>	<p>The agency's policy addresses a code of conduct which states staff/ interns are to adhere to a code of conduct that forbids the use of physical abuse, profanity, threats, intimidation and inappropriate language. All staff are aware and acknowledge the agency's code of conduct upon hiring.</p>	
<p>The agency has a process in place for reporting and documenting child abuse hotline calls.</p>	<p>Compliance</p>	<p>The agency has a process in place for reporting and documenting child abuse hotline calls.</p>	
<p>Youth were informed of the Abuse and Contact Number</p>	<p>Compliance</p>	<p>All youth are informed of the Abuse Hotline number during intake.</p>	

Grievance			
The program(s) have an accessible and responsive grievance process for youth to provide feedback and address complaints. Program director/ supervisor has access to and can manage grievances unless it is towards themselves.	Compliance	The program has an accessible and responsive grievance process for youth to provide feedback and address complaints. Eight grievances were reviewed from October 2024-April 2025. The supervisor manages all grievances unless it is towards themselves.	
<u>Shelter only:</u> Grievances are maintained on file at minimum for 1 year.	Compliance	All grievances are maintained for a minimum of one year according to the programs policy and procedure.	
<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	Locked grievance boxes (and blank forms) were observed posted on the wall in the hallway outside each wing of the boys and girls dorm. The grievance policy and procedure was posted above each locked grievance box.	
<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	Evidence in the program's log book was observed from October 2024 - April 2025 that the supervisor checks the grievance box every weekday.	
<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	Each of the eight grievances reviewed were resolved within 72 hours of being submitted.	
Additional Comments: There are no additional comments for this indicator.			
1.03: Incident Reporting			Satisfactory with Exception
Provider has a written policy and procedure that meets the requirement for Indicator 1.03	YES		
	If NO, explain here:		
	The agency has a policy 5.01, Incident reporting, last reviewed 07/01/2024 by the CEO.		
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	From November 1, 2024 - May 7, 2025, the program did not have any occurrences of notifying the CCC later than two hours after a reportable incident occurring or within two hours of learning of the incident.	
The program completes follow-up communication tasks/special instructions as required by the CCC	Compliance	Evidence the program completes follow-up communication tasks/special instructions as required by CCC is observed in the incident report documentation.	

<p>Agency internal incidents are documented on incident reporting forms and all CCC reportable incidents were consistently reported to CCC as required.</p>	<p>Exception</p>	<p>A total of 48 internal incidents were recorded from November 1, 2024 - May 7, 2025. Forty-seven of forty-eight incidents were documented on internal incident report forms. Thirteen of the 48 incidents were CCC reportable and each were consistently reported to the CCC as required.</p>	<p>Initial observation of one CCC report (#202502003 dated 04/07/2025) was not documented on an internal incident report form. An internal incident report form was completed by the COO and provided prior to completion of the on-site review.</p>
<p>Incidents are documented in the program logs and on incident reporting forms</p>	<p>Compliance</p>	<p>Verification of incident reports documented in the program's electronic logbook was observed.</p>	
<p>All incident reports are reviewed and signed by program supervisors/ directors</p>	<p>Compliance</p>	<p>Internal incident report forms are completed and sent the shift supervisor for review and signature and then the residential supervisor for review and signature. A total of 48 internal incidents were recorded from November 1, 2024 - May 7, 2025, all reviewed and signed by the supervisor.</p>	
<p>Additional Comments: The following types of incidents were recorded: Program Disruption (6), Medical (3), Mental Health/ Substance Abuse (2), and Complaints Against Staff (2). The three medical incidents were each episodic occurrences and no medical errors were documented in the past six months.</p>			
<p>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>)</p>			<p>Satisfactory</p>
<p>Provider has a written policy and procedure that meets the requirement for Indicator 1.04</p>	<p>YES</p>		
	<p>If NO, explain here:</p>		
	<p>The agency has a policy and procedures 7.02, Staff Training reviewed July 1, 2024 by the President and Chief Executive Officer.</p>		
<p>First Year Direct Care Staff</p>			

<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>The program has policy and procedures for all first year direct staff to complete specific training. Four (4) first year staff were reviewed and all direct care staff completed their pre-service training requirements including:</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, as seen on their individual training log and signed certificates. 	
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All staff completed the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days from date of hire.	Compliance	The four (4) first youth staff all completed the United States Department of Justice (DOJ) Civil Rights and Federal Funds training within thirty (30) days of hire date.	
All direct care CINS/FINS staff for shelter and community counseling services, including independent contractors (full-time, part-time, and on-call) and interns met the minimum requirement of 80 hours of training for the first full year of employment.	Compliance	All four Children In Need of Services/Families In Need of Services (CINS/FINS) direct care staff files reviewed met the requirement of eighty (80) hours of training for the first full year of employment.	
All staff receives all mandatory training during the first 90 days of employment from date of hire.	Compliance	All four staff files reviewed received all mandatory training during the first ninety (90) days of employment from date of hire.	
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	Two (2) of the four (4) staff reviewed assist with medication distribution. Both staff received in-person training from a Registered Nurse prior to administering medication to shelter youth.	
Staff that are Utilizing NETMIS			
Any staff that is utilizing NETMIS has evidence of completing NetMIS Training in their training file.	Compliance	Two (2) of the four (4) staff reviewed uses NETMIS. There are certificates of completion in their training file.	
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.</u> (Policy went into effect 7/1/23).	No eligible items for review	The four (4) first year staff reviewed do not require CINS Petition training. There is no eligible items for review.	
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	The four (4) first youth staff reviewed are not non-licensed mental health clinical shelter staff. There is no eligible items for review.	
In-Service Direct Care Staff			
In-service staff completes all of the required annual or 2-year mandatory refresher Florida Network, SkillPro, or other job-related trainings within the required timeframe.	Compliance	Four (4) Staff files reviewed indicated all of the required annual or 2-year mandatory refresher Florida Network, SkillPro, or other job related trainings were completed within the timeframe.	

Community Counseling Direct Care staff completes 24 hours of mandatory refresher Florida Network, SkillPro, and job-related training annually.	Compliance	Community Counseling Direct Care staff files reviewed indicated twenty-four (24) hours of mandatory refresher Florida Network, SkillPro and job related training annually completed.	
Shelter Program Direct Care staff completes 40 hours of mandatory refresher Florida Network, SkillPro, and job-related training annually (<i>E.g. the program has a DCF child caring license</i>).	Compliance	Shelter Program Direct Care staff files reviewed indicated completion of forty (40) hours of mandatory refresher Florida Network, SkillPro, and job related training annually.	
Required Training Documentation			
The agency has a training plan that includes all of the required training topics including the pre-service and in-service.	Compliance	The program has a training plan that includes all of the required training topics including the pre-service and in-service.	
The agency has a designated staff member responsible to manage all employee's individual training files and completes routine tracking and reviews of staff files to ensure compliance.	Compliance	The program has a designated staff member responsible to manage all employee's individual training files and routinely tracks and reviews 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.	Compliance	The program maintains an individual training file and a FLN Training Log for each staff, which includes annual employee training hours tracker form and training certificates sign-in sheets, and agendas for trainings attended.	
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:		The eight (8) staff files reviewed for pre-service and annual training indicated completion of Naloxone Training as required within 90 days of hire or one (1) year from the policy effective date of 7/1/2024.	
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 program has a policy, 6.01 Quality improvement/ Analyzing and reporting, last reviewed 07/01/2024 by the CEO.	
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	Minutes from the last six months (November 2024 through April 2025) of staff's end of month reviews, indicate that case record reviews are being conducted at least quarterly. Summaries of case record reviews were observed as being completed 12/09/2024, 02/10/2025, 03/10/2025, and 4/14/2025.	

<p>The program conducts reviews of incidents, accidents, and grievances quarterly, at a minimum</p>	<p>Compliance</p>	<p>Review of meeting minutes from the last six months show the program conducts monthly reviews of incidents, accidents, and grievances.</p>	
<p>The program conducts an annual review of customer satisfaction data</p>	<p>Compliance</p>	<p>The program conducts an annual review of customer satisfaction data as evidenced in the staff meeting minutes reviewed from 12/09/2024.</p>	
<p>The program demonstrates a monthly review of the statewide End-of-Month ("EOM") report generated by the Florida Network Office. This includes monthly data, fiscal year to date data, benchmarks for residential and community counseling, screening data, report card measures, follow-up reporting measures.</p>	<p>Compliance</p>	<p>YCC showed written proof that they have monthly reviews of the statewide End of the Month reports generated by Florida Network which includes monthly data, fiscal year to date data, benchmarks for residential and community counseling, screening data, report card measures, and follow-up reporting measures.</p>	
<p>The program has a process in place to review and improve accuracy of data entry & collection</p>	<p>Compliance</p>	<p>A review of the staff's monthly meeting minutes, shows evidence of a process in place to review and improve accuracy of data entry and collection within the program.</p>	
<p>There is documentation that findings are regularly reviewed by management and communicated to staff and stakeholders.</p>	<p>Compliance</p>	<p>A review of meeting minutes show that findings are regularly reviewed by management and communicated to staff and stakeholders.</p>	
<p>There is evidence the program demonstrates that program performance is routinely reviewed with the Board of Directors. All final reports that include a Limited or Failed score is submitted electronically or by mail to the providers Executive Committee on the Board of Directors.</p>	<p>Compliance</p>	<p>A review of board meeting minutes demonstrates that program performance is routinely reviewed with the Board of Directors. All final reports that include a Limited or Failed score communicated to the executive committee of the board of directors. Board of Director Meeting Minutes were reviewed from March 25, 2025, January 28, 2025, December 3, 2024, September 24, 2024, July 20, 2024 and May 28, 2024.</p>	
<p>There is evidence that strengths and weaknesses are identified, improvements are implemented or modified, and staff are informed and involved throughout the process.</p>	<p>Compliance</p>	<p>Strengths and weaknesses are identified, improvements are implemented or modified, and staff are informed and involved throughout the process during the monthly staff meetings.</p>	
<p>Additional Comments: There are no additional comments for this indicator.</p>			

