Florida Network for Youth and Family Services
Compliance Monitoring Report for

Youth and Family Alternatives, Inc. - George Harris Youth Shelter
1060 US Hwy 17 South
Bartow, FL 33830

Compliance Monitoring Services Provided by

FOREFRONT

EXECUTIVE SUMMARY

Forefront LLC conducted a joint Quality Improvement (QI) and Florida Network of Youth and Family Services (FNYFS) monitoring visit for the Youth and Family Alternatives George W. Harris Youth Shelter (GWHYS) for the FY 2019-2020 at its program office located at 1060 US Hwy 17 South, Bartow, Florida. 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. GWHYS is contracted with the Florida Network of Youth and Family Services 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 for July 2019 through June 30, 2020.

The review was conducted by Marcia Tavares, Consultant for Forefront LLC and Peer Reviewer(s). Agency representatives from GWHYS present for the entrance interview were: Melissa Atkinson, Tyron Smith, Amanda Kilian, Natalie Pope, Sebastian Roth, Shekinah Nicolas, Edwina Mackroy, Vidya Maharaj, Sateria Moore, and Michele Almand. The last onsite QI visit was conducted January 16, 2019.

In general, the Reviewer found that GWHYS is in compliance with specific contract requirements. GWHYS **received an overall compliance rating of 100% for achieving full compliance with all thirteen (13) indicators** of the CINS/FINS Monitoring Tool. There were no corrective actions or recommendations made 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

2019-2020 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 02-19-2019-2020

Agency Name: YFA – George Harris Youth Shelter	**Monitor Name: Marcia Tavares**
Contract Type : CINS/FINS	**Region/Office: 1060 US Hwy 17 South, Bartow, Florida 33830**
Service Description: Comprehensive Compliance Monitoring I	**Site Visit Date(s): February 19, 2020**

Major Programmatic Requirements	Explain Rating: Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable	Ratings Based Upon: I = Interview; O = Observation; D = Documentation; PTV = Submitted Prior To Visit; (List Who and What)	Notes: Explain Unacceptable or Conditionally Acceptable: (Attach Supportive Documentation)
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 program in another judicial circuit during each 12-month period of the contract, if requested.	☐	☐	☒	☐	☐	The provider currently has 4 certified peer reviewers namely: Maria Stokes, Laura Hawthorne, Christy Cheshire, and Sebastian Roth.	
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 listing shall identify the awarding entity and contract start & end dates. **PTV**	☐	☐	☒	☐	☐	The provider submitted a list of 4 additional funders for FY2019-2020 as follows: ▪ Heartland for Children (residential only) ▪ United Way of Central Florida (Polk and Highland Counties) ▪ DHHS Basic Center Grant ▪ Department of Health The program also maintains interagency agreements and Memorandums of Agreement (MOUs) with schools, mental health, and substance abuse providers. Fifteen of the 56 agreements reviewed during the onsite visit were renewable and did not have current contract/agreement dates.	

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	Unacceptable	**Conditionally Unacceptable**	**Fully Met**	**Exceeded**	**Not Applicable**		
						This was cited as an exception to be addressed on the agency's QI Report.	
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**	☐	☐	☒	☐	☐	Documentation: General Liability through Alliance of Nonprofits Insurance Company, for limits of coverage $1,000,000 each $3,000,000 aggregate, $500,000 for damage to rented premises, professional liability for limits of coverage $1,000,000 each $3,000,000 aggregate, abuse/molestation for limits of coverage $1,000,000 each $2,000,000 aggregate, and $20,000 medical, effective 6/1/1-6/1/20. Automobile insurance through Alliance of Nonprofits Insurance company for combined limits of liability/property damage for $1,000,000. Policy effective for 6/1/1-6/1/20 Workers Compensation through Bridgefield Employers Insurance Company with limits of $1,000,000 each/aggregate, effective 6/1/1-6/1/20. Florida Network is listed on the Certificate of Insurance as 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**	☐	☐	☒	☐	☐	During the Entrance Conference, the provider indicated that there are no outstanding corrective action item(s) cited by an external funding source.	

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	Unacceptable	**Conditionally Unacceptable**	**Fully Met**	**Exceeded**	**Not Applicable**		
Fiscal Practice a. Agency must have employee and fiscal policy/procedures manuals that are in compliance with GAAP and provide sound internal controls. Agency maintains fiscal files that are audit ready. **PTV**	☐	☐	☒	☐	☐	Documentation: Fiscal Policies and Procedures are contained under "Fiscal Management" in the agencies policy and procedure manual and were last reviewed February 2019. The procedures reviewed appear to be consistent with GAAP and provide for sound internal controls. Procedures are included for general ledger, payroll, petty cash, computer backup, and other relevant financial processes.	
b. Agency maintains a general ledger and the corresponding source documents. 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**	☐	☐	☒	☐	☐	Documentation: YFA provided a detailed General Ledger for 7/1/2019 through 12/31/2019. The agency maintains a detailed general ledger that is structured to track all funding sources as well as activities for the CINS/FINS program. The GL includes: GL code, GL title, document and effective date, document number, transaction description, and debit/credit amount.	
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**	☐	☐	☒	☐	☐	YFA has procedures for petty cash. The provider has 2 petty cash funds that are maintained by the Office Specialist. The total fund amount is $460 and was reconciled onsite. The Office Specialist reported all receipts are submitted to accounting at the main office for reimbursement on the 15th on the month. Reimbursement comes in the form of a check made out to the	

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	Unacceptable	**Conditionally Unacceptable**	**Fully Met**	**Exceeded**	**Not Applicable**		
						Office Specialist, who will then cash it and place money in petty cash box.	
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. (disbursements/invoices are approved & monitored by management). **ON SITE**	☐	☐	☒	☐	☐	Documentation and Observation. Reviewed Bank Statements and Bank Reconciliations for July 2019-January 2020 for operating bank account held with PNC bank. Financial Statements are reported on a monthly basis and were found to be current. Bank reconciliations are conducted typically at the end of each month for the activities and bank statements for the preceding month. Invoices are submitted on a monthly basis with supporting documentation.	
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) been submitted to DJJ. **PTV/ON SITE**	☐	☐	☒	☐	☐	Provider maintains a list of items purchased with DJJ funds; however, no material inventory items amounting to more than $1000 was purchased since the last onsite visit.	
f. Agency submits payroll taxes and deposits (and retirement deposits as applicable), Employee IRS Form W-2 and Independent Contractors IRS Form 1099 forms prior to federal requirements. **ON SITE**	☐	☐	☒	☐	☐	Documentation: Agency provided evidence of payroll taxes being paid to the IRS as reported on 941s submitted for the 3rd and 4th quarters of 2019 and corresponding Deposit Recaps for each quarter. The 941 forms document the amount of payroll taxes that were submitted for Federal and FICA taxes and no balances owed to the IRS were noted.	

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	Unacceptable	**Conditionally Unacceptable**	**Fully Met**	**Exceeded**	**Not Applicable**		
g. Budget to actual reports prepared and reviewed by appropriate management. Variance from the budget are investigated and explained. **PTV/ON SITE**	☐	☐	☒	☐	☐	Documentation: Agency provided a Statement of Revenues and Expenditures report to show year-to-date budget to actual activities for the CINS/FINS program for the current FY through 12/31/2019. The report shows Actual, budget for the period, YTD Budget, current variance, and YTD variance. A review of these documents was conducted. Report shows program budget and variances with YTD net surplus. Variances in budget are monitored on a regular basis and are discussed with the Board.	
h. A Single Audit is performed as part of the annual audit if expenses are greater than $500,000. The agency must submit a Corrective Action Plan for findings cited in the management letter and single audit. An annual financial audit was completed within 120 days after the previous fiscal year/calendar year and that a copy was provided to the Network unless and extension has been requested and approved in writing. Copy of Audit is submitted to the FNYFS by December 31st. **Obtain from FNYFS**	☐	☐	☒	☐	☐	Documentation: Financial audit conducted for year ending June 30, 2018 was completed by Reeder & Associates, PA on 11/08/19. A separate Management Letter requiring a Corrective Action Plan was not issued by the auditor as there were no items needed to be reported. A copy of the audit was submitted and is on file with the Reviewer.	
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**	☐	☐	☒	☐	☐	Documentation: Policies and procedures for MIS Backup Procedures, MIS Security Procedures, Risk Management, and Agency Records were reviewed. A daily back-up is performed on all information saved on various servers throughout the agency. All laptops and computers were	

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	Explain Rating						
Major Programmatic Requirements	**Unacceptable**	**Conditionally Unacceptable**	**Fully Met**	**Exceeded**	**Not Applicable**	**Ratings Based Upon:** **I = Interview** **O = Observation** **D = Documentation** **PTV = Submitted Prior To Visit** **(List Who and What)**	**Notes** **Explain Unacceptable or Conditionally Acceptable:** **(Attach Supportive Documentation)**
						protected with up-to-date antivirus software. The agency has recently installed a new server that securely stores all data and email in the Cloud.	

