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

FOREFRONT

EXECUTIVE SUMMARY

Forefront LLC conducted a joint Quality Improvement (QI) and Florida Network of Youth and Family Services (YFA FNYFS) monitoring visit for the Youth and Family Alternatives, Inc – RAP House (YFA RAP house) for the FY 2020-2021 on February 3-4, 2021. The Compliance Monitoring was conducted in a Hybrid Format that included the Lead Reviewer and Peer Reviewers conducting the QI program review primarily offsite. A team member did conduct the onsite portion of this program review 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 2020 through June 30, 2021.

The review was conducted by Keith Carr, 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 December 18-19, 2019.

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 91% for achieving full compliance with (10) indicators** of the CINS/FINS Monitoring Tool. There was one (1) recommendation 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

2020-2021 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 02-03-04-2020-2021

Agency Name: Youth and Family Alternatives – RAP House						**Monitor Name: Keith Carr, 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): February 3-4, 2021**	
	Explain Rating						
Major Programmatic Requirements	**Unacceptable**	**Conditionally Unacceptable**	**Fully Met**	**Exceeded**	**Not Applicable**	**Ratings Based Upon:** **I = Interview** **O = Observation** **D = Documentation** **PTV = Submitted Prior To Visit** **(List Who and What)**	**Notes** **Explain Unacceptable or Conditionally Acceptable:** **(Attach Supportive Documentation)**
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 and Aimee Johnson, and Kelley Scott. Peers 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 2012-2021: AFC-HHS, USDA, Eckerd CBC, Heartland CBC, KCI, United Way of Pasco, and CNSWFL.	**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 policy aggregate. Automobile Liability Insurance shall be required and shall provide bodily injury and property	☐	☒	☐	☐	☐	D: Workers Compensation and employers liability insurance certificate was reviewed and indicated that is effective 6/1/2020-6/1/2021 and coverage is provided by Bridgefield Employers Ins Co. with limits of $1,000,000 for each accident, employee, or aggregate. General liability is effective 6/1/2020-	**Recommendation:** All insurance coverage limits are provided for Worker's Compensation, General Liability, Professional Liability and Umbrella policy coverage is listed. Automobile limits are not listed in the consolidated insurance form provided to the reviewer. Provide an updated copy of the amount with the description of the

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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**						6/1/2021 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 and products comp og/agg. Automobile liability is provided by North American Elite Ins. effective 6/1/2020-6/1/2021. 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 6/1/2020-6/1/2021. The Florida Network of Youth and Family Services is listed on the Certificate of Liability Insurance as the certificate holder.	financial limits for the agency's automobile insurance coverage.
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.**

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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 starting from November 2018 and others reference January 2019 through March 2019. There are a vast number of fiscal related policies in place to address 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 July 2, 2020 – December 2020. 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 onsite and the petty cash is secured location accessible by lock. The agency fiscal representative provided reconciliation documentation for last 6 months. The staff person that usually conducts	**No corrective action or recommendation required.**

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Major Programmatic Requirements	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable		
						count was unavailable to reconcile on site	
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 July 2020 – January 2021 with monthly 'reconcile cash accounts' submitted from July – December 2020 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/FNYFS funding since the last compliance monitoring 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 2 quarters with the IRS Form 941 for months covering between September 2020 – Dec 2020. A total of 2 quarters showed a zero balance.	**No corrective action or recommendation required.**

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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 a budget to actual reports titled 'Statement of Revenues and Expenditures' for July 1, 2021 – December 31, 2020 that includes current month budget, actual, variance original, 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 an ongoing 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 on June 30, 2020 by Reeder & Associates, PA Certified Public Accountants firm on November 19, 2020 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	☐	☐	☒	☐	☐	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: Security of	**No corrective action or recommendation required.**

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documents are shredded and computer hard drives are wiped prior to discarding. **ON SITE**						Confidential Personal Information; Records Management; Records Retention Schedule, Central Server Disaster Recovery; and Property Losses. The Security of Confidential Personal Information includes definitions, Requirements for Information Security and Internal Responses, Notice to the Department of a Security Breach, Notice to Individuals, Notice to Credit Reporting Agencies, Notice to Third Party Agents; Duties of Third Party Agents; Notice by Agents and Requirement of The agency reports that the data is backed up daily and stored on an active directory server and terminal server using an onsite backup server. 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 91%.** There is one (1) recommendation 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.

SUMMARY OF RECOMMENDATIONS

Recommendation (1)
Automobile limits are not listed in the consolidated insurance form provided to the reviewer. Provide an updated copy of the amount with the description of the financial limits for the agency's automobile insurance coverage.

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 – RAP House
CINS/FINS Program

February 3-4, 2021

Compliance Monitoring Services Provided by

FOREFRONT

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	Limited
1.05 Analyzing and Reporting Information	Limited
1.06 Client Transportation	Satisfactory
1.07 Outreach Services	Satisfactory

Percent of indicators rated Satisfactory: 71.43%
Percent of indicators rated Limited: 28.57%
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, Gender Expression	Satisfactory
2.09 Special Populations	Satisfactory
2.10 Stop Now and Plan (SNAP)	Not Applicable

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

Standard 3: Shelter Care & Special Populations

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

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	Satisfactory
4.03 Medications	Satisfactory
4.04 Medical/Mental Health Alert Process	Satisfactory
4.05 Episodic/Emergency Care	Satisfactory

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

Overall Rating Summary

Percent of indicators rated Satisfactory: 89.29%
Percent of indicators rated Limited: 10.71%
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

Keith Carr, Lead Reviewer, Forefront LLC/Florida Network of Youth and Family Services

Marvin Bliss, Regional Monitor, Florida Department of Juvenile Justice

Saxon Bower B.S., Case Manager, Family Resources

Mark Shearon B.S., Chief Compliance Officer, Arnette House

Charles Harris Jr. M.S., Director of Residential Programs, Safe Children Coalition

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, and (3) Shelter Care/Health Services, which are included in the Children/Families in Need of Services (CINS/FINS) Standards (July 2020/Jan 2021).

Persons Interviewed

- ☐ Chief Executive Officer
- ☐ Chief Financial Officer
- ☐ Chief Operating Officer
- ☐ Executive Director
- ☒ Program Director
- ☒ Program Manager
- ☐ Program Coordinator
- ☐ Clinical Director
- ☐ Counselor Licensed
- ☒ Case Manager
- ☒ Counselor Non-Licensed
- ☐ Advocate
- ☒ Direct – Care Full time
- ☐ Direct – Part time
- ☐ Direct – Care On-Call
- ☐ Intern
- ☐ Volunteer
- ☒ Human Resources
- ☒ Nurse – Full time
- ☐ Nurse – Part time

2# Case Managers
2 # Program Supervisors
0 # Food Service Personnel
1 # Healthcare Staff
0 # Maintenance Personnel
0 # Other (listed by title): _____

Documents Reviewed

- ☒ Accreditation Reports
- ☒ Affidavit of Good Moral Character
- ☒ CCC Reports
- ☒ Logbooks
- ☒ Continuity of Operation Plan
- ☒ Contract Monitoring Reports
- ☒ Contract Scope of Services
- ☒ Egress Plans
- ☒ Fire Inspection Report
- ☒ Exposure Control Plan
- ☒ Table of Organization
- ☒ Fire Prevention Plan
- ☒ Grievance Process/Records
- ☐ Key Control Log
- ☒ Fire Drill Log
- ☒ Medical and Mental Health Alerts
- ☒ Precautionary Observation Logs
- ☒ Program Schedules
- ☒ List of Supplemental Contracts
- ☒ Vehicle Inspection Reports
- ☒ Visitation Logs
- ☒ Youth Handbook

6 # Health Records
4 # MH/SA Records
8 # Personnel /Volunteer Records
8 # Training Records
6 # Youth Records (Closed)
4 # Youth Records (Open)
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

Due to COVID-19, this review was conducted **virtually/on-site/hybrid (virtually and on-site)**.

Monitoring Purpose:

The purpose of this monitoring is to provide an annual quality improvement program review. This is to verify that the agency adheres to all current CINS/FINS standards and contract compliance requirements for residential and non-residential services.

Strengths and Innovative Approaches

The Youth and Family Alternatives RAP House program provided a program update on major operations, staffing, funding and other changes since the last Quality Improvement review. The agency reported that it has added or have new personnel in several positions. The agency provided a staffing update that include a new employee in the supervisory position of Team Lead. Former YDS Barbara Killings was promoted to the Team Leader position in October 2020. The agency also recruited and was able to hire a new Registered Nurse. Stephanie Minchew, was brought to fill the vacant Registered Nurse in January 2021. The agency reported that RAP House was awarded funds to build a new screened-in patio off of the living room. This patio affords the program with the new opportunity give youth in the program some much needed extra space for various types of extra-curricular activities and it functions as a location where youth can go and cool off and calm down when needed while still being supervised by RAP House staff. Further, the funds also provided the opportunity for RAP House to purchase a generator in case of an unforeseen power outage. Additionally, the agency was also able to purchase an air purifier and Personal Protection Equipment to help protect youth and staff from COVID-19. The agency also reported that due to COVID, outreach, community outings and in-person meetings have put on hold.

Narrative Summary

The Youth and Family Alternatives, lnc. (YFA) agency is a Residential and Non-Residential private non-profit service provider located in central southwestern region of Florida. Established in 1970, YFA (Youth and Family Alternatives, Inc.) is an agency that operates over 250 staff that work to provide a broad array of human services to youth and families with the goal of enhancing a nurturing and safe environment for children. Specifically, the agency organization structure is comprised of a Program Manager, a Shelter Supervisor, Office Specialists, Youth Development Specialist (YDS) Shift Leaders, Residential Counselors, a Registered Nurse, and Youth Development Specialists, both full-time and part-time. The agency conducts its operations and delivery of both residential and non-residential services throughout the Pasco and Sumter Counties. The agency utilizes an internal quality improvement team of staff members at all levels and positions that primarily conducts reviews of client files and the delivery of major residential and non-residential program services. The overall goal for the CQI process is to monitor the quality, accuracy and completeness of the services provided. This internal QI team includes various YFA leadership, general management, residential and non-residential staff members. Additionally, this YFA location primarily provides services in Pasco County and is currently accredited by the Council on Accreditation (COA).

The overall findings for the QI Review for YFA RAP House are summarized as follows:

Standard 1 – Management Accountability has a total of seven (7) indicators regarding Management Accountability. Two (2) of the 7 indicators in Standard 1 were rated satisfactory with no exceptions (1.01 and 1.07), five (5) were rated satisfactory with exceptions (1.02, 1.03, and 1.06). Two indicators; Indicator 1.04 – Training and Indicator 1.05 – Analyzing and Reporting Information received a Limited rating.

Standard 2 – Intervention and Case Management has a total of ten (10) indicators that relate to intervention and case management. Several of the indicators were not applicable. The Stop Now And Plan (SNAP) is not applicable as YFA - RAP is not a SNAP provider. Nine (9) of the 9 applicable indicators were rated satisfactory with no exceptions (2.01, 2.02, 2.03, 2.04, 2.05, 2.06, 2.07, 2.08 and 2.09). One indicator, 2.10 - Stop Now And Plan (SNAP), was rated not applicable.

Standard 3 – Shelter Care & Special Populations has a total of seven indicators regarding shelter care. Six of the seven indicators were rated satisfactory with no exceptions (3.01, 3.02, 3.03, 3.04, 3.05, and 3.06). One indicator, 3.07 Video Surveillance System was rated Limited.

Standard 4 – Mental Health and Health Services, is comprised of five indicators. Three of the five indicators were rated satisfactory with no exceptions (4.01, 4.04 and 4.05), and two (4.02 and 4.03) were rated satisfactory with an exception.

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

Standard 1:

Indicator 1.04- Limited

Two (2) out of 4 new hire files reviewed indicated that staff did not receive all of the required trainings within their respective timeframes. One (1) staff was late with completing MAB, two (2) staff did not receive CPR or First Aid training within 90 days as required.

Three (3) out of 4 files reviewed indicated that not all FN trainings were completed within the 1st year of employment. Trainings that were not completed include: medication distribution and serving LGBTQ were completed outside of the required timeframes.