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 program has a policy, 5.05 Transportation of youth, last reviewed 07/01/2024 by the CEO.	
Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	Compliance	The program has a list of approved agency drivers that have been approved by administrative personnel to drive client(s) in agency vehicles. The agency uses two 2019, white, 12-passenger, Ford Transit vans to transport youth.
Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	Compliance	Proof of valid driver's licenses were reviewed for all approved drivers and proof of insurance coverage under the company insurance policy was observed.
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 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.
In the event that a 3 rd party cannot be obtained for transport, the agency's supervisor or managerial personnel consider the clients' history, evaluation, and recent behavior	Compliance	The agency's policy states: the 3 rd party is an approved volunteer, intern, agency staff, or other youth.
The 3 rd party is an approved volunteer, intern, agency staff, or other youth	Compliance	The agency's policy states: the 3 rd party is an approved volunteer, intern, agency staff, or other youth. It is evident in the agency's transportation logs that third parties include youth and other agency staff.
The agency demonstrated evidence via logbook or other written verification that supervisor approval was obtained prior to all single youth transports.	Compliance	The program's logbooks were reviewed from November 1, 2024 - April 30, 2025 and there were 26 single transports observed. The following dates of single transport events were verified in the program's logbook: 2/10/2025, 3/5/2025, 1/30/2025, 11/22/2024, 11/6/2024, 11/01/2024, 12/10/2024 - 12/19/2024, 3/28/2025, 03/29/2025. All of the single transports have written verification that supervisor approval was obtained prior to the single youth transports taking place.

<p>When transporting a single client in a vehicle, there was documentation of the following: a. the transporting employee completed check-in by phone at agreed-upon intervals with the senior program leader, or designee, upon departure and arrival. b. the employee check-ins were documented by the manager or designee receiving the call.</p>	<p>Compliance</p>	<p>The program's logbook documented employee check-ins at agreed upon intervals and were documented by the supervisor receiving the call.</p>	
<p>There is documentation of use of vehicle that notes name or initials of driver, date and time, mileage, number of passengers, purpose of travel and location.</p>	<p>Compliance</p>	<p>The agency maintains transportation logs in each of the programs' vehicles. The agency's transportation logs contain: name or initials of driver, date and time, mileage, number of passengers, purpose of travel and location.</p>	
<p>Additional Comments: There are no additional comments for this indicator.</p>			
<p>1.07 - Outreach Services</p>			<p>Satisfactory</p>
<p>Provider has a written policy and procedure that meets the requirement for Indicator 1.07</p>	<p>YES</p>		
	<p>If NO, explain here:</p>		
	<p>The program has a policy, 1.02 Interagency agreements and Outreach services, last reviewed 07/01/2024 by the CEO.</p>		
<p>The program has a lead staff member designated to participate in local DJJ board, Circuit and Council meetings with evidence that includes minutes of the event or other verification of staff participation.</p>	<p>Compliance</p>	<p>The Chief Operating Officer (COO) is designated to participate in local DJJ Board events. There was evidence of attendance to the DJJ Board and Circuit/Council meetings during this reporting period and entry in NETMIS.</p>	
<p>The program maintains written agreements with other community partners which include services provided and a comprehensive referral process.</p>	<p>Compliance</p>	<p>There was evidence of written community partnership agreements which included service provided and the referral process.</p>	
<p>The program will maintain documentation of outreach activities and enter into NetMIS the title, date, duration (hours), zip code, location description, estimated number of people reached, modality, target audience and topic.</p>	<p>Compliance</p>	<p>The program maintains outreach activities in NETMIS which included title, date, duration, zip code, location, estimated number of attendees, modality target audience and topic.</p>	
<p>The program has designated staff that conducts outreach which is defined in their job description.</p>	<p>Compliance</p>	<p>The Chief Operating Officer is designated to conduct outreach as defined in the job description.</p>	
<p>Additional Comments: There are no additional comments for this indicator.</p>			

Standard Two – Intervention and Case Management			
2.01 - Screening and Intake			Satisfactory with Exception
Provider has a written policy and procedure that meets the requirement for Indicator 2.01		YES	
		If NO, explain here:	
		The agency has a policy, 2.01 - Screening Eligibility for Services, reviewed on 7/01/2024 by the CEO.	
Shelter youth: Eligibility screening form is completed immediately for all shelter placement inquiries.	Compliance	Reviewed five residential files. All files were in compliance with having an eligibility screening form completed immediately.	
Community counseling: Eligibility screening form is completed within 3 business days of referral by a trained staff using the Florida Network screening form.	Exception	Reviewed five community counseling files. Four of five files contained an eligibility screening form completed within 3 business days of referral.	One out of the five files did not complete an eligibility screening form within three business days of the referral.
There is evidence all referrals for service is screened for eligibility and is logged in NetMIS within 72 hours of screening completion.	Compliance	Reviewed five residential and five community counseling files. All files were in compliance for having all referrals screened for eligibility and logged into NetMIS within 72 hours of completion of the screening.	
Youth and parents/guardians receive the following in writing: a. Available service options b. Rights and responsibilities of youth and parents/guardians	Compliance	Reviewed five residential and five community counseling files. All files were in compliance of the indicator with having youth and parents receive available service options and rights and responsibilities of the youth and parents in writing.	
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	Compliance	Reviewed five residential and five community counseling files. All files were in compliance of this indicator with youth and parents having the following available: possible actions occurring through involvement with CINS/FINS services and grievance procedures.	
During intake, all youth were screened for suicidality and correctly assessed as required if needed.	Compliance	Reviewed five residential and five community counseling files. All files were in compliance of this indicator as the	
Additional Comments: There are no additional comments for this indicator.			
2.02 - Needs Assessment			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 2.02		YES	
		If NO, explain here:	
		The agency has a policy, 3.05 - NIRVANA and Re-Classification Alert Form, reviewed 7/01/2024 by the CEO.	
Shelter Youth: NIRVANA is initiated within 72 hours of admission	Compliance	Reviewed five residential files. All files were in compliance of this indicator for having initiated a NIRVANA within 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	Reviewed five community counseling files. All files were in compliance of this indicator because the NIRVANA was initiated at intake and completed within 2 or 3 face-to-face contacts after the initial intake.	
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.	Compliance	Reviewed five residential and five community counseling files. All files were in compliance of this indicator because supervisor signatures were documented on all completed NIRVANA assessment and chronological notes are located in each file.	
(Shelter Only) NIRVANA Self-Assessment (NSR) is completed within 24 hours of youth being admitted into shelter. If unable to complete, there must be documentation in NetMIS and the youth's file explaining the barriers to completion.	Compliance	Reviewed five residential files. All files were in compliance of this indicator because a NIRVANA Self-Assessment was completed within 24 hours of each youth being admitted.	
A NIRVANA Post-Assessment is completed at discharge for all youth who have a length of stay that is greater than 30 days.	Compliance	Reviewed five residential files. One closed residential file contained a NIRVANA Post-Assessment completed at discharge. All other files were still open.	
A NIRVANA Re-Assessment is completed every 90 days excluding files for youth receiving SNAP services.	Compliance	Reviewed five community counseling files. One closed file was applicable and contained a NIRVANA Re-Assessment.	
All files include the interview guide and/or printed NIRVANA.	Compliance	Reviewed five residential and five community counseling files. All files were in compliance of this indicator.	
Additional Comments: There are no additional comments for this indicator.			
2.03 - Case/Service Plan			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 2.03	YES		
	If NO, explain here:		
	The agency has a policy, 3.05 NIRVANA and Re-Classification Alert Form, last reviewed 7/01/2024 by the CEO.		
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	Reviewed five residential and five community counseling files. All applicable files were in compliance of this indicator because the program uses a case plan through NetMIS and is based on information gathered during the screening, initial intake, and from the NIRVANA assessment.	
Case/Service plan is developed within 7 working days of NIRVANA	Compliance	Reviewed five residential and five community counseling files. All applicable files had case/ service plans developed in seven working days of the NIRVANA.	

<p>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</p>	<p>Compliance</p>	<p>Reviewed five residential and five community counseling files. All applicable files were in compliance of the indicator because all case service plans contained: 1. Individualized and prioritized need(s) and goal(s) identified by the NIRVANA 2. Service type, frequency, location 3. Person(s) responsible 4. Target date(s) for completion and actual completion date(s) 5. Signature of youth, parent/guardian, counselor, and supervisor 6. Date the plan was initiated</p>	
<p>Case/service plans are reviewed for progress/ revised by counselor and parent (if available) every 30 days for the first three months and every 6 months after</p>	<p>Compliance</p>	<p>Reviewed five residential and five community counseling files. Files contained proof of case/ service plan reviews every 30 days for the first three months and every 6 months after, where applicable.</p>	
<p>Additional Comments: There are no additional comments for this indicator.</p>			
<p>2.04 - Case Management and Service Delivery</p>			<p>Satisfactory</p>
<p>Provider has a written policy and procedure that meets the requirement for Indicator 2.04</p>	<p>YES</p>		
	<p>If NO, explain here:</p>		
	<p>The agency has a policy, 4.05 Case Management and Service Delivery, last reviewed 7/01/2024 by the CEO. □</p>		
<p>Counselor/Case Manager is assigned</p>	<p>Compliance</p>	<p>A counselor/ case manager is assigned in each file reviewed. Five residential and five community counseling files were reviewed.</p>	