CONCLUSION

YFA George W. Harris has met the requirements for the CINS/FINS contract as a result of full compliance with all thirteen (13) indicators of the Administrative and Fiscal Contract Monitoring Tool. Consequently, the **overall compliance rate for this contract monitoring visit is 100%.** There are no corrective actions cited or recommendations made as a result of the contract monitoring visit. Overall, the provider is performing satisfactorily in meeting the fiscal and administrative terms of its contract. In addition, all of the indicators reviewed were carried out in a manner which meets the standard as described in the report findings.

If applicable, the provider must submit a corrective action plan to address the Corrective Action 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. Recommendations made are suggestions regarding fiscal issues observed during the review. These items do not necessarily require a written response.

Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Youth and Family Alternatives, Inc. – George W. Harris
Residential Program

February 19-20, 2020

Compliance Monitoring Services Provided by

FOREFRONT

CINS/FINS Rating Profile

Standard 1: Management Accountability

1.01 Background Screening	Limited
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: 85.71%
Percent of indicators rated Limited: 14.29%
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: 96.55%
Percent of indicators rated Limited: 3.45%
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

Marcia Tavares - Lead Reviewer Consultant-Forefront LLC/Florida Network of Youth and Family Services

Jonathan Thompson - Department of Juvenile Justice

Raylene Coe - Crosswinds

Victor Garcia-Borbon – Hillsborough County Children Services

Cynthia Starling – CDS Family and Behavioral Health Services Inc

Quality Improvement Review

YFA GWH – February 19-20, 2020
Lead Reviewer: Marcia Tavares

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
- **0** # Food Service Personnel
- **0** # Healthcare Staff
- **0** # Maintenance Personnel
- **N/A** # 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
- **4** # Health Records
- **4** # MH/SA Records
- **18** # Personnel /Volunteer Records
- **7** # Training Records
- **24** # Youth Records (Closed)
- **12** # Youth Records (Open)
- _ # Other:

Surveys

- **3** # Youth
- **3** # Direct Care Staff
- **0** # Other: _____

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

Rating Narrative

YFA George W. Harris (GWH) Shelter is located at 1060 US Hwy 17 South, Bartow, Florida. The shelter is licensed for 24 beds by the Department of Children and Families effective through December 19, 2020. The shelter facility is located on a large campus that includes its administrative/staff offices and the residential facility. The GWH program is the agency's Children in Need of Services/Families in Need of Services (CINS/FINS) program in Bartow, Florida which is sub-contracted with the Florida Network of Youth and Family Services (Florida Network) to provide temporary residential and non-residential services. Funding through CINS/FINS allows the agency to serve both male and female youth up to seventeen years old that are locked out, runaway, ungovernable and/or truant, homeless, abuse, neglected, or at-risk. The agency also provides services to special populations who meet the criteria for staff secure shelter, domestic minor sex trafficking (DMST), youth referred by the Juvenile Justice Court System for domestic violence and probation respite, intensive case management (ICM), and family and youth respite aftercare services (FYRAC). YFA GWH is also a SNAP provider.

During the past year, YFA GWH has accomplished the following:

- The agency hired a new program manager Tyron Smith who is currently finishing his master's in social work. The new manager has several years of experience in the child welfare field. Since his hire, Mr. Smith has implemented new ideas to make the workplace more efficient. He has also added several key players to the team namely: Andy Cochran, Matthew Wallace, Shekinah Nicolas, and Robin Warren.
- Andy Cochran joined the team as the Outreach Coordinator. Andy is a military veteran who strives to continue to serve his community and country. Andy has been very essential to the shelter with collecting donations for the children, searching for homeless youth and assisting homeless adults in the community.
- Matthew Wallace joined the team as a counselor taking the place of a former counselor who had been with the agency for ten years. Matthew is currently finishing up his master's program in Mental Health Counseling.
- Shekinah Nicholas a former volunteer who joined the staff as a Life Skills Coordinator. Ms. Nicholas has presented fresh ideas and events for the youth in the shelter.
- Robin Warren joined the team as its part-time nurse and has over 24 years of experience in the health care field.
- YFA GWH received DJJ Appropriations for 2019-2020 to be used as follows:
    - Emergency backup generator

  - Commercial epoxy flooring in common areas
  - Exterior updates to building & outdoor security
  - 6 Motorola two-way radios for staff communication
  - New furniture for high traffic areas
- The Leadership Committee hosted its annual Low Country Broil which was a huge success, bringing in almost $2000 dollars in donation to the shelter.
- The annual Heroes of Harris softball game between Bartow Police Department and Bartow Firefighters is scheduled for May 2020.

Standard 1: Management Accountability

Overview

YFA-GWH is under the leadership of the Vice President of Operations who oversees the residential program manager. The program manager supervises a team of staff including: a youth development specialist team leader (YDSIII), 6 shift leaders, 6 fulltime YDS (4 funded by DJJ, 2 by Basic Center), 5 part time YDS, a YDS cook, and an office specialist, In addition, the residential component of the program is staffed by 2 counselors, a contracted registered nurse, an outreach staff, and a Life Skills staff. The non-residential CINS/FINS Family Help component serves the Polk, Hardee, and Highlands counties and is staffed by a program supervisor, 6 counselors, 1 intensive care manager, and an office specialist. The program had two vacant positions at the time of the QI review for 1 fulltime YDS and 1 shelter counselor.

Significant changes since the last onsite QI includes the hiring of a new program manager and team aforementioned. The VP stated a corrective action plan (CAP) was implemented as a result of DCF's review, citing child resources records as conditional or non-compliance with regard to documentation of monthly life skills training and missing documents required to be included in the youth records. YFA GWH responded with a CAP dated 1/10/2020 which is currently in progress.

The program uses the statewide NetMIS to enter consumer demographics, specific services provided, services that are needed but unavailable, applicant's ineligibility for services, consumers that terminate services and their reasons for doing so, and ethnicity, cultural, and racial identity and services, resources, and case dispositions. An Executive Data Report is generated monthly and distributed by the Associate Data Analyst to Program Directors, Vice Presidents, and Senior Leadership. Management analyzes this data to determine if services adequately support the needs of the consumer population and to identify positive and negative trends and patterns. Each program is responsible to monitor their performance, and performance is to be reviewed during supervisor meetings and at all-staff program meetings. The review of performance outputs and outcomes focuses on identifying both negative and positive trends and patterns in the data, and identifying areas that need improvement and developing action plans as required. Compliance issues or areas of concern noted in any performance reviews and reports are reviewed by management and an internal plan is developed to address areas that need improvement. CQI activities and initiatives are reported to agency staff at all levels to ensure everyone works to achieve appropriate performance targets and implements plans to improve performance. Staff receive this information directly through training, committee participation, via emails

from their management, the Associate Data Analyst, or the QI Department, and during regularly scheduled staff meetings in which QI should be a standing agenda item for all programs.

The following indicators in standard 1 were rated satisfactory with exceptions: 1.04 – Training Requirements; 1.05 – Analyzing and Reporting Information; and 1.06 – Client Transportation; and 1.07 – Outreach Services. Indicator 1.01 – Background Screening received a “Limited” rating. All other indicators in standard one were rated satisfactory with no deficiencies.

