Florida Network for Youth and Family Services
Compliance Monitoring Report for

Youth and Family Alternatives – George W. Harris Runaway and Youth Crisis Shelter

1060 US-17, Bartow, FL 33830

Compliance Monitoring Services Provided by

FOREFRONT

EXECUTIVE SUMMARY

Forefront LLC conducted a joint Quality Improvement (QI) and Compliance Monitoring program review of the Youth and Family Alternatives, Inc. George W. Harris Runaway and Youth Crisis Shelter (YFA GWH) on behalf of the Florida Network of Youth and Family Services (FNYFS). This compliance monitoring visit was conducted to review the Youth and Family Alternatives, Inc. George W. Harris Runaway and Youth Crisis Shelter residential and non-residential CINS/FINS program. The Compliance Monitoring program review was conducted for the FY 2020-2021 on April 21-22, 2021, in a Hybrid Format that included the Lead Reviewer and Peer Reviewers conducting the QI program review primarily offsite. A Forefront team member conducted the onsite portion of this program review at its program office located at 1060 US-17, Bartow, Florida 33830. Forefront LLC (Forefront) is an independent third-party compliance monitoring firm that is contracted by the FNYFS to perform onsite program reviews to assess the agency's adherence to fiscal, programmatic, and overall contract requirements. Youth and Family Alternatives, Inc. is contracted with the Florida Network of Youth and Family Services (FNYFS) to provide direct residential and non-residential program 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 compliance monitoring review was conducted by Lead Reviewer Nitara LaTouche and Keith Carr, Consultants for Forefront LLC. Agency representatives from YFA - GW Harris Runaway and Youth Crisis Shelter present for the entrance interview were: Tyron Smith, Program Manager; Natalie Pope, Residential Supervisor; Jovia Dukes, YDS Team Lead; and Amanda Killian, VP of Quality Improvement. The last onsite QI visit was conducted February 19, 2020.

In general, the Reviewer found that YFA – GW Harris Runaway and Youth Crisis Shelter is in compliance with specific contract requirements. **YFA GW Harris Runaway and Youth Crisis Shelter received an overall compliance rating of 91% for achieving full compliance with (10) indicators** of the CINS/FINS Monitoring Tool. There were no corrective actions as a result of the monitoring visit.

The following report represents the results of the in-depth evaluation of the provider's General Administrative performance, with all findings clearly documented. Copies of all completed tools utilized during the visit to determine these ratings will be maintained on file with the Reviewer. If any information or clarification is required, please contact Keith Carr by E-mail: keithcarr@forefrontllc.com

2020-2021 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 04-21-22-2020-2021

Agency Name: Youth and Family Alternatives – GW Harris RYCC	**Monitor Name: Nitara LaTouche, Lead Reviewer**
Contract Type : CINS/FINS	**Region/Office: 1060 US-17, Bartow, FL 33830**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): April 21-22, 2021**

Major Programmatic Requirements	Explain Rating: Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable	Ratings Based Upon: I = Interview; O = Observation; D = Documentation; PTV = Submitted Prior To Visit; (List Who and What)	Notes: Explain Unacceptable or Conditionally Acceptable: (Attach Supportive Documentation)
I. Administrative and Fiscal							
DJJ Quality Improvement Peer Reviewer a. Provider shall demonstrate that a minimum of two (2) staff members have been trained to be certified as DJJ QI Peer reviewers. Provider shall participate in a minimum of one (1) on-site quality assurance review of a similar type program in another judicial circuit during each 12-month period of the contract, if requested.	☐	☐	☒	☐	☐	Documentation The program currently has two (2) certified DJJ QI peer reviewers for this location: Christy Cheshire, Senior Case Manager and Sebastian Roth, Non-Residential Program Supervisor. YFA Certified 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**	☐	☐	☒	☐	☐	Documentation The agency provided the following list of additional current contracts for FY 2020-2021: USDA, Eckerd CBC, Heartland CBC, Kids Central Inc., United Way of Central FL, 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	☐	☒	☐	☐	☐	Documentation 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	Automobile limits are not listed in the consolidated insurance form provided to the reviewer. Provide an updated copy of the amount of the financial limits for the agency's automobile insurance coverage.

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$500,000 policy aggregate. Commercial General Liability with a limit of $500,000 per occurrence, and $1,000,000 policy aggregate. Automobile Liability Insurance shall be required and shall provide bodily injury and property damage liability covering the operation of all vehicles used in conjunction with performance of this contract, with a minimum limit for bodily injury of $250,000 per person; with a minimum limit for bodily injury of $500,000 per accident; with a minimum limit for property damage of $100,000 per accident and with a minimum limit for medical payments or $5,000-$10,000 per person. Florida Network is listed as payee or co-payee. **PTV**						$1,000,000 for each accident, employee, or aggregate. General liability is effective 6/1/2020-6/1/2021 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 adv injury, $3,000,000 for general aggregate and $3,000,000 for 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	

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						Certificate of Liability Insurance as the certificate holder.	
External/Outside Contract Compliance a. Provider has corrective action item(s) cited by an external funding source (Fiscal or Non-Fiscal). **ON SITE**	☐	☐	☐	☐	☒	Interview During the Entrance Conference, the provider indicated that there are no outstanding corrective action item(s) cited by an external funding source.	**No corrective action or recommendation required.**
Fiscal Practice a. Agency must have employee and fiscal policy/procedures manuals that are in compliance with GAAP and provide sound internal controls. Agency maintains fiscal files that are audit ready. **PTV**	☐	☐	☒	☐	☐	Documentation 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. The agency has multiple fiscal related policies in place to address fiscal protocols and financial processes to provide internal controls that appear to be in line with GAAP requirements. Additionally, the agency also has policies that address confidentiality, record storage, loss prevention, data security and disposal.	**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**	☐	☐	☒	☐	☐	Documentation The agency provided a general ledger report for dates from July 2, 2020 – February 28, 2021. The fiscal detail report includes the GL code, functional	**No corrective action or recommendation required.**

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						expense code, funding source code, location code, activity code, effective date, document number, transaction description, and the debit and credit amounts.	
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**	☐	☐	☒	☐	☐	Observation Petty cash is maintained onsite. The petty cash is secured in location accessible by lock. The agency fiscal representative provided reconciliation documentation for last 3 months. Petty cash count was observed and reviewed while onsite. Cash onsite is maintained by Residential Team Leader. At the time of this onsite review, the correct petty cash balance was reconciled.	**No corrective action or recommendation required.**
d. Financial records and reports are current. Includes bank statements reconciled within 6 weeks of receipt. Vendor invoices past 6 months. Invoices are submitted on a monthly basis with supporting documentation. (Disbursements/invoices are approved & monitored by management). **ON SITE**	☐	☐	☒	☐	☐	Documentation Financial records included bank transactions and statements from July 2020 – January 2021 with monthly 'reconcile cash accounts' submitted from August 2020 – January 2021 for operating bank account PNC Bank. Invoices appear to be submitted on a monthly basis based on documentation reviewed. All disbursements and invoices are	**No corrective action or recommendation required.**

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						approved and monitored by management.	
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**	☐	☐	☐	☐	☒	Interview Program Manager reported no material inventory was purchased with DJJ/FNYFS funding since the last compliance monitoring visit.	**Not Applicable. 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**	☐	☐	☒	☐	☐	Documentation The agency provided evidence of payroll taxes and deposits for 2 quarters with the IRS Form 941 for months covering between Q3: July - September 2020 and Q4: Oct - Dec 2020. A total of 2 quarters showed a zero balance.	**No corrective action or recommendation required.**
g. Budget to actual reports prepared and reviewed by appropriate management. Variance from the budget are investigated and explained. **PTV/ON SITE**	☐	☐	☒	☐	☐	Documentation The agency provided a budget to actual reports titled 'Statement of Revenues and Expenditures' for July 1, 2021 – February 28, 2021; Statement of Revenues and Expenditures - 20.21 Community Counseling From 7/1/2020 Through 6/30/2021; Statement of Revenues and Expenditures - 20.21 community Counseling-ICM Only	**No corrective action or recommendation required.**

