Florida Network for Youth and Family Services
Compliance Monitoring Report for

Youth and Family Alternatives – RAP House

7522 Plathe Road, New Port Richey, FL 34653

Compliance Monitoring Services Provided by

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, Inc – RAP House (RAP house) for the FY 2019-2020 at its program office located at 7522 Plathe Road, New Port Richey, 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. RAP House is contracted with the Florida Network of Youth and Family Services (FNYFS) to provide direct services to Children/Families in Need of Services (CINS/FINS). The services to be provided are identified in Contract Section A - Descriptions and Specifications and Section B - Delivery and Performance, and are funded with General Revenue Funds effective for July 2019 through June 30, 2020.

The review was conducted by Nitara LaTouche, Consultant for Forefront LLC and Peer Reviewer(s). Agency representatives from YFA - RAP House present for the entrance interview were: Cayse Houston, Program Manager, Isabel Fernandes, Residential Supervisor, Kelley Scott, Family Help Supervisor, and Amanda Killian, VP of Quality Improvement. The last onsite QI visit was conducted October 24-25, 2018.

In general, the Reviewer found that YFA RAP House is in compliance with specific contract requirements. **YFA RAP House received an overall compliance rating of 100% for achieving full compliance with (11) indicators** of the CINS/FINS Monitoring Tool. There were no corrective actions 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 12-18-19-20192020

Agency Name: Youth and Family Alternatives – RAP House	Monitor Name: Nitara LaTouche, Lead Reviewer
Contract Type : CINS/FINS	Region/Office: 7522 Plathe Road, New Port Richey, FL
Service Description: Comprehensive Onsite Compliance Monitoring	Site Visit Date(s): December 18-19,2019

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)
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.	☐	☐	☒	☐	☐	I: The program currently has 3 certified DJJ QI peer reviewers for this location; Cayse Houston, Aimee Johnson, and Kelley Scott. The have participated in QI Peer Reviews for the current QI season.	**No corrective action or recommendation required.**
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**	☐	☐	☒	☐	☐	D: The VP of Finance provided the following list of additional current contracts for FY 2019-2020: Department of Health, Eckerd CBC, Heartland CBC, KCI, United Way of Pasco, and YMCA.	**No corrective action or recommendation required.**
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	☐	☐	☒	☐	☐	D: Workers Compensation and employers liability insurance certificate was reviewed and indicated that is effective 6/1/2019-6/1/2020 and coverage is provided by Bridgefield Employers Ins Co with limits of $1,000,000 for each accident, employee, or aggregate.	**No corrective action or recommendation required.**

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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)
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**						General liability is effective 6/1/2019-6/1/2020 and coverage is provided by Alliance of Nonprofits for Ins with limits of $1,000,000 for each occurrence, $500,000 for damage to rented premises, $20,000 for medical expenses, $1,000,000 for personal and injury, $3,000,000 for general aggregate. Automobile liability is provided by Alliance of Nonprofits for Ins with a combined single limit of $1,000,000 effective 6/1/2019-6/1/2020. There is additional policies for umbrella liability with limits of $3,000,000 for each occurrence or aggregate that is effective 6/1/2019-6/1/2020 and professional liability and abuse/molestation coverage with limits of $1,000,000 per occurrence or $3,000,000 aggregate that is effective from 6/1/2019-6/1/2020. The Florida Network of Youth and Family Services is listed on the Certificate of Liability Insurance as the certificate holder.	

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External/Outside Contract Compliance a. Provider has corrective action item(s) cited by an external funding source (Fiscal or Non-Fiscal). **ON SITE**	☐	☐	☐	☐	☒	I: During the Entrance Conference, the provider indicated that there are no outstanding corrective action item(s) cited by an external funding source.	**No corrective action or recommendation required.**
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**	☐	☐	☒	☐	☐	D: The agency provided a series of policies labeled as 'Financial Management' that were last reviewed in February 2019. Policies reviewed cover the agencies protocols and financial processes to provide internal controls that appear to be in line with GAAP requirements.	**No corrective action or recommendation required.**
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**	☐	☐	☒	☐	☐	D: The agency provided a general ledger report for dates from May 2019-October 2019. The detail report includes GL code, functional expense code, funding source code, location code, activity code, effective date, document number, transaction description, and the debit and credit amounts.	**No corrective action or recommendation required.**
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**	☐	☐	☒	☐	☐	O,I: Petty cash ledger system was observed and reviewed while onsite, to be maintained as required, with the correct balance when reconciled. Petty cash maintained is $225. Cash on hand was counted and verified to be $40.47, $114.53 in receipts, and	**No corrective action or recommendation required.**

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						remaining balance of $70 was documented as allowances paid for youth.	
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**	☐	☐	☒	☐	☐	D: Financial records included bank transactions and statements from March 2019 – October 2019 with monthly 'reconcile cash accounts' submitted from June – October 2019 for operating bank account PNC Bank. Invoices appear to be submitted on a monthly basis based on documentation reviewed. All disbursements and invoices are approved and monitored by management.	**No corrective action or recommendation required.**
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**	☐	☐	☐	☐	☒	I: Program Manager reported no material inventory was purchased with DJJ funding since the last onsite visit.	**No corrective action or recommendation required.**
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**	☐	☐	☒	☐	☐	D: The agency provided evidence of payroll taxes and deposits for 3 quarters with the IRS Form 941 for months covering between January – September 2019. 2 quarters showed a zero balance and the 3rd quarter showed an overpayment was made.	**No corrective action or recommendation required.**

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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)**
g. Budget to actual reports prepared and reviewed by appropriate management. Variance from the budget are investigated and explained. **PTV/ON SITE**	☐	☐	☒	☐	☐	D: The agency provided budget to actual reports titled 'Statement of Revenues and Expenditures' for 5/2019 - 10/201 that includes current month actual, current month budget, over/under month budget, YTD actual, YTD budget, YTD over/under budget, and any deficit or surplus. Variances for the program budget are monitored by management and discussed with the Board on a regular basis.	**No corrective action or recommendation required.**
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**	☐	☐	☒	☐	☐	D: The agency provided a copy of the single independent audit completed for the fiscal year ending in June 2019 by Reeder & Associates, PA Certified Public Accountants firm on November 8, 2019 and provided for this review. A separate management letter that required a corrective action plan was not issued at the time of this audit.	**No corrective action or recommendation required.**
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**	☐	☐	☒	☐	☐	D,I: The agency maintains written policies and procedures to ensure security of confidential personal information. The fiscal policies that were provided for this review to meet the requirements fall under the following categories: Financial Management, Risk Management,	**No corrective action or recommendation required.**

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						Information Management and a Record Retention Schedule. The central server disaster policy states that only authorized YFA staff have access to pertinent server information via appropriate security measures. The data is backed up daily and stored on an active directory server and terminal server using a onsite backup server. There is also a secondary backup through a cloud based service CrashPlan that is managed offsite. All servers have backup units in the event of a power outage.	

CONCLUSION

YFA RAP House has met the requirements for the CINS/FINS contract as a result of full compliance with eleven (11) applicable indicators of the Administrative and Fiscal Contract Monitoring Tool. Two of the thirteen indicators were not applicable because: 1) the provider does not have any outstanding corrective action item(s) cited by an external funding source and 2) does not have any current inventory purchased with DJJ/FN Funds. Consequently, **the overall compliance rate for this contract monitoring visit is 100%.** There are no corrective actions cited as a result of the contract monitoring visit. Overall, the provider is performing satisfactorily in meeting the fiscal and administrative terms of its contract. In addition, the majority of indicators reviewed were carried out in a manner which meets the standard as described in the report findings.

