Florida Network of Youth and Family Services Quality Improvement Program Report

Review of YFA New Beginnings
Residential Program

December 4 - 5, 2019

Compliance Monitoring Services Provided by

Quality Improvement Review

YFA New Beginnings – December 4 - 5, 2019
Lead Reviewer: Ashley Davies

CINS/FINS Rating Profile

Standard 1: Management Accountability

1.01 Background Screening	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: 100.00%
Percent of indicators rated Limited: 0.00%
Percent of indicators rated Failed: 0.00%

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 Sexual Orientation, Gender Identity/ Expression	Satisfactory
2.09 Special Populations	Satisfactory
2.10 Stop Now and Plan (SNAP)	Satisfactory

Percent of indicators rated Satisfactory: 100.00%
Percent of indicators rated Limited: 0.00%
Percent of indicators rated Failed: 0.00%

Standard 3: Shelter Care & Special Populations

3.01 Shelter Environment	Satisfactory
3.02 Program Orientation	Satisfactory
3.03 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: 100.00%
Percent of indicators rated Limited: 0.00%
Percent of indicators rated Failed: 0.00%

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: 100.00%
Percent of indicators rated Limited: 0.00%
Percent of indicators rated Failed: 0.00%

Overall Rating Summary

Percent of indicators rated Satisfactory: 100.00%
Percent of indicators rated Limited: 0.00%
Percent of indicators rated Failed: 0.00%

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.

Reviewer

Members

Ashley Davies, Consultant-Forefront LLC, Florida Network of Youth and Family Services

Jennifer Schad, Regional Monitor, Department of Juvenile Justice

Melissa Gryzb, Data Intake Coordinator, Arnette House

Alex Culbreth, Residential Counselor, CDS Family & Behavioral Health Services

Saxon Bowler, Case Manager, Family Resources

Quality Improvement Review

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Methodology

This review was conducted in accordance with FDJJ-1720 (Quality Assurance Policy and Procedures), and focused on the areas of (1) Management Accountability, (2) Intervention and Case Management, (3) Shelter Care, and (4) Mental Health/Health Services which are included in the Children/Families in Need of Services (CINS/FINS) Standards (July 2019).

Persons Interviewed

☒ Chief Executive Officer
☐ Chief Financial Officer
☐ Program Coordinator
☐ Direct – Part time
☐ Volunteer
☒ Clinical Director
☒ Counselor Non-Licensed
☐ Advocate
☐ Nurse – Full time
☐ Executive Director
☒ Program Director
☒ Direct – Care Full time
☐ Direct – Care On-Call
☐ Intern
☒ Counselor Licensed
☒ Case Manager
☒ Human Resources
☒ Nurse – Part time
☐ Chief Operating Officer
☐ Program Manager
1 # Case Managers
1 # Program Supervisors
NA # Food Service Personnel
1 # Healthcare Staff
NA # Maintenance Personnel
NA # Other (listed by title): _____

Documents Reviewed

☐ Accreditation Reports
☒ Affidavit of Good Moral Character
☒ CCC Reports
☒ Logbooks
☐ Continuity of Operation Plan
☐ Contract Monitoring Reports
☐ Contract Scope of Services
☒ Egress Plans
☒ Fire Inspection Report
☐ Exposure Control Plan
☒ Table of Organization
☒ Fire Prevention Plan
☒ Grievance Process/Records
☒ Key Control Log
☒ Fire Drill Log
☒ Medical and Mental Health Alerts
☒ Precautionary Observation Logs
☒ Program Schedules
☐ Supplemental Contracts
☐ Telephone Logs
☒ Vehicle Inspection Reports
☐ Visitation Logs
☒ Youth Handbook
5 # Health Records
3 # MH/SA Records
6 # Personnel /Volunteer Records
8 # Training Records
5 # Youth Records (Closed)
5 # Youth Records (Open)
NA # Other: _____

Surveys

3 # Youth
3 # Direct Care Staff
0 # Other: **NA**

Observations During Review

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

Comments

Additional Comments regarding observations, other important findings of interest, etc.

Strengths and Innovative Approaches

The shelter received an $8,700.00 grant from Suncoast Credit Union Foundation. With the grant they were able to update the kitchen and dining room with new floors, new dining room furniture, new paint, and new wall décor.

Hernando County Sherriff's office continues to be a huge partner to the shelter. They provided the manpower for painting the kitchen and dining room in order to save money to have the floors completed. They continue to support thorough "Cook for Kids", quarterly events with the youth, Leadership Council, and providing the shelter with Thanksgiving and Christmas dinner as well as Christmas gifts.

The shelters first Fall Festival event was a huge success and they will continue that event annually.

The shelter will be hosting the first annual KenDucky Derby Race. The first race is set for April 25, 2020.

Standard 1: Management Accountability

Overview

YFA New Beginnings is managed by a VP of Operations who oversees a Shelter Manager. Day-to-day activities at the shelter are carried out by nine full-time and six part-time Youth Development Specialists (YDS). There was one Cook position vacant. The shelter received DJJ Appropriations for 2019-2020 to be used for an emergency back-up generator, commercial epoxy flooring in common areas, exterior updates to the building and outdoor security, six Motorola two-way radios for staff communication, and new furniture for high traffic areas.

The programs comprehensive CQI Plan for FY 2019-2020 describes the CQI structure, committees, stake holders, CQI cycles, data collection and analysis, reporting, and corrective actions. Staff are assigned to teams such as Peer Review, Outcomes Measurement, Risk Prevention and Management, Training, Safety Committee, Employee Retention, and Stakeholder Involvement. Each team has an appointed team leader who is responsible for coordinating team meetings and attending the CQI Council meetings. The CQI council and CQI teams meet quarterly. The CQI teams are responsible for providing updates and recommendation to the CQI Council on a quarterly basis regarding areas outlined in the purpose and goals for each team. Quarterly reports are completed for each team. Annual reports are required from each CQI Team by July 31st for the fiscal year activities. The shelter manager reviews information in JJIS and NetMIS monthly to ensure accuracy of data entry and collection.