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Major Programmatic Requirements	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable		
						From 7/1/2020 Through 2/28/2021; and Statement of Revenues and Expenditures - 20.21 Community Counseling-SNAP Only From 7/1/2020 Through 2/28/2021 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.	
h. A Single Audit is performed as part of the annual audit if expenses are greater than $500,000. The agency must submit a Corrective Action Plan for findings cited in the management letter and single audit. An annual financial audit was completed within 120 days after the previous fiscal year/calendar year and that a copy was provided to the Network unless and extension has been requested and approved in writing. Copy of Audit is submitted to the FNYFS by December 31st. **Obtain from FNYFS**	☐	☐	☒	☐	☐	Documentation 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.**

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i. Agency maintains confidentiality policy with written policies and procedures to ensure the security and privacy of all employee and client data. Personal information is not easily accessible. Agency maintains a backup system in case of accidental loss of financial information. Security procedures are in place to protect laptops. Obsolete documents are shredded and computer hard drives are wiped prior to discarding. **ON SITE**	☐	☐	☒	☐	☐	Documentation 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 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. The agency reports that all agency 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.	**No corrective action or recommendation required.**

CONCLUSION

YFA George W. Harris Runaway and Youth Crisis Shelter 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 due to the following: 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 are no corrective actions cited as a result of the contract monitoring visit. Overall, the provider is performing satisfactorily in meeting the fiscal and administrative terms of its contract. In addition, the majority of indicators reviewed were carried out in a manner which meets the standard as described in the report findings.

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 a 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, Inc. – George W. Harris
CINS/FINS Program

April 21-22, 2021

Compliance Monitoring Services Provided by

FOREFRONT

CINS/FINS Rating Profile

Standard 1: Management Accountability

1.01 Background Screening	Failed
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	Limited
1.07 Outreach Services	Satisfactory

Percent of indicators rated Satisfactory: 42.86%
Percent of indicators rated Limited: 42.86%
Percent of indicators rated Failed: 14.28%

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)	Satisfactory

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

Standard 3: Shelter Care & Special Populations

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

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

Standard 4: Mental Health /Health Services

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

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

Overall Rating Summary

Percent of indicators rated Satisfactory: 80.72%
Percent of indicators rated Limited: 15.72%
Percent of indicators rated Failed: 3.57%

Rating Definitions

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

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

Reviewer

Members

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

Kristine Harshaw – Regional Monitor, Department of Juvenile Justice

Duane Gross – Children's Home Society of Florida

Diane Lindsay – Tampa Housing Authority

Rhonda Rhodes, LCSW – Hillsborough County Children's Services

Quality Improvement Review

Youth and Family Alternatives, Inc. (George W. Harris) – April 21-22, 2021
Lead Reviewer: Nitara LaTouche

Methodology

This review was conducted in accordance with FDJJ-1720 (Quality Assurance Policy and Procedures), and focused on the areas of (1) Management Accountability, (2) Intervention and Case Management, 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
- **0** # Case Managers
- **0** # Program Supervisors
- **0** # Food Service Personnel
- **0** # 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
- **5** # MH/SA Records
- **8** # Personnel /Volunteer Records
- **9** # Training Records
- **8** # Youth Records (Closed)
- **7** # Youth Records (Open)
- **0** # Other: _____

Surveys

5 # Youth

18 # Direct Care Staff

0 # Other: **N/A**

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 **hybrid (virtually and on-site)**.

Quality Improvement Review

Youth and Family Alternatives, Inc. (George W. Harris) – April 21-22, 2021
Lead Reviewer: Nitara LaTouche

Monitoring Purpose:

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

Narrative Summary

Youth and Family Alternatives, Inc. has 3 locations across the state of Florida, and is a private not-for-profit community based care agency that provides prevention services, adoption case management, foster case management, reunification, supportive housing and youth crisis shelters. The Youth and Family Alternatives, Inc. G. W. Harris Runaway and Youth Crisis Shelter (GWH) is located at 1060 U.S. Highway 17 South, Bartow, FL 33830. The program is funded by the Florida Network of Youth and Family Services and is contracted to provide Children in Need of Services (CINS) and Families in Need of Services (FINS) and provides both community counseling and shelter services. The community counseling program at GWH is a prevention program that serves youth between the ages of 6-17 years old at risk of runaway, may be habitually truant, and exhibit ungovernable behaviors to assist families with services geared towards improving their behaviors in Polk, Hardee, and Highland counties. The shelter provides services to youth between the ages of 10 and 17 years old, that are at risk of runaway, homelessness, in need of short-term respite or crisis placement due to family conflict or may be in need of emergency shelter placement due to abuse and/or neglect.

Strengths and Innovative Approaches

Due to the COVID-19 pandemic, the closures that occurred in March 2020, impacted the agency as they continued to operate 24/7 with a reduced staff and reduced client base. The program had to implement several changes to their daily operations in order to maintain optimal safety for staff and youth. The agency reduced the census numbers from 21 to an average of 9-15 youth and incorporated new protocols that allowed for more social distancing as available. The program had to significantly increase sanitation and cleaning schedules and youth were limited to one in each room when possible. It was required that everyone wore masks at all times, except for youth during sleep hours.

Despite the agency's best efforts and following new safety precautions, unfortunately, they suffered from a COVID outbreak on July 12, 2020. The Department of Health was contacted and tested all current youth and staff in house as well as all their families if desired. Additional testing was also offered to external coordinating partners who worked 1:1 with some of the youth and families. As a result, 6 youth and 6 staff (including program manager and residential supervisor) tested positive. Program staff that tested positive were sent home to self-quarantine and the program had to close their doors to any new intakes or discharges. The program made the decision to quarantine all positive youth to the dorm and moved all youth that tested negative to the great room with mattresses available for them to sleep. The dedication of the program manager was evident as they volunteered to stay at the shelter to supervise youth that tested positive around the clock for 14 days in order to reduce exposure to any other staff.

During sleeping hours, one staff was isolated to the staff station which was equipped with full personal protective equipment. Youth were directed to sleep with their heads in the hallway so that they were visible from the staff station to allow the program manager to obtain rest as needed. Fortunately, none of the youth had to be hospitalized and some youth were asymptomatic. Staff remained separated from the positive youth for the entire quarantine period.

At the end of the 14 days, youth and staff that tested positive were re-tested and due to testing positive again, the Department of Health recommended the quarantine be continued for another 10 days. Staff supervised youth as required during the extended period, and no other staff working or youth residing in-house tested positive in the second testing during this period. The program received an outpouring of community support as meals were arranged via a Meal Train setup.

Several updates were provided by the program that occurred during the last year at GWH. The program had the following new hire and staff changes as follows: A Counselor joined the team on 6/24/20. The previous registered nurse (RN) left the agency due to a travelling nurse opportunity that developed as a result of the COVID-19 pandemic and a new nurse joined as the new Part-time RN on 10/5/20. One of our staff members left GWH upon completing his Master's Degree in mental health counseling and another member was promoted from Life Skills to Counselor during the transition of this staff member and her previous position was dissolved. The Counselor is currently in pursuit of her Master's degree in Clinical Social Work. Another staff member was hired on 11/21/16 as a PT YDS, however, she continued to be promoted to several other positions including FT YDS, Shift Lead, and has now been promoted to Team Lead as of September 2020.

The program currently has 3 full-time YDS Shift Leads, 4 full-time YDS staff, and 2 part-time YDS staff, as well as one Cook. A staff member left GWH in March due to COVID-19 restrictions, however, since the Basic Center Grant ran out September 29, 2020, this position was not filled again.

The previous Cook passed away 1/24/21 after battling extensive medical issues. The program noted the effect this had on those that knew her and was able to celebrate her dedicated service that she had shown through a celebration of life service where past youth and staff came to share the impact she had made on them.