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

Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Youth and Family Alternatives, Inc. – RAP House Residential Program

December 18-19, 2019

Compliance Monitoring Services Provided by

Quality Improvement Review

Youth and Family Alternatives (RAP House) – December 18-19,2019
Lead Reviewer: Nitara LaTouche

CINS/FINS Rating Profile

Standard 1: Management Accountability

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

Percent of indicators rated Satisfactory: 85.71%
Percent of indicators rated Limited: 14.28%
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	Limited
2.09 Special Populations	Satisfactory
2.10 Stop Now and Plan (SNAP)	Not Applicable

Percent of indicators rated Satisfactory: 88.89%
Percent of indicators rated Limited: 11.11%
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	Limited
3.05 Behavior Management Strategies	Satisfactory
3.06 Staffing and Youth Supervision	Satisfactory
3.07 Video Surveillance System	Satisfactory

Percent of indicators rated Satisfactory: 85.71%
Percent of indicators rated Limited: 14.29%
Percent of indicators rated Failed: 0.00%

Standard 4: Mental Health /Health Services

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

Percent of indicators rated Satisfactory: 80.00%
Percent of indicators rated Limited: 20.00%
Percent of indicators rated Failed: 0.00%

Overall Rating Summary

Percent of indicators rated Satisfactory: 85.71%
Percent of indicators rated Limited: 14.28%
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

Nitara LaTouche - Lead Reviewer Consultant-Forefront LLC/Florida Network of Youth and Family Services

Marvin Bliss - Department of Juvenile Justice

Paulette Hinton – Orange County Youth and Family Services

Erik Kline - Family Resources

Constance Shaw – Bethel Community Foundation

Quality Improvement Review
Youth and Family Alternatives (RAP House) – December 18-19,2019
Lead Reviewer: Nitara LaTouche

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
_____ # Case Managers
_____ # Program Supervisors
_____ # Food Service Personnel
_____ # Healthcare Staff
_____ # Maintenance Personnel
1 # Other (listed by title): **VP of Operations**

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
9 # Health Records
10 # MH/SA Records
20 # Personnel /Volunteer Records
11 # Training Records
13 # Youth Records (Closed)
6 # Youth Records (Open)
_____ # Other: _____

Surveys

4 # Youth
5 # 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

The program is COA accredited and has a DCF Child Care license that expires in March 2020.

The program has recently partnered with Eckerd CBC to begin a new emergency overnight bed project that will accommodate 2 youth overnight in order to reduce youth sleeping in the offices of case managers when trying to secure foster care placements.

The program has maintained funding with Basic Centers Grant for 2 positions. The Intensive Case Manager position will work in-home with youth deemed to be habitual runaways and the Outreach Coordinator position will focus work on homeless youth and their families.

The program recently promoted a new Residential Supervisor that has experience working in the residential program. The program has created a new cook position that manages all of the daily cooking, cooks for the kid's volunteers, and provides independent living skills by teaching and cooking with youth.

The program has recently painted and upgraded the facility to make it more welcoming and inviting. This program reports this new makeover has given the facility a more trauma-informed atmosphere.

Standard 1: Management Accountability

Overview

<u>Narrative</u>

Youth and Family Alternatives, Inc. has 3 locations across Florida. The agency is managed by a President/Chief Executive Officer (CEO) and Vice President of Operations (VPO). The VPO oversees the Shelter Manager for the RAP House and Family Help Supervisors for the North region. The Shelter Manager oversees the daily operations of the residential program and supervises the Residential Supervisor. The Family Help Supervisor oversees the management and daily operations of the non-residential program. The program recently promoted a new Residential Supervisor, Isabel Fernandes, who provides daily support to Youth Development Specialist staff. The program has recently created a new cook position that manages all of the daily cooking for the shelter. The Program reports 5 vacancies currently with 2 positions in the process of being filled for the shelter.

The HR department completes screening of all employees and volunteers for the agency. They utilize a pre-hire aptitude test for Youth Development Specialists and Family Support Worker Staff called 'Criteria Basic Skills Test' (CBST) and 'Customer Service Aptitude Profile' (CSAP). The results assist in providing insight into which work abilities will be best suited for the work field of the applicant.

The agency has a dedicated Quality Improvement team that provides oversight and assistance for all programs in reviewing records, facility inspections, staff interviews and various other continuous quality improvement activity. The program collects and reviews data from various sources on a regular basis. All incidents, accidents, grievances, outcome data, and customer satisfaction data is discussed in Compliance Committee meetings and staff meetings across the program leadership and staff. The data is reviewed and compared across programs and locations within the agency to increase consistency when possible.

All indicators in standard one were rated satisfactory with exceptions noted in 1.01 – Background Screening, 1.03 – CCC Reporting, 1.04- Training, and 1.05 – Analyzing and Reporting Information. The exceptions noted in 1.06- Transportation resulted in a limited rating. All other indicators in standard four were rated satisfactory with no exceptions.

Standard 2: Intervention and Case Management

Overview
Rating Narrative

The program is overseen by the Vice President of Operations, Family Help Supervisor (North region), an Office Specialist, and 7 counselors. There is 1 vacancy at the time of the review.

The program operates during normal business hours 8:00am -5:00pm, Monday thru Friday. All calls are received by the on-call counselor, who completes a screening for eligibility and assesses the severity of service needs. Any calls received after hours are referred to the residential facility for screening and determining eligibility. Crisis calls may be referred to the Program Director or Manager for consultation. Services are provided in three counties; West Pasco, Sumter, and Citrus. Services are provided in the youth's home, the office location, or a community location such as the youth's school, etc. The program utilizes a paper file for the youth's record and the files had to be transported to this location for review.

The program provides services to special populations meeting the eligibility criteria for domestic violence (DV), domestic minor sex trafficking (DMST), probation respite (PR), staff secure, family youth respite aftercare (FYRAC) and intensive case management services. Intensive Case Management Services are provided as a separate contract for Circuit 6 only. The program does not provide SNAP services at this location. At the time of the review, the program reported not having any current youth records that meet any of the above criteria except for domestic violent services.

All indicators in standard two were rated satisfactory with exceptions in indicator 2.02 – Needs Assessment, 2.06 – Adjudication, 2.07 – Youth Records, and 2.09 – Special Populations. The exceptions in 2.08 resulted in a limited rating due to the lack of clear documentation indicating the youth's preferred pronoun was being used in the file. The agency does not provide SNAP services and therefore, indicator 2.10 – SNAP, is not applicable. All of the remaining indicators for this standard are satisfactory with no exceptions.

Standard 3: Shelter Care

Overview
Rating Narrative

The program is supported by a Vice President of Operations that oversees the operations and administration of the program, a Shelter Manager, an Office Specialist, a Residential Supervisor, 2 Residential Counselors, a full time cook, and full time and part time Youth Development Specialists. The program recently promoted Isabel Fernandes, into the Residential Supervisor position. There are currently 5 vacancies in the program with 2 potential applicants currently in the recruitment process.

The program has painted and upgraded the facility since the last onsite visit. The program reported updating the interior to make the program more trauma informed atmosphere. The facility has brand new lockers for youth to store their personal belongings if needed. The facility appeared to be well maintained, friendly, and welcoming for youth. There are 2 agency vehicles used for youth transportation that appeared to be well maintained and equipped with the required safety equipment.

There is a very structured program schedule in place that allows youth to have access to various activities including faith-based and rewarding outings. The daily schedule of the program allows for one hour of physical activity and set scheduled time to complete homework or receive assistance with school work as needed. If youth do not have homework, they have access to age appropriate reading materials to read. The schedule is posted in common areas and easily accessible for both youth and staff.

The program utilizes a 4 level behavior management system that is designed to encourage youth with a positive reward system. The four levels are grouped into ‘pillars’ and are listed as followed; Orientation, Education, Graduation, and Collegiate. When a youth drops a level due to non-compliance with program rules, they are placed on ‘reflection’. Each level includes different incentives that range from outings and home visits to the opportunity to earn ‘RAP Bucks’ that gives the youth money to purchase gifts from a reward closet.

All indicators in standard three were rated satisfactory with exceptions noted Indicator 3.04 – Logbooks which resulted in a limited rating. All other indicators in standard three were rated satisfactory with no exceptions.

Standard 4: Mental Health/Health Services

Overview
Rating Narrative

The residential counseling program is overseen by the Shelter Manager, a Residential Supervisor, a part time Shelter Nurse, 2 residential counselors, and a contracted licensed Clinical Director.