All indicators in standard one were rated satisfactory with no exceptions. There was one deficiency noted in indicator 1.06 Client Transportation due to three instances reviewed on mileage logs that were not filled out in their entirety. This deficiency did not result in an exception. There were no other deficiencies noted in standard one.

Standard 2: Intervention and Case Management

Overview

YFA New Beginnings provides residential and non-residential counseling and case management services across three counties in circuit five, Citrus, Hernando, and Sumter.

The non-residential services are provided at the agency’s office, local schools, and at the offices of other community-based organizations. The non-residential program consists of a non-residential master’s level Program Director and five full-time

Counselors. The residential program has two master's level Counselors providing services.

The non-residential program also offers Family/Youth Respite Aftercare Services (FYRAC). Intensive Case Management (ICM) services and Stop Now and Plan (SNAP) services are not offered at this location.

The residential program has provided domestic violence respite and probation respite services. At the time of the review the program had not provided any staff secure or domestic minor sex trafficking services. The agency is currently maintaining paper files.

All indicators in standard two, with the exception of indicator 2.10 Stop Now and Plan (SNAP), were rated satisfactory with no exceptions or deficiencies noted. Indicator 2.10 was rated not applicable as the agency does not provide SNAP services at this location.

Standard 3: Shelter Care

Overview

YFA New Beginnings residential program is led by a Shelter Manager. The shelter runs three shifts. Each shift is led by a Shift Lead and staffed with Youth Development Specialists (YDS). There are currently nine full-time and six part-time YDS.

The shelter received an $8,700.00 grant from Suncoast Credit Union Foundation. With the grant they were able to update the kitchen and dining room with new floors, new dining room furniture, new paint, and new wall décor.

The shelter has a daily program schedule in place that is posted in the dayroom for youth and staff to view. The schedule allows youth quiet time and time to complete homework. The schedule includes structured activities seven days a week with minimal idle time.

The program has an effective behavior management system (BMS) in place. The system is called the Youth Development System (YDS). The youth is explained the program rules and expectations at admission. The YDS consists of four different phases (Orientation, Education, Graduation, and Collegiate).

The youth shelter consists of a large dayroom, a separate kitchen and dining room, a multi-purpose room, numerous staff offices, and a separate dorm area housing all the male and female sleeping rooms separated by a staff work area. There are bathrooms on both the male and female sides which are shared by the youth.

The shelter is licensed by the Department of Children and Families for twenty-four beds. At the time of the on-site review there were seven CINS/FINS youth in the shelter.

All indicators in standard three were rated satisfactory with no exceptions or deficiencies noted.

Standard 4: Mental Health/Health Services

Overview

The residential counseling services in the shelter are provided by two master's level counselors. The agency does not have a licensed staff member that works primarily at the New Beginnings youth shelter location. The shelter has access to a Licensed Mental Health Counselor (LMHC), who works for the agency, who reviews all suicide risk assessments and consults and reviews with staff regarding youth placed on elevated or sight and sound supervision status.

All youth are screened for suicide at intake using the six approved questions on the CINS Intake Assessment form and the Evaluation of Imminent Danger for Suicide (EIDS). If youth receive a positive screening they are placed on sight and sound supervision until seen and assessed by a qualified mental health professional. All staff receive training on suicide prevention.

Health services are overseen by a part-time Registered Nurse (RN). The RN is on-site approximately twenty hours each week. The RN will distribute all medications when on-site and trained Youth Development Specialists (YDS) will distribute medications when the RN is not on-site.

The RN provides training for all newly hired staff on the medication distribution process and the Pyxis Med-Station 4000 Medication Cabinet. Refresher training is provided for as needed.

All medications in the facility are stored in the Pyxis Med-Station 4000 Medication Cabinet. The RN completes a weekly inventory of all medications on-site. YDS complete shift-to-shift inventories of all controlled medications and maintain perpetual inventories of all other medications.

All indicators in standard four were rated satisfactory with the only exception noted in indicator 4.05 Emergency/Episodic Care. The exception noted in 4.05 was due to two incident reports not documenting notification to the parent/guardian of emergency medical care. All other indicators in standard four were rated satisfactory with no deficiencies.

STANDARD 1: MANAGEMENT ACCOUNTABILITY

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
Standard One – Management Accountability							
1.01: Background Screening and compliance with DJJ OIG statewide procedures regarding BS of employees, contractors and volunteers							
Provider has a written policy and procedure that meets the requirement for Indicator 1.01						☒ YES ☐ NO (explain) The agency has a policy in place titled RGC 1.01 Background Screening of Employees/Volunteers/Interns/Contracted Providers. The policy was last revised on March 26, 2019 and last approved on September 9, 2019 by the Chief Executive Officer and the Chief Operating Officer.	No exceptions
RATING	☒	☐	☐	☐	☐	There were six newly hired staff who were reviewed for a background screening completed prior to hire. All six documented a background screening was completed prior to hire with an eligible rating. All six staff also had a pre-employment suitability assessment completed, using the Criteria assessment, with a rating of “recommended” or “highly recommended”. All six newly hired staff had documentation of E-Verify obtained from the Department of Homeland Security. The Affidavit of Annual Compliance was completed and submitted on January 3, 2019.	No exceptions
1.02: Provision of an abuse free environment to ensure safety and abuse free environment for youth in care							

Quality Improvement Review

Quality Improvement Indicators	Rating	Explain				Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
Provider has a written policy and procedure that meets the requirement for Indicator 1.02						☒ YES ☐ NO (explain) The agency has a policy in place titled RGC 1.02 Provision of an Abuse Free Environment. The policy was last revised on March 26, 2019 and last approved on May 9, 2019 by the Chief Executive Officer and the Chief Operating Officer.	No exceptions
RATING	☒	☐	☐	☐	☐	The program has a code of conduct which prohibits the use of physical abuse, profanity, threats, and intimidation. Staff are to follow the American Counseling Association Code of Ethics. The program has signage to reflect all youth are accepted regardless of sexual orientation, gender identity, or gender expression. There are postings for the Florida Abuse Hotline throughout the program, in the dining hall, living room, and shelter areas. The program has a process in place for documenting child abuse hotline calls. A review of incidents reported to the Department's Central Communications Center did not include any allegations of abuse or neglect by staff. The program had one example of management taking immediate action with staff discipline for verbally aggressive language. The staff had received a verbal warning and was terminated two days later for another incident of the same type. The program has a process for youth to file grievances. The process is outlined in the youth handbook. There is a locked grievance	No exceptions