The program also reported a loss of funding from the three (3) year federal RHY Basic Center Grant which ended on September 29, 2020 that was not renewed. As a result, both the Outreach and Life Skills position was dissolved.

In an effort to fill vacant positions, the office specialist and program manager designed a 12-hour YDS schedule in March 2021 which would be launched at the GWH location only. The new proposed schedule was accepted and is currently in place at the location and the program manager feels it is working well so far. The program engaged with staff to obtain their feedback and reported receiving favorable responses to the changes. Some staff stated the new schedule

gave them a better work-life balance and allowed them the opportunity to pursue other interests such as school, other part time employment, and hobbies. The program has noticed that filling positions with this new schedule format seems to be easier allowing for an improvement in set schedules.

Additionally, the program reported that they lost one vehicle due to mold which brought them down to having 2 mini vans instead of 3 vehicles.

Furthermore, YFA GWH was able to receive DJJ Appropriations in 2019-2020 which resulted in the following:

- Emergency Back Up Generator installed
- Commercial Epoxy Flooring in Common Areas installed
- Exterior Updates to Building (roof vents) & Outdoor Security (camera system)
- New Furniture for the updated computer lab
- Painting throughout the whole shelter
- New electronics including a big-screen TV for the computer lab as well as laptops
- An air hockey table
- A shipping container for additional exterior storage needs

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

Standard 1: One of the indicators in Standard 1 was rated satisfactory (1.07) and 1.02 and 1.03 were rated satisfactory with exceptions. Indicators 1.04, 1.05 and 1.06 were rated limited and 1.01 received a failed rating.

Standard 2: Five of the indicators in Standard 2 were rated satisfactory (2.02, 2.05, 2.06, 2.07, 2.08) and five were rated satisfactory with exceptions (2.01, 2.03, 2.04, 2.09, 2.10).

Standard 3: Three of the indicators in Standard 3 were rated satisfactory (3.02, 3.03, 3.05) and four were rated satisfactory with exceptions (3.01, 3.04, 3.06, 3.07).

Standard 4: Three of the indicators in Standard 4 were rated satisfactory (4.01, 4.02, 4.04) and 4.05 was rated satisfactory with exceptions. Indicator 4.03 was rated a limited.

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

Standard 1:

Indicator 1.01 - Failed

Two staff were missing evidence of suitability assessments prior to date of hire. 3 staff did not have an eligible screen prior to date of hire. One staff was employed with agency originally in 11/2015, left and was rehired 11/16/20 after 10 days of resignation, however, they would have been eligible for a re-screen and there was no evidence of this on file until 3/15/21 and the staff was considered eligible on 3/29/21.

One staff was transferred to shelter on 3/29/21 but did not have an eligible screen until 4/15/21. One staff was screened eligible on 4/5/21, which was received after date of hire 3/29/21. As of

review date on 4/21/21, one staff still did not have an eligible screen since date of hire 10/5/2020. Screening was still in process on DJJ screening form, however, the agency was able to obtain the eligible screen on day 2 of the review. This is a repeat finding from the previous QI review.

Indicator 1.04 - Limited

Four of the nine employee files reviewed indicated several missing and late trainings (first year and in-service employees). Discovered missed trainings were DJJ SkillPro Pt.2, CPR, First Aid, Fire Safety Equipment, Human Trafficking, Child Abuse, PREA, Sexual Harassment, USDOJ Civil Rights & Federal Funds, Program Orientation, Understanding Youth/Adolescent Development, Suicide Prevention Pt.1. Late trainings were DJJ SkillPro Pt. 1, PREA, Sexual Harassment.

Indicator 1.05 - Limited

The agency did not provide consistent evidence of case record review reports for both residential and non-residential case files to indicate reviews are conducted on a quarterly basis. There was no clear consistent analysis or evidence to verify that corrective measures implemented by the programs are regularly reviewed by management and monitored to assess if interventions have been properly implemented.

Indicator 1.06 - Limited

A review of the last six months of transportation events was conducted. A review of this documentation revealed a total of 56 transport events did not have supervisor approval. Additionally, one travel was missing a depart time and three (3) travels were missing return times.

Standard 4:

Indicator 4.03 - Limited

There were a total of 19 medication errors reported out of 31 CCC incidents. There is evidence that one staff member alone has had 8 medication errors since October. Nurse has re-trained this staff three times. Three out of nine staff training files reviewed were missing updated Epi pen, CPR, and First Aid trainings. Furthermore, weekly inventory logs for razors are inconsistent as well as sharps in the kitchen are not being logged.

Quality Improvement Review

Youth and Family Alternatives, Inc. (George W. Harris) – April 21-22, 2021
Lead Reviewer: Nitara LaTouche

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	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 **X** Policy 'Background Screening of Employees/ Volunteers/Interns/ Contracted Providers' - RGC 1.01 was reviewed and revised 3/26/19 by the CEO.	Policy does not include verbiage on suitability assessment tool and scoring function for all direct care staff. Volunteer background screening policy does not include the practice reported by HR and program staff that includes shelter will maintain any completed background screens.
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.		**X**				6 out 8 employee files reviewed contained a suitability prescreening that included evidence of a passing rate prior to date of hire.	**Exception:** 2 staff did not include a suitability screen 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,		**X**				Policy indicates that HR will screen volunteers with 10 hours or more a month but there is no current tracking system to determine that volunteers serving program are meeting this criterion and upon interview with HR and Program Manager it was reported that the Shelter Program is responsible for obtaining and maintaining the	**Exceptions:** 3 staff did not have an eligible screen prior to hire date.

volunteers/interns, and contractors						volunteer background screens when applicable. Per interview with the PM, it was reported that they have 13 volunteers, but it was reported that none of the 13 volunteers exceeds 10 hours per month for the period under review. 5 out of 8 files reviewed completed the required background screen prior to date of hire.	One staff was re-hired on 11/16/20, after 10 days of resignation, however, they would have been eligible for a re-screen and there was no evidence of this on file. One staff was screened eligible on 4/5/21 which was received after date of hire 3/29/21.
Five-year re-screening completed every 5 years from initial date of hire			**X**			No employees were deemed eligible for 5 year re-screen during period of review.	
Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?	**X**					Evidence provided that affidavit of compliance was submitted to BSU on 1/26/21.	
Proof of E-Verify for all new employees obtained from the Department of Homeland Security		**X**				Eight employee files were reviewed. Seven of the eight files reviewed contained proof of e-verify obtained from the Department of Homeland Security. There was a staff rehire after 10 days of resignation. There was no evidence in that one file that demonstrated the agency conducted a review to validate and confirm the employee's e-verify status.	**Exception:** With the staff rehire, the agency did not conduct the proper protocol to provide evidence to confirm an employee's proof of e-verify.
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) X** The policy Abuse Free Environment 1.02 was last reviewed by President/CEO on 5/9/2019 and met the requirements for this indicator.	Policy does not include that Program Director/Supervisor will manage and have access to grievances unless it is towards themselves
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.	**X**					The program has a code of conduct in place and the staff is aware of the policy.	