Standard 2: Intervention and Case Management

Overview
Rating Narrative

YFA GWH provides centralized intake and screening twenty-four hours per day, seven days per week, and every day of the year. The agency has trained personnel in place to complete centralized intake and screening twenty-four hours per day, seven days a week year-round to status offenders that include runaways, truants, ungovernable and lockout youth. Staff have been trained to evaluate the needs of youth and their families and make recommendations based on what services are most appropriate at the time of contact. Services within the program include: intensive crisis counseling; parent training; individual, family and group counseling services; runaway center services, community mental health services; case managing services and substance abuse prevention education. Referrals and aftercare services commence when the youth are admitted for services. Aftercare planning includes referring youth to community resources, ongoing counseling, peer support, advocacy, and educational assistance.

The non-residential Family Help component offers both school and home-based services in Polk, Hardee, and Highlands counties. Family Help is staffed by a program supervisor, 6 counselors, and an intensive case manager, all having a master's or bachelor's degree. The counselors are responsible for providing case management services and linking youth and families to community services. The program advises that it rotates YFA-employed licensed mental health counselors to cover this agency site from month to month to ensure reviews of suicide assessments within the required time frames. Non-Residential, family/youth respite aftercare services (FYRAC) is provided to youth between the ages of six (6) and eighteen (18) years of age referred, following a Domestic Violence arrest on a household member and/or youth on probation, regardless of adjudication status, at risk of violating. Intensive case management services are provided to youth ages 6-17 who are chronically truant/ungovernable, are court involved or likely to entire the petition process and may require more intensive and lengthy service provided by designated staff trained to provide intensive case management.

The shelter program provides services to special populations defined as domestic violence respite, domestic minor sex trafficking, probation respite, and staff secure for youth ages 10 through 17 who have been charged with an offense of domestic violence (including youth who have previously adjudicated for other issues) specifically designed to provide a safe alternative to secure detention for youth with pending or adjudicated charges for domestic violence. During the review period, the program served youth

meeting the criteria for staff secure, domestic violence and probation respite, ICM, and SNAP. No DMST or FYRAC youth were served since the last QI review.

The agency is currently maintaining paper files and youth records are maintained in a neat and orderly manner including typed needs assessments.

The following indicators in standard 2 were rated satisfactory with exceptions: 2.02 – Needs Assessment; 2.03 – Case/Service Plan; 2.04 – Case Management and Service Delivery; 2.09 – Special Populations; and 2.10 - SNAP. All other indicators in standard 2 were rated satisfactory with no deficiencies.

Standard 3: Shelter Care

Overview
Rating Narrative

Include the following information:

YFA operates the George W. Harris shelter in Bartow, Florida. The shelter is licensed by the Department of Children and Families (DCF) for 24 beds through 12/19/2020. The shelter provides residential services to youth in the Department of Juvenile Justice (DJJ) CINS/FINS program as well as youth referred by Heartland for Children the local not-for-profit agency responsible for the foster care system in Florida's Circuit 10. The youth census during the QI Visit was 15 youth: 4 respite, 1 court ordered, 6 DCF, and 4 community beds.

The shelter program staff structure includes: a program manager and a total of 18 YDS staff (6 shift leads, 7 full time YDS (one is the cook), 5 part-time YDS) who operate around 3 shifts, a life skills specialist, and outreach specialist. The residential clinical component includes two counselor positions, one of which is vacant.

The agency ensures the agency's use of proactive behavioral management techniques that emphasizes positive and preventative measures in the management of the youth behavior. The program utilizes a tiered system which consists of three levels of advancement within the Advancing Youth Development (AYD) curriculum. Advancement for eligibility to leveling up consists of a baseline time period for each level; Orientation (3 days), Educations (4 days), Graduation (7 days). Each level prescribes its own requirements for youth which promotes positive behavioral choices and healthy decisions among program participants. Each level during the youth's placement at the residential facility will focus on twelve key areas to promote positive youth development. There are five areas with specific targeted behavioral goals that are consistent with the six identified character development issues from the Character Counts Curriculum. The BMS uses a variety of awards/incentives to encourage participation and completion of the program. The youth pace of advancement is dictated by the youth’s behavior, cooperation, progression towards goals, and expectation compliance.

All of the indicators in standard 3 were rated satisfactory with no exceptions.

Standard 4: Mental Health/Health Services

Overview
Rating Narrative

The residential counseling services in the shelter are overseen by the program manager and 2 rotating agency licensed mental health counselors. Trained youth care staff completes screening and the CINS/FINS Intake assessment during intake. All direct care staff members are trained on the suicide risk screening process and utilize the CINS Intake form to immediately identify youth who are admitted with special needs and risks, such as risk of suicide, mental health, substance abuse, physical health, or security risk factors, etc. The licensed mental health professional is notified immediately if risks and/alerts are present and recommendations regarding placement and supervision are provided to the direct care staff. Alerts are documented on the program's alert board in the medication room, kitchen, and youth's file.

At the time of the QI review the provider had a licensed part time registered nurse (RN) recently contracted on 12/30/2019 to provide services on-site. The facility was without a nurse on staff from March 22, 2019 through December 29th; however, diligent efforts to hire a new nurse were demonstrated including 111 applications received and three offers for employment were made before the program finally hired a part time nurse who works 10-17 hours a week. The duties assigned to the registered nurse includes: oversight of the general practice of distributing medication to residents in the shelter; oversight of medication inventory and storage practices; training of all staff authorized to distribute medication; and completion of health screenings and medical follow ups on an as needed basis. All but one training files reviewed onsite supported staff maintained valid CPR/First Aid training certificates.

During the tour of the facility, medications were observed to be stored in a locked room in their own separate containers in client specific drawers in the Pyxis Med Station 4000. Topical medications are stored separately from oral medication. The program has a list of staff who are authorized to distribute medication including super users. Medication records for each youth are maintained in the youth's file.

The program maintains 56 written agreements with other community partners which include medical and mental health services and a comprehensive referral process.

One of the indicators in standard 4 was rated satisfactory with exception: 4.03-Medications. 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 provider's Background Screening policy and procedure, RGC 1.01, was last reviewed on 3/26/19 and signed by the CEO. RGC 1.01 meets the requirement for background screening. There is also an un-numbered protocol entitled Aptitude Test Results and Standards for YDS and FSW Staff approved by the VP of Operations on 12/19/2019 that addresses the pre-hire aptitude test and pass rate.	
RATING	☐	☒	☐	☐	☐	A total of eighteen background screening files were reviewed for sixteen new hires and two staff eligible for 5 -year rescreening during the review period. All sixteen new employees were background screened with eligible results obtained prior to the hire date. One of the two eligible 5-year re-screenings was completed prior to the staff's 5-year anniversary. The provider completed the Annual Affidavit of Compliance with Level 2 Screening Standards and submitted it via fax to the Department of Juvenile Justice Background Screening Unit on January 24, 2020, prior to the January 31st deadline. The agency uses Criteria Basic Skills Test (CBST) to screen new youth care and case management	**Exception (Limited Rating)** The agency did not complete a CBST pre-employment assessment for one new youth care staff re-hired. The 5-year re-screening for one eligible staff, DOH 10/29/14, was completed 30 days too early (9/27/18) which does not meet the requirement that allows DJJ re-screenings to be conducted a maximum of 12 months in advance. **Due to the finding of an exception for 5-year re-screening for two consecutive QI reviews, this indicator is considered a "limited" rating.**