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. For example, some forms only referenced the first name of staff members. Training records lack clear organization and uniformity for the requested sample of staff member training files that were reviewed. The current training file format for staff members does not allow a consistent and orderly review each staff member's training hours as required by the FL Network indicator. Overall, the agency's Training records do not include an individual training file for each staff, nor does it

include an annual employee training hours tracking form and related documentation, such as certificates, sign-in sheets, and/or agendas for each training attended.

Indicator 1.05- Limited

A clear analysis and quarterly reviews were not completed for non-residential programs on a quarterly basis or the last 6 months for the period under review. Attachments only show information for residential and a minimum of 2 would reflect quarterly reviews for the 6 month period under review. Agency needs to institute consistent practice for quarterly reviews for both residential and non-residential client file reviews. This is a repeat finding for the non-residential client file review.

Standard 3:

Indicator 3.07- Limited

The original requested period of actual overnight camera footage was not available. The agency could not provide the reviewer with specific video camera footage to verify the agency's adherence to bed check compliance requirement for some dates requested to ensure that direct care staff were completing the bed counts as documented. The agency has submitted a work order for the system to be repaired on 2/1/21, 2 days before the QI program review, after the requested dates for video could not be provided. There were a total of 3 supervisory reviews and limited examples of supervisors and managers conducting reviews on a bi-weekly basis. The reviewer did not have documented evidence of consistent and ongoing examples of Supervisor conducting reviews every 14 days. At the time of this QI program review, the agency did not have the ability to provide back-up recordings of camera footage in the last 30 days.

Quality Improvement Review

Youth and Family Alternatives – RAP House February 3-4, 2021
Lead Reviewer: Keith Carr

CINS/FINS QUALITY IMPROVEMENT TOOL

Quality Improvement Indicators:	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable	Review Based Upon Document Source *For example: Interview/Surveys, Observation, and/or Type of Documentation*	Notes: Explain any items that have any deficiencies, exceptions or are not applicable.
Standard One – Management Accountability							
1.01: Background Screening and compliance with DJJ OIG statewide procedures regarding BS of employees, contractors and volunteers							
Provider has a written policy and procedure that meets the requirement for Indicator 1.01						☒ YES ☐ NO (explain) There is no policy number for this item. Policy and procedure 1.01 was approved on 5/15/2019 by Mark Wickham.	
Agency utilizes an employee suitability prescreening assessment with a passing rate criterion prior to an offer of hire for direct care staff working with youth or the agency has provided an explanation to for staff hired with a non-passing/low score.	☒	☐	☐	☐	☐	There is a practice in place for this item. The facility uses CBST (Criteria Basic Skills Test) and having interviewed both Cayse Houston (Program Manager) and Sherry Hagerdorn (HR Generalist) and additionally viewing a memo from Melissa Adkins (VP of Operations) dated 12/19/19 stipulates that a cutoff score of less than 30 correct answers requires review. Seven (7) files were reviewed 6 employees and all 6 showed this screening step prior to hire date.	
Background screening completed prior to hire/start date or exemption obtained prior to working with youth (if rated ineligible) for new hires, volunteers/interns, and contractors	☒	☐	☐	☐	☐	Six (6) files reviewed for this indicator. Of those files, all 6 had pre-screened criminal background histories that were deemed eligible prior to their individual date of hire.	
Five-year re-screening completed every 5 years from initial date of hire	☐	☐	☒	☐	☐	There were no items available for review, as there were no employees rostered from the year 2015.	
Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?	☒	☐	☐	☐	☐	The Facility did provide a notarized 1/11/2021 document dated titled Annual Affidavit of Compliance with Level 2 Screening Standards.	

Proof of E-Verify for all new employees obtained from the Department of Homeland Security	☒	☐	☐	☐	☐	A total of seven (7) of the eight (8) files were eligible to be reviewed to determine the agency's adherence to this indicator. All 7 of the eligible staff member files contained proof of E-Verify compliance and confirmation of completion for all new employees obtained from the Department of Homeland Security.	
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) Policy and procedure 1.02 was approved on 5/15/2019 by Mark Wickham.	The policy and procedures do not include the most recent updates from the revised FN QI Standards Jan 2021 since last revision.
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Abuse Free Environment							
Agency has a code of conduct of policy and there is evidence that staff are aware of agency's code of conduct.	☒	☐	☐	☐	☐	The agency has a code of conduct of policy and there is evidence that staff are aware of agency's code of conduct.	
Child Abuse Registry telephone number is visible to youth and posted common areas of the facility	☒	☐	☐	☐	☐	Program Manager took this writer on video tour of the facility. It was noted that the Florida Abuse phone numbers et. al are posted in multiple places in the facility including the kitchen.	
Youth were informed of the Abuse and Contact Number (see youth survey results)	☒	☐	☐	☐	☐	The youth have a handbook that is given to them which stipulate this item.	
Management takes immediate action to address any incidents of threats or abuse	☐	☐	☒	☐	☐	At the time of this QI program review, the agency did not have any sample of incidents of threats, harm or abuse. There were no grievances or survey results reported that indicated issues related to threats, harm and intimidation. An interview with the Program Manager was conducted. The Program Manager reported that all applicable incidents are handled immediately through an internal review process that can result in a written performance review, reprimand and re-training or dismissal if required. The agency addresses all incidents within 24 hours or less.	
Grievance Process							
Agency has a formal grievance process	☒	☐	☐	☐	☐	The agency has a formal grievance policy in place. The Program Manager informed writer in an interview that there is a grievance form in both English and Spanish. The agency has 3 keys. Keys are assigned to the Program Manager, the site supervisor and the team lead.	

						The grievance box is checked by a supervisor/manager 7 days a week.	
Locked box accessible to only management and available to youth in a common area	☒	☐	☐	☐	☐	The agency has three (3) locked grievance box locations within the shelter. The boxes are located dayroom area and one on each dormitory wing.	
Direct care does not handle the complaint/grievance unless assistance is asked for by the youth. Program director/supervisor will have access to and manage grievances unless it is towards themselves.	☒	☐	☐	☐	☐	Agency procedures require that supervisors and managers be the only staff members that have access to the grievance boxes. The agency only has 3 keys that exist for accessing box.	
72-hour resolution requirement by management. If this does NOT occur within the 72 hour period, there is sufficient documentation explaining the cause for the delay in resolution.	☐	☒	☐	☐	☐	The agency reports that no more than 72 hours passes before all grievances are resolved, however, in an interview with the Program Manager reported all Grievances are handled within 24 hours, 7 days a week. In addition, the facility provided eight (8) items for the grievance category from 1/2020 through 4/2020. This meets the requirement for maintaining them for one year. The agency provided a written letter on 1/27/2021 confirming that no have had no grievances filed since 4/2020. Upon clarification of the lack of grievances after this time period, the Program Manager stated the program conducts house meetings as often as daily to address any issues that would cause a grievance escalation. Once residents are asked to express themselves for this issue, it resolves the issues. The agency has some grievances are submitted on college rule paper instead of the actual YFA Grievance Form. Some grievance reports submitted by residents lacked date due to them being hand written on college rule paper. The agency policy states that all grievances will be addressed in 3 days or less. There is no explanation for cause explaining when resolution did not occur within the 72 hour requirement for 1 grievance.	**Exception:** The agency policy states that all grievances will be addressed in 3 days. There is no explanation for cause explaining resolution did not occur within 72 hour requirement. Three grievances are submitted on college rule paper instead of the actual YFA Grievance Form and the youth do not date when they are submitting these grievances, therefore, the date of resolution cannot be confirmed. One grievance submitted did not have a date nor does not it have evidence of any resolution by the agency at all.
1.03: Incident Reporting							
Provider has a written policy and procedure that meets the requirement for Indicator 1.03						☒ YES ☐ NO (explain) Policy and procedure 1.03 was approved on 5/15/2019 by Mark Wickham.	

Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
During the past 6 months, the program notified the Department's CCC (Central Communication Center) no later than two hours after any reportable incident occurred or within two hours of the program learning of the incident	☐	☒	☐	☐	☐	A request of all incidents reported by the agency to DJJ was requested. A DJJ Quality Improvement (QI) Peer Review Team Member secured and provided a 6 month DJJ-CCC report that included a total number of incidents reported and accepted by the DJJ Central Communications Center (CCC). The CCC reported the total number of incidents indicated that thirty-six (36) incidents recorded in the system in the last 6 months.	**Exceptions:** One (1) incident was found and documented as not being reported as required. One (1) incident that occurred on 11/12/2020 was not called in to the DJJ- CCC until on 11/13/2021. On 01/4/21 at 3:20 p.m., Residential Team Lead reported to the CCC an incident related to the discovery/recovery of contraband being found. On 1/3/21 at 8:30 a.m., there was contraband discovered by resident and given to staff originally but not reported within the 2 hour timeframe. This incident was documented as a Failure To Report (FTR) or not reported as required by the DJJ-CCC.
The program completes follow-up communication tasks/special instructions as required by the CCC	☒	☐	☐	☐	☐	The agency has detailed evidence of incident update and related follow up activity and all associated verbal, written and documentation required to address incident requiring official follow up by the DJJ CCC. Of the 36 total number of incidents reported and accepted by the DJJ CCC, twenty (20) of these incidents required action by the agency that was documented in the DJJ CCC incident update section.	
Incidents are documented in the program logs and on incident reporting forms	☒	☐	☐	☐	☐	The agency maintains all incidents in an internal incident documentation binder system. All reportable and DJJ CCC incidents are recorded and filed by date of occurrence. A review of the agency program logbook	

						found evidence of reportable incidents to the CCC documented with CCC number, date and brief description of incident.	
All incident reports are reviewed and signed by program supervisors/directors	☒	☐	☐	☐	☐	All incidents are reviewed by the agency residential lead and the program manager to ensure that the have been reported as required. The agency requires that the supervisors review all incidents for timeliness, accuracy and completeness.	
1.04: Training Requirements (Staff receives training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions)							
Provider has a written policy and procedure that meets the requirement for Indicator 1.04						☐ YES ☒ NO (explain) Policy and procedure 1.04 was approved on 5/15/2019 by Mark Wickham.	The policy and procedures do not include the most recent updates from the revised FN QI Standards since last revised in 2019.
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
First Year Direct Care Staff							
All staff completed the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days from date of hire. *(Staff hired before January 1st were required to complete no later than December 31, 2020)*	☒	☐	☐	☐	☐	A total of eight (8) training files were reviewed. Four (4) of the 8 files were first year direct care employee training files. Four (4) client files were in-services direct care employees training files. All 4 employee training files contained evidence of completing DOJ Civil Rights & Federal Funds training.	
All staff receives all mandatory training during the first 90 days of employment from date of hire.	☐	☒	☐	☐	☐	Four (4) of the 8 files were first year direct care files. Four employee files for first year staff contained evidence of completing required SkillPro Trainings within the first 90 days. For 2 out of 4 staff training files, all of the required SkillPro trainings were in order and did not exceed the 90-day limit.	**Exception:** 2 out of 4 new hire files reviewed indicated that staff did not received all of the required trainings within their respective timeframes. 1 staff was late with completing MAB, 2 staff did not receive CPR or First Aid training within 90 days as required.