Child Abuse Registry telephone number is visible to youth and posted common areas of the facility	**X**					The Residential Supervisor was able to conduct a virtual tour and show that the Abuse Hotline and SOGIE signage was visibly posted in the common areas for the youth to read both in English and Spanish in multiple locations.	
Youth were informed of the Abuse and Contact Number (see youth survey results)	**X**					The program outlines that all youth are notified of the abuse reporting hotline at intake and orientation. If at any time an incident should occur with a staff and youth or youth-on-youth, an incident report is written, the Abuse Hotline is always contacted, and the Program Manager/Director is informed. It is clear that no profane language, threats, or intimidation is accepted on their grounds.	
Management takes immediate action to address any incidents of threats or abuse		**X**				There was 1 grievance dated 1/31/21 reported a youth feeling threatened by another youth which was found in the grievance box as unchecked at the time of review. However, the Residential Supervisor explained that they recalled this occasion and this incident was resolved during a house meeting which is the primary way the program is use to resolving problems through their "open door" policy where the youth have access to staff at any time or they can voice concerns through group sessions.	**Exception:** 1 grievance was found during the tour of the facility dated from 1/31/21 and the date of resolution was not documented so unable to determine the exact timeframe of immediate action, however, the Residential Supervisor advised this was addressed in a house meeting with youth and reports it was resolved.
Grievance Process							
Agency has a formal grievance process	**X**					The program has a formal grievance process as the youth can fill out a form and place in a locked box (an envelope stamped "CONFIDENTIAL" is available near the grievance box") and the staff does not have access.	
Locked box accessible to only management and available to youth in a common area	**X**					The grievance boxes are only accessible to the management and are reported to be checked every day. The program advised that they have a reduction in grievances due to utilizing the house meetings to resolve any peer to peer issues and management maintain an open door policy with youth to allow issues to be resolved before escalating.	
Direct care does not handle the complaint/grievance unless assistance is asked for by the youth. Program director/supervisor will have	**X**					The Residential Supervisor on the virtual tour was able to confirm that the direct care staff does not have access to the grievance box. If there is a grievance specific to a supervisor, it would be escalated to their direct supervisor. It was reported that the Residential	

access to and manage grievances unless it is towards themselves.						Supervisor checks the locked boxes for any grievances submitted by the youth. However, the residential counselor advised that they would assist with checking the grievance box if the Supervisor was unable in the past but after further discussion of the requirements they will be changing this practice going forward to supervisor only due to the counselor position not beng deemed as management.	
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.		**X**				For the past (6) months, from September – March, there were a total of (4) grievances which were submitted by youth seeking resolution. One of the four grievances submitted (dated 9/10/20) was resolved within the 72-hour resolution requirement (9/11/20).	**Exception:** The program initially provided a letter stating that they did not have any grievances, but a grievance submitted on 9/4/20, 9/10/20, 9/11/20, and 1/31/21 was later provided. For the 9/4/20 grievance, it was resolved on 9/11/20 (after the 72-hour resolution requirement). For the 1/31/21 grievance, it did not document any resolution. Additionally, during the onsite visit a grievance was left in box for agency to contact Forefront immediately upon receipt of grievance and Lead received call from PS on 4/27/21 at 11:16am. Supervisor explained that this was due to her being out of the office on Friday and Monday and going forward the program will explore options for weekend checks of the grievance box when supervisory staff is not on schedule.

Quality Improvement Review

Youth and Family Alternatives, Inc. (George W. Harris) – April 21-22, 2021
Lead Reviewer: Nitara LaTouche

1.03: Incident Reporting							
Provider has a written policy and procedure that meets the requirement for Indicator 1.03						**YES X NO (explain)** The policy, 1.03 - Incident Reporting, meets the requirements and was reviewed and approved on 2/21/2019.	
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		**X**				During the past (6) months, the program notified the CCC of (31) reportable incidents and (1) was outside of the required two-hour window. In reviewing the (31) CCC reports, there were (19) that were medical incidents, specifically – medication errors.	**Exception:** 1/3/21 - late report – medical incident (med error) - youth given medication next day after their due dosage
The program completes follow-up communication tasks/special instructions as required by the CCC	**X**					The program completed follow ups as instructed by the CCC and it was clearly documented on their internal reports.	
Incidents are documented in the program logs and on incident reporting forms	**X**					All reports are signed and dated by the Program Manager/Supervisor.	
All incident reports are reviewed and signed by program supervisors/directors	**X**					The incident reports are reviewed and signed by the Program Manager or Resident Supervisor.	
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 X NO (explain)** The policy, 1.04 - Training, was reviewed and approved by the President/CEO on 2/1/2021.	
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)*		X				Eight out of 9 training files reviewed demonstrated documentation of the DOJ Civil Rights and Federal Funds training within 30 days from date of hire as required.	**Exception:** 1 out of 9 training staff files did not complete the USDOJ Civil Rights & Federal Funds training – TOTAL = 1 missing trainings
All staff receives all mandatory training during the first 90 days of employment from date of hire.		X				Three out of 5 training files reviewed demonstrated documentation of completed trainings that met the required timeframes.	**Exception:** 2 of the 5 (90-day) training files reviewed did not complete all of the required trainings Civil Rights, Program Orientation, Understanding Youth/Adolescent Development, CPR, First Aid, Suicide Prevention Pt. 1 - (missing trainings) - TOTAL = 6 Missing Trainings
All staff completes all mandatory Florida Network and SkillPro training during the first-year employment.		X				Two of the four (1st year) training files reviewed completed their required Florida Network and SkillPro trainings.	**Exception:** Two of the four (1st year) training files reviewed did not complete the required Florida Network and SkillPro trainings.
Non-licensed Mental Health Clinical Shelter Staff (within first year of employment)							
Non-licensed mental health clinical shelter staff Assessment of Suicide Risk Training			X			No non-licensed clinical shelter staff were eligible to review during this period.	
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			X			No non-licensed clinical shelter staff were eligible to review during this period.	

license number of the licensed mental health professional supervisor).							
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).*		**X**				Two of the four direct care staff completed their required trainings. Two of the four direct care staff had several missing or late trainings.	**Exception:** The missing trainings for two of the four staff were noted as the following: DJJ SkillPro Pt. 2, CPR (2), First Aid (2), Fire Safety Equipment (2), Human Trafficking, Child Abuse, PREA, Sexual Harassment - TOTAL = 11 Late Trainings: DJJ SkillPro Pt. 1, PREA, Sexual Harassment – TOTAL = (3)
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.	**X**					Per information provided on the FileInvite platform, there was evidence provided to confirm the program maintains an individual training file for each staff member. It includes an annual employee tracking form, certificates and sign-in sheets.	
Provider has a written policy and procedure that meets the requirement for Indicator 1.05						**YES X NO (explain)** Policy and procedure 1.05 was approved on May 15, 2019 by the CEO.	
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		**X**				Interviewed the Residential Program Manager, Program Supervisor for Community Counseling and VP of QI for this indicator. 6 months of data was	**Exception:** The agency did not provide evidence that verifies case file

						requested which should include at least 2 quarters of data for this indicator. Only 1 quarterly case review for community counseling program was provided for Feb 2021. A subsequent follow-up visit was conducted by QI for a random sample of files focusing on the items identified needing corrective action. A sample of 4 supervision notes provided for non-res and 1 case review by QI in Feb 2021. The case review indicated that service plans were needing to be measurable and individualized based on services provided to youth. The QI case review results were provided to the program and a CAP was put in place to address items below 85% compliance. The QI department advised there would be follow up within 90-120 days and identified the specific areas of concerns for service plans that would be reviewed at the follow-up visit. Follow up visit from QI department regarding areas identified on internal CAP was completed and results were shared with the program that documented the significant improvements made by the program to address CAP items. Residential program received quarterly case review in Nov 2020 and Community Counseling program received QI case review on Feb 2021. November case review identified areas for improvement: missing suicide assessments, forms not all filled out including sight and sound, youth signatures missing and suicide assessments not signed by PM; late needs assessments, late service plans, and service plans not measurable. Follow up visit from QI department regarding areas identified on internal CAP was completed in March 2021. The QI department sends a notification to the program in advance on 2/17/21 with names of files to be reviewed to ensure that the program has files ready. Internal QI reviewed sample on 3/5-3/8/21, but the results of these findings were not provided at the time of the review.	reviews are being consistently conducted on CINS/FINS clients on a quarterly basis. Further, CQI client file review findings provided to the program (residential) do not have consistent documentation to verify that corrective measures implemented by the programs are regularly reviewed by management and monitored to assess if interventions have been properly implemented, and the desired performance has been achieved.