Quality Improvement Indicators	Rating: Satisfactory	Explain: Deficiency Identified	Explain: No Eligible Items For Review	Explain: No Practice	Explain: Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation. Summarize Findings Based on Completed Worksheets	Notes: Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
						box available to youth in the common area, near the living room. The program's policy prohibits direct care workers from handling the grievance documents. The residential director is responsible for retrieving, reviewing, and addressing the grievances. Grievances are maintained by the program for a minimum of one year. Grievances for the past six months were reviewed. The program had fifteen grievances in the past six months. Fourteen of the grievances had documentation it was resolved within seventy-two hours by management. One grievance did not include the date the youth filled out the form so it could not be determined the time frame for how long it took to resolve.	
1.03: Incident Reporting							
Provider has a written policy and procedure that meets the requirement for Indicator 1.03						☒ YES ☐ NO (explain) The agency has a policy in place titled RGC 1.03 Incident Reporting. The policy was last revised on December 4, 2018 and last approved in February 2019 by the Chief Executive Officer and the Chief Operating Officer.	No exceptions
RATING	☒	☐	☐	☐	☐	Nineteen incidents from the past six months were reviewed. Of the incidents, one incident was called in by an outside source. The reported incidents included four medication errors, seven medical transports, and three contraband found.	No exceptions

Quality Improvement Indicators	Rating: Satisfactory	Rating: Explain – Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
						The program notified the Department's Central Communication Center (CCC) no later than two hours of the incident or within two hours of learning of the incident. Of the eighteen applicable incidents, all had a reference in the logbook regarding an incident but some without complete details. All eighteen applicable incidents were documented with detail on the program's incident reporting form. For each, there was documentation the incident was reviewed by a program supervisor or the program director.	
1.04: Training Requirements **Staff receives training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions**							
Provider has a written policy and procedure that meets the requirement for Indicator 1.04						☒ YES ☐ NO (explain) The agency has a policy in place titled RGC 1.04 Training. The policy was last revised on March 26, 2019 and last approved in August 2019 by the Chief Executive Officer and the Chief Operating Officer.	No exceptions
RATING	☒	☐	☐	☐	☐	The shelter had an annual training plan in place for the 2019-2020 fiscal year. The plan addressed training requirements for new hires and on-going annual training. There were four staff training files reviewed for first year training requirements. Three of the four staff documented over the required eighty hours of training and the fourth staff	No exceptions

Quality Improvement Indicators	Rating: Satisfactory	Explain: Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation. Summarize Findings Based on Completed Worksheets	Notes: Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
						documented 77.5 hours with approximately one month left to receive the additional hours. All four staff documented all required trainings. There were four staff training files reviewed for annual training requirements. All four staff documented well over the required forty hours of training for the last completed training cycle. All four staff documented all required trainings were completed. An individual training file is maintained for each staff, which includes training hours tracking forms and any related documentation.	
1.05: Analyzing and Reporting Information **The program collects and reviews several sources of information to identify patterns and trends. Program should have sample reports of aggregated data and committee/workgroup minutes analyzing information.**							
Provider has a written policy and procedure that meets the requirement for Indicator 1.05						☒ YES ☐ NO (explain) The agency has a policy in place titled RGC 1.05 Data Collection and Evaluation. The policy was last revised on September 1, 2018 and last approved on February 26, 2019 by the Chief Executive Officer and the Chief Operating Officer.	No exceptions
RATING	☒	☐	☐	☐	☐	The program conducts quarterly case record reviews on the Continuous Quality Improvement (CQI) worksheet. The program reviews incidents and accidents quarterly in the Risk Prevention and Management Team Meeting. The program conducts an annual review of customer satisfaction data. There is a monthly	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						review of NetMIS data reports. There was documentation findings are regularly reviewed by management and communicated to staff and stakeholders through a variety of meetings. The program has Stakeholder Involvement Team meetings, staff meetings, and Leadership Council meetings. Through the varied cumulation of data, there was documentation of strengths and weaknesses being identified, and where improvements are needed. The varied data is reviewed on a regular basis.	
1.06: Client Transportation **Policy is established to avoid situations that put youth or staff in danger of real or perceived harm, or allegations of inappropriate conduct by either staff or youth.**							
Provider has a written policy and procedure that meets the requirement for Indicator 1.06						☒ YES ☐ NO (explain) The agency has a policy in place titled RGC 1.06 Client Transportation. The policy was last revised on April 18, 2019 and last approved in May 2019 by the Chief Executive Officer and the Chief Operating Officer.	No exceptions
RATING	☐	☒	☐	☐	☐	The program's policy states drivers need approval by administrative personnel, through human resources. The program's insurance policy has an inclusion clause which covers any employee of the company while driving their vehicles. The program maintains a list of approved drivers. The policy prohibits the transporting of a client without maintaining at least one other passenger in the vehicle	A review of single party transports for the past six months found three transports with incomplete or missing mileage. However, this deficiency did not result in an exception.