<p>The Counselor/Case Manager completes the following as applicable:</p> <ol style="list-style-type: none"> 1. Establishes referral needs and coordinates referrals to services based upon the on-going assessment of the youth's/family's problems and needs 2. Coordinates service plan implementation 3. Monitors youth's/family's progress in services 4. Provides support for families 5. Monitoring progress of court ordered youth in shelter 6. Makes referrals to the case staffing to address problems and needs of the youth/family 7. Accompanies youth and parent/guardian to court hearings and related appointments 8. Refers the youth/family for additional services when appropriate 9. Provides case monitoring and reviews court orders 10. Provides case termination notes 11. Provides follow-up after 30 days post discharge 12. Provides follow-up after 60 days post discharge 	<p>Compliance</p>	<p>Reviewed five residential and five community counseling files. All files were in compliance of this indicator. The counselor/ case manager completes the following when applicable:</p> <ol style="list-style-type: none"> 1. Establishes referral needs and coordinates referrals to services based upon the on-going assessment of the youth's/family's problems and needs 2. Coordinates service plan implementation 3. Monitors youth's/family's progress in services 4. Provides support for families 5. Monitoring progress of court ordered youth in shelter 6. Makes referrals to the case staffing to address problems and needs of the youth/family 7. Accompanies youth and parent/guardian to court hearings and related appointments 8. Refers the youth/family for additional services when appropriate 9. Provides case monitoring and reviews court orders 10. Provides case termination notes 11. Provides follow-up after 30 days post discharge 12. Provides follow-up after 60 days post discharge 	
<p>The program maintains written agreements with other community partners that include services provided and a comprehensive referral process</p>	<p>Compliance</p>	<p>Verification of written agreements with various community partners was observed. Each of the written agreements were current included a comprehensive referral process.</p>	
<p>Additional Comments: There are no additional comments for this indicator.</p>			
<p>2.05 - Counseling Services</p>			<p>Satisfactory</p>
<p>Provider has a written policy and procedure that meets the requirement for Indicator 2.05</p>	<p>YES</p>		
	<p>If NO, explain here:</p>		
	<p>The agency has a policy 4.03 Counseling Services, last review 7/01/2024 by the CEO.</p>		
<p>Shelter Program</p>			
<p>Shelter programs provides individual and family counseling</p>	<p>Compliance</p>	<p>Proof of individual and family counseling services provided was evident in each of the five residential files reviewed.</p>	
<p>Group counseling sessions held a minimum of five days per week</p>	<p>Compliance</p>	<p>A review of the program's daily schedule shows group counseling sessions are held at least five days per week. Verification of group sessions documented on group logs confirm delivery of group counseling sessions.</p>	

<p>Groups are conducted by staff, youth, or guests and group counseling sessions consist of :</p> <ol style="list-style-type: none"> 1. A clear leader or facilitator 2.Relevant topic - educational/informational or developmental 3. Opportunity for youth to participate 4. 30 minutes or longer 	<p>Compliance</p>	<p>A review of the program's group documentation shows groups are conducted by staff, youth, or guests and consists of: a clear leader, topic, opportunities for youth to participate and are 30 minutes or longer in duration.</p>	
<p>Documentation of groups must include date and time, a list of participants, length of time, and topic.</p>	<p>Compliance</p>	<p>All group documentation reviewed from November 2024 through May 2025 included the date and time, list of participants, duration and group topic.</p>	
<p>Community Counseling</p>			
<p>Community counseling programs provide therapeutic community-based services designed to provide the intervention necessary to stabilize the family. Services are provided in the youth's home, a community location, the local provider's counseling office or virtually if written documentation is provided in the youth's file for reasons why it is in the best interest of the youth and family.</p>	<p>Compliance</p>	<p>Reviewed five community counseling files. All files were in compliance of the indicator. All services are designed to provide the intervention necessary to stabilize the family. Services are provided in the counseling offices and no virtual services were offered.</p>	
<p>Counseling Services</p>			
<p>There is evidence the program completes review of all case files for coordination between presenting problem(s), psychosocial assessment, case/service plan, case/service plan reviews, case management, and follow-up.</p>	<p>Compliance</p>	<p>Five of five community counseling files reviewed contained evidence the program completed reviews of the case files for coordination between presenting problems, the NIRVANA assessment, service plan, case management and follow-up. Reviews are documented as applicable.</p>	
<p>Maintain individual case files on all youth and adhere to all laws regarding confidentiality.</p>	<p>Compliance</p>	<p>All laws of confidentiality are maintained in each of the youth case files reviewed.</p>	
<p>Case notes maintained for all counseling services provided and documents youth's progress.</p>	<p>Compliance</p>	<p>All case files reviewed contained case notes documenting the youth's progress for all counseling services provided.</p>	
<p>On-going internal process that ensures clinical reviews of case records and staff performance.</p>	<p>Compliance</p>	<p>The case files are reviewed on a regular basis ensuring clinical services are being conducted on case records and staff performance.</p>	

<p>When an intake is conducted through virtual means, consent is confirmed by the counselor, documented in the file, and reviewed with the supervisor during supervision/case review. There is written documentation provided in the youths file for reasons why virtual sessions are in the best interest of the youth and family.</p>	<p>No eligible items for review</p>	<p>There were no observations that intake is being conducted through virtual means.</p>	
<p>Additional Comments: There are no additional comments for this indicator.</p>			
<p>2.06 - Adjudication/Petition Process</p>			<p>Satisfactory</p>
<p>Provider has a written policy and procedure that meets the requirement for Indicator 2.06</p>		<p>YES If NO, explain here: The agency has several policies 4.06 CINS Adjudication Services and 4.07 CINS Petition Process, last reviewed on 7/01/2024 by the CEO.</p>	
<p>Must include: a. DJJ rep. or CINS/FINS provider b. Local school district representative</p>	<p>Compliance</p>	<p>The program has a policy which was reviewed and reflects that the adjudication/ petition process includes a DJJ rep. or CINS/ FINS provider and the local school district. Evidence of monthly meeting hosted by the provider verify that all required parties are included.</p>	
<p>Other members may include: a. State Attorney's Office b. Others requested by youth/ family c. Substance abuse representative d. Law enforcement representative e. DCF representative f. Mental health representative</p>	<p>Compliance</p>	<p>Case staffing/ Truancy meetings over the last six months verify that additional participants may include: State Attorney's Office, others requested by the youth or family, substance abuse representative, law enforcement representative, DCF representative, and mental health representative.</p>	
<p>The program has an established case staffing committee, and has regular communication with committee members</p>	<p>Compliance</p>	<p>The program has an established case staffing committee and meets on a regular basis. Individual cases are staffed among the committee members and referred for appropriate services.</p>	
<p>The program has an internal procedure for the case staffing process, including a schedule for committee meetings</p>	<p>Compliance</p>	<p>There is a schedule for committee meetings and an internal process for case staffing.</p>	
<p>The youth and family are provided a new or revised plan for services</p>	<p>No eligible items for review</p>	<p>Youth are referred through the case staffing/ truancy process for appropriate services, however there were no court-ordered CINS petition cases to review in the past six months.</p>	

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	There were no court-ordered CINS petition cases to review in the past six months.	
If applicable, the program works with the circuit court for judicial intervention for the youth/family	No eligible items for review	There were no court-ordered CINS petition cases to review in the past six months.	
Case Manager/Counselor completes a review summary prior to the court hearing	No eligible items for review	There were no court-ordered CINS petition cases to review in the past six months.	
Additional Comments: There are no additional comments for this indicator.			
2.07 - Youth Records			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 2.07	YES		
	If NO, explain here:		
	The agency has a policy and procedure 6.00.01, Youth Records reviewed July 1, 2024 by the President and CEO.		
All records are clearly marked 'confidential'.	Compliance	All records reviewed were marked confidential.	
All records are kept in a secure room or locked in a file cabinet that is marked "confidential"	Compliance	Observation of the records room verifies all records were kept in a secure room inside file cabinets marked confidential.	
When in transport, all records are locked in an opaque container marked "confidential"	Compliance	All records in transport are locked in a black locking roll suitcase marked confidential.	
All records are maintained in a neat and orderly manner	Compliance	All records were maintained in a neat and orderly manner.	

<p>SHELTER FILES contain the following: Table of Contents that outlines documents in each section:</p> <ul style="list-style-type: none"> •Screening •Informed Consent • Photograph of the youth • Shelter Intake Form • Suicide Assessment (if needed) • NIRVANA Self Report (NSR) • NIRVANA full Assessment • Plan of Service • Chronological Notes • Medication Inventory Form • Approved contact list • Copies of referrals made & Follow-Up (if needed) • Discharge summary once case is closed 	<p>Compliance</p>	<p>The agency was in compliance for this indicator. All shelter records contained a table of contents with the following sections identified: 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), and Discharge summary once case is closed.</p>	
<p>COMMUNITY COUNSELING FILES contain the following: Table of Contents that outlines documents in each section:</p> <ul style="list-style-type: none"> • Screening • Informed Consent • Community Counseling Intake Form • Suicide Assessment (if needed) • NIRVANA full Assessment • Plan of Service • Chronological case notes • Copies of referrals made & Follow-Up (if needed) • Discharge summary once the case is closed 	<p>Compliance</p>	<p>The agency was in compliance for this indicator. All community counseling files reviewed contained a table of contents with the following sections identified: 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), and 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>Compliance</p>	<p>The program's logbook is maintained electronically and is kept secure. Access can be made immediately available upon request for audit purposes.</p>	
<p>Records are retained for the duration of the time specified by the contract.</p>	<p>Compliance</p>	<p>The agency was in compliance for this indicator.</p>	
<p>Additional Comments: There are no additional comments for this indicator.</p>			

2.08 - Specialized Additional Program Services		Satisfactory with Exception	
Provider has a written policy and procedure that meets the requirement for Indicator 2.08	YES		
	If NO, explain here:		
	The agency has several policies, 4.08.01 - Staff Secure Facility & Staff Secure Beds - Staffing, 4.08.02 - Domestic Minor Sex Trafficking Program Services, 4.08.04 - Domestic Violence Respite, 4.08.05 - Probate Respite Services, 4.08.07 - Intensive Case Management Services, 4.08.06 - Family/Youth Respite Aftercare Services, last reviewed 7/01/2024 by the CEO.		
Staff Secure			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	No eligible items for review	The agency had no cases of staff secure in the past six months or back to the date of the last review.	
Staff Secure policy and procedure outlines the following: a. In-depth orientation on admission b. Assessment and service planning c. Enhanced supervision and security with emphasis on control and appropriate level of physical intervention d. Parental involvement e. Collaborative aftercare	Compliance	The agency has a policy and procedure that is in compliance with all of the requirements listed.	
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 had no cases of staff secure in the past six months or back to the date of the last review.	
Staff Assigned: a. One staff secure bed and assigned staff supervision to one staff secure youth at any given time b. Program assign specific staff during each shift to monitor location/ movement of staff secure youth c. Agency clearly documents the specific staff person assigned to the staff secure youth in the logbook or any other means on each shift	No eligible items for review	The agency had no cases of staff secure in the past six months or back to the date of the last review.	
Agency provides a written report for any court proceedings regarding the youth's progress	No eligible items for review	The agency had no cases of staff secure in the past six months or back to the date of the last 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 had no domestic minor sex trafficking cases in the past six months or back to the date of the last review.	