						The agency submitted a YFA residential shelter case file review scoring tool that was dated 11/1/20. The status of the clients listed in the tool indicate the youth files are DCF, rather than CINS/FINS. Per the definition in the agency's internal CQI plan that states that peer review is for teams to conduct case record reviews to assess quality and compliance. The agency utilizes the Case Review for identifying positive and negative trend data in case documentation and services delivery. The agency provided a copy of CQI worksheet dated 12/9/20. The CQI worksheet included a review of the major deficiencies identified during a residential case file review.	
The program conducts reviews of incidents, accidents, and grievances quarterly, at a minimum	**X**					The program provided meeting notes for their compliance committee meeting scheduled. They discussed critical incidents in February 2021. Critical incidents are included in their weekly huddle called a weekly ELT huddle data report. The VP of QI did provide incident report data for the first two quarters of the fiscal year. There were recent discussions in February, March and April 2021. The agency had a recent increase of medication errors. In June 2020, the agency discussed a plan to implement a series of interventions including training, disciplinary action, and increasing the hours the registered nurse is onsite. There is evidence in monthly meeting shelter minutes that the agency is reminding all staff of the importance and seriousness of reducing medication errors.	
The program conducts an annual review of customer satisfaction data		**X**				There is evidence provided by the agency indicating they conduct a review of customer satisfaction data. The First Quarter Stakeholder involvement team meeting minutes from November 18, 2020 and second Quarterly Stakeholder involvement team meeting minutes from February 11, 2021 were reviewed. The minutes mentioned the data received were DJJ surveys from RAP House and New Beginnings but	**Exception:** There is no customer satisfaction data for the GWH Shelter. The minutes mentioned the data received were DJJ surveys from RAP House and

						none for Harris and none for CINS/FINS population. There was no indication of a resolution provided.	New Beginnings but none for Harris and none for CINS/FINS population. There was no indication of a resolution provided.
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.	**X**					There is evidence the agency reviews Florida Network comparison reports on a monthly basis in the following areas: intakes, bed days, residential year-to-date performance, non-residential year-to-date performance, SNAP in schools, community counseling, needs assessments. There is evidence that the agency has worked directly with the Florida Network in effort to reduce its current level of medication errors.	
The program conducts a monthly review of NetMIS data reports.	**X**					There is evidence the program does conduct monthly review of NetMIS data reports.	
The Florida Network conducts monthly reconciliation by comparing NetMIS data to JJIS data. Agency has evidence that they have reconciled any differences noted.	**X**					VP of IT reviews data reports from the Florida Network and then sends the information to the shelter Office Specialist who will correct and reconcile any deficiencies that may be found.	
The program has a process in place to review and improve accuracy of data entry & collection	**X**					The program does have a process in place to review and improve accuracy of data entry and collection. The office specialist reviews and corrects any deficiencies identified.	
There is documentation that findings are regularly reviewed by management and communicated to staff and stakeholders.	**X**					There is evidence that deficiencies in program services and areas of risk are identified. For example, the agency has a CQI plan that conducts case file reviews on an intermittent basis. There is evidence that the agency places a high priority on informing its staff members of the seriousness of medication errors by establishing a medication error focus group and through monthly shelter meeting minutes.	
There is evidence that strengths and weaknesses are identified, improvements are implemented or modified, and staff are		**X**				The agency did not provide consistent evidence of case record review reports for both residential and non-residential case files to indicate reviews are conducted on a quarterly basis. It does not appear consistent evidence of strengths and/or weaknesses in	

informed and involved throughout the process.						overall maintenance of case records are being assessed and monitored for improvements or progress in areas of concern.	
Provider has a written policy and procedure that meets the requirement for Indicator 1.06						**YES X NO (explain)** The policy, 1.06 - Client Transportation was reviewed and approved on 5/15/19 by the President/CEO.	
Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	**X**					The program provided travel logs dated from September - current from two vehicles: a 2017 & 2018 Kia van. The agency provided documentation outlining an approved list of staff who are authorized to drive the agency vehicles.	
Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	**X**					The approved staff provided valid driver's licenses which enables them to utilize the agency vehicle and to be covered under the agency auto insurance. Initially, the agency provided an expired auto certificate of insurance dated 6/1/19-6/1/20 but later provided a current certificate to the lead reviewer.	
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 party is NOT present in the vehicle while transporting	**X**					The agency policy outlines that the staff would avoid single transports unless there would be at least one other passenger in the vehicle. The policy outlined that the supervisor would be informed if a single transport would be needed and the passenger would sit in the rear of the vehicle.	
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	**X**					If there is not another passenger available, the agency would take into account the youth's recent behavior, history, and evaluation. The agency provided a Single Passenger Request log in which the driver would contact the Supervisor or Program Manager in advance of the travel to receive authorization prior to the travel. In addition, a DashCam was installed in each vehicle and to remain operable. However, in February 2021, the travel logs came to reflect that the cameras were not turned on. After further discussion with the Residential Supervisor and Program Manager, a work order was placed March 2021 as the DashCams lost their adhesive but they were still operational.	

The 3rd party is an approved volunteer, intern, agency staff, or other youth		**X**				The agency provided documentation of transport activity for all vehicles for the past months. A review of this documentation revealed a total of 56 transport events did not have supervisor approval.	**Exception:** (56) of the (6) month travels reviewed did not have a supervisor's approval
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.		**X**				In reviewing the past (6) months of transport activity for all vehicles, the majority of travel logs were updated reflecting the name of the vehicle, the date, name of the driver, date and time (time out/time returned), mileage, DashCam usage, purpose of the trip, any stops (if applicable), and location of travel.	**Exception:** (1) travel was missing a depart time; (3) travels were missing return times
Provider has a written policy and procedure that meets the requirement for Indicator 1.07						**YES X NO (explain)** The provider's policy and procedure for Outreach Services #CS580 was last reviewed on March 14, 2019 by the President/CEO and Board Chair. The policy fully meets the requirement for this indicator.	
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 other verification of staff participation	**X**					The provider maintains an outreach binder that documents all outreach activities, and meetings with the corresponding agendas with notes. Since the agency's last review, the Outreach Specialist position was cut due to budgetary changes. The agency's management team has taken on these Outreach duties. Due to Covid-19 the Outreach has been limited mostly to DJJ/JAC monthly and quarterly meetings. The Residential Supervisors, acting in capacity of the Outreach Specialist, were able to obtain a monetary donation from an event with the local Rotary Club. This event was the first face-to-face meeting since the Covid Pandemic started. The provider participates in the local DJJ board and council meetings to ensure CINS/FINS services are represented. The agendas and notes are included in the outreach binder.	

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.	**X**					The Residential Supervisors, acting in capacity of the Outreach Specialist, were able to obtain a monetary donation from an event with the local Rotary Club. This event was the first face-to-face meeting since the Covid Pandemic started. The provider participates in the local DJJ board and council meetings to ensure CINS/FINS services are represented.	
The program maintains written agreements with other community partners which include services provided and a comprehensive referral process.	**X**					The program maintains many Interagency agreements with a wide array of county and local agencies, schools and providers. Most of the Interagency Agreements have not been updated since its original agreement date. This reviewer was advised by the Program Manager that he had spoken to a representative from the Florida Network and he was informed that if the "agreements" did not have an actual expiration date... that they did not need to be updated. Many of the Interagency Agreements depict the verbiage "This agreement shall be in effect until amended or canceled by either party." The Program Manager stated that he did communicate this to some of the agency partners, but they stated that as long as the agreement doesn't need amending there is no reason to update on their end.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.01						**YES** **NO (explain) X** The agency has a written screening and intake policy that was reviewed on 3/26/2019 and approved on 5/19/2019 by the CEO. The policy and procedure are documented as 2.01.	The policy does not meet the standard as it does not incorporate the updates contained in Quality Improvement Standards Manual of 1/1/2021 regarding the timeframes for referrals and screening in the residential (immediately) and community counseling (3 days) programs.