All staff completes all mandatory Florida Network and SkillPro training during the first-year employment.	☐	☒	☐	☐	☐	1 out of the 4 first year staff member training files had evidence of all Florida Network trainings. All 4 files included the SkillPro printout delineating each of the required trainings were completed within the 1st year of employment. A SkillPro log that lists each training course, credit hours, mode, score and date of training.	**Exception:** 3 out of 4 files reviewed indicated that not all FN trainings were completed within the 1st year of employment. Trainings that were not completed include: medication distribution and serving LGBTQ were completed outside of the required timeframes.
Non-licensed Mental Health Clinical Shelter Staff (within first year of employment)							
Non-licensed mental health clinical shelter staff Assessment of Suicide Risk Training	☐	☐	☒	☐	☐	The agency did not have an applicable non-licensed mental health staff person. The agency has the training capacity to provide Suicide Prevention training for non-licensed staff members.	
Documentation of non-licensed mental health clinical staff person's training in Assessment of Suicide Risk form or written confirmation by a licensed mental health professional of training (includes date, signature and license number of the licensed mental health professional supervisor).	☐	☐	☒	☐	☐	The agency did not have an applicable non-licensed mental health staff person.	
In-Service Direct Care Staff							
Direct care staff completes 24 hours of mandatory refresher Florida Network, SkillPro, and job-related training annually *(40 hours if the program has a DCF child caring license).*	☐	☒	☐	☐	☐	There is a policy (1.04) which stipulates training for this facility. The training documents submitted indicate training topics that staff members have completed. The agency training forms are missing documentation of training hours. Current training documentation provided is not able to determine the total hours obtained as required. The facility did not have a log for the 5 applicable training files pulled for the annual employee training files. Thus, it is difficult to understand what trainings are current and what is still outstanding. For example, one employee file listed multiple completed trainings records in the file. This is repetitive and duplicative making an accurate count difficult to calculate. Of the 105 documents presented in	**Exception:** Some training certificates had no dates with which to judge where those hours should be applied, only first names, and in one file multiple certificates of the same training/same date were submitted and the dates for completion of the training were not

						this file, 23 trainings were reviewed and did not have dates. In general, the agency provided training records and no singular training log that lists and organizes all CINS/FINS required trainings. The current format in which employee trainings are listed does not incorporate individual training files for each staff, which includes an annual tracking of CINS/FINS related trainings that employee completed. There is a SkillPro training log. There is a RELIAS training log. There is an Orientation Training log that lists the training and initials of the employee and trainer. There are YFA Training Verification Forms and certificates of completion for individual training topics completed by each employee. Further, there is a YFA Shelter Site Orientation log this is used to track the initial topics covered during the on-boarding of new employee. This YFA Shelter Site Orientation log only list topics and groups topics by tiers a gives a sum total of hours according to the tier. However, there is no CINS/FINS training log to organize general CINS/FINS trainings which are the bulk of trainings topics and hours completed by all employees. This is finding from previous QI program reviews and still remains not addressed by the agency.	clearly indicated or listed for the training completed.
Required Training Documentation							
The program maintains an individual training file for each staff, which includes an annual employee training hours tracking form and related documentation, such as certificates, sign-in sheets, and agendas for each training attended.	☐	☒	☐	☐	☐	Of the 8 files reviewed each contained some reference to training records from the prior year and earlier from DJJ SkillPro and other trainings attended. For the completed trainings, certificates or related documentation was provided. In regard to an annual employee training tracking form, CINS/FINS trainings are not in organized in an individualized training log. Training completion certificates exist, but are disorganized and are difficult to verify completed training for all other remaining topics. Overall, the agency's Training records do not include an individual training file for each staff, nor does it include an annual employee training hours tracking form and related documentation, such as certificates, sign-in sheets, and/or agendas for each training attended. There was no training log to assist with the tallying of total hours completed per individual training topic.	**Exception:** There was no evidence of a standardized training log that includes the total number of training hours as required per FNYFS requirements. Additionally, some of the training certificates were notably absent last names, total training hours per training, and dates of training rendering the ability to accurately assess information useless.

						The agency reports that they are moving toward a new training log system, however, the older training files have not yet been converted.	
Provider has a written policy and procedure that meets the requirement for Indicator 1.05						☒ YES ☐ NO (explain) Policy and procedure 1.05 was approved on 5/15/2019 by Mark Wickham. The CQI plan was also provided for this indicator.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Case record review reports demonstrate reviews are conducted quarterly, at a minimum	☐	☒	☐	☐	☐	At the time of the document request, the agency provided evidence of CQI quarterly file reviews conducted in September 2020 for Residential and June 2020 (from the previous FY 19-20) for Non-Residential. Additional Compliance Reports for residential client files were provided that focus on reviewing a sample of files for general items; such as screenings, intakes and services options, client rights and consents done the months of January 2021 and June 2020 within the FY 20-21 which demonstrate compliance with the quarterly review of files. The agency submitted examples of completing file reviews for residential file reviews and limited information on non-residential client file reviews.	**Exception:** The agency has limited evidence of conducting quality improvement reviews on a quarterly basis for the non-residential client records. There is some evidence of non-residential client file reviews that are dated further back than the last 6 months which were completed by the CQI Team; however, nothing was provided to be reviewed for the current FY 20-21. A clear analysis and quarterly reviews were not completed for non-residential programs on a quarterly basis or the last 6 months for the period under review. This is a repeat finding.
The program conducts reviews of incidents, accidents, and grievances quarterly, at a minimum	☒	☐	☐	☐	☐	The Reviewer observed documentation from the Risk Management meetings minutes. The meetings included the number of accidents and incidents. A quarterly review of grievances indicated that only one grievance had been	

						submitted within the review time frame. Risk Management Meetings occurred in July and again in October. The Vice President (VP) of QI/Risk Prevention states that they are in the process of scheduling another meeting for the current period. The agency provided an incident tracking report with visual pie, line and bar char graphs that is used to provide the latest information on the status, type and volume of reported incidents.	
The program conducts an annual review of customer satisfaction data	☒	☐	☐	☐	☐	The agency meets this requirement as the reviewer observed the satisfaction surveys from the residential and non-residential programs. It was noted that the programs experienced some issues getting non-residential surveys back and the agency was addressing the issue with postage.	
The program conducts an annual review of outcome data and (if applicable) there is evidence of annual reconciliation that occurs through communication from the Florida Network via email or phone call when corrections are needed and the information is corrected and submitted within the requested timeframes.	☒	☐	☐	☐	☐	Documentation indicates that Compliance Committee meetings are led by the VP of QI/Risk Prevention. The objective of the committee is to review the internal findings. The Compliance Committee reviews all major incidents and corrective actions received from their funders. The agency provided evidence of meetings. The agency also provided evidence of meetings with findings that required corrective actions on 11/17/2020. Annual data was also reviewed in full in the document titled 2019-2020 CQI Annual report.	
The program conducts a monthly review of NetMIS data reports.	☒	☐	☐	☐	☐	The reviewer interviewed the Program Manager to obtain an understanding of their current process. The VP of Technology generates the reports and the management team reviews to ensure the accuracy. The agency provided evidence that their reports are produced for review on a monthly basis.	
The Florida Network conducts monthly reconciliation by comparing NetMIS data to JJIS data. Agency has evidence that they have reconciled any differences noted.	☒	☐	☐	☐	☐	In an interview with the Program Manager, she reported that there is a practice in place to do monthly reconciliation between the two database platforms. The emails generated from the Network that highlight discrepancies between the two platforms goes directly to the VP of Technology. Emails were provided to support the interview. The reviewer observed NETMIS updates, long LOS and Certification emails that were provided by the Program Manager from August 2020-Jan 2021.	
The program has a process in place to review and improve accuracy of data entry & collection	☒	☐	☐	☐	☐	An interview with the Program Manager indicates how the agency executes the data entry process. After the data is entered, the Residential Supervisor reviews the data for accuracy and completeness prior to it going to the contracts department.	

There is documentation that findings are regularly reviewed by management and communicated to staff and stakeholders.	☒	☐	☐	☐	☐	The agency provided the reviewer with staff meeting minutes. Specifically, the agency provided documentation in the form of Quarterly Stakeholder Team meetings minutes from August 2020-January 2021. In addition, there was supporting documentation that management has effective communication to the staff of any data/trends that have been identified.	
There is evidence that strengths and weaknesses are identified, improvements are implemented or modified, and staff are informed and involved throughout the process.	☒	☐	☐	☐	☐	The agency has evidence of collecting samples of client records for review to determine if the files meet all required service delivery requirements. The agency provided a RAP CQI chart that monitors and displays the results of chart review scores. The agency explained that scores below 85% require corrective actions. Documentation of these corrective actions are located in the RAP CQI worksheet signed document. The YFA CQI fiscal year 2019/2020 was also reviewed. This report noted program trends, strengths, and opportunities. Documentation was produced that displayed an increase in medications errors and in response to the increase in medication errors documentation was provided that showed a medication focus group was created, as well as a medication corrective action plan that aims to reduce medication errors.	
Provider has a written policy and procedure that meets the requirement for Indicator 1.06						☒ YES ☐ NO (explain) Policy and procedure 1.06 was approved on 5/15/2019 by CEO Mark Wickham.	
Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	☒	☐	☐	☐	☐	Documentation of YFA RAP House Staff Approved Drivers was provided to the reviewer. There is a total of 24 approved staff including the Program Manager.	
Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	☒	☐	☐	☐	☐	Policy documentation was provided to meet the requirement. The agency also provided limits of insurance coverage limits along with 4 other files pertaining to the insurance held by the agency on the approved drivers.	
Agency's Transportation policy prohibit transporting a client without maintaining at least one other passenger in the vehicle during the trip and include exceptions in the event that a 3rd	☒	☐	☐	☐	☐	The agency's policy states that a single transport can occur if the 3rd party is not available. All vehicles have a dash camera that is assigned by VIN number. The Policy states that in the event of a single transport that staff must obtain permission from the supervisor or designee and that they factor in the client's history, evaluation, and	

party is NOT present in the vehicle while transporting						recent behaviors. The youth is to sit in the back row and the staff is to notify the home when they have reached the destination safely with the company phone that is provided.	
In the event that a 3rd party cannot be obtained for transport, the agency's supervisor or managerial personnel consider the clients' history, evaluation, and recent behavior	☐	☒	☐	☐	☐	Reviewer reviewed the three van logs date ranges from August-January. A logbook entry made on 10/8/2020 by a supervisor was found that granted permission to a request for the single transport event. The logbook entry was found to be a late entry. This entry was written in the logbook at 10:10am on the last line of page 229. A review of the logbook found that in most instances logbook entries were not written on the last line of each page.	**Exception:** There was one exception for the single transport. The single transport event occurred without prior approval from a supervisor. The transport was documented in the agency logbook after the transport occurred.
The 3rd party an approved volunteer, intern, agency staff, or other youth	☒	☐	☐	☐	☐	The agency does make efforts to avoid single transport and documented on 9/11/2020 with staff riding along on transport as the third party. Reviewer interviewed Program Manager who confirmed that they only had one single transport since August due to their efforts to prevent them.	
There is documentation of use of vehicle that notes name or initials of driver, date and time, mileage, number of passengers, purpose of travel and location.	☒	☐	☐	☐	☐	The Reviewer assessed 3 van logs that included date ranges from August 2020 to January 2021. All the van logs reviewed contained the required documentation verifying that the agency use of vehicles requires documenting name or initials of driver, date and time, mileage, number of passengers, purpose of travel and location.	
Provider has a written policy and procedure that meets the requirement for Indicator 1.07						☒ YES ☐ NO (explain) Policy number CS580 meets the requirement for indicator 1.07. It was reviewed and approved on 3/14/2019 by President/CEO Mark Wickham	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
The program has a lead staff member designated to participate in local DJJ board and council meetings with evidence that includes minutes of the event or	☒	☐	☐	☐	☐	A provider meeting has not been conducted due to the COVID pandemic for this current quarter, the agency's Community Counseling Supervisor states that she has been in contact with the circuit's Chief Probation Officer to coordinate a virtual meeting soon.	

other verification of staff participation						There was documentation minutes for 1 meeting that were provided to support a joint Pinellas/Pasco alliance virtual meeting on November 17, 2020.	
Outreach and prevention services are provided by designated staff and include increasing community awareness, offering informational and educational CINS/FINS services to youth and families.	☒	☐	☐	☐	☐	Documentation was provided in the form of entered outreach entries from the NETMIS platform. Dates ranged 8/4/2020-1/26/2021.	
The program maintains written agreements with other community partners which include services provided and a comprehensive referral process.	☒	☐	☐	☐	☐	A Memorandum of Understanding agreements were provided for several community partners. BayCare Behavioral, Fifth Third Bank and Junior Service League are examples of active MOUs. The Reviewer was provided with a total of (10) signed MOUs.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.01						☐ YES ☒ NO (explain) The agency has both policy and procedure in place which meets the requirements. RGC 2.01 Reviewed Date 3/1/2019, Revision Date 3/26/2019, Signed Date 5/15/2019. Signed and approved on by Mark Wickham.	The policy and procedures do not include the most recent updates from the revised FN QI Standards since last revised.
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Shelter youth: Eligibility screening is completed immediately for all shelter placement inquiries. If staff on duty cannot complete the screening, an on-call supervisor is contacted and eligibility is determined within 30 minutes from initial inquiry.	☒	☐	☐	☐	☐	Four (4) of the eight (8) youth records reviewed were applicable for youth receiving shelter services. All four youth had a screening completed the day of their intake into the shelter.	
Community counseling: Eligibility screening is completed within 3 business days of referral by a trained staff using the NetMIS form	☒	☐	☐	☐	☐	Four of 8 youth records were applicable for youth receiving community counseling services. All four youth records had an initial screening completed within three business days of their referral. All four screenings were completed the day the referral was received.	
Youth and parents/guardians receive the following in writing: a. Available service options b. Rights and responsibilities of youth and parents/guardians	☒	☐	☐	☐	☐	All 8 youth records contained documentation to indicate the youth's parent and guardians received the following during youth's admission process that included available service options, rights and responsibilities of youth and parent/guardians and parent/guardian brochure.	