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		
						candidates prior to employment. CBST is a web-based system that provides pre-employment testing in minutes through the company Criteria Pre-Employment testing. The online tool includes various aptitude and basic skills testing and offers real time scoring emailed to the provider and also store in the Results section of the agency's account. Score reports for each test are different, but most skills and aptitude tests include both a raw score (number of questions answered correctly) and a percentile ranking that indicates how well someone did relative to other test-takers. The CBST was completed prior to hire and passing scores above 30 was verified for 12 of the 15 applicable new hires; however, the pre-employment assessment score for three new hires did not meet the required passing score of 30 established by the agency.	
1.02: Provision of an abuse free environment to ensure safety and abuse free environment for youth in care							
Provider has a written policy and procedure that meets the requirement for Indicator 1.02						☒ YES ☐ NO (explain) The provider's policy and procedure for Abuse Free Environment, # RGC1.02 was last reviewed on May 19, 2019 and was approved by the CEO. The policy fully meets the requirements for this indicator.	
RATING	☒	☐	☐	☐	☐	The provider has provisions for an abuse free environment. The Florida Abuse Registry Hotline number, client rights and responsibility are prominently displayed and posted on each wing of the dormitory and the common area. The agency maintains a copy of all abuse reports. The provider does have a code of conduct that prohibits the use of physical abuse, profanity, threats or intimidation. Management takes immediate action to	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		
						address incidents of physical and/or psychological abuse, verbal intimidation, use of profanity, and/or excessive use of force. The provider has a grievance procedure in place that is explained in the program handbook. There are three formal locked grievance boxes located in both the male and female dorms. The is also a locked grievance box located in the common area. The youth have access to the grievance forms in all three locations. The Residential Supervisor is assigned to check the locked boxes every 24 hours and resolve any grievance. However, the program reports that have had no formal grievances in the past year. The Program Manager advised of a more informal process where the youth discuss any issues during a daily house meeting. The youth also have access to a locked suggestion box that is located near the front entrance.	
1.03: Incident Reporting							
Provider has a written policy and procedure that meets the requirement for Indicator 1.03						☒ YES ☐ NO (explain) The provider's policy and procedure for Incident Reporting #RM760 was last reviewed on February 26, 2019 and was approved by the CEO and Board Chair. The policy fully meets the requirements for this indicator.	
RATING	☒	☐	☐	☐	☐	During the prior six months (September 2019 through February 2020), fourteen incidents were reported and accepted by the Central Communication Center (CCC).The fourteen CCC reports were reviewed and the following details were noted: all fourteen incidents were reported within the required two-hour timeframe, thirteen of the incidents were medical transports, 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		
						one was a youth arrest. The incidents were noted in the program log book. The agency followed up with a phone call to the CCC on the medical transports and provided details of the hospital visit with hospital discharge instructions attached to the CCC incident report. The program completed follow-up communication and special instructions with the CCC.	
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 provider's policy and procedure for Training Requirements #RGC1.04 was last reviewed on August 21, 2019 by the CEO and by the COO on August 14, 2019. The policy fully meets the requirements for this indicator.	
	☐	☒	☐	☐	☐	Seven staff training files were randomly selected including three first year and three in-service employee training files. Additionally, one training file for the non-licensed Mental Health Clinical Shelter position was also reviewed. All three of the first-year training files had completed the required training topics within their first 120 days of employment. The files had the following total number of training hours: 127.25, 127.75, and 63.25; the latter staff still has 8 months remaining to complete the 80 hours required. All three of the in-service staff had exceeded the 40 hours of training required annually. The files had the following total number of training hours completed: 66.75, 66.25, and 73.75. The three in-service staff	**Exception** One training file had an expired CPR/First Aid certificate.

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		
						completed both annual and refresher training topics required. Only one staff had an expired CPR/First Aid certificate. The documentation of one non-licensed mental health clinical staff training in assessment of suicide risk was completed and verified by licensed mental health professional.	
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 program has multiple policies and procedures that outline its Continuous Quality Improvement (CQI) process (QI 300), CQI Teams (QI 310), and Data Collection and Evaluation (QI 350), all approved 2/26/2019 by the CEO. In addition, the agency has a comprehensive CQI Plan for 2020 that describes the agency's CQI structure, committees, stakeholders, CQI cycles, data collection and analysis, reporting, and corrective actions.	
RATING	☐	☒	☐	☐	☐	The VP of QI and QI Coordinators are responsible for coordinating case record reviews. The CINS/FINS program has a formal case record review once per year (50 files res/non-res) and follow up within 90 days. In addition, the VP of QI will conduct quarterly record reviews of 5-10 files randomly selected. Upon completion of case record reviews, the results are aggregated, and a report is submitted to the VP of QI to be presented to the Chief Administrative Officer and VP of Programs; quarterly review reports are sent to the Program Directors. A review of peer record review reports for the	**Exception** Peer record reviews for the past two quarters was not evident for the CINS/FINS program. No additional peer record review was completed for the 2nd quarter FY 2019-2020 for the residential program and none was conducted for the non-Residential program since the beginning of the FY.

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		
						last 2 quarters was conducted. There was a peer record review conducted by QI in September 2019 during the first quarter FY 2019-2020 for the residential program; however, no additional peer record review was completed for the 2nd quarter. Peer record reviews for the past two quarters was not evident for the Non-Residential program. Deficiencies were addressed and communicated to the Program Directors via email. Incidents, accidents, and grievances are reviewed quarterly by the Risk Prevention and Management Team (RPMT) to identify trends and patterns that can be improved through corrective action, training, or other opportunities. The RPMT is facilitated by the VP of CQI and meets quarterly. Monthly incidents are reported by each program to the VP of CQI who aggregates the data into an incident report roll-up that is reviewed quarterly by the RPMT. The Incident Report Rollup contains the aggregated monthly report of incidents, accidents, and grievances (if applicable) for the agency's programs. A roll-up report for the current FY July 2019 through January 2020 was reviewed and RPMT meetings were recorded for October 2019 and February 2020, including sign-in sheets and minutes that support review of the incident data by the committee. Consumer surveys are administered by the program staff and entered into Netmis as well as aggregated Stakeholder Involvement Team. The team meets quarterly to review findings of the satisfaction reports and reports their findings to VP of QI who communicates results to the leadership team. Strengths, weaknesses, and goals are reviewed and documented in the minutes and discussed at the meetings. The Stakeholder	

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		
						Involvement Team met quarterly on 10/01/19 and 2/27/20. Copies of the agendas and minutes for these dates were reviewed. Outcome data is reviewed through a process of huddle boards and scorecard reporting which covers 5 areas: retention, recruitment, budget, safety, and compliance. Each program meets 1-2 times per week and data is included in weekly scorecards that are sent to leadership for review. During the QI period Weekly scorecard submissions were verified through emails. Florida Network benchmark outcomes data are reviewed by the Residential Director upon receipt and deficiencies are addressed immediately and communicated to staff via staff meetings as necessary. Netmis data is reviewed on a monthly basis by the Residential Director and submitted to the Data Administrator (DA). Discrepancies and deficiencies are corrected. Staff meeting agendas reviewed for meetings held July, October, and December 2019 support a review of outcomes and data with staff.	
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 provider's policy and procedure for Client Transportation #RGC 1.06 was last reviewed on May 15, 2019 by the CEO and by the COO on May 9, 2019. The policy fully meets the requirements for this indicator.	
RATING	☐	☒	☐	☐	☐	The agency utilizes the form "Monthly Trip and Mileage Log" which provides the date, time of departure, name of driver, safety equipment, number of clients to and from, client initials, web camera, purpose of trip, stops on the	**Exception** The supervisor's approval for single transport is listed on the "Single Party Transportation Log" as "yes" with a

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		
						round trip, odometer start and end, time return, and comments. The agency also utilizes the form "Single Party Transportation Log" which provides the date, client name, signature of the transporter, reason for trip/destination, time of departure from shelter, time of arrival at the destination, and time of arrival back to the shelter, mileage to and from supervisor approval, supervisor initials, phone link to the name of staff member, and phone link staff initials. The agency has implemented a transportation policy with drivers approved by administrative personnel. The agency provided an approved drivers list with documentation of the staff having a valid Florida driver's license, and the staff being covered by company insurance. The policy indicates that if a third party is used in transportation, it will be an approved volunteer, intern, agency staff, or other youth. If a third party cannot be obtained for transport, the agency supervisor will consider the client's history, evaluation, and recent behavior.	supervisor initial. However, there is no documentation of prior approval for any single transport by a supervisor.
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.**							
Provider has a written policy and procedure that meets the requirement for Indicator 1.07						☒ YES ☐ NO (explain) The provider's policy and procedure for Outreach Services #CS580 was last reviewed on March 14, 2019 by the CEO and Board Chair. The policy fully meets the requirement for this indicator.	
RATING	☐	☒	☐	☐	☐	The provider maintains an outreach binder that documents all outreach activities, and meetings with the	**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		
						corresponding agendas with notes. The Outreach Specialist is very active in the community and attends numerous meetings to include: Homeless Coalition, United Way, Continuum of Care Membership meetings, Veterans Court, and numerous additional meetings. The Outreach Specialist has been highly successful in securing many donations including food, clothing and hygiene items. He is making many visits to homeless camps where he distributes hygiene kits, and food items, He has also been able to locate youth who are homeless and get them admitted into shelter and other appropriate services for the families. The provider participates in the local DJJ board and council meetings to ensure CINS/FINS services are represented. The agendas and notes are included in the outreach binder.	The Interagency Agreements need to be updated. The binder was reviewed, and it was found that in excess of 15 of 56 were outdated. The Program Manager advised that he is aware of the issue and will be completing updated agreements as soon as possible.