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						during the trip, whenever possible. The program's policy defines third party as an approved volunteer, intern, or agency staff. Their policy does not include another youth as an approved third party. The program's policy includes exceptions in the event a third party is not present in the vehicle during a transportation. In the event a third party cannot be obtained for transport, the program's supervisor needs to give approval, the client's history, evaluation, and recent behavior is also considered. The policy allows for the transporter to maintain an open line of communication throughout the transport if staff feels it is necessary. The program's form for documentation of a single party transport includes the date, client's name, reason, supervisor approval and initials, departure location and time, destination and time, mileage to and from, and staff name. A review of approximately twenty single party transports for the past six months found three transports with incomplete or missing mileage. All other transports documented all information was filled out in its entirety. All single party transports reviewed also documented approval was obtained by a supervisor prior to the transport taking place.	
1.07: Outreach Services **The agency participates in local DJJ board and council meetings to increase public safety by reducing juvenile delinquency through effective prevention, intervention and treatment services and ensure CINS/FINS services are represented in a coordinated approach.**							

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
Provider has a written policy and procedure that meets the requirement for Indicator 1.07						☒ YES ☐ NO (explain) The agency has a policy in place titled RGC 1.07 Community Outreach and Education. The policy was last revised on March 27, 2017 and last approved on March 14, 2019 by the Chief Executive Officer and the Chief Operating Officer.	No exceptions
RATING	☒	☐	☐	☐	☐	The program maintains a binder with documentation of inter-agency agreements. The program has agreements with Baycare, Bene's Career Academy, Pasco Kids First, United Way of Hernando County, Lighthouse for the Visually Impaired and Blind, Pasco Sheriff's Office Special Victims Unit, Sumter County School Board, and Saint Leo University. All agreements are up-to-date. All outreach events attended by staff were documented in NetMIS. The staff attended twenty-one events in the last six months. The staff attended the Department of Juvenile Justice Circuit meetings. Copies of agendas and minutes from the last two meetings were provided.	No exceptions

STANDARD 2: INTERVENTION AND CASE MANAGEMENT

Quality Improvement Indicators	Rating: Satisfactory	Rating (Explain): Deficiency Identified	Rating (Explain): No Eligible Items For Review	Rating (Explain): No Practice	Rating (Explain): Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
Standard Two – Intervention and Case Management							
2.01: Screening and Intake							
Provider has a written policy and procedure that meets the requirement for Indicator 2.01						☒ YES ☐ NO (explain) The agency has a policy in place titled RGC 2.01 Eligibility Screening and Intake. The policy was last revised on March 26, 2019 and last approved in May 2019 by the Chief Executive Officer and the Chief Operating Officer.	No exceptions
RATING	☒	☐	☐	☐	☐	A total of ten files were reviewed, five residential and five non-residential. Of the five non-residential files, four were closed and one was open. Of the five residential files, three were closed and two were open. In nine out of the ten files reviewed an eligibility screening was completed within seven calendar days of the referral. One non-residential file had a referral received May 18, 2019 but screening was not completed until September 6, 2019. The case manager made multiple attempts to contact the guardian and the youth was rescreened September 6, 2019 and then the intake was completed. All ten files had a document signed by the parent/guardian confirming receipt of the available service options, rights and responsibilities of youth and	No exceptions

Quality Improvement Indicators	Rating: Satisfactory	Rating (Explain): Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation. Summarize Findings Based on Completed Worksheets	Notes: Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
						parents/guardians, parent/guardian brochure, possible actions through CINS/FINS services, and grievance procedures. There is no document clearly outlining which documents the guardians and youth receive but upon interview with the case manager supervisor it was explained that in an effort to reduce intake time and paperwork, parents are now given a welcome packet containing all the above referenced documents and sign one sheet denoting receipt of the above mentioned documents.	
2.02: Needs Assessment							
Provider has a written policy and procedure that meets the requirement for Indicator 2.02						☒ YES ☐ NO (explain) The agency has a policy in place titled RGC 2.02 Needs Assessment. The policy was last revised on March 26, 2019 and last approved in May 2019 by the Chief Executive Officer and the Chief Operating Officer.	No exceptions
RATING	☒	☐	☐	☐	☐	A total of ten files were reviewed, five residential and five non-residential. Of the five non-residential files, four were closed and one was open. Of the five residential files, three were closed and two were open. All five non-residential files and all but one residential file had the Needs Assessment initiated within seventy-two hours of admission, was completed within two to three face-to-face contacts after initial intake, were conducted by a	No exceptions

Quality Improvement Indicators	Rating: Satisfactory	Explain: Deficiency Identified	Explain: No Eligible Items For Review	Explain: No Practice	Explain: Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
						bachelor's or master's level staff, and included a supervisor's review signature upon completion. The one residential file in which the Needs Assessment was missing, the youth just entered the shelter and it has not been completed yet, but the counselor is still within the allotted time. No youth were identified with suicide risk in the non-residential files. All five residential files identified youth with an elevated risk of suicide, and all were referred for an assessment for suicide risk conducted by or under the direct supervision of a licensed mental health professional.	
2.03 Case/Service Plan							
Provider has a written policy and procedure that meets the requirement for Indicator 2.03						☒ YES ☐ NO (explain) The agency has a policy in place titled RGC 2.03 Service Plan Development and Service Monitoring. The policy was last revised on March 26, 2019 and last approved in May 2019 by the Chief Executive Officer and the Chief Operating Officer.	No exceptions
RATING	☒	☐	☐	☐	☐	A total of ten files were reviewed, five residential and five non-residential. Of the five non-residential files, four were closed and one was open. Of the five residential files, three were closed and two were open. All five non-residential files had the Case Plan developed within seven working days of the Needs Assessment.	No exceptions

	Rating					Review Based Upon	Notes
		Explain					
Quality Improvement Indicators	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable	Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
						All five files included individualized and prioritized need(s) and goal(s), service type, frequency, and location, person(s) responsible, and target completion dates. All five files also included the signatures of youth, parent/guardian, counselor and supervisor, an initiation date, and are reviewed for progress every thirty days for the first three months and every six months after. All applicable Case Plans had completion dates. For the residential files, four were developed within seven working days of the Needs Assessment. These four also included individualized and prioritized need(s) and goal(s), service type, frequency, and location, person(s) responsible, target dates for completion, and contained signatures of the counselor and supervisor, the initiation date, and are reviewed for progress every thirty days for the first three months and every six months after. One file did not contain completion dates but is still open and two others did not contain a parent/guardian signature, but agreement was procured over the phone. One file did not contain a Case Plan at all, but the youth just entered the program a few days ago therefore the counselor is still in compliance.	
2.04: Case Management and Service Delivery							