Agency has evidence that the FNYFS was contacted for approval prior to admission for all Domestic Minor Sex Trafficking (DMST) placements.	No eligible items for review	The agency had no domestic minor sex trafficking cases in the past six months or back to the date of the last review.	
There is evidence the youth was entered into NetMIS as a Special Populations youth at admission and a Human Trafficking Screening Tool (HTST) was completed.	No eligible items for review	The agency had no domestic minor sex trafficking cases in the past six months or back to the date of the last review.	
Services provided to these youth specifically designated services designed to serve DMST youth	No eligible items for review	The agency had no domestic minor sex trafficking cases in the past six months or back to the date of the last review.	
Did the placement of DMST youth require additional supervision for the safety of the youth or the program? If so, did the agency provide the appropriate level of supervision and safety measures?	No eligible items for review	The agency had no domestic minor sex trafficking cases in the past six months or back to the date of the last review.	
Length of Stay: a. Youth in program do not have length of stay in DMST placement that exceeds seven (7) days b. Agency has approval for stays and support beyond seven (7) days for DMST placements that are obtained on a case-by-case basis? (If applicable.)	No eligible items for review	The agency had no domestic minor sex trafficking cases in the past six months or back to the date of the last review.	
Agency has evidence that staff assigned to DMST youth under this provision are to enhance the regular services available through direct engagement in positive activities designed to encourage the youth to remain in shelter	No eligible items for review	The agency had no domestic minor sex trafficking cases in the past six months or back to the date of the last review.	
All other services provided to DMST youth are consistent with all other general CINS/FINS program requirements	No eligible items for review	The agency had no domestic minor sex trafficking cases in the past six months or back to the date of the last review.	
Domestic Violence <input type="checkbox"/>			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	Yes	Three closed files were reviewed.	
Youth admitted to DV Respite placement have evidence in the file of a pending DV charge	Compliance	Three of three files reviewed. All files contained documentation of pending Domestic Violence charges.	
Data entry into NetMIS within (3) business days of intake and discharge	Compliance	Three of three files reviewed. All files were in compliance with this indicator.	
Youth length of stay in DV Respite placement does not exceed 21 days. If more than 21 days, documentation exists in youth file of transition to CINS/FINS or Probation Respite placement, if applicable.	Compliance	Three of three files reviewed. All three files youth length of stay did not exceed 21 days.	

Case plan in file reflects goals for aggression management, family coping skills, or other intervention designed to reduce propensity for violence in the home	Compliance	Three of three files were reviewed. One of the three files contained a case plan with goals. Two of the three files did not have a case plan and not in care long enough to have one.	
All other services provided to Domestic Violence Respite youth are consistent with all other general CINS/FINS program requirements	Compliance	Three of three files reviewed. All three files were in compliance with this indicator.	
Probation Respite			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	Yes	Two closed files were reviewed.	
All probation respite referrals are submitted to the Florida Network.	Compliance	The two closed files reviewed were submitted to the Network.	
All Probation Respite Referral come from DJJ Probation and there is evidence that the youth is on Probation regardless of adjudication status.	Compliance	Two of the closed files reviewed were referred from DJJ Probation and contained documentation of youth on probation.	
Data entry into NetMIS and JJIS within (3) business days of intake and discharge	Compliance	Two of the closed files reviewed were in compliance with this indicator.	
Length of stay is no more than fourteen (14) to thirty (30) days. Any placement beyond thirty (30) days contains evidence in the file that the JPO was contacted in writing to request the need of an extension no later than the 25th day the youth was admitted into the program.	Compliance	Two of the closed files reviewed lengths of stays were no more than 14 to 30 days.	
All case management and counseling needs have been considered and addressed	Compliance	Two of the closed files reviewed addressed and considered case management and counseling needs.	
All other services provided to Probation Respite youth are consistent with all other general CINS/FINS program requirements	Compliance	Two of the closed files were in compliance with this indicator.	
Intensive Case Management (ICM)			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	Yes	Three open files were reviewed.	
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.	Compliance	Three of three files reviewed. All files contained documentation of eligibility for more intensive lengthy services.	

<p>Services for youth and family include: a. Two (2) direct contacts per month b. Two (2) collateral contacts per week c. Direct and collateral contacts not obtained must have documentation to support attempts made to obtain them. All reasonable attempts (at minimum of three) must be made to reach all contacts (direct and collateral) and documented in the case file and NetMIS.</p>	<p>Compliance</p>	<p>Three of three files reviewed. All files documented two direct contacts per month, two collateral contacts per week or documented attempts made to make the contacts.</p>	
<p>Assessments include a. NIRVANA at intake b. NIRVANA Re-Assessment every 90 days c. Post NIRVANA at discharge as aligned with timeframe requirements</p>	<p>Exception</p>	<p>Three of three files reviewed. All three files contained documentation of NIRVANA initiated during intake. Two of the three files are not due for re-assessment.</p>	<p>One of the three files reviewed was due for a NIRVANA re-assessment.</p>
<p>Service/case plan demonstrates a strength-based, trauma-informed focus</p>	<p>Compliance</p>	<p>Three of three files reviewed. All files contained a case plan.</p>	
<p>For any virtual services provided, there is written documentation in the youths' file as to why virtual contact is in the best interest of the youth and family</p>	<p>No eligible items for review</p>	<p>The program is not providing virtual services.</p>	
<p>Family and Youth Respite Aftercare Services (FYRAC)</p>			
<p>Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")</p>	<p>No eligible items for review</p>	<p>The agency had no FYRAC cases in the past six months or back to the date of the last review.</p>	
<p>Youth is referred by DJJ for a domestic violence arrest on a household member, and/or the youth is on probation regardless of adjudication status and at risk of violating.</p>	<p>No eligible items for review</p>	<p>The agency had no FYRAC cases in the past six months or back to the date of the last review.</p>	
<p>Agency has evidence that all FYRAC referrals have documented approval from the Florida Network office</p>	<p>No eligible items for review</p>	<p>The agency had no FYRAC cases in the past six months or back to the date of the last review.</p>	

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

There is evidence of completed 30 and/or 60 day follow-ups and is documented in NetMIS following case discharge.	No eligible items for review	The agency had no FYRAC cases in the past six months or back to the date of the last review.	
Youth and family participate in services for thirteen (13) sessions or ninety (90) consecutive days of services, or there is evidence in the youth's file that an extension is granted by DJJ circuit Probation staff	No eligible items for review	The agency had no FYRAC cases in the past six months or back to the date of the last review.	
Any service that is offered virtually, is documented in the youth's file why it was in the youth and families best interest.	No eligible items for review	The agency had no FYRAC cases in the past six months or back to the date of the last review.	
All data entry in NetMIS is completed within 3 business days as required.	No eligible items for review	The agency had no FYRAC cases in the past six months or back to the date of the last review.	
Additional Comments: There are no additional comments for this indicator.			
2.09- Stop Now and Plan (SNAP)			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 2.09	YES		
	If NO, explain here:		
	The agency has a policy and procedures 4.15 SNAP Intake Requirements, 4.16 SNAP Group Delivery, 4.17 SNAP Fidelity Adherence Monitoring, 4.18 SNAP Discharge Requirements and 4.19 SNAP in Schools and Communities last reviewed by the President CEO July, 1 2024.		
SNAP Clinical Groups Under 12			
Youth are screened to determine eligibility of services with the required documents: a. Florida Network Youth Screening Form b. SNAP® Brief Intake Screening Checklist	Compliance	Three of three files were reviewed. All files contained the 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	Compliance	Three of three files were reviewed. All files contained a SNAP Child Screening Interview Report, Community Counseling Form, Reinforcement Trap Cycle Diagram and Consent to Treatment and Participation in Research Form.	
The NIRVANA was completed at initial intake, or within two sessions.	Compliance	Three of three files were reviewed. All files contained an initial NIRVANA report.	