Youth are screened at admission for physical health related conditions and mental health conditions. All youth are screened using the CINS Intake Assessment Form using the approved 6 questions to determine if there are any suicidal or homicidal ideation for the youth which is followed by the completion of the Evaluation of the Imminent Danger of Suicide (EIDS) assessment when deemed necessary. The non-licensed therapists completes the assessments prior to reducing the level of supervision and supervision consultation by the licensed clinical director is often provided via phone when the clinical director is not onsite.

The medications are stored in the Pyxis 4000 Med Station and kept in a locked room that is not accessible by youth. There are 3 superusers that have access to the Pyxis Med Station. There is a weekly inventory completed and youth care staff are responsible for completing the daily medication counts.

Training is to be completed by the RN for all staff to cover distribution of medication and proper techniques to administer medication, legal requirements, usage and side effects of medication, and training on the use of epi-pens. All staff are trained in CPR and First Aid.

All indicators in standard four were rated satisfactory with exceptions noted in 4.02 resulting in a limited rating. All other indicators in standard four were rated satisfactory with no exceptions.

STANDARD 1: MANAGEMENT ACCOUNTABILITY

Quality Improvement Indicators	Rating: Satisfactory	Explain: Deficiency Identified	Explain: No Eligible Items For Review	Explain: No Practice	Explain: Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
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 has a policy & procedure Background Screening of Employees/ Volunteers that was reviewed by the agency's COO, John Luff on September 9, 2019.	The program policy met three of the standard's indicators. However, policy did not meet the indicator listed in the standard to address the scoring function of the suitability assessment tool.
RATING	☐	☒	☐	☐	☐	The agency's human resource department conducts background screening on all employees prior to hire. Eighteen new hire employee's files reviewed and eighteen files had the DJJ background screening present. Evidence showed that all employees were background screened prior to date of hire. Program Manager reported one volunteer providing a therapy dog that visits the program periodically. On day 2 of the site visit, the program provided a list with 2 volunteers and evidence of background screening that was completed prior to the volunteer's start date. Pre-employment Suitability Assessment for three staff was not applicable. Three employees scored below the 30%. Program policy does not	**Exceptions:** Affidavit of Compliance was signed and notarized on February 15,2019. Date shows it was out of compliance with required submission date to DJJ prior to January 31st which does not adhere to the program's internal policy or FN requirements. 1 employee 5-year rescreen was completed too early and last screening result provided was on 9/7/18 (1 year before the due date), which is outside the standard acceptable guidelines per DJJ, and was due to be completed in Sept 2019.

Quality Improvement Indicators	Rating: Satisfactory	Explain: Deficiency Identified	Explain: No Eligible Items For Review	Explain: No Practice	Explain: Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
						indicate any consideration for test score below 30% . However, VPO provided documentation during the onsite review for consideration regarding the result of low assessment scores that HR will need to review any results for scores below 30% which will need to be considered when policy is revised.	
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 agency has a policy & procedure Provision of an Abuse Free Environment that was reviewed and signed by the CEO and President on February 26,2019. The policy meets all indicator requirements.	
RATING	☒	☐	☐	☐	☐	Employee's orientation training forms indicated that program staff was trained on code of conduct that prohibits child abuse. The employee Orientation Forms were signed by the employee and supervisor. Phone number for the Florida Abuse Hotline is posted throughout the facility giving Youth and staff unimpeded access to call. Program has a locked grievance box that is accessible to all youth located in (girl's hall, boy's hall, day room). Grievance forms are written in English and Spanish. Keys to grievance boxes are kept with program manager/supervisor who check it daily. Six grievances reviewed and all were addressed within the 72 hours timeframe by the program supervisor/manager. Blank grievance forms	There were no exceptions for this indicator.

Quality Improvement Indicators	Rating: Satisfactory	Explain: Deficiency Identified	Explain: No Eligible Items For Review	Explain: No Practice	Explain: Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
						were observed to be available to youth in all three locations. The program has signage posted throughout the facility (abuse hotline, 911, LGBTQ, anti-bullying).	
1.03: Incident Reporting							
Provider has a written policy and procedure that meets the requirement for Indicator 1.03						☒ YES ☐ NO (explain) The agency has a policy and procedure titled Incident Reporting that was revised on December 4, 2018 and reviewed by the Board Chair and President /CEO on February 26, 2019.	
RATING	☐	☒	☐	☐	☐	The agency requires that all incident reports are sent via email and password protected for youth's confidentiality. Reportable incident types include incidents involving property damage, staff and client incident/accident(s), media coverage as well as protocols for DJJ Central Communications Center (CCC) and the Department of Children and Families (DCF). A review of ten reported CCC incidents within the last six months was conducted. All incidents were reported within two hours and was documented on the appropriate incident reporting forms. The program provided evidence of follow up that was reviewed and signed by program manager. Documentation regarding follow up was attached to each incident report.	**Exceptions:** 4 CCC incidents were not documented in the program log book: Youth JS 9/8/19; TD 10/19/19; AJ 12/2/19; AR 11/27/19, however, there was a completed incident form.

Quality Improvement Indicators	Rating: Satisfactory	Explain: Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
						Most of the program incidents were medically related and staff assisting with transporting youth when parents were unable to transport. One incident involved staff falsification that resulted in the staff termination.	
1.04: Training Requirements **Staff receives training in the necessary and essential skills required to provide CINS/FINS serves and perform specific job functions**							
Provider has a written policy and procedure that meets the requirement for Indicator 1.04						☒ YES ☐ NO (explain) The agency has a Training policy & procedure that was reviewed by the agency's COO on August 14,2019 that met all the standard's indicators.	
RATING	☐	☒	☐	☐	☐	The agency policy indicated that all staff received 80 hours of training during their first year of hire and 40 hours thereafter. A total of six new employee's training files were reviewed and all employees exceeded their training requirements with a minimum of 130 training hours within the 120 days of hire. A total of five files reviewed for employees following their first year of employment. All five employees exceeded the required hours with a minimum of 61.25 training hours. There were no lapsed training dates noted during this review. The agency provided evidence of the employees' annual training plan via the agency's online system. Individual files were	**Exceptions:** The program utilizes multiple databases to capture staff trainings and do not track the individuals training hours or trainings in one training file. Printed copies of employee's orientation training forms were not consistent with employee's first and last name making it difficult to clearly identify staff with completed orientation training. E.g. Some forms had employee's first name only.

Quality Improvement Indicators	Rating: Satisfactory	Explain: Deficiency Identified	Explain: No Eligible Items For Review	Explain: No Practice	Explain: Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
						also kept electronically and reviewed. Program manager provided some printed copies of the employee's training certificates and sign in sheets.	
1.05: Analyzing and Reporting Information **The program collects and reviews several sources of information to identify patterns and trends. Program should have sample reports of aggregated data and committee/workgroup minutes analyzing information.**							
Provider has a written policy and procedure that meets the requirement for Indicator 1.05						☒ YES ☐ NO (explain) The agency has several policies including CQI process, QI 300, a data collection and evaluation, QI 350, policy & procedure that was reviewed by the agency's COO on February 26, 2019 and additionally a draft CQI plan that provides a comprehensive overview of all CQI activities for the agency was provided to address the indicator requirements for this standard.	
RATING	☐	☒	☐	☐	☐	The program has a draft CQI plan pending approval that is dated 12/11/19 was provided for this review. The CQI plan covers the programs protocols and policies on continuous quality improvement, the role of the compliance committee, and all of the vast activities of the quality improvement department. It addresses the guidance for programs completing reviews and any related activities needing to analyze the strengths and weaknesses of the program and the implementation of improvements through the Compliance Committee and program leadership. Communication is shared throughout the various departments to address any identified areas of concern.	**Exception:** Program meeting minutes did not clearly indicate NetMIS data is reviewed monthly. E.g. Aug 2019 The program manager indicated that during monthly team meetings file reviews are completed and discussed with staff. However, there is insufficient documentation to evidence that quarterly record review reports are completed regularly to evidence strengths and weaknesses are identified and analyzed to identify trends of improvement or areas of concern.