STANDARD 2: INTERVENTION AND CASE MANAGEMENT

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 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 written Screening and Intake policy that meets the requirements of the QI Indicator. The policy and procedure reference number is documented as RGC 2.01 with a policy review on 3/26/2019 and approved by the CEO on 5/15/2019.	
RATING	☒	☐	☐	☐	☐	During the QI review 5 residential files, (2 open, 3 closed), and 5 non-residential files, (2 open, 3 closed), were reviewed. All files contained screening and intake forms. Documentation was provided showing that youth and parent/guardians received client rights and responsibilities, grievance procedures, available services, parent/guardian brochure, and possible actions through involvement with CINS/FINS Services, (Case staffing, CINS petition, CINS adjudication).	No exceptions.
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 written needs assessment policy that meets the requirements of the QI Indicator. The policy and procedure reference number is RGC 2.02 with a review on 3/01/2019 and approved by the CEO on 5/15/2019.	

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	☐	☒	☐	☐	☐	A total of 12 files were reviewed, 5 residential files, (2 open, 3 closed), and 5 non-residential files, (2 open, 3 closed), and 4 case staffing files, 3 open 1 closed). All 5 residential case files reviewed had a Needs Assessment initiated within 72 hours of admission. All 5 non-residential files contained Needs Assessments that were initiated and completed within 2-3 face-to-face visits. All files reviewed contained a summary of the needs assessment and all, but one was signed by a BA or MS level staff member and signed by a licensed supervisor.	**Exception** One file contained a needs assessment that was not completed by a bachelor's or master's level staff member as required by the indicator.
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 written needs assessment Policy that meets the requirements of the QI Indicator. The policy and procedure reference number are RGC 2.03 with a review on 3/01/2019 and approved by the CEO on 5/19/2019.	
RATING	☐	☒	☐	☐	☐	During the QI review 5 residential files, (2 open, 3 closed), and 5 non-residential files, (2 open, 3 closed), were reviewed. All files reviewed contained a comprehensive individualized service/case plan. Each plan contained at a minimum, date of initiation of plan, needs and goals responsible individuals, realistic target and completion dates, and required signatures. One service plan was missing type, frequency, and location of services provided. However, progress notes did confirm that services were provided, and goals were met upon discharge.	**Exception** One of the service plans was implemented on 11/27/19, more than 7 days after the completion of the needs assessment (11/14/19).
2.04: Case Management and Service Delivery							
Provider has a written policy and procedure that meets the requirement for Indicator 2.04						☒ YES ☐ NO (explain) The agency has a written case management and service delivery policy that meets the requirements of the QI	

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)
						Indicator. The policy and procedure reference number is documented as RGC 2.04 with a review on 3/26/2019 and approved by the CEO on 5/15/2019.	
RATING	☐	☒	☐	☐	☐	During the QI review 5 residential files, (2 open, 3 closed), and 5 non-residential files, (2 open, 3 closed), were reviewed. All files reviewed contained assessments, referrals and service plans with all required indicator data. Service engagement is clearly documented. In addition, each file contained evidence of program staff monitoring youth/family progress in services. Four (4) case staffing files were reviewed and provided evidence of program staff addressing issues identified through assessments and monitoring of youth/family needs.	**Exception** Three of the closed residential files reviewed did not contain 30 or 60 day reviews after exit.
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 written counseling services policy that meets the requirements of the QI Indicator. The policy and procedure reference number is documented as RGC 2.05 with a review on 3/26/2019 and approved by the CEO on 5/15/2019.	
RATING	☒	☐	☐	☐	☐	During the QI review 5 residential files, (2 open, 3 closed), and 5 non-residential files, (2 open, 3 closed), were reviewed. Each file contained evidence of counseling services to reflect case coordination, case service plans, case service reviews, case management, and follow-ups. Counseling services were also documented in progress notes as well as in youth case service plans. All ten (10) files reviewed were clearly marked and maintained confidentially in accordance with the agency policy and procedure and met network indicator requirements. Chronological notes were documented in all reviewed files. A review of sign-in sheets and group notes provided	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		
						evidence of group session/counseling dates, participants, and goals/objectives.	
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 written adjudication and petition process policy that meets the requirements of the QI Indicator. The policy and procedure reference number is documented as RGC 2.06 with a review on 3/01/2019 and approved by the CEO on 5/15/2019.	
RATING	☒	☐	☐	☐	☐	Three (4) case staffing files were reviewed. Each of the 3 files documented a written request from a committee member. Progress notes outlined case staffing events. Copies of case staffing notes, service plans, correspondence letters and recommendations from committee participants are located in the youth files as well as in binders labeled CINS Case Staffings/Court. Each file contained the required documentation and met the required timeframes for notification to the committee members and youth/family.	No exceptions.
2.07: Youth Records							
Provider has a written policy and procedure that meets the requirement for Indicator 2.07						☒ YES ☐ NO (explain) The agency has a written adjudication and petition process policy that meets the requirements of the QI Indicator. The policy and procedure reference number is documented as RGC 2.07 with a review on 3/26/2019 and approved by the CEO on 5/15/2019.	
RATING	☒	☐	☐	☐	☐	All youth files are marked and kept confidential in a locked room. Twelve (12) youth records were reviewed and provided evidence of files maintaining neat organization	No exceptions.

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)
						and were easily accessible to program staff. All reviewed files were marked confidential. Files transported offsite requiring transport were locked in an opaque container marked confidential.	
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 written policy, RGC 2.08 that meets the requirement for Indicator 2.08, Sexual Orientation, Gender Identity, and Gender Expression. The policy was approved by the CEO on 5/21/19.	
RATING	☒	☐	☐	☐	☐	A review of the policies and procedures indicated protocols are in place to address all of the requirements of the indicator. During a tour of the facility, “hate free zone” rainbow signs, “Being Out, Being Safe” LGBTQ posters, and diversity Harris Shelter poster were posted throughout the facility in the youth lounge, kitchen, and lobby. The program also distributes the “Being Out, Being Safe” brochures published by the National Runaway Safeline, to youth during life skills group discussion and make them available for guests in the lobby of the shelter. The program provides training/educational material, “I Provide Safety Support and Respect”, for staff/volunteers to read and acknowledge receipt during hire and/or prior to providing volunteer service. Documentation of training was verified for new staff during orientation and in-service staff was trained as verified on the Paylocity list on 1/8/2019. The program has not served any youth during the annual review period who met the criteria for the indicator. However, staff interviewed during the visit stated youth meeting the criteria is addressed by pronouns, name, and	No exceptions.

Quality Improvement Indicators	Rating: Explain — 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)
						gender they prefer, and room assignment is made accordingly.	
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 written policy, RGC 3.07 that meets some of the requirement for Indicator 2.09, Special Populations. The policy was approved by the CEO on 5/21/19.	Domestic Violence (DV) and Probation Respite policies and procedures do not include the requirement for data entry into Netmis and JJIS within 24 hours of intake and 72 hours of discharge. It also does not include procedures for the transition of youth to CINS/FINS if stay is over 21 days for DV youth. Probation respite P&P needs to be updated to include accepting referrals regardless of adjudication status.
RATING	☐	☒	☐	☐	☐	During the review period, the program did not serve any youth meeting the requirement for Domestic Minor Sex Trafficking or FYRAC. One applicable closed file was reviewed for Staff Secure. There is evidence the youth staff secure placement met the legal requirements outlined in Chapter 984 F.S for being formally court ordered into staff secure services. Specific staff is assigned during each shift to monitor the location and movement of the staff secure youth at all times. Staff assigned to monitor the youth is noted on a form that includes 3 shifts/page where staff documents youth attitude, chores, medication, visitors, calls and behavior management system. Each shift is signed by assigned staff. and youth care signature the program logbook.	**Exceptions** ***Domestic Violence***: • One DV youth case plan did not include signatures of any party. • The needs assessment for one of the three DV youth was missing the youth's information section of the assessment, assessment summary, and signatures of counselor and supervisor. • JJIS discharge data entry exceeded 72 hours for 2 of 3 youth file reviewed ***Probation Respite*** • Two of 3 probation respite files did not include a service plan and one was missing progress notes.