The following is also available to the youth and parents/guardians: a. Possible actions occurring through involvement with CINS/FINS services (case staffing committee, CINS petition, CINS adjudication) b. Grievance procedures	☒	☐	☐	☐	☐	All 8 youth records contained documentation to indicate the youth's parent and guardians received the following at the day of the youth's admission have evidence of Possible actions occurring through involvement with CINS/FINS services (Case Staffing committee, CINS/FINS petition, CINS/FINS adjudication and confirmation of receiving information on the grievance procedure.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.02						☒ YES ☐ NO (explain) The agency has both policy and procedure in place which meets the requirements. RGC 2.02 Reviewed Date 3/1/2019, Revision Date 3/26/2019, Signed Date 5/15/2019. Signed and approved on by Mark Wickham.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Completion of Needs Assessment							
Shelter Youth: Needs Assessment initiated within 72 hours of admission	☒	☐	☐	☐	☐	Four of the 8 youth records reviewed were applicable for youth receiving shelter services. All four youth had a screening completed the day of their intake into the shelter.	
Non-Residential youth: Needs Assessment is done within 2 to 3 face-to-face contacts after the initial intake **OR** updated, if most recent assessment is over 6 months old	☒	☐	☐	☐	☐	Four of 8 youth records were applicable for youth receiving community counseling services. All four (4) youth records had an initial screening completed within three (3) business days of their referral. All four screenings were completed the same day the referral was received by the agency.	
Needs Assessment is conducted by a bachelor's or master's level staff member	☒	☐	☐	☐	☐	All 8 youth records reviewed had a needs assessment completed by a bachelor's or master's level staff member.	
Needs Assessment includes a supervisor's review signature upon completion	☒	☐	☐	☐	☐	There were 4 residential youth applicable for having a needs assessment including a supervisor review and signature for all four youth records. There were 4 non-residential youth applicable for having a needs assessment including a supervisor review and signature and all met the requirement.	
Suicide Risk as a Result of the Needs Assessment							

Youth was identified with an elevated risk of suicide as a result of the Needs Assessment	☒	☐	☐	☐	☐	Four (4) youth client file records were reviewed. Of the 4 client files, three (3) were found to be identified with an elevated risk of suicide as a result of the agency completing a needs assessment on these youth.	
If yes, the youth was referred for an Assessment of Suicide Risk conducted by or under the direct supervision of a licensed mental health professional	☒	☐	☐	☐	☐	All 3 youth were referred for an Assessment of Suicide Risk conducted by a licensed mental health professional.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.03						☒ YES ☐ NO (explain) The agency has both policy and procedure in place which meets the requirements. RGC 2.03 Reviewed Date 3/1/2019, Revision Date 3/26/2019, Signed Date 5/15/2019. Signed and approved on by Mark Wickham.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Case/Service plan is developed within 7 working days of Needs Assessment	☒	☐	☐	☐	☐	There were 7 of the 8 applicable youth files for the completion of a case/Service plan. One youth was released from the residential program prior to the seven day requirement of having a completed Case/Service plan. A total of 7 youth records were reviewed. Of these, three were residential with one being open and two being closed. Four non-residential youth records with two being open and two being closed were reviewed. All youth records had a Case/Service plan completed within the seven day requirement.	
Case plan service Plan includes: 1. Individualized and prioritized need(s) and goal(s) identified by the Needs Assessment 2. Service type, frequency, location 3. Person(s) responsible 4. Target date(s) for completion and Actual completion date(s) 5. Signature of youth, parent/ guardian, counselor, and supervisor 6. Date the plan was initiated	☒	☐	☐	☐	☐	All 7 completed youth Case/Service plans had evidence of being individualized and included prioritized needs and goals identified by the need's assessment. All 7 completed Case/Service Plans were found to have service type, frequency and location identified. All 7 completed Case/Service Plans were found to have identified the person responsible. All seven completed Case/Service Plans had evidence of target dates for completion. All 7 Case/Service Plans had documentation actual completion dates, as well as evidence of the youth's signature, parent's/guardian's and supervisor's signature. All 7 completed Case/Service Plans were found to contain the signature of the counselor, All seven completed	

						Case/Service Plans were found to contain that the date the plan was initiated.	
Case/service plans are reviewed for progress/revised by counselor and parent (if available) every 30 days for the first three months and every 6 months after	☒	☐	☐	☐	☐	Six of the 7 completed Case/Service Plans contained a review for progress/revised by the counselor and parent (if available) every 30 days for the first 3 months and every 6 months after. One youth was under the 30 day requirement.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.04						☐ YES ☒ NO (explain) The agency has both policy and procedure RGC 2.04 in place which meets the requirements. Signed and approved on by Mark Wickham, revision Date 3/26/2019, signed Date 5/15/2019.	The policy and procedures do not include the most recent updates from the revised FN QI Standards since last revised.
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Counselor/Case Manager is assigned	☒	☐	☐	☐	☐	There were eight (8) youth records reviewed, two (2) open residential services, 2 closed residential services, 2 open non-residential services and 2 closed residential services. Eight of the 8 youth records reviewed had a Counselor/Case Manager assigned.	
The Counselor/Case Manager completes the following as applicable: 1. Establishes referral needs and coordinates referrals to services based upon the on-going assessment of the youth's/family's problems and needs 2. Coordinates service plan implementation 3. Monitors youth's/family's progress in services 4. Provides support for families 5. Monitors out-of-home placement (if necessary) 6. Makes referrals to the case staffing to address problems and needs of the youth/family 7. Accompanies youth and parent/guardian to court hearings and related appointments	☒	☐	☐	☐	☐	Eight (8) of the 8 youth records reviewed indicated the counselor established a referral based on the identified needs and coordinates referrals to services based on the on-going assessment of the youth and family presenting problems and needs. All 8 youth records reviewed indicated coordination of the service/case plan implementation. All 8 youth records reviewed indicated the counselor reviews the youth's/family's progress in service. The 8 youth records reviewed indicated the counselor provided support for families. Four (4) of the 8 youth records were applicable for the counselor to monitor out of home placement for non-residential youth. All 4 records indicated the counselor/case manager provided monitoring. Eight of the 8 youth records reviewed contained evidence that the counselor made referrals to the case staffing to address identified problems and needs. There were no youth applicable for the counselor to accompany the youth and family to court hearings due to the courts being closed during the COVID-19 pandemic. Eight of the 8 youth records	

8. Refers the youth/family for additional services when appropriate 9. Provides case monitoring and reviews court orders 10. Provides case termination notes 11. Provides follow-up after 30 days of exit 12. Provides follow-up after 60 days of exit						reviewed indicated the counselor referred the youth/family for additional services. Eight of the 8 youth records reviewed indicated the counselor monitored and reviewed court orders. If the youth had no court orders or court supervision, the youth documented that it was not applicable. Eight of the 8 youth records reviewed and five (5) were applicable for the counselor provided case termination notes. Four of 4 youth records reviewed were not residential youth and were applicable for a 30-day follow-up, Further, 4 records indicated the counselor/case manager provided follow-up. Four of 4 youth records reviewed were not residential youth and were applicable for a 60-day follow-up.	
The program maintains written agreements with other community partners that include services provided and a comprehensive referral process	☒	☐	☐	☐	☐	The agency has evidence of written partnership agreements with other community and local area partners that included services provided and a referral process that addresses the needs of the youth and their families.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.05						☒ YES ☐ NO (explain) The agency has both policy and procedure RGC 2.05 in place which meets the requirements. Signed and approved on by Mark Wickham, revision Date 3/26/2019, signed Date 5/15/2019.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Youth and families receive counseling services, in accordance with the youth's case/service plan, to address needs identified during the assessment process	☒	☐	☐	☐	☐	There were eight (8) youth records reviewed, two (2) open residential services, 2 closed residential services, 2 open non-residential services and 2 closed non-residential services. All 8 client files reviewed include detailed documentation that captures the youth's presenting problems and other past and present issues identified through the intake and assessment process.	
Shelter Program							
Shelter programs provides individual and family counseling	☒	☐	☐	☐	☐	The agency provides counseling services for all eligible clients. All youth records reviewed include information that identifies the proper type of individual or family counseling based on the client's presenting problems and needs.	
Group counseling sessions held a minimum of five days per week	☒	☐	☐	☐	☐	There were four (4) residential youth applicable to assess for having group counseling five days a week.	

						There were 4 applicable residential client files reviewed to verify if the agency met the group counseling requirements. The documentation includes evidence of date and time of the group, and participants. Sessions are conducted 5 days per week group sessions.	
Group counseling sessions consist of: a. Length of at least 30 minutes b. Opportunity for youth engagement c. Clear and relevant topic (informational/developmental/ educational) d. Clear leader or facilitator	☒	☐	☐	☐	☐	The group counseling sessions provided by the agency include designator leader of facilitator. Group counseling sessions have appropriate and relevant topics, education, as well as relevant information. Group counseling sessions consists of opportunity for youth to participate. Group counseling sessions consists of length of groups sessions is 30 minutes or longer.	
Community Counseling							
Community counseling programs provide therapeutic community-based services designed to provide the intervention necessary to stabilize the family. Services are provided in the youth's home, a community location, or the local provider's counseling office.	☒	☐	☐	☐	☐	There were 4 non-residential youth applicable for having a need for therapeutic community-based services designed to provide the intervention necessary to stabilize the family in the event of crisis, keep families intact, minimize out-of-home placement, provide aftercare services for youth returning home from shelter services, and prevent the involvement of youth and families involved in delinquency. All four met the requirement.	
Counseling Services							
Reflect all case files for coordination between presenting problem(s), psychosocial assessment, case/service plan, case/service plan reviews, case management, and follow-up	☒	☐	☐	☐	☐	Eight of the 8 youth records reviewed indicated the counselor/case manager provided case coordination between presenting problems and follow-ups	
Maintain individual case files on all youth and adhere to all laws regarding confidentiality	☒	☐	☐	☐	☐	The agency has an individual client file for all 8 youth records. Each youth record reviewed during this process includes evidence that each file is marked confidential. The agency's program manager was interviewed and reported that all files are maintained in the locked client file when not in use.	
Case notes maintained for all counseling services provided and documents youth's progress	☒	☐	☐	☐	☐	Eight of the 8 youth records reviewed indicated the counselor/case manager provided case coordination between presenting problem and maintaining case notes for all services provided and documents the youths' progress.	