There is evidence of the completed the Pre - Child Behavior Checklist (CBCL) by the caregiver and is located within the file.	Compliance	Three of three files reviewed. All files contained a Pre-Child Behavior Checklist (CBCL).	
There is evidence of the completed Pre - TOPSE is completed by the caregiver and is located within the file.	Compliance	Three of three files were reviewed. All files contained a Pre-Tool to Measure Parenting Self-Efficacy (TOPSE).	
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	Two open files and one closed file were reviewed. The one closed file contained a child and a parent foal 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	Two open files and one closed file were reviewed. The one closed file contained a Post-CSBL.	
There is evidence of the completed Post - TOPSE is completed by the caregiver and is located within the file.	Compliance	Two open files and one closed file were reviewed. The one closed file contained a Post-TOPSE.	
There is evidence of the completed SNAP Discharge Report located within the file for any discharged youth.	Compliance	Two open files and one closed file were reviewed. The closed file contained a discharge report.	
There is evidence of the SNAP Boys/SNAP Girls Child Group Evaluation Form located in the file.	Compliance	Two open files and one closed file were reviewed. The closed file contained the SNAP Boys Child Group Evaluation.	
There is evidence of the SNAP Boys/SNAP Girls Parent Group Evaluation Form located in the file.	Compliance	Two open files and one closed file were reviewed. The closed file contained the SNAP Boys Parent Group Evaluation.	
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 program does not provided SNAP Clinical Groups for youth ages 12-17.	
The file contains the completed Florida Network Community Counseling Intake Form and is located within the file.	Not Applicable	The program does not provided SNAP Clinical Groups for youth ages 12-17.	

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 program does not provided SNAP Clinical Groups for youth ages 12-17.	
The NIRVANA was completed at initial intake, or within two sessions.	Not Applicable	The program does not provided SNAP Clinical Groups for youth ages 12-17.	
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	The program does not provided SNAP Clinical Groups for youth ages 12-17.	
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	The program does not provided SNAP Clinical Groups for youth ages 12-17.	
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	The program does not provided SNAP Clinical Groups for youth ages 12-17.	
All closed files contained evidence in the file a NIRVANA was completed at discharge.	Not Applicable	The program does not provided SNAP Clinical Groups for youth ages 12-17.	
SNAP for Schools & Communities			
The program demonstrated all of the required weekly attendance sheets that included youth names and/or identifying numbers completed with the teacher and trained SNAP Facilitator signatures. <i>(This must include a total of 13 attendance sheets for a full cycle)</i>	Compliance	Three of three closed cycles were reviewed. All three cycles had attendance sheets for each session with signatures.	
The program maintained evidence of a completed 'Way to Go Goal' Sheet within the file.	Compliance	Three of three closed cycles were reviewed. All three cycles contained a goal sheet.	
The program maintained evidence of both pre AND post Measure of Classroom Environment (MoCE) completed documents for the class reviewed.	Compliance	Three of three closed cycles were reviewed. All three cycles contained a pre and post Measure of Classroom Environment (MoCE).	

The program maintained evidence of completed pre and post evaluation documents for the class reviewed.	Compliance	Evidence of required completed evaluation documents were present in each of the files reviewed.	
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.	Compliance	Three of three closed cycles were reviewed. All three cycles contained completed feedback form.	
There is evidence of one (1) Fidelity Adherence Checklist completed per classroom for the 13-week classroom sessions which is located in the file.	Compliance	Three of three closed cycles were reviewed. All three cycles contained a Fidelity Adherence Checklist.	

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

Standard Three – Shelter Care

3.01 - Shelter Environment **Satisfactory with Exception**

Provider has a written policy and procedure that meets the requirement for Indicator 3.01	YES	
	If NO, explain here:	
	The program has a policy 8.03 Facility Environment & Safety and 4.25 Daily Programming last reviewed on July 1, 2024 by the CEO.	

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.	Exception	YCC was very clean and the furniture was in good shape. The program was free of insect infestation at the time of the onsite walk-thru. The shelter has a female and male wing. On the female wing, two bathrooms that were very clean, free of odor and no contraband was observed. The shower was free of mildew and all fixtures were in good working order. There was no sign of graffiti in the shelter. The lighting throughout the shelter was adequate. The outside areas were getting a facelift. The maintenance workers were planting new plants and putting down fresh mulch. All the doors were secured. YCC has new fobs that can be used to open doors. Reviewer noticed several egress plans on the hallways. There is a bulletin board on each female and male common, on this board are shelter rules, abuse hotline number and other information for the youth.	During the tour, this reviewer noticed the four bathroom trash cans did not have lids on them. On the second day of the on-site review, the trash cans were replaced with ones that had lids.
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<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>YCC has two 2019 Ford Transit vans that are used for transportation. The vans were observed to have two fire extinguishers, two flashlights, and two glass breakers/seat belt cutters. The vans were in good condition with normal wear and tear.</p>	
<p>Facility Inspection: All chemicals are listed, approved for use, inventoried weekly and perpetually, stored securely and Material Safety Data Sheets (MSDS) are maintained on each item (minimum 1 time per week or per agency policy). A perpetual inventory will be the primary means of maintaining a current and real-time inventory. The weekly inventory will be conducted weekly at a minimum to ensure that a perpetual inventory is being maintained consistently and accurately. If more than one location is used to store chemicals, there is an inventory wherever chemicals are stored that is current and well maintained unless previously approved by the Network.</p>	<p>Exception</p>	<p>The chemical closet was very neat and organized. MSDS are maintained on each item in the chemical closet. Weekly and perpetual chemical inventory logs were reviewed for November 2024, December 2024, January 2025, April 2025 and May 2025. Weekly inventories were maintained during the months referenced to ensure that perpetual inventory was consistent and accurate. Perpetual logs reflected the current and real-time inventory.</p>	<p>There were no weekly inventories or perpetual logs provided for February 2025 and March 2025 due to the person completing the forms exiting the agency according to information provided in interview with the COO. Duties for maintaining the inventories was designated to another staff member and inventory logs resumed in April and May 2025.</p>
<p>Facility Inspection: Washer/dryer are operational & general area/lint collectors are clean. Agency has a current DCF Child Care License which is displayed in the facility. Each youth has own individual bed with clean covered mattress, pillow, sufficient linens and blanket. Youth have a safe, lockable place to keep personal belongings, if requested.</p>	<p>Compliance</p>	<p>This reviewer observed a very large, clean laundry room. They have a total of six washers and seven dryers. The dryers were free of lint. There was a stack of clean laundry bags for the youth to put their dirty clothes in to be washed. The DCF Child Care License is current with an issue date of August 7th, 2024. Reviewer observed a total of 18 bedrooms with one single twin bed, six bedrooms with two twin beds, and two bedrooms designated for sight and sound youth with two twin beds for a total of 34 beds. All beds were neatly made with freshly cleaned bedding, which included a mattress, linen, pillow and blanket. Youth do have a safe, lockable place to keep personal belongings.</p>	
<p>Additional Facility Inspection Narrative (if applicable)</p>			

<p>Fire and Safety Health Hazards: a. Annual facility fire inspection was conducted, and the facility is in compliance with local fire marshal and fire safety code within jurisdiction. b. Agency completes a minimum of 1 fire drill on each shift monthly (within 2 minutes or less). c. Completes 1 mock emergency drill per shift per quarter. d. All annual fire safety equipment inspections are valid and up to date (extinguishers, sprinklers, alarm system and kitchen overhead hood, including fire extinguishers in all vehicles).</p>	<p>Exception</p>	<p>The date of the agency's current fire inspection is August 7, 2024. The agency conducted fire drills as follows:1st Shift: 11/25/24, 12/31/24, 1/7/25, 2/9/24, 3/8/35, 4/29/25 2nd Shift: 11/30/24, 12/31/24, 2/28/25, 3/15/25. As applicable 3rd Shift: 11/25/25, 12:31/25, 2/28/25, 3/28/25, 4/30/25. Mock emergency drills were completed on the following dates: 1st Shift: 11/4/25, 2nd Shift: 11/30/25, 12/3/25, 1/31/25. 2/28/25, 3/19/25, 3rd Shift: 11/4/25. All extinguishers inspected on September 18, 2024, Sprinkler wet system inspected on March 12, 2025, Sprinkler dry system inspection 3/12/25, Exhaust hood fire suppression inspections March 3, 2025,</p>	<p>There were three missing drills in total: 2nd shift for January and April 2025, 3rd shift is missing January 2025. There was not an emergency drill observed on the 1st and 3rd shift for the first quarter of 2025.</p>
<p>Fire and Safety Health Hazards: a. Agency has a current Satisfactory Residential Group Care inspection report from the Department of Health. b. Agency has a current Satisfactory Food Service inspection report from the Department of Health and food menus are posted, current and signed by Licensed Dietician annually. c. All cold food is properly stored, marked and labeled and dry storage/pantry area is clean and food is properly stored. d. Refrigerators/Freezers are clean and maintained at required temperatures and all small and medium sized appliances are operable and clean for use as needed.</p>	<p>Compliance</p>	<p>The agency has current fire, health and safety inspections. YCC has a food service inspection report dated for April 21, 2025. Reviewer observed two pantry areas, one with snacks and one with regular food items. All areas were neat, clean, and organized. The items with clearly labeled with a date the items was placed in there. The fridge temperature: 34 degrees Fahrenheit and the freezer temperature: -13 degrees Fahrenheit. All kitchen appliances are clean and operable for use as needed.</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>While at YCC reviewer observed youth in the classroom interacting with the teacher, Outside for large motor activities, and also saw one youth in a counseling session. Reviewer was informed by the COO that they have faith-based groups that come weekly to the shelter. The daily schedule is posted in several areas of the shelter for the youth to see. The youth have access to a library for their enjoyment.</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 program has a policy 4.01 Shelter Program and Orientation last reviewed on July 1, 2024 by the CEO.		
<p>Youth received a comprehensive orientation and handbook provided within 24 hours</p>	Compliance	<p>All youth go through an orientation/ intake where a handbook is given to them at that time,</p>	
<p>Orientation includes the following:</p> <p>a. Youth is given a list of contraband items</p> <p>b. Disciplinary action is explained</p> <p>c. Dress code explained</p> <p>d. Review of access to medical and mental health services</p> <p>e. Procedures for visitation, mail and telephone</p> <p>f. Grievance procedure</p> <p>g. Disaster preparedness instructions</p> <p>h. Physical layout of the facility</p> <p>i. Sleeping room assignment and introductions</p> <p>j. Suicide prevention- alerting staff of feelings or awareness of others having suicidal thoughts</p>	Compliance	<p>There were three open files and two closed files that were reviewed. All five files showed evidence that the orientation information was gone over and given to the youth including a copy of the handbook, contraband, disciplinary actions, dress code, visitation, grievance procedure and disaster instructions were given to the youth. Three youth files were missing bed assignments. On the second day of the review the bed assignment was updated in the youth files. Five files did not have the Intake Alert Classification Form in the youths chart. On day two of the on-site review the COO provided three out of the five Intake Alert Classification Forms with evidence the document was emailed to the shift supervisors at the time of intake as in accordance with the program's policy.</p>	