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		
						No court appearance was applicable requiring staff to document progress to the court. Three closed files were reviewed for Domestic Violence Respite DV Respite. All three youth were referred for domestic violence charges by the JAC/Detention Screener. Their stays in the DV Respite placement did not exceed 21 days; consequently, none of the youth were transitioned to the CINS/FINS shelter. The case plans addressed the issues of anger management and coping skills to help reduce the reoccurrence of violence in the home. Other services provided to DV youth are consistent with general CINS/FINS program requirements. Three closed files were reviewed for Probation Respite referrals. Staff are updating the youth in the Referrolator. The length of stay is determined by assessing the needs of the youth; all three youth were discharged before being in shelter 30 days. There is evidence of case management and counseling services to address needs identified. All other services provided to Probation Respite youth are consistent with general CINS/FINS program requirements. Three of the Intensive Case Management (ICM) files were reviewed 2 active/open and one closed case. The three youth served met the criteria for ICM services; two were referred by the case staffing committee and one was court ordered. None of the three files demonstrated the youth and family had six direct contacts and six collateral contact each month during a 5-month period. The Child Behavior Checklist (CBCL) was completed within 14 days of intake in all three cases. An approved self-report assessment was completed at intake in the 3 files but one did not have a completed self-report assessment within 90	• JJIS discharge data entry exceeded 72 hours for 1 of 3 youth file reviewed ***Intensive Case Management*** • Three ICM cases reviewed did not have 6 direct contact and 6 collateral contacts completed over a 5-month period. Email communication with the Florida Network regarding incomplete contacts was not was documented for all files reviewed. • One of the 90-day self-report assessment was completed 2 weeks beyond the 90-day required timeframe.

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		
						days. The case plans address the issues of truancy and case management services demonstrated effort of the staff to engage the family and access supports when needed.	
2.10: STOP NOW AND PLAN (SNAP)							
Provider has a written policy and procedure that meets the requirement for Indicator 2.10						☒ YES ☐ NO (explain) The agency has a written policy, RGC 2.10 that meets the requirement for SNAP. The policy was approved by the CEO on 2/11/2020.	
RATING	☐	☒	☐	☐	☐	There were 4 SNAP clinical group youth files reviewed for 2 active and 2 closed cases. All 4 files documented the youth were screened to determine eligibility using the NETMIS screening form and the SNAP Brief Intake screening form. There was a signed consent form in each file signed by the parent/guardian prior to receiving services. A needs assessment was completed at intake in each file. Two of the 4 files did not complete the pre-CBCLs at intake; 1 of the two noted the reason in the progress notes. Post-CBCLs were completed at discharge in 2 applicable files. A pre-Teacher Report Form (TRF) was completed in 2 of 4 files at intake and at discharge for 2 applicable cases; documentation in the progress notes noted the reason for missing TRF in 2 files. TOPSE assessments were completed at intake and discharge for 2 of 4 youth and PAT assessments were completed after intake in all 4 files but at discharge in 2 applicable files. The two closed files included a completed SNAP Discharge Report Summary. One SNAP in Schools session was reviewed. The group documented weekly attendance sheets with the youths' names and signatures of the teacher and SNAP facilitator	**Exception** • One of the 4 files did not complete the pre-CBCL at intake and/or document reason it was not completed • TOPSE assessments were not completed at intake for 2 of 4 youth • Four SNAP youth files reviewed were found to have the PAT Assessment and 3 had the TOPSE assessment completed after the intake with no documentation in the file as to the reason(s) they were not completed during the intake.

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		
						for all thirteen sessions. A Class Shoot for Your Goal sheet was also completed. Pre and post evaluations are completed for the youth participants and also the teacher. One Fidelity Adherence Checklist was completed for the session.	

STANDARD 3: SHELTER CARE

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 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 policy RGC 3.01 meets the requirement of the indicator and was last approved 8/20/19 by the Chief Operating Officer and Chief Executive Officer of Prevention Services.	
RATING	☒	☐	☐	☐	☐	The policy dictates the shelter environment shall be clean, neat, well maintained, safe, and to the extent possible, reflect a home-like environment. Highlighted sections in logbooks include daily and safety inspections, cleaning and repairs, daily transitions via the facility schedule, shift turn-over process, daily chores along with the documentation logs and Corrective Actions in addition to scheduling and faith-based activities. Specific procedures include discussion of the maintenance of office areas, bedroom and bathroom areas, laundry and linen area, living areas, kitchen and dining areas, public areas, grounds, pest control, and garbage disposal. During the tour of the facility, an inspection of the shelter environment was conducted. Mandatory requirements were observed to be throughout the facility which include; first aid, egress maps, fire extinguisher locations, grievance boxes, and suicide response kits were in plain sight and strategically located in the facility. The furniture	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		
						was observed to be in good condition and youth rooms had clean sheets and comforters. The facility utilizes a contractor to treat the building for insects once a month. The facility was observed to be very clean and insect & rodent free. The grounds were clean of trash and well maintained as landscape services are contracted and services are provided twice a month. A locked cabinet is in the medical room which contains three sets of key rings (one supervisor & two floor keys). The supervisor keys include egress keys, medical unit, and office keys and the two All Bathrooms and shower areas were found to be clean and functional. Key turn-overs are tracked on the Daily shift leader reports and in the facility logbooks. Reviewed documentation validated that the Key control measures are being followed and documented as required. The program has fresh interior paint in the dining room, offices, and great room. The entire interior of the building is slotted to be painted by November. There is no evidence of graffiti in the building. Interior lighting is bright and functional. There is 360 degrees of exterior lighting which illuminated the building, parking lot and premises. The program utilizes three vehicles (2 Vans, 1 SUV) for transportation purposes. All three vehicles were locked and secured. Emergency equipment was present in all three vehicles with the exception of one item. The vehicles utilize a single tool with seatbelt cutter, and glass breaking capability. Vehicles are missing air bag deflaters as they were under the impression it served three purposes. The program was advised to have flashlights, and multi-purpose tools within reach of the driver to allow for response capabilities in an emergency. The tools and	

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		
						flashlights were stored in a box in the rear of the vehicle during the inspection. All three vehicles contained first aid kits, eye wash, and cold wraps. The Disaster plan was updated July 1, 2019 for the 201-2020 fiscal year. The Fire Safety Inspection was completed on 10/10/19 by the Bartow Fire Department with no violations noted. The Water-Based Fire Protection Systems Inspection (Sprinkler System) was inspected on 1/27/20 and after the inspection, fire suppression unit was restored to normal operation and all control valves were left in the open "on" position. Additionally, the Water-Based Fire Protection Systems (Hydrant) was inspected with no deficiencies noted. The Annual Exhaust Hood Fire Suppression System (kitchen) was inspected on 1/14/20 with no deficiencies noted. The Fire Inspection and Testing Report completed 10/16/18 with no deficiencies noted. The Fire Alarm Inspection and Testing Report was inspected on 7/5/18 with no deficiencies noted. The Residential Group Home Inspection Report was completed on 2/18/20 with one violation (lighting in laundry room). Residential Group Home Inspection Report dated 12/17/18 noted one deficiency (lighting in the laundry room). Lighting has been corrected but could not locate the date of correction. The lighting was recently corrected. The agency has a current DCF Child Care License that is valid until December 18, 2020. The agency also received their COA accreditation through 10/21/20. Fire drills are required to be conducted at least once a month and not to exceed two minutes in induration. The Fire drill binder contained multiple drills each month met the mandatory duration period. Additionally, it was	

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		
						validated that one fire drill was held on each shift per for the last two quarters.	
3.02: Program Orientation							
Provider has a written policy and procedure that meets the requirement for Indicator 3.02						☒ YES ☐ NO (explain) The agency policy RGC 3.02 meets the requirement of the indicator and was last approved 5/15/19 and signed by the Chief Operating Officer and Chief Executive Officer of Prevention Services signed and approved the policy on 5/15/19.	
RATING	☒	☐	☐	☐	☐	Four youth records were reviewed for this indicator. Each youth received an orientation within 24 hours of admission all files contained thorough documentation program orientation process. Client orientation is completed within twenty-four (24) hours and includes the following topics; information on shelter admission requests, shelter admissions, abuse hotline, youth room assignment, shelter orientation, correspondence, grooming, laundry/linens/bedding, grievances, staffing levels, youth supervision, and the alert system. Youth admitted to the shelter go through a new client orientation process consisting of specific 20 areas, encompassing all of the required documented on the Client Orientation Check List.	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 written policy and procedure, RGC 3.03 - Youth Room Assignment that meets the requirement of the indicator and was last approved 5/15/19 and signed by the Chief Operating Officer and Chief Executive Officer of Prevention Services.	