On-going internal process that ensures clinical reviews of case records and staff performance	☒	☐	☐	☐	☐	Eight of the 8 youth records reviewed indicated the counselor/case manager provided case coordination between presenting problems and an internal process that ensures clinical reviews of both case records and staff performance.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.06						☒ YES ☐ NO (explain) The agency has both policy and procedure RGC 2.06 in place which meets the requirements. Signed and approved on by Mark Wickham, revision date 3/26/2019, signed date 5/15/2019.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Case Staffing Initiation and Notifications							
If parent/guardian initiates, staffing is held within 7 days	☐	☐	☒	☐	☐	There were no youth applicable for the parent/guardian initiates placement of a staffing being held within 7 days. Interview with the agency indicate that the program initiates the case staffing.	
The youth, family and case staffing committee are contacted within a minimum of five working days a. Notification to youth/family no less than 5 working days prior to staffing b. Notification to committee no less than 5 working days prior to staffing	☒	☐	☐	☐	☐	Three (3) of the 4 nonresidential youth were applicable for notification to the family no less than five (5) working days prior to staffing. All 3 youth records met the requirements for notification of the staff and notification to the committee.	
Case Staffing Committee							
Must include: a. DJJ rep. or CINS/FINS provider b. Local school district representative	☒	☐	☐	☐	☐	All 3 applicable youth records indicated the case staffing includes evidence of local school district representative and CINS/FINS provider involvement in all staffings.	
Other members may include: a. State Attorney's Office b. Others requested by youth/ family c. Substance abuse representative d. Law enforcement representative e. DCF representative f. Mental health representative	☐	☐	☒	☐	☐	None of the 3 applicable youth records included the state of attorney's office, mental health representative, substance abuse representative, law enforcement representatives, DCF representative and others requested by youth and family.	
The program has an established case staffing committee, and has	☒	☐	☐	☐	☐	An interview with the agency indicates that the program has an established case staffing committee, and when the	

regular communication with committee members						organization has applicable youth, there is regular communication with designated committee members.	
The program has an internal procedure for the case staffing process, including a schedule for committee meetings	☒	☐	☐	☐	☐	The agency reports that it has an internal procedure for the case staffing process that involve the development of a schedule for committee meetings.	
As a result of the Case Staffing							
The youth and family are provided a new or revised plan for services	☒	☐	☐	☐	☐	Youth and family services are provided all relative information related to new or revised plans for services	
Written report is provided to the parent/guardian within 7 days of the case staffing meeting, outlining recommendations and reasons behind the recommendations	☒	☐	☐	☐	☐	Three of 3 applicable non-residential youth records contained a written report to the parent/guardian completed within 7 days of the case staffing.	
If applicable, the program works with the circuit court for judicial intervention for the youth/family	☐	☐	☒	☐	☐	None of the youth records reviewed were applicable for judicial intervention.	
Case Manager/Counselor completes a review summary prior to the court hearing	☐	☐	☒	☐	☐	None of the youth records reviewed were applicable for a review summary prior to a court hearing.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.07						☒ YES ☐ NO (explain) The agency has both policy and procedure RGC 2.07 in place which meets the requirements. Signed and approved on by Mark Wickham, revision date 3/26/2019, signed date 5/15/2019.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
All records are clearly marked 'confidential'.	☒	☐	☐	☐	☐	There were eight (8) youth records reviewed, two (2) open residential services, 2 closed residential services, 2 open non-residential services and 2 closed non-residential services. All 8 client records reviewed were marked confidential on initial file format sheet.	
All records are kept in a secure room or locked in a file cabinet that is marked "confidential"	☒	☐	☐	☐	☐	An interview with the agency's Program Manager indicated that all client files are maintained in a metal file cabinet housed in a locked room that is marked confidential.	
When in transport, all records are locked in an opaque container marked "confidential"	☒	☐	☐	☐	☐	When in transports, all records are locked in an opaque container marked confidential and all youth records were neat and orderly.	

All records are maintained in a neat and orderly manner so that staff can quickly and easily access information	☒	☐	☐	☐	☐	All files reviewed were provided to the review team through the electronic file upload platform. The agency maintains a uniform file format for each residential and non-residential client file.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.08						☒ YES ☐ NO (explain) The agency has both policy and procedure RGC 2.08 in place which meets the requirements. Revision Date 3/26/2019, Signed Date 5/15/2019. These documents were signed and approved by the agency CEO Mark Wickham.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Use of youth's preferred name/ pronoun: a. Youth are addressed according to their preferred name and gender pronouns b. Youth's preferred name and gender pronouns are used in logbook and on all outward-facing documents and census boards	☒	☐	☐	☐	☐	Reviewer reviewed three (3) closed residential files. All 3 youth had evidence that documented that the program addressed the youth by their desired name and gender pronouns. Further, these residential closed files, communication log pages maintained by the program meets the requirement in terms of utilizing the youth's preferred name and gender pronouns in the file and the communication log. These clients were closed/discharged so their names were not on the current census board.	
Youth in need of specialized support is referred to qualified resources (as applicable)	☐	☐	☒	☐	☐	Of the 3 residential files reviewed, none of the youth required specialized resources.	
Youth preference is considered and documented for room assignment and youth is not roomed in isolation due to sexual orientation, gender identity, or gender expression	☒	☐	☐	☐	☐	The reviewer reviewed 3 closed residential files. All youth records reviewed contained evidence that all the youth's room assignments were listed and their preference in room assignment was considered. One youth desired a single room and the program placed the youth accordingly.	
Youth is provided hygiene products, undergarments and clothing that affirms their gender identity or gender expression	☒	☐	☐	☐	☐	The program provides all necessary toiletries and basic body hygiene products. The program has a clothing storage area for youth that need clothing. All youth are permitted to wear clothing that is reflective and affirms their preferred expression of gender.	
The agency has signage and brochures/publication placed in common areas indicating that all youth are welcome regardless of sexual orientation, gender identity, and gender expression	☒	☐	☐	☐	☐	During a virtual tour with the Program Manager this reviewer witnessed approximately twelve (12) signs that were displayed in multiple areas of the shelter including the front entrance, dorm, dining room and living room. The youth/residents made some signs as an art project that were displayed to welcome all youth regardless of sexual orientation, gender identity and gender expression.	

Provider has a written policy and procedure that meets the requirement for Indicator 2.09						☒ YES ☐ NO (explain) The agency has both policy and procedure RGC 3.07 in place which meets the requirements. Signed and approved on by Mark Wickham, revision date 3/26/2019, signed date 5/15/2019.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Staff Secure							
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? **(If no, select rating "No eligible items for review")**	☐YES	☒ NO				The provider did not serve any youth who met the criteria for Staff Secure, DMST, Intensive Case Management, or FYRAC since the last QI review.	
Staff Secure policy and procedure outlines the following: a. In-depth orientation on admission b. Assessment and service planning c. Enhanced supervision and security with emphasis on control and appropriate level of physical intervention d. Parental involvement e. Collaborative aftercare	☐	☐	☒	☐	☐	N/A	
Program only accept youth that meet legal requirements of F.S. 984 for being formally court ordered in to Staff Secure Services	☐	☐	☒	☐	☐	N/A	
Staff Assigned: a. One staff secure bed and assigned staff supervision to one staff secure youth at any given time b. Program assign specific staff during each shift to monitor location/ movement of staff secure youth c. Agency clearly documents the specific staff person assigned to the staff secure youth in the	☐	☐	☒	☐	☐	N/A	

logbook or any other means on each shift							
Agency provides a written report for any court proceedings regarding the youth's progress	☐	☐	☒	☐	☐	N/A	
Domestic Minor Sex Trafficking (DMST)							
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? **(If no, select rating "No eligible items for review")**	☐YES		☒ NO			The provider did not serve any youth who met the criteria for Staff Secure, DMST, Intensive Case Management, or FYRAC since the last QI program review.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Agency has evidence that the FNYFS was contacted for approval prior to admission for all Domestic Minor Sex Trafficking (DMST) placements	☐	☐	☒	☐	☐	N/A	
Services provided to these youth specifically designated services designed to serve DMST youth	☐	☐	☒	☐	☐	N/A	
Did the placement of DMST youth require additional supervision for the safety of the youth or the program? If so, did the agency provide the appropriate level of supervision and safety measures?	☐	☐	☒	☐	☐	N/A	
Length of Stay: a. Youth in program do not have length of stay in DMST placement that exceeds seven (7) days b. Agency has approval for stays and support beyond seven (7) days for DMST placements that are obtained on a case-by-case basis? (If applicable.)	☐	☐	☒	☐	☐	N/A	
Agency has evidence that staff assigned to DMST youth under this provision are to enhance the regular services available	☐	☐	☒	☐	☐	N/A	

through direct engagement in positive activities designed to encourage the youth to remain in shelter							
All other services provided to DMST youth are consistent with all other general CINS/FINS program requirements	☐	☐	☒	☐	☐	N/A	
Domestic Violence							
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? **(If no, select rating "No eligible items for review")**	☒YES		☐ NO				
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Youth admitted to DV Respite placement have a pending DV charge and have evidence of being screened by JAC/Detention, but do not meet criteria for secure detention	☒	☐	☐	☐	☐	The Reviewer assessed three (3) closed DV Respite Residential files. All 3 documented that the youth had a charge and was being held at the Juvenile Assessment Center.	
Data entry into NetMIS and JJIS within (3) business days of intake and discharge	☒	☐	☐	☐	☐	Data reports were sent to support that the agency was entering and discharging the youth from the database platforms within the required time period. The Program Manager supplied the supportive documentation via email from the Florida Network of Youth and Family Services.	
Youth in program do not have length of stay in DV Respite placement that exceeds 21 days. If more than 21 days, documentation exists in youth file of transition to CINS/FINS or Probation Respite placement, if applicable.	☒	☐	☐	☐	☐	A total of three (3) DV Respite files were reviewed and two (2) of the 3 had a residential stay longer than 21 days. The agency supplied the Reviewer with documentation that indicated the transition of the youth from DV Respite into the CINS/FINS Program on the two (2) youth that were applicable.	
Case plan in file reflects goals focusing aggression management, family coping skills, or other intervention design to reduce reoccurrence of violence in the home	☒	☐	☐	☐	☐	The Reviewer conducted an evaluation of the 3 closed DV Respite Case Service plans. All 3 case service plans addressed anger management and use of coping skills to reduce the escalation of their circumstances that would result in violence in the home reoccurring.	

All other services provided to Domestic Violence Respite youth are consistent with all other general CINS/FINS program requirements	☒	☐	☐	☐	☐	A total of 3 DV client files that were reviewed. All files reviewed meet the standard for an eligible CINS/FINS youth. All 3 youth had the assessments conducted within the required time frames and all were in compliance with CINS/FINS program requirements.	
Probation Respite							
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? **(If no, select rating "No eligible items for review")**	☐YES		☒ NO			The provider did not serve any youth who met the criteria for Staff Secure, DMST, Intensive Case Management, or FYRAC since the last QI program review.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
All probation respite referrals are submitted to the Florida Network.	☐	☐	☒	☐	☐	N/A	
Probation Respite Referral come from DJJ Probation and are all youth referred on probation regardless of adjudication status	☐	☐	☒	☐	☐	N/A	
Data entry into NetMIS and JJIS within (3) business days of intake and discharge	☐	☐	☒	☐	☐	N/A	
Length of stay is no more than fourteen (14) to thirty (30) days? (Placement beyond thirty (30) days requires the approval of the JPO and/or CPO)	☐	☐	☒	☐	☐	N/A	
All case management and counseling needs have been considered and addressed	☐	☐	☒	☐	☐	N/A	
All other services provided to Probation Respite youth are consistent with all other general CINS/FINS program requirements	☐	☐	☒	☐	☐	N/A	
Intensive Case Management (ICM)							
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? **(If no, select rating "No eligible items for review")**	☐YES		☒ NO			The provider did not serve any youth who met the criteria for Staff Secure, DMST, Intensive Case Management, or FYRAC since the last QI program review.	

Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
Youth receiving services was court ordered or referred by case staffing committee	☐	☐	☒	☐	☐	N/A	
Services for youth and family include: a. Four (4) direct contacts per month b. Four (4) collateral contacts per month	☐	☐	☒	☐	☐	N/A	
Assessments include: a. A Child Behavior Checklist (CBCL) is completed within 14 days of intake and at discharge (if applicable) b. An approved self-report assessment that was completed at intake c. An approved self-report assessment that was completed every 90 days following intake and at discharge (if applicable)	☐	☐	☒	☐	☐	N/A	
Case plan demonstrates a strength-based, trauma-informed focus	☐	☐	☒	☐	☐	N/A	
Agency has evidence that ICMS has a strength-based perspective in one or more of the following areas; engaging the family, advocating on their behalf, initiating change agent activities, helping to access supports in the community, teaching problem solving skills, modeling productive behaviors, and/or successful completion of youth and family developmental milestones	☐	☐	☒	☐	☐	N/A	
Family and Youth Respite Aftercare Services (FYRAC)– Non-residential Only							
Does the agency have any cases in the last 6 months or since the last onsite QI review was	☐YES		☒ NO			The provider did not serve any youth who met the criteria for Staff Secure, DMST, Intensive Case Management, or FYRAC since the last QI program review.	

conducted? **(If no, select rating "No eligible items for review")**							
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Youth is referred by DJJ for a domestic violence arrest on a household member, and/or the youth is on probation regardless of adjudication status and at risk of violating	☐	☐	☒	☐	☐	N/A	
Agency has evidence that all FYRAC referrals have documented approval from the Florida Network office	☐	☐	☒	☐	☐	N/A	
Intake and initial assessment sessions meets the following criteria: a. Face-to-face gathering of family history and demographic information b. Includes development of the service plan and is documented through signature of the youth and his/her parent/guardian as well as orientation to the program	☐	☐	☒	☐	☐	N/A	
Life Management Sessions meets the following criteria: a. Sessions are face-to-face, sixty (60) minutes in length and focus on strengthening the family unit b. Individual Sessions are with the youth and family and focus to engage, identify strengths and needs of each member that help to improve family functioning	☐	☐	☒	☐	☐	N/A	
Group Sessions: a. Focus on the same issues as individual/family sessions with the overall goal of strengthening	☐	☐	☒	☐	☐	N/A	

relationships and prevention domestic violence b. Shall be no more than eight (8) youth at one (1) time and shall be for a minimum of sixty (60) minutes per session							
Youth and family participate in services for thirteen (13) sessions or ninety (90) consecutive days of services, or there is evidence in the youth's file that an extension is granted by DJJ circuit Probation staff	☐	☐	☒	☐	☐	N/A	
2.10: STOP NOW AND PLAN (SNAP)							
Provider has a written policy and procedure that meets the requirement for Indicator 2.10						☒ YES ☐ NO (explain) The agency does not provide SNAP services at this location. Policy last approved on 2/11/20 by Mark Wickham.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
SNAP Clinical Groups							
Youth are screened to determine eligibility of services	☐	☐	☐	☐	☒	N/A	
Needs assessment is completed at initial intake, or within two face-to-face sessions	☐	☐	☐	☐	☒	N/A	
SNAP Assessments a. Child Behavior Checklist (CBCL) is completed by the caregiver (pre & post) b. Teacher Report Form (TRF) completed by the teacher (pre & post) c. Tool for Parenting Self Efficacy (TOPSE) completed by the caregiver (pre & post) d. Prevention Assessment Tool (PAT) (pre & post)	☐	☐	☐	☐	☒	N/A	
SNAP discharge report summary	☐	☐	☐	☐	☒	N/A	

SNAP Boys/SNAP Girls **Parent** Group Evaluation Form	☐	☐	☐	☐	☒	N/A	
SNAP Boys/SNAP Girls **Child** Group Evaluation Form	☐	☐	☐	☐	☒	N/A	
SNAP in Schools							
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Weekly attendance sheet with youth names and/or identifying number completed with signatures of teacher and facilitator(s) (For a total of 13 attendance sheets)	☐	☐	☐	☐	☒	N/A	
"Class Goal" sheet	☐	☐	☐	☐	☒	N/A	
Measure of Classroom Environment (MoCE) (Pre and Post) is used to identify baseline and treatment outcomes of reported classroom dynamics.	☐	☐	☐	☐	☒	N/A	
Pre and Post Evaluations	☐	☐	☐	☐	☒	N/A	
One SNAP® Fidelity Adherence Checklist completed per classroom in a 13 – week SNAP in Schools group and uploaded to Dropbox	☐	☐	☐	☐	☒	N/A	
Provider has a written policy and procedure that meets the requirement for Indicator 3.01						☒ YES ☐ NO (explain) The agency has both policy and procedure in place which meets the requirements. These documents were signed and approved RGC 3.01 on 8-15-2019 by the agency CEO Mark Wickham.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Facility Inspection	☒	☐	☐	☐	☐	On February 4, 2021, the reviewer was provided a virtual tour of the youth shelter conducted by the Residential Director. The agency informed the review team of physical plant improvements. The agency reported that new flooring had been installed since last onsite program review. A tour of all major areas resulted in the facility appearing to be clean and well kept. The	

						outside grounds were neat and free of debris or unsafe items. The resident bathrooms appeared to be clean and all were in working condition. The kitchen was organized and all stored food was clearly marked. The refrigerator and freezer temperature were within the required minimally acceptable range. The open design of the common area / day room allows natural light to enter. The youth have access to the facility's back yard and basketball and volleyball courts. All fire drills conducted as required 1 per shift each month over last 6 months. All mock emergency drills completed as required in the last 6 months.	
Fire and Safety Health Hazards	☒	☐	☐	☐	☐	The agency provided evidence that the date of fire inspection was conducted on 1/28/2021. The Fire Extinguishers were inspected on 7/6/2020, the Kitchen Overhead Hood Suppression System on 2/6/2020, and Sprinkler System was documented as occurring on 2/24/2020. A Backflow System inspection was conducted 12/23/2020.	
Youth Engagement							
a. Youth are engaged in meaningful, structured activities (e.g., education, recreation, counseling services, life and social skill training) seven days a week during awake hours. Idle time is minimal. b. At least one hour of physical activity is provided daily. c. Youth are provided the opportunity to participate in a variety of faith-based activities. Non-punitive structured activities are offered to youth who do not choose to participate in faith-based activities. d. Daily programming includes opportunities for youth to complete homework and access a variety of age appropriate, program approved books for reading. Youth are allowed quiet time to read.	☒	☐	☐	☐	☐	The agency has a daily schedule posted in the day room/common area of the shelter facility. The daily shelter schedule is comprehensive and lists a full array activities. The agency posts a list of the events scheduled to occur every day. The schedule lists the time of the activity, the approach and format. The agency also informs the residents of the positive character trait they are trying to work on and the outcome they want to accomplish from the activity. The activities listed meets the general standards for the quality improvement and contract monitoring indicator. The agency has a comprehensive list of activities that all youth are offered to attend or inform them of what they are interested in participating in. Residents' participation in religious activities is voluntary. If youth elect not to participate in certain activities such as religious or faith-based events, they are not forced to attend or are they penalized in any way.	

e. Daily programming schedule is publicly posted and accessible to both staff and youth.							
Provider has a written policy and procedure that meets the requirement for Indicator 3.02						☒ YES ☐ NO (explain) The RGC 3.02 policy was reviewed last on 3/26/2019 and signed by CEO Mark Wickham.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Youth received a comprehensive orientation and handbook provided within 24 hours	☒	☐	☐	☐	☐	The agency reported that at intake all youth receive a full Orientation booklet of the program services and all rules. Residents are also informed of what they can expect to experience during their shelter stay. This is all documented on the "Facility Client Orientation Checklist." The agency also uses the "Admission Sleeping Assignment Form" when making room assignments. Evidence of these tasks being completed were found in all five (5) client files.	
Orientation includes the following: a. Youth is given a list of contraband items b. Disciplinary action is explained c. Dress code explained d. Review of access to medical and mental health services e. Procedures for visitation, mail and telephone f. Grievance procedure g. Disaster preparedness instructions h. Physical layout of the facility i. Sleeping room assignment and introductions j. Suicide prevention- alerting staff of feelings or	☒	☐	☐	☐	☐	There were five (5) youth client files reviewed to determine the agency's adherence to this requirement. Of the 5 files reviewed, each file had clear documentation confirming that the program orientation was completed and signed off by both the youth and staff.	

awareness of others having suicidal thoughts							
Documentation of each component of orientation, including orientation topics and dates of presentation, as well as signatures of the youth and staff involved is maintained in the individual youth record	☒	☐	☐	☐	☐	There were five (5) youth client files reviewed to determine the agency's adherence to this requirement. Each client filed contained evidence of a staff person documenting delivering orientation information to the client. The file also included major categories including orientation topics and the date that the information was provided. Additionally, there is information that includes signatures of the youth and staff involved documented in each youth file.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.03						☒ YES ☐ NO (explain) The agency has a policy that meets all requirements for this indicator. The policy is labeled as RGC 3.03 and was last reviewed on 3/26/2019 and signed by Mark Wickham.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
A process is in place that includes an initial classification of the youths, to include:							
a. Review of available information about the youth's history, status and exposure to trauma b. Initial collateral contacts, c. Initial interactions with and observations or the youth d. Separation of younger youth from older youth, e. Separation of violent youth from non-violent youth f. Identification of youth susceptible to victimization g. Presence of medical, mental or physical disabilities h. Suicide risk i. Sexual aggression and predatory behavior	☒	☐	☐	☐	☐	A review of 5 youth files (2 open and 3 closed) was conducted by the reviewer. All files were clearly marked and contained evidence of meeting all requirements of this indicator. The agency uses several methods to capture information to meet this indicator. Specific forms used to accurately classify youth in the program include the Youth Description Sheet, CINS/FINS Intake Form, Evaluation of Suicide Risk among Adolescents, and the Health Care Screening Form. All these forms completed during this process, plus the observations of the staff completing the intake are used to make the decision where to place the youth during the shelter stay.	

j. Sexual orientation gender identity/ expression k. Acute health symptoms requiring quarantine or isolation							
An alert is immediately entered into the program's alert system when a youth is admitted with special needs and risks such as risk of suicide, mental health, substance abuse, physical health or security risk factors	☒	☐	☐	☐	☐	A review of the 5 files found that all youth admitted to the shelter that have allergies have a sticker placed on the front of their client file. If the youth have other behavior, health or mental health issues, a code is placed on the front of the youth's file. Those alerts and allergies are then transferred to the alert board that is posted in the staff station covered by a blind to protect their privacy and be in alignment with the agency's Confidentiality policy.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.04						☐ YES ☒ NO (explain) The policy is labeled RGC 3.04 and was last reviewed on 3/26/2019. This policy was signed by Mark Wickham.	The policy and procedures do not include the most recent updates from the revised FN QI Standards Jan 2021 since last revision.
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Logbook entries that could impact the security and safety of the youth and/or program are highlighted	☒	☐	☐	☐	☐	The sample of logbook pages reviewed include evidence of entries that document safety and security checks. The agency logbook pages reviewed contained evidence of counts, head counts, perimeter and building checks, searches for contraband, as well as maintenance requests.	
All entries are brief, legibly written in ink and include: • Date and time of the incident, event or activity • Names of youth and staff involved • Brief statement providing pertinent information • Name and signature of person making the entry	☒	☐	☐	☐	☐	A sample of logbook pages were requested to assess the agency's adherence for this indicator. Logbook pages reviewed include dates from 10/11/20 (12am to 8am) to 10/17/2020 (4pm to 12am) and 11/1/20 (8am to 4pm) to 11/7/20 (12am to 8am). The last sample of logbook pages reviewed were 12/13/20 (12am to 8am) to 12/19/20 (4pm to 12am). All entries were legible and neat. All signatures were entered by person making the entry. Entries included pertinent information and date/time of the activity or event.	
Recording errors are struck through with a single line. The staff person must initial and date the correction. The use of	☒	☐	☐	☐	☐	The review of the sample of logbook pages with errors contain evidence on pages that errors are marked with a line strike through the identified error. Identified errors include evidence of an initial and date that the strike	

whiteout and erasures is prohibited.						through was made. No white-out or scribbles were detected in the notes.	
The program director or designee reviews the facility logbook(s) every week and makes a note chronologically in the logbook indicating the dates reviewed and if any correction, recommendations and follow-up are required and sign/date the entry	☒	☐	☐	☐	☐	A review of the samples of logbook pages indicates that the Team Leader reviewed the files that were observed on 10/16,10/22,10/29,11/2, and 11/11/2020. No corrections or recommendations were documented as needed by the supervisor or management.	
All staff review the logbook of the previous two shifts and makes an entry signed and dated into the logbook indicating the dates reviewed	☒	☐	☐	☐	☐	A review of the aforementioned logbook page samples contained evidence that staff signed in at the beginning of each shift stating that they reviewed the last two work shifts.	
At the beginning of their shift, oncoming supervisor and shelter counselor reviews the logbook of all shifts since their last log entry and makes a signed and dated entry and into logbook indicating the dates reviewed.	☒	☐	☐	☐	☐	There is evidence that the counselors and shelter supervisor review the logbook from the date of their last entry. Additionally, the counselors and supervisor sign and date the entry into the logbook and log the date that the logbook was reviewed.	
Logbook entries include: a. Supervision and resident counts b. Visitation and home visits	☒	☐	☐	☐	☐	Staff made entries at the beginning of each shift stating what youth were present for client counts at that time and if medications were due. Other occurrences such as general visitors and when which youth went on home visits/furlough are also documented. However, home visits were on hold for past several months due to COVID-19.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.05						☒ YES ☐ NO (explain) The Agency has a clear policy to meet the requirement for this standard. The policy is labeled RGC 3.05 and was last reviewed on 3/26/2019 and was signed off by the agency CEO Mark Wickham.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
The program has a detailed written description of the BMS,	☒	☐	☐	☐	☐	The behavior management description is clearly identified in the program orientation information provided at intake. Youth and parents sign off on the “Behavior Management	