	Rating					Review Based Upon	Notes
		Explain					
Quality Improvement Indicators	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable	Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
						The program team meeting minutes demonstrate several topics are covered during team meetings including daily program operations, trainings, documentation in logbooks, daily activities, issues/concerns, and file reviews. One example indicated the Netmis data was discussed but this was not always evidenced in minutes provided. The Program Manager also includes 'Kudos' and 'Thank You' as a way to recognize staff and boost team morale. The VP of Quality and team members completes a formal record review for each program and compiles this information into a report. The agency provided March 2019 and Aug 2019 peer review results with communication to include the files reviewed, all identified areas scored below 85%, and areas to improve with action steps and person responsible. The form indicates a timeframe to complete and requires a signature once corrected. There is a section for follow up, however, this does not appear to be utilized currently. According to the VP of Quality and the Program Manager, the CQI team completes an annual peer review, which appears to be a comprehensive formal review of files randomly selected for residential and non-residential programs. Each program is responsible to	Results from record reviews are documented informally as part of monthly staff minutes but do not provide the same level of results or analytics as the reports completed by the CQI team. For example, it is unclear how many files are reviewed during the staff meeting, results of the file review individually or collectively for the total files reviewed that month. The minutes do indicate trends found such as missing information on required forms, 'youth pictures', or staff 'not finishing files' but limited information is documented in the minutes to clearly identify what the strength or weakness is for each area and the steps the program is making to improve any deficiencies.

Quality Improvement Indicators	Rating: Satisfactory	Explain: Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
						conduct their own quarterly record reviews for compliance with this indicator. Email correspondence addresses incident reports for dates as follows were provided: 12/3/19, 5/23/19. The QI department generates reports on a quarterly basis and presents the findings to the compliance committee for review. An annual report is emailed for the past fiscal year that summarizes the agencies total highest number of reported incidents and the repeat offenders and any variances to analyze the programs that are needed. Minutes were provided from October 3, 2019 risk prevention and management team meeting minutes to discuss facility safety issues, danger to self/others, med errors, serious illness/injuries/death, restrictive behavior, and general trends or patterns. Stakeholder team meeting 10/1/19 and 12/2019 were provided to include review of client satisfaction surveys.	
1.06: Client Transportation **Policy is established to avoid situations that put youth or staff in danger of real or perceived harm, or allegations of inappropriate conduct by either staff or youth.**							
Provider has a written policy and procedure that meets the requirement for Indicator 1.06						☐ YES ☒ NO (explain) The agency has a policy RGC 1.06 Client Transportation that was revised on 4/18/19 and approved on 5/15/19 by the CEO and approved by the COO on 5/9/19.	Policy states that the supervisor or designee is aware when single transport is required and that this is documented in the log but the policy is missing that the program supervisor is 'made aware prior to transportation' and the form currently used

Quality Improvement Indicators	Rating: Satisfactory	Explain: Deficiency Identified	Explain: No Eligible Items For Review	Explain: No Practice	Explain: Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
							doesn't allow a place for this to be captured in practice.
RATING	☐	☒	☐	☐	☐	Agency provided a list of 27 approved drivers for the program. The list is provided to insurance agency and updated annually. Correspondence from the insurance company indicated they do not add or delete drivers throughout the year but recommends that the agency monitors the driving history of their staff on a regular basis. There are 3 vehicles with individual mileage and trip log forms. Each form indicates Month and year, and VIN# for each vehicle. The forms also include date, driver, safety equipment checks are conducted, # of youth, single transport of youth, stops (for each round trip), odometer start and end readings, and a notes column. The agency also maintains a separate binder for all single transports for each van. The single transport log form includes date, client name, reason for trip, supervisor approval received to indicate yes/no, supervisor initials, departure from and time, destination and time of arrival, mileage, and staff name. There is no time for when supervisor approves the transport prior to occurrence. The agency does not record any of the transports in the program log book. Chevy van contained mileage 6/25/19 -11/12/19 has 8 logged occurrences for single transport.	**Exception:** Transports are not recorded in the paper log book and are maintained in a separate file, however, the forms for single transport do not include times that the staff member speaks with the supervisor and it is not clearly documented in real time to evidence supervisor approval is obtained prior to transport as required per policy 4.14 and QI standard 1.06. The mileage form does not include the time only the date, however, the form for single transports is on the single transport form. There was 1 occurrence in the single transport log that the time and location was left blank for 10/18/19 on the equinox single transport log form. Dodge: Missing information on the mileage form for 8/30 to indicate number of youth. Missing supervisor approval on 2 occasions on 9/6/19 per mileage sheet but no note explaining if this was a typo or error. One line striking yes and no is circled. Line scribbled out on 9/4/19 and was previously circled as a single transport and changed without explanation. There were several incidents that were missing if they were single transport on

Quality Improvement Indicators	Rating: Satisfactory	Explain: Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
						Equinox contained mileage sheets for 6/10/19 – 12/14/19 and there are 23 occurrences in the log of single transport. Dodge van contained mileage 8/19/19 - 12/16/19 and 51 occurrences of single transport occurred. Dash cams were recently obtained for the shelter per the policy revision on 4/18/19. A dash cam is maintained for each van and the 12-hour footage is uploaded onto the SharePoint cloud storage for the provider. During the observation of dash cam footage for 12/12/19 you could see staff driving the vehicle with youth inside the vehicle. Per the policy, this footage is uploaded daily during the 8-4 shift. Previous times on the camera were incorrect and the shelter manager explained this how now been corrected and displays the correct dates for the footage.	10/8/19, 9/18/19, 9/11/19, 9/16/19, 9/27/19, 10/1/19, 10/26/19, and 10/28/19. Chevy: Missing indication of single transport on 6/7, 6/8, 6/11, 9/21 – changed without note. Blank lines in November 2019 that included a yes and then void without explanation. Pencil was used on some of the mileage forms and was harder to read. Equinox: Missing 7/24/19 and no indication of passenger traveling and not in supervisor approval.
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 agency has written policy Community Outreach and Education that was revised on December 14,2018 and signed by the Board Chair and President on March 14,2019. The policy meets all indicator requirements.	

Quality Improvement Indicators	Rating: Satisfactory	Explain: Deficiency Identified	Explain: No Eligible Items For Review	Explain: No Practice	Explain: Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation. Summarize Findings Based on Completed Worksheets	Notes: Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
RATING	☒	☐	☐	☐	☐	The policy outlines that all levels of staff are formally assigned responsibility for community education and all staff are encouraged to participate in state, county, and district boards as appropriate. Agency's NetMIS report indicated that they have participated in over 165 variety community outreaches from July 2019 through December 2019. Each month such as Circuit 6 Coordinator meeting, Pasco County Jail Book Donation, Survival kits, Human Trafficking Prevention, and Homeless Coalition. Minutes of the provider meetings, agenda, handouts, and attendance/signature sheets were present for each month May 2019 through December 2019. In addition, program manager provided evidence of their quarterly meeting Runaway/Homeless Youth Task Force. The meeting allows community partners such as law enforcement to bring awareness to the homeless population. Meeting agendas, sign in sheet, and handouts were also presented for each quarter were observed while onsite. The agency provided evidence of 12 interagency agreement with community partners. They are as follows: Pasco Juvenile Assessment Center, Board Pasco County School, Verizon Event Center, Pasco Kids First, Fifth Third Bank, BLDG 28, BayCare Behavioral Health, Junior Service	No exceptions

	Rating						
		Explain					
Quality Improvement Indicators	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable	**Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation** **Summarize Findings Based on Completed Worksheets**	**Notes** **Explain Exception, Failed, or Not Applicable Indicators:** **(Attach Supportive Documentation)**
						League, Salvation Army Center, Pasco County Services for Juveniles: Port Richey Chief of Police, Public Defender Office, and Harbor Behavioral Health Care Institute.	