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	☒	☐	☐	☐	☐	The Shift Leader or Youth Development Staff on duty is responsible for reviewing the youth's case record and intake packet to assess risk or special needs in determining room assignment. Youth who are determined to be a potential threat will be separated from other youth. Room assignments are documented on the Admission Sleeping Assignment Form which takes into consideration the following criteria: behavioral history, age, maturity level, individual needs, general physical statue, gang affiliation (if applicable), any allege offense(s), level of aggression, sexual misconduct/sexual predatory behaviors, any emotional disturbances, suicide risks/ideations, medical or physical disabilities, collateral contracts, or other special needs noted. There were four residential files (2 open, 2 closed) reviewed for this indicator. All four youth files contained documentation of the youth's history, status and exposure to trauma, age, gender, history of violence, disabilities, physical strength/size, gang affiliation, risk of suicide, sexually aggressive or reactive behavior, gender identification, alerts, collateral contacts, and initial interactions/observations. Youth room assignments are made with consideration of various tools and data compiled during intake and orientation. Youth determined to be a potential threat to staff, other youth, or themselves are assigned in bedrooms closer to the staff monitoring station and are separated from other youth.	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 written policy and procedure, RGC 3.04 Log Books, that meets the requirement of the indicator and	

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		
						was last approved 5/21/19 and signed by the Chief Operating Officer and Chief Executive Officer of Prevention Services.	
RATING	☒	☐	☐	☐	☐	The policy dictates that logbooks in the shelter are to document all daily activities, events, and incidents in the program. Furthermore, the operating procedure requires highlighted logbook entries that could impact security and safety of the program, date and time of incident, event or activity, names of youth and staff involved, brief statement of pertinent information, and staff making entry with date and time of signature. The program confirmed logbooks are retained for a period of no less than three years. The Program Director or designee shall review the logbook every week and make a note in the logbook as to any corrections, recommendations, and follow up required. The oncoming supervisor and YDS staff shall review the logbook for the previous two shifts. It was reported during the entrance interview that the program attempted to launch an electronic logbook program but has resorted back to manual logbook entries due to system issues. During the electronic logbook trial period, there were duplicate documentation entries placed within the electronic and hardcopy logbooks. The review on logbook documentation was focused on the manual entries into the hardcopy logbooks. There are three logbooks that were reviewed for the past six months. The logbook is utilized for the common area and male dorms, and one for documentation and procedures and one is used for the female dormitories. The staff did not follow the log book requirement to strike out the error and initial. The Program Director reviewed the facility logbook weekly and noted any follow up	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		
						needed. Three logbooks were reviewed. All logbooks contained shift turn-over inputs which detail the census, medical count, key exchange, and any significant issues from the previous shift. Throughout logbooks there were annotations of, intakes, discharges, snack and meal times, 15-minute checks and headcounts. Proper annotation protocol was present throughout all three logbooks and weekly supervisory reviews were consistent in all three logs.	
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 written policy and procedure, RGC 3.05- Behavioral Management, that meets the requirement of the indicator and was last approved 5/15/19 and signed by the Chief Operating Officer and Chief Executive Officer of Prevention Services.	
RATING	☒	☐	☐	☐	☐	The agency ensures the agency's use of proactive behavioral management techniques that emphasizes positive and preventative measures in the management of the youth behavior. The program utilizes a tiered system which consists of three levels of advancement within the Advancing Youth Development (AYD) curriculum. Advancement for eligibility to leveling up consists of a baseline time period for each level; Orientation (3 days), Educations (4 days), Graduation (7 days). Each level prescribes its own requirements for youth which promotes positive behavioral choices and healthy decisions among program participants. Each level during the youth's placement at the residential facility will focus on twelve key areas to promote positive youth development. There are five areas with specific targeted behavioral goals that are consistent with the six identified character	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		
						development issues from the Character Counts Curriculum. The BMS uses a variety of awards/incentives to encourage participation and completion of the program. The youth pace of advancement is dictated by the youth's behavior, cooperation, progression towards goals, and expectation compliance. The program is a "Hands Off" Facility so the utilization of mechanical restraints is not allowed. Physical restraint is used only in emergency or crisis situation and only after less restrictive interventions has proven ineffective. The staff utilize de-escalation strategies to manage difficult situations. Staff are trained in Managing Youth Behavior (MAB) and Why Try curriculums to training staff on de-escalation tactics. Shift Leaders and Supervisor/Shift Leaders provide feedback to staff and informal evaluation of their use of the BMS. The youth also use "reflection" time to discuss directly with the Residential Supervisor their concerns with the Behavior Management systems in place. There were three residential files (2 closed, 2 open) reviewed for this indicator. Documentation was evident in all 4 records that thorough orientation is conducted and documented for each youth. The documentation reviewed is detailed and reflected the fulfillment of BMS educational, consent, and feedback mechanisms which are available for the youth.	
3.06: Staffing and Youth Supervision							
Provider has a written policy and procedure that meets the requirement for Indicator 3.06						☒ YES ☐ NO (explain) The agency has a written policy and procedure RGC 3.06 which details Staffing levels and On-Call/Scheduling that addresses all of the key elements of the QI indicator and	

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)
						was approved by the Chief Operation Officer and the Chief Executive Officer of Prevention Services 5/15/19.	
RATING	☒	☐	☐	☐	☐	The procedures address Ratios, On-call duties, and Youth Supervision. The Ratios section discusses the following topics; the need for both male and female staff working at all times with a staff awake ratio of 1:6 and an asleep ration of 1:12, utilization of part-time employees, documentation requirements for staff in the log, and On-Call procedures. On-Call procedures include contact information for on-call staff, who is allowed to make contact, and circumstances in which to contact them. The program utilizes cameras to provide surveillance coverage of both the interior & exterior of the facility. There are a total of 22 cameras which provide adequate monitoring of the facility and youth. 7 cameras are currently offline. The surveillance system records and stores data on a back-up device for 30 days. A random selection of overnight checks was conducted and verified staff's observation and documentation of bed checks every 15 minutes. The selection consisted of 4 days with 4 hours of video review consisting of staggering hour blocks. This allows for validation of the awake and asleep ratio and staffing requirements. Staffing ratios of 1:6 during wake hours and 1:12 during sleep hours were observed to be in compliance as well. Comparison between video evidence and logbook entries correlated. There was a presence of a consistent 2-minute delay from the logbook entry to video visual checks, however, the delay can be attributed to system delays. All checks were consistently on or before the 15-	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		
						minute increments in both the logbook and videos reviewed.	
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 written policy and procedure, RGC 3.08- Video Surveillance that addresses all of the key elements of the QI indicator and was approved by the Chief Operation Officer and the Chief Executive Officer of Prevention Services 8/21/19.	
RATING	☒	☐	☐	☐	☐	The policy ensures that the shelter provides a secure environment, protects its facilities, and enhances the safety of youth, staff, and visitors. The video surveillance is used to only meet critical goals for security and in a manner that is sensitive to interests of privacy, free assembly, and expression. Video surveillance of public area will be limited to uses that do not violate the reasonable expectation of privacy as defined by law. The procedure outlines 8 components required for the postings; usage of video recording/camera, cameras placed in general work areas (excluding bedrooms and bathrooms), limited staff access, and saving of video footage which were all displayed correctly. There is a written notice displayed at the front entrance of the facility which indicates video surveillance in the building. Staff maintain 2 logbooks: 1 for the girls and 1 for the boys. The surveillance system is equipped with 22 cameras with 7 that are inoperable on the exterior of the facility. Full surveillance system replacement is pending ETA within 30 days. The new system will offer multiple angles of	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		
						overlapping video which will prevent dead spaces event of future camera outages. The surveillance system captures and retains video images recorded with day, time, and location and enables facial recognition. Video surveillance is only accessible by designated personnel (Residential Supervisor, Program Director) and is to be reviewed a minimum of every 14 days and noted in a logbook and the Video Surveillance Log Binder. Observation of the video surveillance noted that data was available up to 30 days. Random dates and hour blocks were reviewed for overnight bed checks. It was noted at times that bed checks varied sometimes for over a minute as staff would first enter the bed check entry electronically and then conduct the bed check. At the time of the review the reviewer interviewed the Director and Residential Supervisor and discovered that 7 of the 22 cameras are not functioning.	