Quality Improvement Review

Youth and Family Alternatives, Inc. (George W. Harris) – April 21-22, 2021
Lead Reviewer: Nitara LaTouche

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.	**X**					Program Manager was interviewed, and 5 residential (1 open and 4 closed) files were reviewed. All files contained a screening completed within the timeframe required by the standard.	
Community counseling: Eligibility screening is completed within 3 business days of referral by a trained staff using the NetMIS form		**X**				A total of 5 community counseling files were reviewed for screening eligibility. Four of the five client files reviewed had evidence that the eligibility screening is completed with 3 business days of the referral. This finding is within the timeframe outlined by the standard. One client file did not meet the 3 business day requirement from the date of referral to the date of screening.	**Exception:** 1 community counseling file did not meet the three day referral to screening requirement.
Youth and parents/guardians receive the following in writing: a. Available service options b. Rights and responsibilities of youth and parents/guardians	**X**					10 files were reviewed-- 5 residential (1 open and 4 closed), 5 community counseling (2 open and 3 closed). 10/10 files contained written information on the available services and rights and responsibilities in the agency's 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	**X**					10 files were reviewed-- 5 residential (1 open and 4 closed), 5 community counseling (2 open and 3 closed). 10/10 files contained written information on the possible actions through their involvement with CINS/FINS services and grievance procedures.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.02						**YES X NO (explain)** The agency has a written Needs Assessment policy that meets the requirement of the QI indicator. The policy and procedure reference number are 2.02. with a policy review on 3/26/2019 and approved by the CEO on 5/19/2019.	

Quality Improvement Review

Youth and Family Alternatives, Inc. (George W. Harris) – April 21-22, 2021
Lead Reviewer: Nitara LaTouche

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	**X**					This writer reviewed a total 5 residential files (1 open and 4 closed). All 5 files were initiated within 72 hours of admission.	
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	**X**					5 community counseling files were reviewed. All 5 community counseling files reviewed contained Needs Assessments which completed within 2-3 sessions.	
Needs Assessment is conducted by a bachelor's or master's level staff member	**X**					10 files were reviewed. The needs assessments in all files were conducted by bachelor's or master level staff members.	
Needs Assessment includes a supervisor's review signature upon completion	**X**					10 files were reviewed. All files reviewed contained a summary of needs and were reviewed and signed by a Program Supervisor.	
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	**X**					Two (2) files (1 residential and 1 community counseling) contained documentation of youth who was identified risk of suicide as a result of a Needs Assessment.	
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	**X**					In both files the youth were referred for an Assessment of Suicide Risk which was conducted by or under the supervision of a licensed mental health professional.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.03						**YES X NO (explain)** The agency has a written Care and Service Plan policy that meets the requirement of the QI indicator. The policy and procedure reference number is 2.03 with a policy review on 3/26/2019 and approved by the CEO 5/19/2019.	
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	**X**					This writer reviewed a total of ten (10) files-- 5 residential (1 open and 4 closed), 5 community counseling (3 open and 2 closed). All files were completed within 7 working	

						days following completion of the assessment and contained a comprehensive individualized service/case plan.	
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		**X**				5/10 files reviewed plans contained the following elements: date of plan initiation, needs and goals, and responsible individuals, and required signatures. All service plans were well developed and written so that the youth and families could understand them. Aftercare plans were initiated at the time that the original service plans were developed and allowed for linkages to community resources to be completed in a timely manner. The progress notes were clear and aligned with the care/service plans.	**Exception:** 5/5 community counseling files reviewed lacked frequency of service, target and completion dates.

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	**X**					5/5 community files reviewed had service plan reviews that were documented in the chronological notes in all files. However, the files contained a summary sheet of the case reviews which was also used for documentation. The standard is the cases should be reviewed every thirty days (30) for 3 months and every 6 months thereafter. The dates of the review documents were unclear. In talking with someone from the program, some of the dates on the sheet were dates that the case was reviewed with the youth and family and some of the dates were dates that were reviewed with the supervisor.	

Quality Improvement Review

Youth and Family Alternatives, Inc. (George W. Harris) – April 21-22, 2021
Lead Reviewer: Nitara LaTouche

Provider has a written policy and procedure that meets the requirement for Indicator 2.04						**YES** **NO (explain) X** The agency has a written screening and intake policy that was reviewed on 3/26/2019 and approved on 5/19/2019 by the CEO. The policy and procedure are documented as 2.04.	The policy does not meet the standard as it does not incorporate the updates contained in Quality Improvement Standards Manual of 1/1/2021 which states that the program maintains written agreements with community partners that include services provided and a comprehensive referral process.
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Counselor/Case Manager is assigned	**X**					This writer reviewed a total of ten (10) files were reviewed, 5 residential (1 open and 4 closed), 5 community counseling (3 open and 2 closed). All the files documented an assigned counselor/ case manager.	
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)	**X**					In all of the files reviewed the counselor/case manager has developed a comprehensive case plan based on the needs assessment. Service plans were coordinated and monitored for progress and/or barriers. Service engagement was clearly documented and when families were not engaged staff attempted to engage them by telephone and correspondence. Staff monitored the services provided and their effectiveness. The two youth that I reviewed for case staffing intervention were the result of program staff addressing issues identified through assessments and monitoring youth/family needs. Appropriate community referrals were made.	

6. Makes referrals to the case staffing to address problems and needs of the youth/family 7. Accompanies youth and parent/guardian to court hearings and related appointments 8. Refers the youth/family for additional services when appropriate 9. Provides case monitoring and reviews court orders 10. Provides case termination notes 11. Provides follow-up after 30 days of exit 12. Provides follow-up after 60 days of exit						Case termination notes with aftercare plans were evident in the 6 files that were closed. 4/10 did not have 30/60 follow-up due be recently closed. 2 applicable files had 30/60 follow-up documented in the records.	
The program maintains written agreements with other community partners that include services provided and a comprehensive referral process	**X**					Include examples of written agreements with community partners: Peace River Mental Health Center, Tri-County Mental Health Center, Polk County Schools, Behavioral Health Center of Winter Haven.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.05						**YES X NO (explain)** The agency has a written counseling services policy that was reviewed on 3/26/2019 and approved on 5/19/2019 by the CEO. The policy and procedure are documented as 2.05. An observation was made that the verbiage "Non-Residential programs" should be switched out with Community Counseling.	
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	**X**					10/10 files were reviewed. All files demonstrated evidence of case coordination, case management and aftercare. All files documented counseling services being provided according to the assessment and service plan.	
Shelter Program							
Shelter programs provides individual and family counseling	**X**					5/5 files reviewed demonstrated evidence that individual and family therapy was being conducted.	
Group counseling sessions held a minimum of five days per week	**X**					Group Notes were provided from October to April. In reviewing the notes groups were being provided a minimum of 5 days a week.	

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	**X**					Group notes had all the elements delineated in the standard: clear leader or facilitator; relevant group topics; opportunity for youth to participate, sign in sheets and a time frame of a minimum of 30 minutes.	
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.	**X**					In the 5/5 files reviewed services were provided in the school as well as in the office and telephonically. Program staff is very adept at service engagement with these youth and families and used an array of therapeutic modalities to help the youth and families stabilize and progress.	
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	**X**					The case files clearly reflected coordination between the presenting problems, psychosocial assessment, case plan, service plan reviews, case management and follow-up. The integration of the elements and advocacy of the YFA counselors was seen especially in resistant youth and families.	
Maintain individual case files on all youth and adhere to all laws regarding confidentiality	**X**					5/5 files were reviewed. The program creates individualized case files that adhere to all laws regarding confidentiality.	
Case notes maintained for all counseling services provided and documents youth's progress	**X**					Case notes are maintained on each youth and family. The case notes are well written and documents the youth's progress and barriers to that progress.	
On-going internal process that ensures clinical reviews of case records and staff performance	**X**					There is evidence that the program has a process that ensures clinical review of case records.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.06						**YES X NO (explain)** The agency has a written Adjudication/Petition Process policy that meets the requirement of the QI indicator. The policy and procedure reference number are 2.06 with a policy review on 3/26/2019 and approved by the CEO 5/19/2019.	