STANDARD 2: INTERVENTION AND CASE MANAGEMENT

Quality Improvement Indicators	Rating: Satisfactory	Rating – Explain: Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
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's policy and procedure for RGC 2.1 Eligibility Screening and Intake, was last reviewed on 3/26/19 and approved by COO on 5/15/19. The provider's policy and procedure for RGC 510-Parental Notification was last reviewed on 3/26/19 and approved on 5/15/2019 by COO. All requirements for this indicator are addressed with this policy.	
RATING	☒	☐	☐	☐	☐	A total of 10 files were reviewed: 5 residential (3 open 2 closed) and 5 non-residential (3 open 2 closed) files were reviewed. 2 of the 3 residential files did not have dates (Supervisor). The Agency's procedure stated that a Counselor will contact the family and conduct the initial screening and document on the Centralized Intake Screening Form. For all files reviewed the screening was conducted within seven working days in accordance with the Agency's policy and procedure. There is a procedure in place for the nonresidential program which allows for calls after regular hours of operation helping families	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 their youth. All screening were entered into the NETMIS system within three (3) business days. For all files reviewed all Rights and Responsibilities were signed by parent, and youth, The Grievance Procedure and outlie of services were provided to parent(guardian) and youth.	
2.02: Needs Assessment							
Provider has a written policy and procedure that meets the requirement for Indicator 2.02						☒ YES ☐ NO (explain) The Agency's policy and procedure for RGC 2.01 Needs Assessment, was last reviewed on 3/26/2019 and approved on 5/15/2019 by COO.	
RATING	☐	☒	☐	☐	☐	10 files were reviewed: Residential-3 Open 2 Closed; Nonresidential-2 Open 3 Closed. 2 Residential Open files had no dates from Supervisor and 1 Residential Closed file with no Supervisor signature. For files reviewed, the Needs Assessment was reviewed to determine if it was completed within 72 hours of admission. 4 out 5 residential files were completed within the required timeframe. All non-res files reviewed were completed within two (2) to three (3) face to face contacts as indicted in the agency's policy and procedure following the initial intake process. All files reviewed the Needs Assessment were	**Exceptions:** 2 Residential Open files had no dates from Supervisor and 1 Residential Closed file with no Supervisor signature. 1 Closed file reviewed by another Reviewer noted that several sections on the Needs Assessment had sections incomplete/blank and there was no summary complete to indicate the services needed for the service plan. During the review, it was observed that 1 Residential file presented to reviewer that was previously closed and has recently been re-opened did not have a completed Needs Assessment in the open file. The Needs Assessment in the current open file

Quality Improvement Indicators	Rating: Satisfactory	Explain: Deficiency Identified	Explain: No Eligible Items For Review	Explain: No Practice	Explain: Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
						completed by a Bachelor's or Master's level staff member and signed by a supervisor.	only has the Youth's demographic information. There is no date/time, referral statement/ signatures and dates missing. Assessment was blank and staff indicated that youth needs assessment was still being completed. Based on the intake date, the needs assessment appeared to be incomplete outside of the 72 hour timeframe requirement.
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's policy and procedure for RGC 2.03 Case/Service plan was last reviewed 3/26/2019 and approved on 5/9/2019 by COO.	
RATING	☒	☐	☐	☐	☐	10 files were reviewed 5 Residential and 5 Nonresidential. All files had identifiable responsible persons, target dates, plan initiated date, signatures of youth, parent/guardian, counselor/case manager and supervisor. For all files reviewed the Service Plan addressed the specific needs identified in the Needs Assessment. The Service Plan used by the agency included the date the plan was initiated, identified clear measurable goals, type, frequency, location of services, responsible parties, targeted dates, actual competition dates, signatures of parent/guardian, youth, counselors, supervisor. The Case/Service Plan are monitored and reviewed every thirty (30) days for the first three months and then every six months for	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)
						progress in achieving goals and objectives thereafter. Any and all reviews are documented under: Service /Treatment Plan Review with staff initials as required. The Case/Service Plan may be revised anytime there are needed changes. At the end of ninety days (90) a new Case/Service Plan must be developed with the youth and parent/guardian. All files reviewed had Case/Service Plans had documentation of 30 day reviews.	
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's policy and procedure for RGC 2.04 Case Management and Service Delivery was last reviewed on 3/26/2019 and approved on 5/9/2019 by COO.	
RATING	☒	☐	☐	☐	☐	10 files were reviewed 5 Residential and 5 Nonresidential. Each file has an assigned Counselor/Case Manager who will ensure delivery of service, make appropriate referrals according to the service plan. All 10 files meet the requirements according to the Agency's policy and procedure. According to the agency's policy and procedure each youth is assigned a Counselor/Case Manager to ensure adequate delivery of service. Case Management and Service Delivery entails the establishing and coordinating referrals according to the Needs Assessment and the Case/Service Plan,	No exceptions

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		
						monitoring of out of home and state placement, youth/family progress in services, and case termination and follow up.	
2.05: Counseling Services							
Provider has a written policy and procedure that meets the requirement for Indicator 2.05						☒ YES ☐ NO (explain) The Agency's policy and procedure for RGC 2.05 Counseling Services was last reviewed on 3/26/2019 and approved on 5/9/19 by COO.	
RATING	☒	☐	☐	☐	☐	10 open and closed files were reviewed: 5 Residential and 5 Nonresidential. All files reflected the proper case coordination between presenting problem, needs assessment, service plan, case management reviews and follow-ups as required. Case notes are maintained for youth and indicate youth's progress in counseling services accordingly. All files had documentation of counseling services if needed according to the Treatment Plan. Structured groups were well documented for all Residential groups; group topics were indicated on the group session log along with timeframes.	No exceptions.
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's policy and procedure for RGC 2.06 Adjudication/Petition Process was last	

Quality Improvement Indicators	Rating: Satisfactory	Explain: Deficiency Identified	Explain: No Eligible Items For Review	Explain: No Practice	Explain: Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
						reviewed 3/26/19 and approved by COO on 5/9/19. All requirements for this indicator are addressed with this policy.	
RATING	☐	☒	☐	☐	☐	All 3 files indicated that the staffing is held within 7 days of parent/guardian initiating staffing. The case staffing involves all required parties and members including local school district and CINS FINS provider. The youth and family were all provided a new or revised plan based on the outcome of the case staffing. 3 Case Staffing Files reviewed have the notification of Case Staffing mailed to parents as indicated in the policy and procedure for this indicator.	**Exceptions:** 1 out 3 Case Staffing notification letters to parent reviewed was dated a month after the actual Case Staffing meeting.
2.07: Youth Records							
Provider has a written policy and procedure that meets the requirement for Indicator 2.07						☒ YES ☐ NO (explain) This agency has a policy RGC 2.07 Youth Records, which was last reviewed on 3/26/2019 and approved on 5/9/2019 by COO. All requirements for this indicator are addressed with this policy.	
RATING	☐	☒	☐	☐	☐	10 files were reviewed: 5 Residential and 5 Nonresidential.	**Exceptions:** 2 of the 5 Residential files reviewed were not marked “CONFIDENTIAL”-Reviewer

Quality Improvement Indicators	Rating: Satisfactory	Explain: Deficiency Identified	Explain: No Eligible Items For Review	Explain: No Practice	Explain: Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
						Files are kept on a cart in a secured locked room. Files are transported in a locked opaque container. All files have tabs with index titles. Reviewed files were organized and neat. It was observed that 4 of the 5 files reviewed had items out of place; according to Administrator these items are moved so that the assigned Case Manager/Counselor can remember to complete the form.	mentioned this to Staff and Staff immediately took corrective action. 3 of the 5 Nonresidential files reviewed were not marked “CONFIDENTIAL”. The opaque container used to transport the nonresidential files was not marked “CONFIDENTIAL” but was locked.
2.08: Sexual Orientation, Gender Identity, Gender Expression							
Provider has a written policy and procedure that meets the requirement for Indicator 2.08						☒ YES ☐ NO (explain) The agency has a policy RGC 2.08 ‘Sexual orientation, Gender Identity, & Gender Expression that was last approved on 5/21/19 by the CEO and COO.	
RATING	☐	☒	☐	☐	☐	2 files appear applicable to meet this indicator for review. 1 file unable to review due to program archiving offsite. According to the Program Manager, the file storage is located in Tampa warehouse and it takes approximately 1 week to retrieve files from warehouse. 1 closed file was available and reviewed for this indicator. It was observed that the Needs assessment had several incomplete sections. The program reports that they offer specialized support when needed and take into consideration the youth’s preference when assigning rooms. Youth are free to choose	**Exceptions:** 1 file was missing and reported to be archived prior to onsite visit. Program archived file that was closed on 6/13/19 so the youth record was unavailable for review. Program stated they will hold files longer moving forward and provided written documentation of current process. The needs assessment did not include a summary write-up and there was no indication of the youth’s preferred name and gender pronouns. One form in the file referred to the youth as ‘binary female’ another form referred to youth as ‘non-