STANDARD 4: MENTAL HEALTH/HEALTH SERVICES

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 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 provider's policy and procedure for Healthcare Screening, #RGC 4.01 fully meets the requirements for this indicator and was approved on May 15, 2019 by the CEO.	
RATING	☒	☐	☐	☐	☐	Reviewed two open and two closed residential youth files. Each of the files contained the required healthcare admission screening form which included information on the youth's current medications, existing medical conditions, allergies, recent injuries or illnesses, and observations. Although no medical follow-ups or scheduling were needed by any of the youth in the files reviewed, the program staff explained that any such necessary medical follow-up or scheduling is coordinated with the child's parent or guardian. The program highlights entries in the daily log any medically relevant issues (e.g.: medications) and allergy and medical alerts are on the file(s) as applicable and on the kitchen board. The reviewer noted that there is a place in each file for medical referrals, but none of the files reviewed required an instance of such a referral. The facility was without a nurse on staff from March 22, 2019 through December 30, 2019; however, diligent efforts to hire a new nurse were demonstrated including	No exceptions.

Quality Improvement Indicators	Rating: Explain — 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)
						111 applications received and three offers for employment were made before the program finally hired a part time nurse who works 10-17 hours a week. The program nurse reviewed the health screenings of two of the new intake files reviewed under this indicator within the required five days. The reviewer noted that the nurse's signature was not dated; however, since it was done during the review, it met the requirements of the agency's policy and this indicator. Furthermore, the Program Manager was able to demonstrate that the nurse reviewed and signed the health screening of a youth in the shelter program for over five days.	
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.**							
Reviewer verified that the provider has a written policy and procedure that meets the requirement for Indicator 4.02						☒ **YES** ☐ **NO (explain)** The provider's policy and procedure for Suicide Prevention, #RGC 4.02, fully meets the requirements for this indicator and was approved on May 15, 2019 by the CEO.	
RATING	☒	☐	☐	☐	☐	A total of four files were reviewed, two open and two closed. Each file evidenced completion of the suicide risk screening at intake and the results of the screenings were reviewed and signed by the supervisor in timely fashion. In three of the four files reviewed, the youth was placed on sight-and-sound supervision pending assessment by a licensed professional or a non-licensed professional under the direct supervision of a licensed professional. The program advises that it rotates YFA-employed licensed mental health counselors to cover this agency site from month to month to ensure reviews of suicide assessments	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		
						within the required time frames (24 hours or morning of 1st business day fallowing the screening). The program advised that it may use telephonic and/or electronic reviews to expedite services and ensure timeliness. Each of the four files reviewed, contained the required assessment by a licensed professional or non-licensed professional under the direct supervision of the licensed professional within 24 hours from the completion of the suicide risk screening or the morning of the 1st business day after completion of the screening (if performed between 5:00 pm Friday and 9:00 am Monday). The reviewer noted that the non-licensed professional performing the assessment under the direct supervision of a licensed professional, omitted credentials and title when signing the assessment. In each of the files reviewed, the youth was placed on the appropriate level of supervision based on the results of the suicide risk assessment. The staff person assigned to monitor each applicable youths' files documented behavior at 30 minutes or less intervals. and included the time of day, behavioral observations, any warning signs observed and the observers' initials.	
4.03: Medication							
Provider has a written policy and procedure that meets the requirement for Indicator 4.03						**☒ YES X** **☐ NO (explain)** The provider's policy and procedure for Medication Control and Management, #RGC 4.03 fully meets the requirements for this indicator and was approved on December 10, 2019 by the CEO.	

Quality Improvement Review

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	☐	☒	☐	☐	☐	Reviewed the Pyxis Med Station with a Super User Staff member and one current youth file on medication. The program uses the Pyxis Med-Station 4000 to store medication. It is in a locked room that is inaccessible to youth. It is a biometric locking cabinet that requires a combination of passcode and thumb print to open. The system keeps an inventory of all narcotics and controlled medications stored in the Med-Station. The program uses a Medication Distribution Log to track distribution of medication to youth by non-licensed and licensed staff. The program has four Super Users, who are authorized to dispense medications and an additional seven General Users, who are also authorized to dispense medication. Medication Logs and inventories are maintained in the locked Med-Station room and checked daily by staff on each shift. The program staff clears all medication discrepancies after each shift. Medication counts are performed by shift leads at the beginning of each shift. The program stores oral medications separately from injectable and topical medications. There were no refrigerated medications on site at the time of the review; however, there is a thermometer to monitor the temperature inside the designated medication storage refrigerator. It was at 43 degrees at the time of the review, which meets the required parameters for this standard. The facility does not use over-the-counter medications without a prescription. If a youth is in need of an over-the-counter medication, the parent/guardian is contacted and is to take the youth to see a doctor.	**Exception** At the time of the review, no staff person was identified as responsible for performing monthly reviews of the Pyxis Med Station and no supporting documentation was observed to verify practice.

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)
						The reviewer confirmed that the program staff verifies all medications are prescribed to, and current for, the youth at intake. The program will accept youth prescribed injectable medications; however, the youth must either be able to self-inject or have a family or other person able to come to the facility to administer the injection, as there is no full-time nurse on staff. All staff receive Epi pen training along with their CPR and First Aid training, as evidenced by the signed Epi Pen training document in each staff person's training file (copies of which were obtained by the reviewer).	
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 provider's policy and procedure for Medical and Mental Health Alert System, #RGC 4.04, fully meets the requirements for this indicator and was approved on May 15, 2019 by the CEO.	
RATING	☒	☐	☐	☐	☐	Reviewed four files: two open and two closed. Each of the youth files had either a medical, mental health condition or food allergy (or a combination of these) noted on the face of their file. The reviewer confirmed that each youth was appropriately placed on the program's alert system based on the information gathered at intake on the NetMIS and Health Screening forms. The program maintains a medical alert board in the medication room and a special dietary needs board in the kitchen showing any allergies or special diet	No exceptions.

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)
						requirements of all youth in residence. Both boards are reviewed by staff at the beginning of each shift. The reviewer confirmed, after review of a sampling of seven training files, that staff are required to complete CPR and First Aid training, which includes information and instruction on recognizing and responding to the need for emergency care for medical/mental health issues and/or food allergy reactions as required by this indicator.	
4.05: Episodic/Emergency Care							
Provider has a written policy and procedure that meets the requirement for Indicator 4.05						☒ **YES** ☐ **NO (explain)** The provider's policy and procedure for Episodic/Emergency Care, #RGC 4.05 fully meets the requirements for this indicator and was, approved on May 15, 2019 by the CEO.	
RATING	☒	☐	☐	☐	☐	There were thirteen medical CCC reports during the reporting period commencing August 1, 2019 through February 20, 2019. Three files of youth involved in an episodic emergency care situation were reviewed (all were closed). The program's incident reporting records were referenced to verify the reporting to CCC and parental notification requirement for this indicator. The discharge follow-up documentation was in each of the files reviewed and was also attached to the incident report stored separately by the program. The program documented each episodic emergency care incident in the program's daily log book, as well as in the chronological records of each youth's file. The reviewer confirmed all staff completed CPR and First Aid training, which includes information and instruction on	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		
						recognizing and responding to the need for emergency care for medical/mental health issues and/or food allergy reactions as required by this indicator. Reviewer observed the facility has knife for life and wire cutters located in the Med Station, Kitchen, Copy Room and Dorm station. The facility also has wall-mounted First Aid kits in the Med Station, Kitchen, Copy Room and Dorm station.	