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
Provider has a written policy and procedure that meets the requirement for Indicator 2.04						☒ YES ☐ NO (explain) The agency has a policy in place titled RGC 2.04 Traditional and Intensive Case Management and Service Delivery. The policy was last revised on March 26, 2019 and last approved in May 2019 by the Chief Executive Officer and the Chief Operating Officer.	No exceptions
RATING	☒	☐	☐	☐	☐	A total of ten files were reviewed, five residential and five non-residential. Of the five non-residential files, four were closed and one was open. Of the five residential files, three were closed and two were open. All five non-residential and all five residential files clearly had a counselor/case manager assigned where the counselor/case manager established referral needs and coordinated services based upon the on-going assessment of the youth's/family's needs and coordinated Case Plan implementation. All files contained proof of monitoring the youth's/family's progress in services and provided support for the families. None of the files reviewed necessitated out-of-home monitoring or referral to case staffing. For non-residential files, the case manager accompanies youth and parent/guardian to court hearings as applicable, but this is not applicable for residential counselors. All non-residential and residential files contained documentation where referrals are made	No exceptions

Quality Improvement Indicators	Rating: Satisfactory	Explain: Deficiency Identified	Explain: No Eligible Items For Review	Explain: No Practice	Explain: Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation. Summarize Findings Based on Completed Worksheets	Notes: Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
						as applicable, documentation of case monitoring, case termination notes, and proof of thirty- and sixty-day follow-ups after exit from the respective programs.	
2.05: Counseling Services							
Provider has a written policy and procedure that meets the requirement for Indicator 2.05						☒ YES ☐ NO (explain) The agency has a policy in place titled RGC 2.05 CINS/FINS Counseling and Residential Group Care Services. The policy was last revised on March 26, 2019 and last approved in May 2019 by the Chief Executive Officer and the Chief Operating Officer.	No exceptions
RATING	☒	☐	☐	☐	☐	A total of ten files were reviewed, five residential and five non-residential. Of the five non-residential files, four were closed and one was open. Of the five residential files, three were closed and two were open. All non-residential files and four of the five residential files reflected case coordination between presenting problem and the Needs Assessment, Case Plan, and case management and follow-ups. The one residential file that lacked these items was the recently opened file that does not yet contain the Needs Assessment or the Individual Plan. All ten files also contained case notes for all counseling services provided and documented the youth's progress, evidenced on-going internal processes that ensure clinical review of case records	No exceptions

Quality Improvement Indicators	Rating: Satisfactory	Explain: Deficiency Identified	Explain: No Eligible Items For Review	Explain: No Practice	Explain: Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
						and staff performance, and provided evidence of youth and families receiving counseling services in accordance with the Case Plan where applicable, including the provision of individual and family counseling. The non-residential files did not contain documentation regarding groups since groups are not offered to or required for non-residential clients. All five residential files contained documentation reflecting the provision of group sessions at least five days a week and the documentation clearly provided a date and time of group, a list of participants, a clearly identified facilitator, a relevant topic, an opportunity for youth to participate, and a length of at least thirty minutes.	
2.06: Adjudication/Petition Process							
Provider has a written policy and procedure that meets the requirement for Indicator 2.06						☒ YES ☐ NO (explain) The agency has a policy in place titled RGC 2.06 Adjudication and Petition Process. The policy was last revised on March 26, 2019 and last approved in May 2019 by the Chief Executive Officer and the Chief Operating Officer.	No exceptions
RATING	☒	☐	☐	☐	☐	A total of three non-residential files were reviewed. None of the case staffing meetings were initiated by a parent/guardian. All three files documented notification to the family and the committee no less than five working days prior to the staffing. The	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						documentation in all the files also indicated that each staffing included a school district representative a DJJ representative or CINS/FINS provider, at least one parent, a law enforcement representative, and the youth. Revisions to the case plan as a result of the staffing are also represented and a written report was provided to the parent/guardian within seven days of the case staffing meeting. None of the files reviewed contained a judicial intervention or review summary in preparation for the court hearings despite the agency's policy stating it is required by the case manager/counselor to prepare a review before the hearing. All files did contain a Case Staffing Summary Sheet after the case staffing meeting. Upon interview with the Case Manager Supervisor reviewer was informed that this program does not attend court and only attends Case Staffing Meetings, for which proper documentation is evident in all files. The agency utilizes a CINS/FINS Case Staffing Notebook which includes documentation of the regular communication with committee members and serves as proof of the established internal procedure for the case staffing process.	
2.07: Youth Records							
Provider has a written policy and procedure that meets the requirement						☒ YES ☐ NO (explain)	No exceptions

Quality Improvement Indicators	Rating: Satisfactory	Explain: Deficiency Identified	Explain: No Eligible Items For Review	Explain: No Practice	Explain: Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
for Indicator 2.07						The agency has a policy in place titled RGC 2.07 Youth Records. The policy was last revised on March 26, 2019 and last approved in May 2019 by the Chief Executive Officer and the Chief Operating Officer.	
RATING	☒	☐	☐	☐	☐	A total of ten files were reviewed, five residential and five non-residential. Of the five non-residential files, four were closed and one was open. Of the five residential files, three were closed and two were open. Upon review, all ten files were marked “confidential”, were kept in a locked file room within a locked file cabinet that was also marked “confidential”, and when in transport the records are locked in an opaque container marked “confidential”. All open files were in a neat and orderly manner.	No exceptions
2.08: Sexual Orientation, Gender Identity, Gender Expression							
Provider has a written policy and procedure that meets the requirement for Indicator 2.08						☒ YES ☐ NO (explain) The agency has a policy in place titled RGC 2.08 Sexual orientation, Gender Identity, and Gender Expression. The policy was last revised on March 26, 2019 and last approved in May 2019 by the Chief Executive Officer and the Chief Operating Officer.	No exceptions
RATING	☒	☐	☐	☐	☐	All volunteers who enter the shelter are required to read the Zine, located in the lobby, prior to entering the shelter. The volunteers then sign a statement stating	No exceptions