Quality Improvement Indicators	Rating: Satisfactory	Explain: Deficiency Identified	Explain: No Eligible Items For Review	Explain: No Practice	Explain: Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation. Summarize Findings Based on Completed Worksheets	Notes. Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
						and request which hygiene products they prefer to use. The agency had signage posted in the common areas indicating that all youth are welcome. All youth surveyed reported that they feel this is a safe place for all clients regardless of their gender identity or sexual orientation. All youth surveyed also reported that they do not feel they have had any adults at the program trying to change their mind about their sexual orientation, gender identity, or the way they express their gender.	binary female' but since the needs assessment checked 'female' only and did not address the youth's gender identity or orientation from intake it was unclear to determine the youth's preference. The intake form indicated non-binary female and listed their orientation as 'pansexual'. However, other documents such as 'follow up assessment of suicide risk' listed the youth as female binary.
2.09: Special Populations							
Provider has a written policy and procedure that meets the requirement for Indicator 2.09						☐ YES ☒ NO (explain) The agency has a policy RGC 3.07 'Special Populations' that was last revised on 3/26/19 and was approved on 5/15/19 by the CEO and 5/9/19 by the COO.	At the time of the review, the PR and DV sections in policy doesn't include all of the language captured in the standard. For example, verbiage that 'youth must have a pending DV charge' or 'data entry into NetMIS and JJIS within 24 hours for admission and 72 hours of release' needs to be included.
RATING	☐	☒	☐	☐	☐	The agency has one comprehensive policy that addresses the procedures for all of the services offered to those meeting the various special populations criteria. The program reported that only 1 youth met the requirements of review since the last onsite monitoring.	**Exceptions:** The needs assessment was not fully complete and lacked a completed summary section. There was no summary recommendations in the needs assessment to give direction to the service plan noted at the time of review which is required for the CINS FINS requirements.

Quality Improvement Indicators	Rating: Satisfactory	Explain: Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
						1 closed file was reviewed for domestic violence. The file did contain evidence that the youth had a pending DV charge at the time of admission. The file demonstrated the youth did not have a stay longer than 21 days. The data was entered into NETMIS for the youth and was on time for discharge timeframes, however, it was outside of the required timeframes for admission. No FYRAC, DMST, or PR youth were reported as receiving services during the review period by the program.	The service plan lacked aggression management in the plan, which was later explained by program staff this was due to the youth not being willing to sign service plan with anger management or aggression management specifically noted on the plan. It was explained to the program staff this information was not observed in any of the progress notes, needs assessment or service plan. Data entry was not consistent with timeframe requirements for special populations criteria. The report for data entry lag reported the youth was entered into NetMIS with 3 days lag instead of the required 24 hours.
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) **Indicate policy number, authorized signee, date(s) of last review/revision/approval, and exceptions in notes.**	**Not Applicable**
RATING	☐	☐	☐	☐	☒		Not Applicable – This agency does not provide SNAP services at this location.

STANDARD 3: SHELTER CARE

Quality Improvement Indicators	Rating: Satisfactory	Explain: Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
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 program does have a policy to support Standard 3.01. Program Policy is RGC 3.01 Residential Group Care Environment. It was last reviewed on 2/15/17 and approved by the CEO and COO on 8/20/19.	No exceptions.
RATING	☒	☐	☐	☐	☐	Facility and site inspection showed all furnishings in good repair. The program is free of insect infestation and has a pest control company come out monthly. Grounds are landscaped and well maintained. Bathrooms and shower areas are clean and functional. There is no graffiti on walls, doors, or windows. Lighting is adequate for tasks performed, exterior areas are free of debris, grounds are free of hazards, dumpster and garbage cans are covered, and all doors are secure. Agency vehicles (2) were equipped with all major safety equipment including first aid kit, fire extinguisher, flashlight, glass breaker, seat belt cutter which is also used to deflate the airbag. In and out access is limited to staff	No Exceptions

Quality Improvement Indicators	Rating: Satisfactory	Explain: Deficiency Identified	Explain: No Eligible Items For Review	Explain: No Practice	Explain: Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
						members and key control requirements. Detailed map and egress plans are in all rooms, client rules are hanging throughout the dormitory, grievance forms and boxes are hung in both the male and female dormitories, the abuse hotline and ccc phone information is located throughout the building next to the phones. The agency has a current DCF Child Care License effective 3/23/19 and expires 3/2020. Interior rooms do not contain contraband and are free from hazardous unauthorized metal/foreign objects. All chemicals are listed, approved for use, inventoried, stored in (3) pantry's all of which are secured and have a MSDS sheet which is inventoried weekly. MSDS binders are kept in office of the office specialist and the chemical closets. Washer and dryer are operational, and area is clean. Each youth has own individual bed with clean covered mattress, pillow, sufficient linens and blankets. Youth have a safe, lockable place to keep personal belongings. Lockers are brand new and were provided by ECA. Annual fire inspection was conducted on 12/16/19 and follows local fire marshal and fire safety code. Agency completes a minimum of 1 fire drill per shift within 2 minutes or less. A total of 17 fire drills were completed in this reporting period, all of which were 2 minutes or less. A total of 6 emergency drills were	

	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					
Quality Improvement Indicators	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable		
						reviewed exceeding the required 1 mock emergency drill per shift per quarter. All annual fire safety equipment inspections are valid and up to date (extinguishers 6/25/19, Sprinkler 11/11/19, alarm system 2/11/19, Hood Exhaust 6/25/19). Agency's DOH inspection was completed on 2/18/19 and was satisfactory, Agency's Food Service Report was also satisfactory and was completed on 9/30/19. All food is properly stored, marked and labeled and dry storage/pantry area is clean, and food is properly stored. Refrigerators/Freezers are clean and maintained at required temperatures and all small and medium sized appliances are operable and clean for use as needed. Both Freezers were between –10 and –5 degrees, Refrigerator is 33. Youth are engaged in meaningful, structured activities as outlined in the daily schedule. Youth receive at least one hour of physical activity, have the opportunity for faith-based activities and non-punitive activities are offered for those that do not choose to participate. Daily programming includes opportunities for youth to complete homework and access a variety of age appropriate, program approved books for reading. Daily programming schedule is publicly posted and accessible to all youth and staff.	
3.02: Program Orientation							