Quality Improvement Review

Youth and Family Alternatives, Inc. (George W. Harris) – April 21-22, 2021
Lead Reviewer: Nitara LaTouche

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	X					Two (2) case staffing files were reviewed. Each file had a written request for a staff initiated by YFA Program staff.	
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	X					2/2 files contained the required documentation and notifications of youth/family and committee members according to the established timeframes.	
Case Staffing Committee							
Must include: a. DJJ rep. or CINS/FINS provider b. Local school district representative	X					The case staffing committee included a CINS/FINS representative and school district representative.	
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	X					No other committee members were involved in either case.	
The program has an established case staffing committee, and has regular communication with committee members	X					The program has an established case staffing committee with consistent members and has regular communication with the members.	
The program has an internal procedure for the case staffing process, including a schedule for committee meetings	X					The program has an internal process for consistent communication, case follow-up and meeting schedule. Copies of correspondence letters, recommendations from the committee members, staffing notes, service plans and progress notes were contained in the youth's file. Advocacy and service engagement by the YFA staff was reflected in the files reviewed.	

Quality Improvement Review

Youth and Family Alternatives, Inc. (George W. Harris) – April 21-22, 2021
Lead Reviewer: Nitara LaTouche

As a result of the Case Staffing							
The youth and family are provided a new or revised plan for services	**X**					In 2/2 files reviewed, the youth and families were provided with revised case 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	**X**					2/2 files reviewed. The parent/guardian were provided with a written report the day of the staffing with the recommendations and rationale.	
If applicable, the program works with the circuit court for judicial intervention for the youth/family					**X**	N/A There was no court involvement.	
Case Manager/Counselor completes a review summary prior to the court hearing					**X**	N/A There was no court involvement.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.07						**YES X NO (explain)** The agency has a written Youth Records policy that meets the requirement of the QI indicator. The policy and procedure reference number are 2.06 with a policy review on 3/26/2019 and approved by the CEO 5/19/2019.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
All records are clearly marked 'confidential'.	**X**					12/12 files were reviewed. All records were marked confidential.	
All records are kept in a secure room or locked in a file cabinet that is marked "confidential"	**X**					All twelve (12) files were maintained in a locked file room as reported by Peer Review staff who toured the facility.	
When in transport, all records are locked in an opaque container marked "confidential"	**X**					A picture of file transport case was provided by program staff.	
All records are maintained in a neat and orderly manner so that staff can quickly and easily access information	**X**					All files reviewed were neat, organized, and information was easily accessible.	

Quality Improvement Review

Youth and Family Alternatives, Inc. (George W. Harris) – April 21-22, 2021
Lead Reviewer: Nitara LaTouche

Provider has a written policy and procedure that meets the requirement for Indicator 2.08						**YES X NO (explain)** The agency does have a policy (Residential Group Care 2.08 Sexual Orientation, Gender Identity and Gender Expression) signed on 5/21/2019 by the CEO.	
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	**X**					There was 1 file identified as a SOGIE youth. It was noted that youth was addressed with the preferred name and gender pronoun. The preferred name was noted in their file on outward facing documents.	
Youth in need of specialized support is referred to qualified resources (as applicable)					**X**	No youth were identified that needed specialized support.	
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	**X**					Youth was considered and documented for room assignment. Youth was in not roomed in isolation due to sexual orientation, gender identity, or gender expression.	
Youth is provided hygiene products, undergarments and clothing that affirms their gender identity or gender expression	**X**					Youth was provided hygiene products, undergarments and clothing that affirms their gender identity or expression.	
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	**X**					The agency has signage placed in common areas indicating that all youth are welcome regardless of sexual orientation, gender identity and gender expression.	

Quality Improvement Review

Youth and Family Alternatives, Inc. (George W. Harris) – April 21-22, 2021
Lead Reviewer: Nitara LaTouche

Provider has a written policy and procedure that meets the requirement for Indicator 2.09						**YES X NO (explain)** The agency does have a policy (Special Populations) reviewed and revised on 3/26/2019 and approved on 5/15/2019 by the CEO.	
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** **X**	**N/A**			The program reports they did not have any youth meeting this criterion since the last onsite 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			**X**				
Program only accept youth that meet legal requirements of F.S. 984 for being formally court ordered in to Staff Secure Services			**X**				
Staff Assigned: a. One staff secure bed and assigned staff supervision to			**X**				

one staff secure youth at any given time b. Program assign specific staff during each shift to monitor location/ movement of staff secure youth c. Agency clearly documents the specific staff person assigned to the staff secure youth in the logbook or any other means on each shift							
Agency provides a written report for any court proceedings regarding the youth's progress			**X**				
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** **X**	**N/A**			The program reports they did not have any youth meeting this criterion since the last onsite QI 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			**X**				
Services provided to these youth specifically designated services designed to serve DMST youth			**X**				
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?			**X**				
Length of Stay: a. Youth in program do not have length of stay in DMST			**X**				

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.)							
Agency has evidence that staff assigned to DMST youth under this provision are to enhance the regular services available through direct engagement in positive activities designed to encourage the youth to remain in shelter			**X**				
All other services provided to DMST youth are consistent with all other general CINS/FINS program requirements			**X**				
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** **X**	**NO**	**N/A**				
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	**X**					There were two files reviewed for DV respite. Both youth had a pending DV charge and evidence of being screened by JAC/Detention, but do not meet criteria for secure detention.	
Data entry into NetMIS and JJIS within (3) business days of intake and discharge	**X**					Data entry into NetMIS and JJIS within 3 business days of intake and discharge was evident for the two youth files.	
Youth in program do not have length of stay in DV Respite placement that exceeds 21 days. If more than 21 days,	**X**					Neither of the youth stays exceeded 21 days.	

documentation exists in youth file of transition to CINS/FINS or Probation Respite placement, if 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	**X**					One of the youth's case plan reflected goals according to what needed to be addressed. The other youth file did not have a case plan developed because the youth was discharged four days after intake.	
All other services provided to Domestic Violence Respite youth are consistent with all other general CINS/FINS program requirements	**X**					All other services provided to the DV respite youth were consistent with all other general 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** **X**	**NO**	**N/A**				
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
All probation respite referrals are submitted to the Florida Network.		**X**				The agency provided two probation respite client files for review. There was evidence of a referral submitted to the Florida Network.	**Exception:** One of the files did not have evidence of a referral submitted to the Florida Network.
Probation Respite Referral come from DJJ Probation and are all youth referred on probation regardless of adjudication status	**X**					Two out of two files reviewed had evidence that the probation respite referral did come from DJJ Probation.	
Data entry into NetMIS and JJIS within (3) business days of intake and discharge	**X**					Two out of two files had their data entered into NetMIS and JJIS within 3 business days of intake and discharge.	
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)	**X**					Length of stay for two files reviewed revealed the youth's placement was a stay of less than 14 days.	

Quality Improvement Review

Youth and Family Alternatives, Inc. (George W. Harris) – April 21-22, 2021
Lead Reviewer: Nitara LaTouche

All case management and counseling needs have been considered and addressed	**X**					All case management and counseling needs have been considered for both client files reviewed.	
All other services provided to Probation Respite youth are consistent with all other general CINS/FINS program requirements		**X**				One of the two client files had evidence that all other services provided was consistent with all other general CINS/FINS program requirements.	**Exception:** One of the two client files reviewed did not have evidence of completed documents that includes the following: consent for services, behavior management acknowledgement, consent for emergency treatment and COVID-19 rapid testing consent.
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** **X**	**NO**	**N/A**				
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	**X**					There were two youth files reviewed for intensive case management. The two youth receiving services was court ordered or referred by case staffing committee.	
Services for youth and family include: a. Four (4) direct contacts per month b. Four (4) collateral contacts per month		**X**				Of the two files reviewed for intensive case management, both files did not demonstrate consistent four direct or collateral contacts per month.	**Exceptions:** One of the client files noted in their supervision notes at least five months of missed 4 direct and collateral contacts per month. The other client file noted in their supervision notes at least five months missed in direct and collateral

							contacts per month. However, notes of attempt were mentioned in progress notes.
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)		**X**				For two out of the two files reviewed, the child behavior checklist was completed within 14 days of intake. There is evidence of an approved self-report assessment that was completed at intake and evidence of an approved self-report assessment that was completed every 90 days.	**Exception:** One of the client files did not provide evidence of an approved self-report assessment that was completed. The other client file did not provide evidence of a self-report assessment that was completed every 90 days thereafter.
Case plan demonstrates a strength-based, trauma-informed focus	**X**					For both client files reviewed, the case plan demonstrated a strength-based, trauma-informed focus.	
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	**X**					From both files reviewed, there is sufficient evidence that the agency has a strength-based perspective in the areas such as engaging the family, advocating on their behalf, initiating change agent activities, helping to access supports in the community.	
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 conducted? **(If no, select rating "No eligible items for review")**	**YES**	**NO** **X**	**N/A**			The program reports they did not have any youth meeting this criterion since the last onsite QI review.	