Quality Improvement Indicators	Rating: Satisfactory	Explain: Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
						they have read and understand the pamphlet and that they will be respectful of any LGBTQ issues while in the shelter. All staff were also required to read the Zine and sign the same statement. This documentation is maintained in the staffs personal file. The shelter has signage located throughout the shelter including in the: lobby, dayroom, hallways, intake office, and classroom, indicating the program is a safe space for all youth regardless of actual or perceived sexual orientation, gender identity, and gender expression. Signage includes signs of rainbows and statements in rainbow colors. Many of the signs throughout the shelter are signs youth in the shelter have painted and made themselves.	
2.09: Special Populations							
Provider has a written policy and procedure that meets the requirement for Indicator 2.09						☒ YES ☐ NO (explain) The agency has a policy in place titled RGC 3.07 Special Populations. The policy was last revised on March 26, 2019 and last approved in May 2019 by the Chief Executive Officer and the Chief Operating Officer.	No exceptions
RATING	☒	☐	☐	☐	☐	The program has not had any examples of Staff Secure youth, Domestic Minor Sex Trafficking, or Family and Youth Respite Aftercare Services (FYRAC) youth in the	No Exceptions

	Rating						
		Explain					
Quality Improvement Indicators	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
						last year. This site also does not provide Intensive Case Management Services. There were three Domestic Violence (DV) files reviewed. All three-youth had a pending DV charge and did not meet criteria for secure detention. Data was entered into JJIS within twenty-four hours of admission and seventy-two hours of release. Two of the youth were in the shelter longer than twenty-one days and were appropriately switched over to a CINS bed after twenty-one days. All three case plans reflected goals focusing on anger management and family coping skills. All other services provide were consistent with all other general CINS/FINS program requirements. There was one Probation Respite file available for review in the last six months. The file documented the referral came from DJJ Probation. Data was entered into JJIS and NetMIS within twenty-four hours of admission and seventy-two hours of release. The length of stay was no more than fourteen to thirty days. All case management and counseling needs were addressed. All other services provided were consistent with all other general CINS/FINS program requirements.	
2.10: STOP NOW AND PLAN (SNAP)							

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
Provider has a written policy and procedure that meets the requirement for Indicator 2.10						☐ YES ☒ NO (explain) Not Applicable	The agency does not provide SNAP services at this location.
RATING	☐	☐	☐	☐	☒	Not Applicable	The agency does not provide SNAP services at this location.

STANDARD 3: SHELTER CARE

Quality Improvement Indicators	Rating					Review Based Upon	Notes
		Explain				Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
Standard Three – Shelter Care							
3.01 Shelter Environment **The shelter's environment is safe, clean, neat and well maintained. The program provides structured daily programming to engage youth in activities that foster health, social, emotional, intellectual and physical development.**							
Provider has a written policy and procedure that meets the requirement for Indicator 3.01						☒ YES ☐ NO (explain) The agency has a policy in place titled RGC 3.01 Shelter Environment. The policy was last revised on February 15, 2017 and last approved on August 20, 2019 by the Chief Executive Officer and the Chief Operating Officer.	No exceptions
RATING	☒	☐	☐	☐	☐	The shelter is clean and well kept. The bedrooms were observed cleaned and organized, free of graffiti and insect infestation. Lighting was adequate and dumpsters were covered. Grounds had no debris and was free of hazardous material. Vehicles were locked and agency vehicle had all major safety equipment. All licenses and inspections were observed and up to date with satisfactory ratings. Laundry area was free of lint and in working condition. Youth have a place to lock up personal belongings if requested. Key control was in compliance. Chemicals were kept in the utility closet and inventoried weekly. Food was properly stored and labeled. The	No exceptions

Quality Improvement Indicators	Rating: Satisfactory	Explain: Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
						refrigerator and freezer were at the appropriate temperatures. The youth schedule was posted and physical activity and faith-based services were offered.	
3.02: Program Orientation							
Provider has a written policy and procedure that meets the requirement for Indicator 3.02						☒ YES ☐ NO (explain) The agency has a policy in place titled RGC 3.02 Program Orientation. The policy was last revised on February 28, 2017 and last approved on May 15, 2019 by the Chief Executive Officer and the Chief Operating Officer.	No exceptions
RATING	☒	☐	☐	☐	☐	There were five files reviewed, three closed and two open. All five files contained evidence of the youth being provided a comprehensive orientation and a Youth Handbook. During the orientation process the handbook is reviewed with youth and program expectations and client rights are explained and discussed. Information on disciplinary action, the grievance procedure, activities, contraband, and the behavior management system is part of the discussion. All Orientation Checklists were initialed and signed by the youth and staff.	No exceptions
3.03: Youth Room Assignment							
Provider has a written policy and procedure that meets the requirement for Indicator 3.03						☒ YES ☐ NO (explain) The agency has a policy in place titled RGC 3.03 Youth Room Assignment. The	No exceptions