and it is explained during program orientation						Acknowledgement Form" at intake showing that they have been informed about the plan.	
Behavior Management Strategies MUST include: a. Supervisors are trained BMS is designed to teach youth new behaviors and help youth understand the natural consequences for their actions b. Behavioral interventions are applied immediately, with certainty, and reflect the severity of the behavior c. BMS uses a wide variety of awards/incentives to encourage participation and completion of the program d. Appropriate consequences and sanctions are used by the program and consequences for behavior are logical and designed to promote skill-building for the youth e. Counseling, verbal intervention and de-escalation techniques are used prior to physical intervention (Only techniques approved by the Florida Network and DJJ are used if physical intervention is required) f. Only staff discipline youth. Group discipline is not imposed g. Room restriction is not used as part of the system or for youth who are physically and/or emotionally out of control	☒	☐	☐	☐	☐	The agency uses the six (6) Pillars of Character for their Behavior Management System. The 6 pillars are Respect, Trustworthiness, Responsibility, Fairness, Caring, and Citizenship. Staff are trained to execute the behavior management plan and to utilize it as tool to identify and apply the program's techniques according to various levels and degrees of the youth's behaviors. An interview with the agency supervisor resulted in them describing when a youth has a problem, they are moved to a "Reflection" level and asked to fill out a "Reflection Sheet" stating what they did, what they were supposed to do and what they can do different. The program has an incentive program as part of the behavior management system. The youth have several rewards for following the behavior management system that include special outings, house responsibilities, RAP Books, and the RAP Store. Additionally, residents in the program are made aware of consequences for violation of program expectations during orientation and throughout the duration of their shelter stay. Further, staff remind residents of the expectations related to the resident's behavior and possible consequences for non-productive behavior during their shelter stay. When consequences are applied to the youth for not following the behavior management rules, youth care workers and counselors are available to assist the youth in processing these events so that they are able to understand how their actions are related to the consequence outlined in the behavior management plan.	

h. Youth should never be denied basic rights such as meals, clothing, sleep, services, exercise, or correspondence privileges							
Program's Use of the BMS							
All staff are trained in the theory and practice of administering BMS rewards and consequences	☒	☐	☐	☐	☐	Nine (9) staff training files were reviewed and all nine files have evidence that staff were trained in the Behavior Management System.	
There is a protocol for providing feedback and evaluation of staff regarding their use of BMS rewards and consequences	☒	☐	☐	☐	☐	The Team Leader reviews all Reflection behavior management system sheets that are turned in. Team Leaders also work with each youth and staff in one-on-one sessions to discuss.	
Supervisors are trained to monitor the use of rewards and consequences by their staff	☒	☐	☐	☐	☐	Team Leaders during their one-on-one session with staff discuss the use of rewards and consequences.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.06						☐ YES ☒ NO (explain) The policy is labeled RGC 3.06 and was last reviewed 3/26/2019 and was signed off by the CEO Mark Wickham.	The policy and procedures do not include the most recent updates from the revised FN QI Standards Jan 2021 since last revision.
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
The program maintains minimum staffing ratios as required by Florida Administrative Code and contract. • 1 staff to 6 youth during awake hours and community activities • 1 staff to 12 youth during the sleep period	☒	☐	☐	☐	☐	The logbooks and staff schedules were reviewed on 11/1/20, 12/13/20, and 10/30/20. The logbook shows that there was 12 youth onsite and two staff as per contractual requirements.	
All shifts must always provide a minimum of two staff present	☒	☐	☐	☐	☐	A review of the schedules over the last six (6) months found that all shifts had documented evidence of a minimum two (2) staff are present on all work shifts.	
Program staff included in staff-to-youth ratio includes only staff that are background screened and properly trained youth care workers, supervision staff, and treatment staff	☒	☐	☐	☐	☐	The staff schedules for the last 6 months reflects the minimum number of staff needed to work each work shift and meets the in staff-to-youth ratio requirement.	

The staff schedule is provided to staff or posted in a place visible to staff	☒	☐	☐	☐	☐	Evidence of the staff schedule was provided during the virtual and onsite tour. The staff schedule is posted in the staff office.	
There is a holdover or overtime rotation roster which includes the telephone numbers of staff who may be accessed when additional coverage is needed	☒	☐	☐	☐	☐	Evidence of the staff schedule was provided. The agency has a part-time, on-call and holdover list. The agency supervisor refers to the list to manage and maintain the number of staff required to fill the staffing schedule when needed.	
Staff observe youth at least every 15 minutes while they are in their sleeping room, either during the sleep period or at other times, such as during illness or room restriction	☒	☐	☐	☐	☐	A review of randomly selected dates of nights were selected to determine the agency's adherence to this bed check indicator. The facility has a split floor plan with a boy's hall and a female hall. The review found that across the nights selected there were no inconsistencies in the bed checks.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.07						☐ YES ☒ NO (explain) The policy is labeled RGC 3.07 and was lasted reviewed on 7/10/2019 and signed off by agency CEO Mark Wickham.	The policy and procedures do not include the most recent updates from the revised FN QI Standards Jan 2021 since last revision.
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Surveillance System							
The agency, at a minimum, shall demonstrate: a. A written notice that is conspicuously posted on the premises for the purpose of security b. System can capture and retain video photographic images which must be stored for a minimum of 30 days c. System can record date, time, and location; maintain resolution that enables facial recognition d. Back-up capabilities consist of cameras' ability to operate during a power outage e. Have cameras placed in interior and exterior general locations of the shelter where youth and staff congregate	☐	☒	☐	☐	☐	The Agency has twenty-four (24) cameras placed in all the common and public areas throughout the shelter facility. There are no cameras placed in inappropriate areas such as bathrooms and sleeping quarters. The camera system stores video up to 30 days and has back-up power capability so that the system will continue to operate during electrical power outages. The agency has evidence of alerting visitors that cameras are used on their premises. When operating correctly, the agency's video camera is capable of capturing and maintaining video for up to 30 day. The system is capable of recording date, time and location. During this QI program review, the video camera system was not operating properly. During the document request process, a request for specific periods of camera footage was made by the Lead Reviewer. The camera system failed to provide a specified period of back-up recorded days of camera footage. The agency was reviewing their cameras and found that there was 11 days of video erased. This requested video	**Exception:** Actual overnight camera footage was not available and the reviewer could not access actual camera footage to view and verify agency direct care staff completing the bed counts as documented. The agency has submitted a work order for the system to be repaired.

and where visitors enter and exit. Cameras are never placed in bathrooms or sleeping quarters. f. All cameras are visible						footage was not available to be reviewed during the QI review. Agency was not able to provide the review team with evidence that the system was checked. The reviewer cannot verify accuracy of the counts due to the lack of availability of camera footage necessary to determine adherence to this indicator due to the surveillance system being inoperable. The review for this indicator was conducted by the reviewing the agency's bed check logs. The agency submitted a work order to the video camera company that installed camera system prior to the onsite review. The agency also contacted the company during the 2-day QI program review.	
A list of designated personnel who can access the video surveillance system is maintained (includes off-site capability per personnel)?	☒	☐	☐	☐	☐	There is a posted list that describes designated staff that can access the video which includes the Program Manager, Shelter Supervisor, Team Lead, and Vice President of Operations. If none of these people are present, the Office Specialist may access the camera system.	
Supervisory review of video is conducted a minimum of once every 14 days and timeframes reviewed are noted in the logbook. The reviews assess the activities of the facility and include a review of random sample of overnight shifts	☐	☒	☐	☐	☐	During the review of this indicator, the video camera log was requested. The agency reported that the Supervisor reviewed the camera system on January 13, 2021 and the date indicated that the camera footage reviewed was January 10, 2021 for 12:10am to 2:30am. However, the Residential Supervisor reviewed the camera system at the time of the request for video footage and noticed video from 1/1/2021 to 1/11/2021 was not available. During the camera footage review process, the agency uploaded an incident report for February 1,2021.	**Exception:** There were a total of 3 supervisory reviews and limited examples of supervisors and managers conducting reviews on a bi-weekly basis. The reviewer did not have documented evidence of consistent and ongoing examples of Supervisors' conducting reviews every 14 days.
Grant the requesting of video recordings to yield a result within 24-72 hours from program quality improvement visits and when an investigation is pursued after an allegation of an incident	☐	☒	☐	☐	☐	Per policy, the agency has a process to address how official requests from third parties that need video camera footage are processed. The agency can provide videos to need to know third parties. Video clips can be provided to these entities in order to support efforts to conduct administrative, quality improvement and during investigations and in conjunction with specific incidents. Dates were originally requested for this review, however, the agency reported being unable to locate the original	**Exception:** At the time of this QI program review, the agency did not have the ability to provide back-up recordings of camera footage in the last 30 days.

						dates requested between 1/1/21- 1/11/21.	
Camera service order/requests will be made within 24 hours of discovery of camera malfunctioning or being inoperable. All efforts made to obtain repairs are documented and maintained	☐	☒	☐	☐	☐	The agency's program director reported that the agency detected that the camera system was not operating properly. As soon as it was detected, a work order request was submitted to the video camera company. Upon receiving the work order request, the company stated they could not do anything about it and that is a system problem. The camera company verified that the system is operating properly doing a remote access evaluation of the system. The agency requested documentation from the camera company stating that they had conducted an inspection of the system and all systems now appear to be operating properly. The company stated that it was just a malfunction in the system.	**Exception:** The agency submitted a work order to repair the back-up camera system. Discovery of the camera system not working properly was detected during the document request process. The work order was submitted to the camera company during the document request process just a few days prior to the start of the program review.
Provider has a written policy and procedure that meets the requirement for Indicator 4.01						☐ YES ☒ NO (explain) The agency has both policy and procedure in place which meets the requirements. RGC 4.01 Reviewed Date 3/26/2019, Revision Date 3/26/2019, Signed Date 5/15/2019. Signed and approved on by Mark Wickham.	The policy and procedures do not include the most recent updates from the revised FN QI Standards Jan 2021 since last revision.
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Preliminary Healthcare Screening							
Screening includes : a. Current medications b. Existing (acute and chronic) medical conditions c. Allergies d. Recent injuries or illnesses e. Presence of pain or other physical distress	☒	☐	☐	☐	☐	The reviewer assigned to this indicator reviewed a total of six (6) client files. A total of four (4) open and two (2) closed client files were to determine the agency's adherence to the indicator. The agency's healthcare screening forms reviewed have evidence that they were all completed at the screening and intake phase. The healthcare screening form captures all past and current acute health conditions, injuries, pains, stressors of all kinds, scars, tattoos and markings and are completed by all direct care staff for all 6 files. An interview with the	

f. Observation for evidence of illness, injury, physical distress, difficulty moving, etc. g. Observation for presence of scars, tattoos, or other skin markings h. Acute health symptoms requiring quarantine or isolation						Program Registered Nurse indicated that she reviews the accuracy and completion of client files completed direct care staff when she is not on duty. All files reviewed had evidence that the follow up review reflected that a review of Health Care Admissions Screening/Intakes were completed by the Registered Nurse(RN). The agency has a practice in place to quarantine youth if necessary.	
Referral and Follow-up							
Youth with chronic medical conditions have a referral to ensure medical care (e.g. diabetes, pregnancy, seizure disorder, cardiac disorders, asthma, tuberculosis, hemophilia, head injuries, etc.)	☐	☐	☒	☐	☐	A review of the sample of client files was conducted to determine if medical follow up was necessary. The files in the sample did not require medical follow up. An interview with the Program Director and RN indicated that the agency has a practice in place to include completing medical follow up referrals. When applicable, designated agency staff document all follow up in the client file.	
When needed, the parent is involved with the coordination and scheduling of follow-up medical appointments	☐	☐	☒	☐	☐	Of the 6 client files in the sample, none of the records indicated that the agency was required to coordinate with parents/guardians to schedule follow-up medical appointments.	
All medical referrals are documented on a daily log.	☐	☐	☒	☐	☐	When applicable, the agency has a practice in place to document all medical and healthcare referrals in a daily log maintained in the client file.	
The program has a thorough referral process and a mechanism for necessary follow-up medical care as required and/or needed	☒	☐	☐	☐	☐	The agency has a practice in place that requires the organization to work with the client's parent/guardian and their medical provider. When applicable, the agency has procedures in place to ensure that all clients receive proper medical care and follow-up.	
Provider has a written policy and procedure that meets the requirement for Indicator 4.02						☒ YES ☐ NO (explain) The agency has both policy and procedure in place which meets the requirements. RGC 4.02 Reviewed Date 3/26/2019, Revision Date 3/26/2019, Signed Date 5/15/2019. Signed and approved on by Mark Wickham.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Suicide Risk Screening and Approval							
Suicide risk screening occurred during the initial intake and screening process. Suicide screening results reviewed and signed by the supervisor and documented in the youth's case file.	☒	☐	☐	☐	☐	A total of three (3) closed client files were reviewed. The client files reviewed indicated that all 3 youth had evidence in the file that each received an initial suicide risk assessment during the initial intake and screening process. All client files reviewed had a suicide screening that was reviewed and signed by a licensed clinician.	