Documentation of each component of orientation, including orientation topics and dates of presentation, as well as signatures of the youth and staff involved is maintained in the individual youth record	Compliance	All five charts had all signatures for staff, youth, and guardian.	
Additional Comments: There are no additional comments for this indicator.			
3.03 - Youth Room Assignment			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 3.03	YES		
	If NO, explain here:		
	The program has a policy 4.26 Classification/ Room Assignment last reviewed on July 1, 2024 by the CEO.		
A process is in place that includes an initial classification of the youths, to include:			
a. Review of available information about the youth's history, status and exposure to trauma b. Initial collateral contacts, c. Initial interactions with and observations of the youth d. Separation of younger youth from older youth, e. Separation of violent youth from non-violent youth f. Identification of youth susceptible to victimization g. Presence of medical, mental or physical disabilities h. Suicide risk i. Sexual aggression and predatory behavior j. Acute health symptoms requiring quarantine or isolation	Compliance	There were three open files and two closed files that were reviewed. During the screening and intake information is given about the youth to determine their history and needs. There are eighteen bedrooms with a single twin bed if a youth needs to have a room alone. There are 6 bedrooms with two twin beds in them, if a youth can share a room with another youth. This allows older and younger youth to be separated if needed.	
An alert is immediately entered into the program's alert system when a youth is admitted with special needs and risks such as risk of suicide, mental health, substance abuse, physical health or security risk factors	Compliance	YCC has two dry erase boards in the direct care area which are used for to identify admitted youth with special needs or risks. Information is added to the board so each staff can be aware of each youths' risk(s).	
Additional Comments: There are no additional comments for this indicator.			
3.04 - Log Books			Satisfactory with Exception
Provider has a written policy and procedure that meets the requirement for Indicator 3.04	YES		
	If NO, explain here:		
	The program has a policy 4.14 Log Books last reviewed on July 1, 2024 by the CEO.		
Log book entries that could impact the security and safety of the youth and/or program are highlighted	Compliance	The program uses an electronic logbook. Logbook entries were reviewed from November 2024 to March 2025. All entries that may impact the security and safety of the youth are highlighted in the electric log book.	

<p>All entries are brief, legibly written in ink and include:</p> <ul style="list-style-type: none"> • 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>Compliance</p>	<p>Reviewer observed several entries from November 2024 through March 2025. All entries reviewed had date, times, name of youth and staff. All entries were brief and ended with a signature or initial of the writer.</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>Exception</p>	<p>The program uses an electronic logbook. There was no evidence of strikethroughs documented in the electronic log for the past six months.</p>	<p>Interview with the residential shift lead from the 1st shift indicated that he was not aware of a strikethrough function in the electronic logbook. The reviewer was able to train the residential shift lead on how to access the strikethrough function and properly document a recording error in the electronic logbook.</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>Compliance</p>	<p>It was noted from November 2024 to present a shift supervisor entry was observed a minimal of every 2 weeks in the electronic logbook. The shift supervisor entries are highlighted in red and indicate the dates reviewed and recommendations, if any.</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>It was noted that staff make an entry when they come on and off shift. There is also indication of staff entries verifying they read the past 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>Compliance</p>	<p>Reviewer observed the electronic log book entries for staff on each shift logging in a documenting that they read the last 2 shifts.</p>	
<p>Logbook entries include:</p> <ol style="list-style-type: none"> Supervision and resident counts Visitation and home visits 	<p>Compliance</p>	<p>Reviewer observed several entries in the electronic logbook made by YCC staff conducting counts, visitation, and home visits.</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 program has a policy 4.29 Behavior Management Strategies last reviewed on July 1, 2024 by the CEO.</p>		

<p>The program has a detailed written description of the BMS and it is explained during program orientation</p>	<p>Compliance</p>	<p>Youth are given a youth handbook which has the Behavioral Management</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>YCC uses a point based system that teaches benefits and consequences. With the point system the youth can level up to get better benefits with that positive points. Consequences for negative behaviors are point-based also which then result in fewer benefits Youth are not allowed to discipline other youth. Staff use verbal redirection when needed. The youth are never denied their basic needs as a discipline.</p>	
<p>Program's use of the BMS</p>			
<p>All staff are trained in the theory and practice of administering BMS rewards and consequences</p>	<p>Compliance</p>	<p>It was observed in the staff training files that every staff member reviewed is trained in the Behavior Management System.</p>	
<p>There is a protocol for providing feedback and evaluation of staff regarding their use of BMS rewards and consequences</p>	<p>Compliance</p>	<p>The supervisors and staff go over the BMS during the monthly staff meeting as observed in staff meeting minutes from November 2024 to March 2025.</p>	
<p>Supervisors are trained to monitor the use of rewards and consequences by their staff</p>	<p>Compliance</p>	<p>Supervisors go through training to observe the staff using the BMS with the youth.</p>	
<p>Additional Comments: There are no additional comments for this indicator.</p>			

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 program has a policy 4.02 Staffing and Youth Supervision last reviewed on July 1, 2024 by the CEO.
The program maintains minimum staffing ratios as required by Florida Administrative Code and contract. <ul style="list-style-type: none"> • 1 staff to 6 youth during awake hours and community activities • 1 staff to 12 youth during the sleep period 	Compliance	It was noted that YCC is following the staff to youth ratio. It was observed through staff schedules and seeing staff on the halls with the youth.
All shifts must always provide a minimum of two direct care staff present that have met the minimum training requirements	Compliance	A review of program schedules for the past six months confirm all shifts are staffed with at least two direct care workers. Each direct care staff training file reviewed contained evidence of all required minimum training requirements.
Program staff included in staff-to-youth ratio includes only staff that are background screened and properly trained youth care workers, supervision staff, and treatment staff	Compliance	All program staff including in supervision ratio were backgrounded screened and properly trained youth care workers.
The staff schedule is provided to staff or posted in a place visible to staff	Compliance	Reviewer observed the staff schedule posted in the master control room, which all staff can see.
There is a holdover or overtime rotation roster which includes the telephone numbers of staff who may be accessed when additional coverage is needed	Compliance	YCC maintains a staff contact list in case additional staff is needed. The list is in the master control room. Additionally, the program can pull staff from other programs to meet ratio, if needed.

<p>Staff observe youth at least every 15 minutes while they are in their sleeping room, either during the sleep period or at other times, such as during illness or room restriction</p>	<p>Exception</p>	<p>Documentation was reviewed to verify at least every 15 minutes staff observe youth while they are in their rooms. A total of 5 dates; April 10th: 11pm,11:16pm, 11.19pm, 11:35pm, and 11:50pm, April 20th: 4:09am, 4:20am,4:37am,4:51am, 5:05am, (5:19am missed check but was logged in as completed in log book), 5:34am, 5:47am, (6:02am missed check but logged in as completed in log book) and 6:15am. April 24th: 3:08am, 3:33am, 3:37am, 3:51am, 4:13am,4:33am, 5:00am. May 2nd, 1:01am, 1:15am, 1:31am, 1:39am, 1:50am, 2:11am, 2:26am, and 2:42am, and May 5th: 2:04am, 2:19am, 2:35am, 2:55am, 3:08am, 3:23am, 3:37am, and 3:52am were observed during the times indicated. All dates and times exception two (where indicated) were confirmed as documented that youth were observed by staff while in their sleeping rooms.</p>	<p>On April 20th, there were two bed checks that were missed by the staff: 5:19 am and 6:02 am were missed, but staff logged into the electronic log and stated the bed checks were completed. A review of the camera verified that the staff was seen sitting on the couch watching tv during the above-stated times. This observation was confirmed by the COO, and a report was made to the CCC for falsification of bed checks.</p> <p>Appeal Granted by the Florida Network - 3.06 previously rated Limited is changed to Satisfactory with Exception.</p> <p>Florida Network Response: Reviewed video clips provided to CCC, which clearly show staff getting up at the required time to conduct checks, although it is not clear that checks were completed.</p>
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Additional Comments: There are no additional comments for this indicator.