Quality Improvement Indicators	Rating: Satisfactory	Explain: Deficiency Identified	Explain: No Eligible Items For Review	Explain: No Practice	Explain: Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
Provider has a written policy and procedure that meets the requirement for Indicator 3.02						☒ YES ☐ NO (explain) The program does have a policy to support Standard 3.02. Program Policy is RGC 3.02 Program Orientation. It was last reviewed on 2/28/17 and approved by the CEO and COO on 5/15/19	
RATING	☒	☐	☐	☐	☐	A total of 6 files were reviewed (3 open/3closed). 6 out of 6 files had a program orientation checklist and evidence that youth received orientation the same day as intake. Program orientation provided the youth with information pertaining to disciplinary action, grievance procedure, emergency/disaster procedures, contraband rules, physical facility layout map or tour, room assignment, suicide prevention alert notification, signature of the youth, daily activity reviewed, and abuse hotline number provided.	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 program does have a policy to support Standard 3.03. Program Policy is RGC 3.03 Youth Room Assignment. It was last reviewed on 3/1/19 and approved by the CEO and COO on 5/15/19.	
RATING	☒	☐	☐	☐	☐	A total of 6 files were reviewed (3 open/3 close). All 6 files contained a youth room assignment form that included an initial classification of the youth, to include youth's	No 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		
						history, status & exposure to trauma, age, gender, history of violence, disabilities, physical size/strength, gang affiliation, suicide risk, sexual aggression or reactive behavior, gender identification, documented alerts, collateral contacts, and initial interactions observed.	
3.04: Log Books							
Provider has a written policy and procedure that meets the requirement for Indicator 3.04						☒ YES ☐ NO (explain) The program does have a policy to support Standard 3.04. Logbook Requirements is RGC 3.04. It was last reviewed on 3/26/19 and approved by the CEO and COO on 5/21/19.	No exceptions.
RATING	☐	☒	☐	☐	☐	After review of last 6 months of logbook entries it was founded that safety and security issues that could impact the youth and/or program are highlighted, however this is not consistent throughout the logbook. Some shifts highlight CCC entries, others do not. There is also terminology that states, "and other stuff." Entries are brief and legibly written in ink. All entries reviewed include date and time of incident/activity/event, names of youth and staff involved, brief statement providing pertinent information, and name and signature of person making entry. The use of white-out is prohibited and there is no evidence of it being used. Program director or designee reviews the facility logbooks every week but is not indicating the dates being	**Exceptions:** Safety Issues are not highlighted consistently throughout the logbook. Some shift summary's highlighted yellow and some are not. Some CCC information highlighted but other CCC entries aren't. Some staff highlight the whole text while others just highlight the time. On 11/17/19 @ 22:36, a staff wrote in the logbook that they could not see what was going on in a youth's room but could only hear what he was doing. The youth was reportedly throwing items and kicking things. On 12/18/19 the same staff wrote that she possibly said something to youth which were sneaking in another youth's room. Also, the staff wrote on 12/18/19 she may have asked for the item but didn't

	Rating						
		Explain					
Quality Improvement Indicators	Satisfactory	Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
						reviewed. Supervisor is reviewing last two shifts and include the shifts being reviewed in the logbook entry while indicating if any correction, recommendations and follow-up is required, which is evidenced by the date and their signature at the time of entry. Supervision, resident counts, visitations, and home visits, med pass, and bed checks are being documented.	remember what was said but that she may have asked what the item was and asked for it. During bed checks on 12/18/19 it was written that youth appears asleep. "I can only see Youth B and Youth K's body figure under a blanket and possibly some of Youth K's hair but not enough to say for sure that it is her hair". All recording errors are not struck through with a clear line with staff initial and date. Instead entries have a single line and at times a scribbled line with the word "void." This was addressed at the last review and continues to be an issue. Direct care staff are signing at the top of the logbook page but no way to indicate if it was done at the beginning of their shift. It also appears that one staff is writing both names. Staff are not indicating they are reviewing the logbook consistently. Most reviews are happening 2-4 hours in to shift. According to Florida Network Policy and Procedure 4.14 and YFA Policy and Procedure 3.04, this must be done at the beginning of shift. There are also a huge number of late entry's in the logbook, but they do not designate the correct time the incident occurred.

Quality Improvement Indicators	Rating: Satisfactory	Explain: Deficiency Identified	Explain: No Eligible Items For Review	Explain: No Practice	Explain: Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
							Weekly supervisory review is occurring, but dates reviewed is not noted in the entry. Supervisory review is consistently addressing the issue with staff not reviewing last 2 shifts.
3.05: Behavior Management Strategies							
Provider has a written policy and procedure that meets the requirement for Indicator 3.05						☒ YES ☐ NO (explain) The program does have a policy to support Standard 3.05. Behavior Management Strategies is RGC 3.05. It was last reviewed on 4/18/17 and approved by the CEO and COO on 5/15/19.	
RATING	☒	☐	☐	☐	☐	A review of the Behavior Management System shows there are positive reinforcements being used to teach youth new behaviors and help youth understand the natural consequences for their actions. The shelter uses a wide variety of rewards and incentives in order to motivate the youth. The youth have a chance to earn "Rap Bucks" for the shelter store where they can purchase games, clothing, snacks, sporting equipment, etc. The Behavior Management System includes four different levels the youth can earn (Orientation, Education, Graduation, and Collegiate). Each level includes different perks including outings and home visits. If for any reason the youth gets a level drop, they get lowered to reflection. In order to be taken off a letter, apologizing for the incident, must be written.	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)
						A paragraph describing which pillars of character failed and what needs to be done to improve it must be written. Respect all staff and follow all of RAP House rules and behavior must be processed with a counselor. Youth must be on reflection for 48 hours from the time the displayed behavior ends. Staff are trained in the theory and practice of administering BMS rewards and consequences. Supervisors are trained to monitor the use of behavioral interventions by their staff to include the use of point-based and level-based interventions. there is a protocol for providing feedback and evaluation of staff regarding their use of the positive and negative consequences. In general, BMS promotes order, safety, security, respect, fairness and protection of resident rights. BMS provides constructive discipline that encourages youth to meet behavior expectations. Disciplinary measures do not deny the youth any meals and snacks, clothing, sleep, physical or mental health services, educational services, exercise, correspondence privileges, or contact with parents/guardians, attorney of record, juvenile probation officer or clergy.	

Quality Improvement Indicators	Rating: Satisfactory	Explain: Deficiency Identified	Explain: No Eligible Items For Review	Explain: No Practice	Explain: Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation. Summarize Findings Based on Completed Worksheets	Notes: Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
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 program does have a policy to support Standard 3.06. Staffing and Youth Supervision is RGC 3.06. It was last reviewed on 3/26/19 and approved by the CEO and COO on 5/15/19	
RATING	☒	☐	☐	☐	☐	The program maintains minimum staffing ratios as required by Florida Administrative Code and contract. Overnight work shifts consistently maintain a minimum of two staff present and at times have 3 staff on duty. Program schedule is provided to staff and is posted in the Staff Only room across from the art room. There is a holdover overtime rotation roster that includes home telephone numbers of staff who may be available when additional coverage is needed. Reviewer reviewed three separate dates 12/5, 12/15, and 12/19 for a total of 12 checks and all were completed within the required 15 minute time frame.	No Exceptions
3.07: Video Surveillance System							
Provider has a written policy and procedure that meets the requirement for Indicator 3.07						☒ YES ☐ NO (explain) The program does have a policy to support Standard 3.07 Video Surveillance. It was last reviewed on 7/10/19 and approved on 8/21/19 by the CEO and COO.	

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)
RATING	☒	☐	☐	☐	☐	The program does provide a written notice that is conspicuously posted on premises for the purpose of security. Cameras are in the interior and exterior general locations of the shelter where youth and staff congregate and where visitors enter and exit. All cameras are visible, and no cameras are placed in the bedrooms or bathrooms. The system can capture and retain video a minimum of 30 days and can record date, time, location and maintain resolution that enables facial recognition. Cameras operate during power outages. There is a list of designated personnel who can access the video surveillance system is maintained and kept in the residential managers office. Supervisory review of video is conducted a minimum of once every 14 days and noted in a binder kept in the residential managers office. The reviews are of random samples of overnight shifts. There is also a process for third party review of video recordings after a request from program quality improvement visits and when an investigation is pursued after an allegation of an incident.	No Exceptions