The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	☒	☐	☐	☐	☐	The agency utilizes a Suicide Assessment tool that has been submitted and approved by the Florida Network of Youth and Family Services.	
Supervision of Youth with Suicide Risk							
Youth are placed on the appropriate level of supervision based on the results of the suicide risk assessment.	☒	☐	☐	☐	☐	Of the 3 client files reviewed, all youth were placed on sight and sound supervision due to indicating positive on at least 1 or more of the 6 risk assessment questions. All of clients were placed on sight and sound until a licensed clinician was consulted and approved the current status of assessment.	
Staff person assigned to monitor youth documented youth's behavior at 30 minute or less intervals	☐	☒	☐	☐	☐	Of the 3 client files placed on sight and sound supervision, all had evidence that observations were conducted in 15 minutes or less. Staff are documenting observation checks on an observation form that tracks check completed on each shift. However, sight and sound check documentation for one youth are summarized and did not appear to capture real time observations of the youth.	**Exception:** The sight and sound checks for one resident are being summarized and not documented in real-time. This is not consistent with the method of documenting the exact time check that is being conducted.
Supervision level was not changed/reduced until a licensed professional or a non-licensed mental health professional under the supervision of a licensed professional completed a further assessment OR Baker Act by local law enforcement	☒	☐	☐	☐	☐	Of the 3 client files placed on elevated supervision, there was evidence that each youth's supervision level was not stepped down until the youth received a follow up Suicide Risk Assessment by the therapist working under the supervision of a licensed clinician.	
Provider has a written policy and procedure that meets the requirement for Indicator 4.03						☒ YES ☐ NO (explain) The agency has both policy and procedure in place which meets the requirements. RGC 4.03 Reviewed Date 3/26/2019, Revision Date 04/03/2020, Signed Date 5/15/2019. Signed and approved on by Mark Wickham.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Medication Storage							
a. All medications are stored in a Pyxis Med-Station 4000 Medication Cabinet that is inaccessible to youth (when unaccompanied by authorized staff)	☒	☐	☐	☐	☐	A total of four (4) youth records (2 open, 2 closed) were reviewed. Program staff that included the Program Director and the RN were interviewed to assess the agency's adherence to this medication indicator.	

b. Pyxis machine is stored in accordance with guidelines in FS 499.0121 and policy section in Medication Management c. Oral medications are stored separately from injectable epi-pen and topical medications d. Medications requiring refrigeration are stored in a secure refrigerator that is used only for this purpose, at temperature range 2-8 degrees C or 36-46 degrees F. (If the refrigerator is not secure, the room is secure and inaccessible to youth.) e. Narcotics and controlled medications are stored in the Med-Station						All narcotics and controlled medications are stored in a BD Care Fusion Pyxis Med-Station 4000 Medication Cabinet. The medication cabinet is stored in the laundry room behind a locked door that is inaccessible to youth. Oral medications are stored in separate bins of the Med Station, apart from topical or injectables. A refrigerator was observed to be secured with a lock in the medication storage room. At the time of the QI program review, the program does not have any prescription or other medications needing refrigeration. At the time of the review the program did not have any narcotic medications. The agency's program practice indicates that narcotics and controlled medications are stored in the Pyxis Med-Station.	
Medication Distribution							
a. Agency maintains a minimum of 2 Super Users for the Med-Station b. Only designated staff delineated in User Permissions have access to secured medications, with limited access to controlled substances (narcotics) c. A Medication Distribution Log shall be used for distribution of medication by non-licensed and licensed staff d. Agency verifies medication using one of four methods listed in the FNYFS Operations Manual e. When nurse is on duty, medication processes are conducted by the nurse f. The delivery process of medications is consistent with the FNYFS Medication Management and Distribution Policy	☒	☐	☐	☐	☐	The agency has a documented list of super and regular users that are authorized to assist in the delivery of medication. The agency has a medication distribution log that tracks all of the medication provided to the youth during their shelter stay. Each youth's medication record is maintained in a universal binder. The agency does implement the use of the Rights method, (right dose, right route, right med, right patient, and right time). The agency utilizes the Rights method to assist in the delivery of medications to ensure that it is consistent and limits mistakes. This method is listed and in alignment with the FNYFS Operations Manual and delivery of medication is consistent with FN medication management policy. The agency does not permit eligible residents to be able to accept youth currently prescribed injectable medications, except epi pens. The agency has documentation that non-licensed direct care staff have received training in the use of Epi-pens provided by the program's RN during medication training provided during the on-boarding process. The agency's program director reported that the program's RN provides medication distribution and Pyxis	

g. Agency does not accept youth currently prescribed injectable medications, except for epi-pens h. Non-licensed staff have received training in the use of epi-pens provided by a registered nurse						medication cabinet training to all new staff. The agency RN is the primary trainer to prepare all designated staff to assist in the delivery of medication. The RN trains all staff to complete an up to date inventory of all controlled substances on each shift.	
Medication Inventory							
a. For controlled substances, a perpetual inventory with running balances is maintained as well as a shift-to shift count verified by a witness and documented b. Over-the-counter medications that are accessed regularly are inventoried weekly by maintaining a perpetual inventory c. Syringes and sharps (needles, scissors, etc.) are secured, and counted and documented weekly	☐	☒	☐	☐	☐	All controlled substances are maintained in a perpetual running balance in order to maintain a shift-to-shift count. This is required to be completed by 2 direct care staff members and is documented on the youth's Medication Distribution Log (MDL). The reviewer conducted a shift count on the medication distribution logs for four (4) clients. Medication counts on the medication distribution log for 1 out of 4 clients was found not to consistent. All over-the-counter medications are inventoried on a weekly basis on a perpetual log. The medication log is reviewed by the designated personnel and signed by the RN. A perpetual inventory is maintained on the youth's MDL each time the resident receives assistance in the distribution of medication. The agency maintains sharps in the facility. The agency has sharps that are secured. The inventory for sharps and all associated documentation indicates that the sharps are counted on a weekly basis. Review of the documentation indicate that the RN is reviewing the medication records of all residents when she is on duty.	**Exception:** Medication counts on the medication distribution log for 1 out of 4 clients was found not to be consistent. Review of counts indicate missing medication counts in daily medication count performed by the agency.
There are monthly reviews of medication management practice via Knowledge Portal or Pyxis Med-Station Reports.	☒	☐	☐	☐	☐	The program RN or Healthcare Specialist conducts monthly reviews of medication management practice via knowledge portal reports from med station. The outcome of these reports is then discussed during director's meetings.	
Medication discrepancies are cleared after each shift.	☒	☐	☐	☐	☐	An interview with the RN indicates that all discrepancies are required to be cleared prior to the close of the current work shift. The RN also submits weekly reviews of discrepancies and requests reports on these occurrences. Review of medication distribution practice indicates that the agency reported six (6) CCC reportable medication related incidents in the last 6 months. Of these incidents, 3 were given late, 2 were missed and 1 involved the youth not getting inhaler on time. Agency nurse was	

						interviewed and reported that she reviews cause of all medication errors and provides retraining on all medication error incident.	
Provider has a written policy and procedure that meets the requirement for Indicator 4.04						☒ YES ☐ NO (explain) The agency has both policy and procedure in place which meets the requirements. RGC 4.02 Reviewed Date 3/26/2019, Revision Date 3/26/2019, Signed Date 5/15/2019. Signed and approved on by Mark Wickham.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Youth with a medical, mental health, or food allergy was appropriately placed on the program's alert system	☒	☐	☐	☐	☐	A total of six (6) client files were reviewed. Each of the client files reviewed had evidence the youth was screened for all possible medical, mental health condition and/or food allergies. All of the client files with alerts were placed in the program's alert system.	
Alert system includes precautions concerning prescribed medications, medical/mental health conditions	☒	☐	☐	☐	☐	A review of the agency's program alert system includes all requirements that includes precautions concerning the prescribed medications, medical and mental health conditions. These alerts are documented in multiple sections in the health screening section of the client's medical file. The agency has a general alert board located in the client's file and also documents the client's name accordingly and the alert in a confidential manner. A nutritional alert clipboard is in the kitchen which includes a list of clients who have an allergy or other kind of nutritional alert.	
Staff are provided sufficient training, information and instructions to recognize/respond to the need for emergency care for medical/mental health problems	☒	☐	☐	☐	☐	The agency's Program Director report that all staff received training on how to respond to residents with youth that have emergency care needs. All staff receive training focused on informing them of the signs and symptoms of mental health. This training provide staff with training topics that educate staff on being aware of common medical issues and signs and behaviors of youth with possible mental health issues.	
A medical and mental health alert system is in place that ensures information concerning a youth's medical condition, allergies, common side effects of prescribed medications, foods and medications that are contraindicated, or other pertinent mental health treatment information, is communicated to all staff	☒	☐	☐	☐	☐	The program has an established medical and mental health alert system. The program utilizes an alert system that uses a letter-focused code system to mark individual files and the shelter census board to indicate to the staff the corresponding alert. The major alerts that make up the system include a-Mental Health, b-Substance Abuse, c-Suicide Risk/History of Self-injurious behavior, d-Medication, e-Allergies, f-Flight Risk and g-History of Physical/ Sexual Aggression. A total of 6 client files were reviewed for medical/mental health alert systems compliance. All files contained evidence of the letter-focused coding system. Codes marked on the census	

						board were marked correctly. Further, all allergies were marked on the outside of all files. When applicable food allergies are listed on the food alert board in the kitchen.	
Provider has a written policy and procedure that meets the requirement for Indicator 4.05						☒ YES ☐ NO (explain) The agency has both policy and procedure in place which meets the requirements. RGC 4.02 Reviewed Date 3/26/2018, Revision Date 3/26/2019, Signed Date 5/15/2019. Signed and approved on by Mark Wickham.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Off-site Emergency Services							
a. If off-site emergency medical or dental care was provided, an incident report was submitted for the medical or dental care b. Upon youth return, there is a verification receipt of medical clearance via discharge instructions with follow-up is present in file c. Youth's parent/guardian was notified d. A daily log is maintained for emergency care provided	☒	☐	☐	☐	☐	A total of three (3) client files were reviewed for compliance, and all 3 required off-site medical care. All 3 files contained evidence that an incident was completed, documentation of medical discharge, parent/guardian notification, and placement in a daily logging system.	
All staff are trained on emergency medical procedures	☒	☐	☐	☐	☐	A review of six (6) staff training files contained evidence in each training file that staff received First Aid, Cardiopulmonary Resuscitation (CPR) and other medical emergency and universal precautions training.	
The program has a Knife-for-life and wire cutters accessible to staff in a secure location(s)	☒	☐	☐	☐	☐	The agency has emergency equipment, wire cutters and a knife-for-life that are located in a locked closet near the day room. The agency also has evidence of first aid kits, fire extinguishers and emergency equipment located in two agency vehicles.	
First aid kit/supplies are fully equipped and inventoried	☒	☐	☐	☐	☐	The agency's first aid kits/supplies are inventoried on a weekly basis. First aid kits are located in the medication room, kitchen and in each of the 2 agency vans.	