<p>3.07 - Video Surveillance System</p>		<p>Satisfactory with Exception</p>
<p>Provider has a written policy and procedure that meets the requirement for Indicator 3.07</p>	<p>YES</p>	
	<p>If NO, explain here:</p>	
	<p>The program has a policy 4.13, Security Cameras last reviewed on July 1, 2024 by the CEO.</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>Observation was made of a sign in the lobby informing visitors that they were being recorded. Reviewer was informed by the COO that they have a new camera system, it captures and retains at least 30 days of footage. The system records date, time, location, and facial recognition. There are only cameras in the location of the shelter where youth and staff congregate and where visitors enter and exit. There are no cameras in the bedrooms or bathrooms. The cameras have backup capabilities and are able to operate during a power outage.</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>There is a list of designated personnel who can access the video surveillance system observed in the master control room of the shelter.</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>Exception</p>	<p>The program's policy indicated a supervisory review of video is conducted a minimum of once every 14 days.</p> <p>Though there was no logbook being maintained, the COO stated that she has conducted supervisory review of video cameras since being appointed as the COO in November 2024. At the conclusion of the on-site review, the COO provided a summary of camera reviews conducted on the following dates: 10/30/2024, 11/02/2024, 11/25/2024, 11/27/2024, 12/06/2024, 12/17/2024, 12/27/2024, 01/07/2025, 01/23/2025, 02/01/2025, 02/08/2025, 02/18/2025, 03/02/2025, 03/28/2025, 03/30/2025, 04/07/2025, and 05/05/2025. Additional documentation of camera reviews conducted by the Compliance Manager dated 04/24/2025, 04/25/25, 04/30/2025 and 05/01/2025 were provided.</p>	<p>Upon initial observation, there was no written documentation or log book that was provided showing the video surveillance is being reviewed by a supervisor every 14 days.</p> <p>The supervisory reviews are not recorded in the logbook. A summary of video reviews was submitted by the COO and Compliance Manager after the exit on the second day of review.</p> <p>Appeal Granted by the Florida Network - 3.07 previously rated Limited is changed to Satisfactory with Exception.</p> <p>Florida Network Response: Reviewed documentation provided to QI team and referenced in the report. Information in the report detailing summary information provided to the QI Team will be moved to the "compliance column" and information in the following sub-indicator stating that the supervisory reviews were not recorded in the logbook will be moved. Sub-indicator 3.07 (3) will remain as exception, and sub-indicator 3.07(4) will be changed to compliance.</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 program's policy indicated that the video reviews shall assess the activities of the facility and include a review of random sample of overnight shifts.</p>	
<p>Grant the requesting of video recordings to yield a result within 24-72 hours from program quality improvement visits and when an investigation is pursued after an allegation of an incident</p>	<p>Compliance</p>	<p>The program has the ability to grant a request for video recording within 24-72 hours from a quality improvement visit or when an investigation is pursued after an allegation of an incident.</p>	
<p>Camera service order/requests will be made within 24 hours of discovery of camera malfunctioning or being inoperable. All efforts made to obtain repairs are documented and maintained</p>	<p>No eligible items for review</p>	<p>The program's policy indicated a request can be made for maintenance within 24 hours of discovery of malfunctions. There was no documentation of camera malfunction requiring a service order/ request in the past six months.</p>	
<p>Additional Comments: There are no additional comments for this indicator.</p>			

Standard Four – Mental Health/Health Services			
4.01 - Healthcare Admission Screening			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 4.01	YES		
	If NO, explain here:		
	The program has a policy 2.02: Healthcare Admission Screening last reviewed July 1, 2024 by the CEO.		
Preliminary Healthcare Screening			
Screening includes : a. Current medications b. Existing (acute and chronic) medical conditions c. Allergies d. Recent injuries or illnesses e. Presence of pain or other physical distress f. Observation for evidence of illness, injury, physical distress, difficulty moving, etc. g. Observation for presence of scars, tattoos, or other skin markings h. Acute health symptoms requiring quarantine or isolation	Compliance	The program completes an admission screening through the use of the Admission Screening Form completed by the direct care staff which included all required elements of current medications, existing medical conditions, allergies, recent injuries or illnesses, presence of pain or other physical distress, observation for evidence of illness, injury, physical distress, difficulty of moving, etc., observations of markings, and acute health symptoms requiring quarantine or isolation. The form is reviewed by medical and mental health and followed-up on, if needed. Five case records were reviewed. Four applicable case records included current medications and the medical condition associated with them. None of the reviewed case records were applicable for chronic conditions, allergies, recent injuries or illnesses, physical distress, difficulty moving, or any acute health symptoms requiring quarantine or isolation.	
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.)	No eligible items for review	The program has a thorough referral process and mechanism for necessary follow-up medical care as required and/or needed; however, no case records were applicable for review.	
When needed, the parent is involved with the coordination and scheduling of follow-up medical appointments	No eligible items for review	The program has a thorough referral process and mechanism for necessary follow-up medical care as required and/or needed; however, no case records were applicable for review.	
All medical referrals are documented on a daily log.	No eligible items for review	The program has a thorough referral process and mechanism for necessary follow-up medical care as required and/or needed; however, no case records were applicable for review.	

<p>The program has a thorough referral process and a mechanism for necessary follow-up medical care as required and/or needed</p>	<p>Compliance</p>	<p>The program has a thorough referral process and mechanism for necessary follow-up medical care as required and/or needed.</p>	
<p>Additional Comments: There are no additional comments for this indicator.</p>			
<p>4.02 - Suicide Prevention</p>			<p>Satisfactory</p>
<p>Provider has a written policy and procedure that meets the requirement for Indicator 4.02</p>	<p>YES</p>		
	<p>If NO, explain here:</p>		
	<p>The program has a policy 3.02: Suicide Prevention, reviewed on July 1, 2024 by the CEO.</p>		
<p>Suicide Risk Screening and Approval (Residential and Community Counseling)</p>			
<p>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.</p>	<p>Compliance</p>	<p>Five residential records, three open and two closed, and four community counseling records, three open and one closed were reviewed. Each record contained a suicide risk screening which occurred during the initial intake and screening process. Each screening was signed by the supervisor and documented in the youth's case file.</p>	
<p>The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services</p>	<p>Compliance</p>	<p>The program utilizes an approved suicide risk assessment.</p>	
<p>Supervision of Youth with Suicide Risk (Shelter Only)</p>			
<p>Youth are placed on the appropriate level of supervision based on the results of the suicide risk assessment.</p>	<p>Compliance</p>	<p>Five residential records, three open and two closed, were reviewed. All five records indicated the youth was placed on the appropriate level of supervision based on the result of the suicide risk screening assessment.</p>	
<p>Staff person assigned to monitor youth maintained one-to-one supervision or constant supervision and documented his/her observations of the youth's behavior at 30 minute or less intervals</p>	<p>Compliance</p>	<p>Four of the five records reviewed contain evidence the staff persons assigned to monitor each youth maintained one-to-one supervision or constant supervision and documentation was present of the observations of the youth's behavior at thirty minute or less intervals.</p>	
<p>Documentation includes the time of day, behavioral observations, any warning signs observed, and the observers' initials and was maintained in either an observation log or in the shelter daily log.</p>	<p>Compliance</p>	<p>Documentation on reviewed observation logs in the four applicable records included all the required elements.</p>	

<p>Supervision level was not changed/reduced until a licensed professional or a non-licensed mental health professional under the supervision of a licensed professional completed a further assessment OR Baker Act by local law enforcement</p>	<p>Compliance</p>	<p>All four applicable records reviewed indicate the level of supervision was not reduced until a licensed professional or a non-licensed mental health professional under the supervision of a licensed professional completed an assessment of a Baker Act was enacted by law enforcement.</p>	
<p>There was evidence that documentation was reviewed by supervisory staff each shift. If program uses an observation log, completed logs are maintained in the youth's file.</p>	<p>Compliance</p>	<p>A review of four youth records included completed supervisory reviews by each shift supervisor on each youth's logs and the documentation was maintained within each youth's record.</p>	
<p>Youth with Suicide Risk (Community Counseling Only)</p>			
<p>Youth identified for suicide risk during intake was immediately assessed by a licensed professional or non-licensed professional (under the direct supervision of a licensed mental health professional) and the parents and supervisor were both notified of the results.</p>	<p>Compliance</p>	<p>Four community counseling youth records, three open and one closed, found one record applicable for being identified as suicide risk during intake. The youth was immediately assessed by a licensed professional or non-licensed professional under the direct supervision of a licensed mental health professional and the parents and supervisor were both notified of the results.</p>	
<p>During the intake, if the appropriate staff is unavailable, youth identified for suicide risk was immediately referred by the provider and the parent/guardian is notified of the suicide risk findings disclosed and advised that an Assessment of Suicide Risk should be completed ASAP by a licensed professional.</p>	<p>No eligible items for review</p>	<p>One youth record was applicable for assessment of suicide risk and the youth was immediately assessed; therefore, this indicator is not applicable.</p>	
<p>Information on resources available in the community for further assessment was provided to the parent/guardian and is documented in the youth's file and signed by the parent/guardian OR a written follow-up notification was sent by certified mail if the parent/guardian was not present during the screening and was notified by telephone.</p>	<p>Compliance</p>	<p>One youth record was applicable for assessment of suicide risk; however, the program provided information on resources available in the community for further assessment should it be needed to the parent/guardian in all four youth records reviewed and it is documented in the youth's case record and signed by the parent/guardian or a written follow-up notification was sent by certified mail if the parent/guardian was not present during the screening and was notified by telephone.</p>	
<p>If the parent/guardian cannot be contacted, all efforts to contact them are documented in the case file.</p>	<p>No eligible items for review</p>	<p>Four community counseling youth records, three open and one closed, were reviewed. In all records, the parent/guardian participated in the screening process; therefore, this indicator is not applicable.</p>	