Quality Improvement Indicators	Rating: Satisfactory	Explain: Deficiency Identified	Explain: No Eligible Items For Review	Explain: No Practice	Explain: Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation. Summarize Findings Based on Completed Worksheets	Notes. Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
						policy was last revised on March 1, 2019 and last approved on May 15, 2019 by the Chief Executive Officer and the Chief Operating Officer.	
RATING	☒	☐	☐	☐	☐	There were five files reviewed, three closed and two open. Each file indicated a review of youth's history/trauma, age, gender, history of violence, disabilities, physical size/strength, gang affiliation, suicidal risk, and sexually aggressive behavior. Alerts were documented, collateral contacts were listed, and initial observations were noted in staff documents. All five youth were appropriately assigned to a room based on the above information.	No exceptions
3.04: Log Books							
Provider has a written policy and procedure that meets the requirement for Indicator 3.04						☒ YES ☐ NO (explain) The agency has a policy in place titled RGC 3.04 Log Books. The policy was last revised on March 26, 2019 and last approved on May 21, 2019 by the Chief Executive Officer and the Chief Operating Officer.	No exceptions
RATING	☒	☐	☐	☐	☐	Logbooks from the last six months were reviewed. Safety and security issues were highlighted. Entries were written in ink, dated, and legible with a signature at the end. No white out was observed. Supervision and resident counts were documented as well as visitations. Errors were struck through with a single line and	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						initialed. Direct care staff and supervisors signed in and reviewed the logbook for the previous two shifts. The program director reviewed the logbook weekly and noted any corrections, recommendations, or follow-ups.	
3.05: Behavior Management Strategies							
Provider has a written policy and procedure that meets the requirement for Indicator 3.05						☒ YES ☐ NO (explain) The agency has a policy in place titled RGC 3.05 Behavior Management Strategies. The policy was last revised on April 18, 2017 and last approved on May 21, 2019 by the Chief Executive Officer and the Chief Operating Officer.	No exceptions
RATING	☒	☐	☐	☐	☐	During intake, the youth is explained the program rules, expectations, and the Behavior Management Strategies (BMS), also called the Youth Development System (YDS). Youth receives the youth handbook and signs off on it at admission, which explains the YDS. The YDS consists of four different phases (Orientation, Education, Graduation, and Collegiate). Youth are placed on Orientation level for three days after entering the program. While on the Orientation level, emphasis is on getting oriented to the program's core values (six pillars of character) and youth development strategies (twelve developmental outcomes).	No exceptions

	Rating						
		Explain				Review Based Upon	Notes
Quality Improvement Indicators	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable	Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
						Upon completion of orientation level, which requires setting a weekly goal, youth advances to the Education level. While on the Education level, emphasis is placed on youth's ability to demonstrate skills learned on the Orientation level as well as to actively engage in educational activities, outings, and groups. Upon completion of the Education level, youth advance to the Graduate level of the program. Once a youth is placed on Graduation level, the expectation is to enhance demonstration of the skills learned on the previous levels of the program and start exemplifying the characteristics of a role model. The final level of the program is Collegiate. While on the Collegiate level, youth are expected to exemplify the characteristics of a role model and serve as peer leaders. Additionally, youth putting the six pillars (Responsibility, Respect, Caring, Citizenship, Fairness, and Trustworthiness) into practice affords them the opportunity to start earning money (Monopoly money) to buy the desired items from the "New Beginning Box." All staff are trained on the BMS during new hire training.	
3.06: Staffing and Youth Supervision							

Quality Improvement Indicators	Rating	Explain				Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
Provider has a written policy and procedure that meets the requirement for Indicator 3.06						☒ YES ☐ NO (explain) The agency has a policy in place titled RGC 3.06 Staffing and Youth Supervision. The policy was last revised on March 26, 2019 and last approved on May 15, 2019 by the Chief Executive Officer and the Chief Operating Officer.	No exceptions
RATING	☒	☐	☐	☐	☐	Staff schedules are emailed to all employees weekly and if/when there are any changes. The schedule is also posted at the staff workstation. A staff list with phone numbers is located at the staff work desk in case additional coverage is needed. The last six months of staff schedules were reviewed, and cross referenced to the logbooks. Appropriate staffing ratios of one staff to six youth during awake hours and one staff to twelve youth during sleeping hours were maintained. There was always at least two members on duty during the overnight shifts. A random sample of overnight shifts were reviewed via the video surveillance system to ensure observations were completed while youth were in their sleeping rooms. The observations were being completed at least every fifteen minutes as required.	No exceptions
3.07: Video Surveillance System							
Provider has a written policy and procedure that meets the requirement for Indicator 3.07						☒ YES ☐ NO (explain) The agency has a policy in place titled RGC 3.07 Video Surveillance System.	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation. Summarize Findings Based on Completed Worksheets	Notes: Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						The policy was last revised on March 26, 2019 and last approved on July 10, 2019 by the Chief Executive Officer and the Chief Operating Officer.	
RATING	☒	☐	☐	☐	☐	The shelter has a video surveillance system that is operational twenty-four hours a day, seven days a week. There were written notices posted around the grounds of the shelter stating that recording was in progress. Cameras were located in the interior and exterior areas of the shelter where youth and staff congregate and where visitors enter and exit. All cameras were visible. There were no cameras in sleeping rooms or bathrooms. The system can retain video and photographic images for up to thirty days. The system captures date, time, and location and maintains resolution for facial recognition. The cameras can operate during a power outage. There was a list of four staff who have access to the video surveillance system. A supervisory review of video is conducted at least every fourteen days and documented in the logbook. The review includes a random sample of overnight shifts. The shelter has a process in place for third party review of video recordings.	No exceptions

STANDARD 4: MENTAL HEALTH/HEALTH SERVICES

Quality Improvement Indicators	Rating	Explain				Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
Standard Four – Mental Health /Health Services							
4.01: Healthcare Admission Screening							
Provider has a written policy and procedure that meets the requirement for Indicator 4.01						☒ **YES** ☐ **NO (explain)** The agency has a policy in place titled RGC 4.01 Healthcare Admission Screening. The policy was last revised on March 26, 2019 and last approved in May 2019 by the Chief Executive Officer and the Chief Operating Officer.	No exceptions
RATING	☒	☐	☐	☐	☐	There were five open residential files reviewed. All five youth had a healthcare screening completed on the day of admission. Three of the youth were on medications and names of the medications were documented. One youth was documented as having asthma and used an inhaler as needed. Three of the youth had different allergies documented. None of the youth had any recent injuries, illnesses, or pain. Four of the youth were documented as having scars or tattoos. There are procedures in place to involve the parent in any follow-up medical care needed for any chronic conditions. All five files reviewed documented the Registered Nurse (RN) reviewed all health screening forms and completed a Nursing Intake Examination within five days of the youth's admission.	No exceptions