STANDARD 4: MENTAL HEALTH/HEALTH SERVICES

Quality Improvement Indicators	Rating: Satisfactory	Explain: Deficiency Identified	No Eligible Items For Review	No Practice	Not Applicable	Review Based Upon Document Source: Interview/Surveys, Observation, and/or Type of Documentation Summarize Findings Based on Completed Worksheets	Notes Explain Exception, Failed, or Not Applicable Indicators: (Attach Supportive Documentation)
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 Admission Screenings number RGC 4.01 was last reviewed on May 15, 2019 by the COO and CEO. All areas required by the indicator were addressed by this policy.	
RATING	☒	☐	☐	☐	☐	A total of five youth records were reviewed. Four were closed and one was an open youth record. All records reviewed contained youth on medications. Each youth had their medications verified during the intake procedure. The healthcare screening contains all elements of the indicator. Two youth were admitted with a chronic condition(asthma) which was addressed by medical for care. All records reviewed showed evidence that all healthcare criteria on the screening form was assessed at admission.	No exceptions
4.02 Suicide Prevention **There is a written plan that details the program's suicide prevention and response procedures. The plan complies with the procedures outlined in the Florida Network's Policy and Procedure Manual for CINS/FINS.**							
Provider has a written policy and procedure that meets the requirement for Indicator 4.02						☐ **YES** ☒ **NO (explain)** The provider's policy and procedure for Suicide Prevention number RGC 4.02 was last	All areas required by the indicator were addressed by this policy except for supervision of youth on suicide precautions. The program completes five-minute checks

						reviewed on May 15, 2019 by the COO and CEO.	but policy states they will complete fifteen-minute checks.
RATING	☐	☒	☐	☐	☐	It was observed that the internal policy states they will complete fifteen-minute checks, however, the program has a 'close supervision 5-minute checks' form that they complete for five-minute checks of youth. Five youth records were reviewed and all five contained a suicide risk assessment during the initial intake process. Three of the five assessments were reviewed and signed off by the licensed clinical director. Two were completed the same day as admission on October 31, 2019 and October 20, 2019 by the therapist and signed off on December 10, 2019 by the licensed clinical director. There was a note stating the therapist conferred by phone with the licensed clinical director. All youth were placed on the appropriate level of supervision as a result of the suicide risk assessment. Four of the five youth records indicated they required being placed on sight and sound supervision due to the results of their assessment. All were placed on sight and sound as required until seen by the non-licensed therapist. One was assessed as standard and did not need to be placed on elevated supervision. Four of the five youth records indicated all four received a re-assessment within 24-hours of the initial assessment and one applicable youth received an assessment within 24-hours of the previous assessment meeting the indicator requirement. All applicable youth received an assessment by a non-licensed therapist prior to having their supervision level changed. There have been no Baker Acts this review period. Monitoring of youth's behavior while on supervision is monitored every fifteen minutes	**Exceptions:** There were inconsistencies with completion of the 5 minute checks form to document youth are being observed when elevated supervision is required. Youth MM Suicide Screening was completed on 10-31-2019 by the non-licensed therapist. The licensed Clinical Director signed and dated for 12-10-2019 as well as the program director. Verbal confirmation was noted to have taken place on 10-31-2019. Youth JB had her screening completed on 10-25-2019 by a non-licensed therapist and signed off by the licensed clinical director on 12-10-2019. Another example is noted on 10-26-2019,a screening completed by therapist and signed off by the licensed clinical director on 12-10-2019 as well as the screening for 10-27-2019 which was completed by the non-licensed therapist and signed off by the licensed clinical director on 12-10-2019. Youth AP had two blank checks on 11-11-2019 at 4:05 and 4:10 Wrong entry time between 8:45 to 8:55 and no staff initials on 11/10/2019 from 5:25 to 5:55. November 10, 2019 Close Supervision five-minute checks form had sixteen late checks exceeding the five-minute requirement by a minimum of eight minutes to twenty-four minutes. Every late check was marked as a late entry onto the form so it is unclear that constant sight and sound is occurring based on the lack of documentation in real time. Youth JB supervision sheet completed for 10-21-2019 has crossed out staff initials from 7:30 to 8:35. A note says "Youth went to take shower during this time and was also in the living room and then may have been with Mrs. Kelly due to this staff giving medicine to other youth." It was unclear who was providing the constant supervision.

						by policy and documentation was available as required in all five-youth records reviewed. Two out of four youth records documented sight and sound checks at regular intervals.	Youth KS, Close Supervision sheet was not signed by staff or supervisor for November 20, 2019. Additional record reviewed youth JR. Close Supervision 5-minute checks sheet showed on November 13, 2019 between the hours of eight and ten, four checks were not initialed by staff. Between the hours of ten and twelve, all twenty-four checks were marked as a late entry. Checks from twelve to one had nine of the checks marked as a late entry. Between the hours of 1:25 to two had eight checks marked as late entry. Between the hours of two to three there were six late entry checks completed. There was a note written by staff stating youth helped another staff with donations during the time noted staff initials missing, staff indicated they were not sure of the exact time but it is unclear in documentation that the youth was under constant sight and sound. The agency stated the licensed clinical director is contracted and not on site every day. Communication between the therapist and licensed clinical director will be by phone and documented on the screening form. The licensed clinical director will come in and sign all the forms completed. Close supervision form states five-minute checks will be completed, policy states 15 minutes checks or under will be conducted on youth. Camera review of the past 30 days of a youth in the facility who was placed on precautionary supervision and had late entries on the Close Supervision 5-minute checklist indicated staff did not document the five-minute checks in real time.
4.03: Medication							

Provider has a written policy and procedure that meets the requirement for Indicator 4.03						☒ **YES** ☐ **NO (explain)** The provider's policy and procedure for Medications number RGC 4.03 was last reviewed on December 12, 2019 by the COO and CEO. All areas required by the indicator were addressed by this policy.	
RATING	☒	☐	☐	☐	☐	The program has a policy and procedure in place for handling controlled medications and narcotics. All medications were stored in the Pyxis station 4000 Medication Cabinet stored in the medical clinic behind a locked door inaccessible to youth. There are three super users for the Pyxis Med Cabinet. Youth who are currently prescribed injectable medications are not accepted into the program, only youth who are prescribed an epi-pen are admitted into the program. All medications are stored in their own separate drawer within the med-station. Oral medications are stored separate from injectable epi-pens and topical medications. The registered nurse has trained all staff in the use of an epi-pen. The program has a separate refrigerator for medications being stored in the medical clinical behind a locked door, with a lock securing it. Currently, there are no medications requiring refrigeration, however the registered nurse is checking the temperature when on-site and documenting the findings on the weekly inventory sheet. During the week of the review, there were no youth prescribed controlled medications or narcotic medications. The program has policy and procedures in place to conduct shift-to-shift counts of controlled substances and staff has to document the medication counts and the staff witness to all counts. During the time of review there were no youth prescribed a controlled medication. A review for the past 30-days	No exceptions

						indicated no youth have been admitted being prescribed a narcotic or controlled substance.	
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 process number RGC 4.04 was last reviewed on May 15, 2019 by the COO and CEO. All areas required by the indicator were addressed by this policy.	
RATING	☒	☐	☐	☐	☐	All five of the youth reviewed were classified as having a medical or mental health condition requiring them to be placed on alert. Records reviewed indicated all five youth were placed on alert as required by the indicator. The alert contained precautions for prescribed medications, medical conditions or mental health conditions to ensure information concerning a youth's medical condition, allergies, common side effects of prescribed medications and any other important information concerning a mental health or medical condition. Staff are provided sufficient information or instructions to properly care for the youth.	No exceptions
4.05: Episodic/Emergency Care							
Provider has a written policy and procedure that meets the requirement for Indicator 4.05						☒ **YES** ☐ **NO (explain)** The provider's policy and procedure for Episodic and Emergency Care number RGC 4.05 was last reviewed on May 15, 2019 by the COO and CEO. All areas required by the indicator were addressed by this policy.	No exceptions.
RATING	☒	☐	☐	☐	☐	A review of four applicable youth records indicated that all had an offsite emergency medical incident. An internal incident report was generated on all four episodic incidents, as well as a corresponding call made to the Department of Juvenile Justice incident Central Communications Center. Upon return to the facility all four youth had instructions for care	No exceptions

						and discharge instructions which were reviewed by medical and filed in the youth record. All four records indicated the youth's parent or guardian were notified of the incident and of youth being transported to the hospital and upon returning to the program. The program has five first aid kits located in the kitchen, laundry, med room, and the two vans. The program has three knife-for-life and wire cutters located in the staff office, kitchen storage room and laundry room.	