<p>When the screening was completed during school hours on school property, the appropriate school authorities were notified.</p>	<p>No eligible items for review</p>	<p>Four community counseling youth records, three open and one closed, were reviewed. In all records, the screening was not completed during school hours on school property; therefore, this indicator is not applicable.</p>	
<p>Additional Comments: There are no additional comments for this indicator.</p>			
<p>4.03 - Medications</p>			<p>Satisfactory</p>
<p>Provider has a written policy and procedure that meets the requirement for Indicator 4.03</p>	<p>YES If NO, explain here: The program has a policy 5.04: Medication Management and Distribution, last reviewed July 1, 2024 by the CEO.</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>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>The program has a policy and procedures in place addressing non-nursing staff who assist with the self-administration of medication. Reviewed training documentation verified all applicable staff received annual medication distribution training was provide by the RN, who completed any necessary training to demonstrate competency.</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 documentation to include meeting agendas of three dates this year in January, February, and April, verified the RN and/or the Shelter Manager at least quarterly review and assess strategies implemented to reduce medication errors, analyze factors which contribute to medication errors, and allow staff the opportunity to practice and role-play solutions.</p>	
<p>The agency has strategies implemented to ensure medications are provided within the 2-hour time frame.</p>	<p>Compliance</p>	<p>The program has strategies to include a set time of day (between breakfast and school) as well as alarms implemented to ensure medications are provided within the two-hour required timeframe.</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>A review of the program schedule and list of non-licensed staff permitted to distribute medication verified all non-licensed staff members who assist with medication distribution are clearly identified and designated.</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 program has a clear method of communicating which youth are on medications with the times and dosage easily discernable by all staff on each shift through use of an alert board maintained in the nurse's office and administration office as well as alert forms maintained with each individual youth record and through use of the Medication Administration Log.</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 program has an internal quality assurance process which ensures appropriate medication management and distribution methods, track medication errors, and identify systemic issues and implement mitigation strategies, as appropriate. The program's delivery process of medications is consistent with the Florida Network of Youth and Family Services (FNYFS) Medication Management and Distribution Policy.</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 or higher level staff did review all medication forms by the next business day.</p>	<p>Compliance</p>	<p>Five reviewed records, three open, and two closed, found four applicable for being prescribed medications. In all applicable youth records there was evidence during admission the youth and parent/guardian (if available) were interviewed by the registered nurse (RN) about each youth's current medications as part of the screening process and/or an interview was conducted by the RN within three business days if the RN was not on the premise at admission. Reviewed documentation contained evidence the on-shift certified supervisor or higher level staff did review all medication forms by the next business day.</p>	

Medication Storage			
<p>a. All medications are stored in a Pyxis ES Medication Cabinet that is inaccessible to youth (when unaccompanied by authorized staff)</p> <p>b. Pyxis machine is stored in accordance with guidelines in FS 499.0121 and policy section in Medication Management</p> <p>c. Oral medications are stored separately from injectable epi-pen and topical medications</p> <p>d. Medications requiring refrigeration are stored in a secure refrigerator that is used only for this purpose, at temperature range 2-8 degrees C or 36-46 degrees F. (If the refrigerator is not secure, the room is secure and inaccessible to youth.)</p> <p>e. Narcotics and controlled medications are stored in the Pyxis ES Station</p> <p>f. Pyxis keys with the following labels are accessible to staff in the event they need to access medications if there is a Pyxis malfunction: a TOP COVER b BACK PANEL- LEFT TALL CABINET LOCK- LEFT, c BACK PANEL- RIGHT TALL CABINET LOCK- RIGHT</p>	<p>Compliance</p>	<p>All medication is stored in the Pyxis ES Medication Cabinet, with the exception of any refrigerated medications, and are inaccessible to youth at all times. The Pyxis machine is stored in accordance with the Florida Statute guidelines and program policy. Oral medications are stored separately from injectable epi-pen and topical medications. Medication requiring refrigeration is stored in a secure refrigerator used only for this purpose and within the required temperature range as evidenced by the temperature log kept in the nurse's office.</p>	

Medication Distribution			
<p>a. Agency maintains a minimum of 2 site-specific System Managers for the Pyxis ES Station</p> <p>b. Only designated staff delineated in User Permissions have access to secured medications, with limited access to controlled substances (narcotics)</p> <p>c. A Medication Distribution Log shall be used for distribution of medication by non-licensed and licensed staff</p> <p>d. Agency verifies medication using one of three methods listed in the FNYFS Policies & Procedures Manual</p> <p>e. When nurse is on duty, medication processes are ALWAYS conducted by the nurse or when the nurse is not onsite, then the designated staff who has been trained by a licensed Registered Nurse provides the medication.</p> <p>f. Agency does not accept youth currently prescribed injectable medications, except for epi-pens</p> <p>h. Non-licensed staff have received training in the use of epinephrine auto-injectors provided by a registered nurse</p>	<p>Compliance</p>	<p>A review of program policy and training documentation verified the program maintains a minimum of two site specific System Managers for the Pyxis ES Station and only designated staff delineated in User Permissions have access to secured medication, with limited access to controlled substances. A Medication Distribution Log is utilized for the distribution of medication by both on-licensed and licensed staff. The program policy and nurse confirmed the use of one of the three approved methods to verify medications. Medication processes are always completed by the nurse, when on-site, or completed by the designated staff, trained by a licensed registered nurse (RN), when the nurse is not on-site. Except for the use of an epi-pen, the program does not accept youth currently prescribed injectable medications. Reviewed training documentation verified all staff have been trained in the use of epi-pens by the RN.</p>	
<p>The medication distribution log documentation includes:</p> <p>a. the time of medication administration</p> <p>b. evidence of youth initials that the dosage was given <input type="checkbox"/></p> <p>c. evidence of staff initials that the dosage was given <input type="checkbox"/></p>	<p>Compliance</p>	<p>Five reviewed records, three open, and two closed, found four applicable for being prescribed medications. In all applicable youth records it was confirmed the program utilized a Medication Distribution Log by non-licensed and licensed staff which included the time of the medication administration and youth and staff initials indicating the dosage was given.</p>	
<p>There is evidence that staff provide youth with medications within one hour of the scheduled time of delivery as ordered by the medication. Documentation is provided for instances this does not occur within the required timeframe.</p>	<p>Compliance</p>	<p>Five reviewed records, three open, and two closed, found four applicable for being prescribed medications. In all applicable youth records there was evidence the staff provided youth with medications within one hour of the scheduled time of delivery as ordered by the prescription. There were no instances of a medication not being provided within the required timeframe within the annual compliance review period, unless the youth refused their dose and this is also documented on the Medication Distribution Log.</p>	

<p>During the review period, there were no instances where youth missed their medication due to failure to open the pyxis machine.</p>	<p>Compliance</p>	<p>There were no reported instances of where youth missed medications due to failure to open the Pyxis machine during the annual compliance 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 re-certification from an RN.</p>	<p>No eligible items for review</p>	<p>There was no evidence any medication error had occurred within the annual compliance review period. There were no instances reported to the Central Communications Center and the nurse also reported there have not been any medication errors during the review period.</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>An observation of medication pass was conducted and verified there is a perpetual inventory with a running balance maintained through Pyxis as well as a shift-to-shift count through reviewed documentation for controlled substances. All over-the-counter medications are accessed regularly and inventoried weekly. The program maintains scissors and razors on-site which are documented at least weekly.</p>	
<p>There are monthly reviews of the Pyxis reports to monitor medication management practice.</p>	<p>Compliance</p>	<p>Documentation reviewed found monthly reviews are conducted of the Pyxis reports to monitor medication management practice.</p>	
<p>Medication discrepancies are cleared after each shift.</p>	<p>Compliance</p>	<p>Medication discrepancies are cleared after each shift, when applicable.</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 program has a policy, 5.03.01: Medical and Mental Health Alert Process, last reviewed on July 1, 2024 by the CEO.	
Youth with a medical, mental health, or food allergy was appropriately placed on the program's alert system	Compliance	Five youth records were reviewed, three open and two closed, and four of five were applicable for having a medical, mental health, or food allergy. A review of the alert boards and the program's alert documentation in the youth case records verified all youth with a medical, mental health, and/or food allergy were appropriately placed on the program's alert system.
Alert system includes precautions concerning prescribed medications, medical/mental health conditions	Compliance	The program's alert system includes precautions concerning prescribed medication and medical/mental health conditions.
Staff are provided sufficient training, information and instructions to recognize/respond to the need for emergency care for medical/mental health problems	Compliance	Reviewed documentation confirmed the staff were provided sufficient training, information, and instructions to recognize/respond to the need for emergency care.
A medical and mental health alert system is in place that ensures information concerning a youth's medical condition, allergies, common side effects of prescribed medications, foods and medications that are contraindicated, or other pertinent mental health treatment information, is communicated to all staff	Compliance	The program maintains a medical and mental health alert system, which ensures information is communicated to all staff concerning a youth's medical condition, allergies, common side effects of prescribed medications, contraindicated foods and medications, or other pertinent mental health treatment conditions.
Additional Comments: There are no additional comments for this indicator.		

4.05 - Episodic/Emergency Care		Satisfactory with Exception	
Provider has a written policy and procedure that meets the requirement for Indicator 4.05	YES		
	If NO, explain here:		
	The program has a policy, 5.03.02: Episodic/Emergency Care, last reviewed on July 1, 2024 by the CEO.		
Off Site Emergency Care			
a. If off-site emergency medical or dental care was provided, an incident report was submitted for the medical or dental care b. Upon youth return, there is a verification receipt of medical clearance via discharge instructions with follow-up is present in file c. Youth's parent/guardian was notified d. A daily log is maintained for emergency care provided	Exception	Three youth records were reviewed, all closed, for emergency care. All three records contained an incident report submitted for medical or dental care. All three youth were applicable for off-site medical care. Of the three reviewed records, two youth returned to the program, the remaining youth refused to return to the program from the hospital. In the two youth records who returned to the program, both youth returned with a receipt of medical clearance via discharge instructions and follow-up instructions. Two youth were applicable for parental notifications and evidence of them being contacted by program staff was verified. Two of the three incidents were documented in the episodic daily log book.	One of three records reviewed contained an incident which was not recorded in the program's daily episodic log book.
All staff are trained on emergency medical procedures	Compliance	Reviewed documentation confirmed all staff were trained in emergency medical procedures.	
The program has a Knife-for-life and wire cutters accessible to staff in a secure location(s)	Compliance	The program maintains a knife-for-life and wire cutters kit which is accessible to all staff in a secure location within the supervisor's desk.	
Additional Comments: There are no additional comments for this indicator.			