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Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
4.02 Suicide Prevention **There is a written plan that details the program's suicide prevention and response procedures. The plan complies with the procedures outlined in the Florida Network's Policy and Procedure Manual for CINS/FINS.**							
Provider has a written policy and procedure that meets the requirement for Indicator 4.02						☒ **YES** ☐ **NO (explain)** The agency has a policy in place titled RGC 4.02 Suicide Prevention. The policy was last revised on March 26, 2019 and last approved in May 2019 by the Chief Executive Officer and the Chief Operating Officer.	No exceptions
RATING	☒	☐	☐	☐	☐	There were three youth files reviewed. In all three files the suicide risk screening occurred at intake using the six questions on the CINS/FINS Intake form. All three screening forms were signed by a supervisor. All three files also documented the Evaluation of Imminent Danger of Suicide (EIDS) was completed on each youth. All three youth were placed on sight and sound supervision until an Assessment of Suicide Risk could be completed. All three files documented the Assessment of Suicide Risk was completed by the counselor within twenty-four hours. All the assessments documented a telephone consultation with a Licensed Clinical Social Worker (LCSW). Supervision of the youth was not changed until after this telephone consultation took place. The LCSW signed all the assessments the next time on site. The counselor maintained clear and consistent documentation regarding who the licensed	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						professional was and the exact time youth was removed from sight and sound. The staff maintain five-minute observations of the youth while on suicide precautions. These observations were documented for all three youth. All observation sheets documented a shift supervisor review.	
4.03: Medication							
Provider has a written policy and procedure that meets the requirement for Indicator 4.03						☒ **YES** ☐ **NO (explain)** The agency has a policy in place titled RGC 4.03 Medication Control and Management. The policy was last revised on September 27, 2019 and approved by the Chief Executive Officer and the Chief Operating Officer.	No exceptions
RATING	☒	☐	☐	☐	☐	All medications are stored in the Pyxis Med-Station 4000 Medication Cabinet. The program provided a list of fourteen staff who are authorized to use the Pyxis Med-Station with four of those staff documented as Super Users. The agency does not accept injectable medications; however, does have two epi-pens on site. All staff have been trained on the use of the epi-pen by the Registered Nurse (RN). Oral medications are stored in a separate drawer in the Pyxis Med-Station then the topical medications. There is a refrigerator in the medication room that is used solely for the purpose of storing any medications requiring refrigeration. There were no medications requiring refrigeration at the	No exceptions

Quality Improvement Indicators	Rating: Satisfactory	Explain: Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
						time of the review; however, there is documentation the temperature of the refrigerator is checked daily. There were several controlled medications at the time of the review and all medications were counted shift- to-shift and verified by a witness. A perpetual inventory with running balances is maintained on each youth's individual Prescription Medication Log Sheet. Only staff who have completed training provided by the RN have User Permissions for the Pyxis Med-Station. The shelter does not have any sharps or any over-the-counter medications. The RN reviews reports in the Knowledge Portal at least monthly. All medication is verified at admission by calling the pharmacy. An RN is on-site two to three days each week. During those times the RN will distribute any medication. Trained staff will distribute medication when the RN is not on-site. Medication discrepancies are cleared out after each shift. There were no open discrepancies at the time of the review. The delivery process of medication is consistent with the FNYFS Medication Management and Distribution Policy.	
4.04: Medical/Mental Health Alert Process							
Provider has a written policy and procedure that meets the requirement for Indicator 4.04						☒ **YES** ☐ **NO (explain)** The agency has a policy in place titled RGC 4.04 Medical and Mental Health Alert System. The policy was last revised on March 26, 2019 and last approved in	No exceptions

Quality Improvement Indicators	Rating: Satisfactory	Rating: Deficiency Identified	Explain: No Eligible Items For Review	Explain: No Practice	Explain: Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
						May 2019 by the Chief Executive Officer and the Chief Operating Officer.	
RATING	☒	☐	☐	☐	☐	There were five youth files reviewed. All five files had medical and allergy alert stickers placed on the top left-hand corner of the file. Alerts documented on the sticker on the front of the file corresponded with the alerts documented on the alert form in the front of each youths file. Any allergies documented in the youths file were documented on the "allergy" sticker on the front of the file. All alerts documented on the alert form in each file corresponded with alerts identified on screening and assessment forms completed during the admission process. All alerts were appropriately documented on the youth census board. The medication room also has a board with all youth listed that are assigned to take medication and how frequently. The kitchen also has a board that has youth allergy/dietary needs listed.	No exceptions
4.05: Episodic/Emergency Care							
Provider has a written policy and procedure that meets the requirement for Indicator 4.05						☒ **YES** ☐ **NO (explain)** The agency has a policy in place titled RGC 4.05 Episodic/Emergency Care. The policy was last revised on March 26, 2019 and last approved in May 2019 by the Chief Executive Officer and the Chief Operating Officer.	No exceptions

Quality Improvement Indicators	Rating					Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
		Explain					
	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
RATING	☐	☒	☐	☐	☐	Seven closed youth files were reviewed. All seven had been transported off-site for emergency medical care. Each incident had a completed incident report and was reported to the Department's Central Communication Center (CCC). Five of the incident reports documented notification to the parent/guardian. Four incidents were reviewed for discharge instructions. All four had complete discharge instructions and documentation they were reviewed by the program's nurse. Two incident reports did not include documentation of notification to the parent/guardian. The program maintains episodic care incidents in a notebook for incident reports not requiring reporting to the CCC. The provider also maintains a daily log of all incidents in the program for the fiscal year. Eight staff training files were reviewed. All eight staff had training on emergency medical procedures. The program has one knife for life and wire cutters located in the medical room in the shelter. The tools were observed as the required items. The program has four first aid kits. First aid kits in the kitchen pantry, medical room in the shelter, and in one van were observed. The second van was offsite, so the first aid kit was not observed. Random expiration dates were checked and valid. The nurse's logbook documenting monthly checks of the first aid kits was observed.	Exception - Two incident reports did not include documentation of notification to the parent/guardian of emergency medical care.

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