Quality Improvement Review

Youth and Family Alternatives, Inc. (George W. Harris) – April 21-22, 2021
Lead Reviewer: Nitara LaTouche

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							
Agency has evidence that all FYRAC referrals have documented approval from the Florida Network office							
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							
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							
Group Sessions: a. Focus on the same issues as individual/family sessions with the overall goal of strengthening 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							
2.10: STOP NOW AND PLAN (SNAP)							
Provider has a written policy and procedure that meets the requirement for Indicator 2.10						**YES X NO (explain)** There is a policy and procedure that meets the requirement of the Indicator, SNAP RGC 2.10. It was created on 8/28/19 and approved by the CEO on 2/11/20.	
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	**X**					A review of three SNAP client files was conducted to determine the agency's adherence to this indicator. A review of the client files provided indicated that all youth had evidence there was a screening completed to determine their eligibility for the SNAP program.	
Needs assessment is completed at initial intake, or within two face-to-face sessions	**X**					A review of three SNAP client files was conducted to determine the agency's adherence to this indicator. A review of the client files provided indicated that all youth had a needs assessment completed during the intake process within a week.	
SNAP Assessments a. Child Behavior Checklist (CBCL) is completed by the caregiver (pre & post)		**X**				A review of three SNAP client files was conducted to determine the agency's adherence to this indicator. Two of the three files had a completed pre-and post-child behavior checklist.	**Exceptions:** One SNAP client file did not have evidence of a completed pre- and post- child behavior checklist.

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)						All three files had evidence of Teacher Report Forms (TRF). However, all TRF forms were blank and marked not applicable (N/A) due to teachers being inaccessible. A review of the three SNAP client files revealed that two of these files had evidence of a pre-and post TOPSE form present in the file. A review of two of the three files contained pre-PAT assessments. One of the three files contained post-PAT assessments.	One SNAP client file did not have evidence of a completed pre- and post- TOPSE form present in the file. One SNAP client file did not have evidence of a completed pre-PAT assessment. Two of the three files did not have evidence of post-PAT assessments.
SNAP discharge report summary	**X**					A review of the two closed SNAP files revealed a discharge report summary. The third file was still open, therefore did not have a discharge summary.	
SNAP Boys/SNAP Girls **Parent** Group Evaluation Form	**X**					A review of the three files provided revealed all files contained the parent group evaluation forms.	
SNAP Boys/SNAP Girls **Child** Group Evaluation Form		**X**				A review of the three files provided revealed two files had a child group evaluation.	**Exception:** One of the closed files did not have evidence of a child group evaluation form.
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)			**X**			The program did not yet have a full cycle completed at the time of the review period.	
"Class Goal" sheet			**X**				
Measure of Classroom Environment (MoCE) (Pre and Post) is used to identify			**X**				

baseline and treatment outcomes of reported classroom dynamics.							
Pre and Post Evaluations			**X**				
One SNAP® Fidelity Adherence Checklist completed per classroom in a 13 – week SNAP in Schools group and uploaded to Dropbox			**X**				
Provider has a written policy and procedure that meets the requirement for Indicator 3.01						**YES X NO (explain)** The agency policy RGC 3.01 meets the requirement of the indicator and was last approved on 8/20/19 by the COO and President/CEO.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Facility Inspection		**X**				The policy dictates the shelter environment shall be clean, neat, well maintained, safe, and to the extent possible, reflect a home-like environment. During the virtual tour of the facility (4/21/21), as well as a physical tour of the facility by Forefront Reviewer, an inspection of the shelter environment was conducted. The furniture in the common areas was observed to be in good condition and youth rooms in both dorms had appropriate bedding. The facility utilizes two contractors to treat the building for insects and rodents quarterly. The facility was observed to be very clean and insect & rodent free. The grounds and landscaping were well maintained. Mandatory requirements were observed throughout the facility which includes; two first aid kits (Kitchen Pantry & Nurse Station) were found to be expired, multiple egress maps, fire extinguisher locations were all up-to-date with inspections, two grievance boxes, whereas one box when opened during the tour by the Residential Supervisor had a grievance form written on 1/31/21 still in it, and a suicide response kit was located in the Nurse Station. All Bathrooms and shower areas were found to be clean and functional.	**Exceptions:** Garbage Dumpster ½ lid remains opened due to Sanitation Truck pushing the dumpster back too far preventing lid from opening. During virtual tour, one of the two operating vans had an unlocked driver's side door. Current Food Menus are signed by Dietician on 10/30/19. It was not current. First Aid Kits in Facility and Vans are expired. Note: PM stated that two (2) First Aid Kits were purchased on 4/21/21 (before the end of the QI review) to replace in vans.

						There is no evidence of graffiti in the building. Interior lighting is bright and functional, and the exterior lighting is functional and set on a timer. Key turn-overs for staff from shift-to-shift are tracked in the facility logbooks. Reviewed documentation verified that the Key control measures are being followed and documented as required. The program utilizes two vehicles (2 Vans) for transportation purposes (another vehicle is on property but not utilized due to needing repairs). One vehicle's driver side door was unlocked during tour, while the other van was locked and secured. Emergency equipment (fire extinguisher, first aid kit, and flashlight) were stored in a box in the rear of both vehicles, however; both first aid kits were expired and a flashlight was missing from one van, and inoperable in the other van. Note: The first aid kits in both vehicles were replaced with new ones by the Program Manager on 4/21/21. Also, new flashlights were placed in both vans on 4/22/21 by the Program Manager. The Disaster plan was updated July 2020 for the 2020-2021 fiscal year. The Fire Safety Inspection was completed on 10/20/20 by the Bartow Fire Department with no violations noted. The Water-Based Fire Protection Systems Inspection (Sprinkler System) was inspected on 11/19/20 with no deficiencies noted. The Annual Exhaust Hood Fire Suppression System (kitchen) was inspected on 9/2/20 with no deficiencies noted. The Residential Group Home Inspection Report was completed on 4/14/21 with one violation (Maintenance: Damaged ceiling tiles). The agency's food menus signed by a Dietician were observed to be out of compliance as the date signed was 10/30/19 and is required to be done annually. The agency has a current DCF Child Care License that is valid until December 18, 2021. The agency also received their COA accreditation through 10/31/24. The program advised that Terminix comes out quarterly to handle pest control. Truly Nolen comes out just to check on the black rodent boxes situated around the outside of the building as per their contract.	Facility Vans (one van missing flashlight and one van has inoperable flashlight). Note: PM was able to replace flashlights on 4/22/21 (before the end of the QI review). Dust accumulation behind washers & dryers.

Fire and Safety Health Hazards		**X**				The fire safety inspection was completed on October 20, 2020 with no violations noted. Fire drills are required to be conducted at least once a month and not to exceed two minutes in duration. Multiple fire drill forms were reviewed for the past 6 months of which three drills exceeded the two-minute timeframe. Additionally, it was verified that one fire drill was held on each shift per for the last two quarters. Note: The agency went from three 8-Hour Shifts to two 12-Hour Shifts in March 2021.	**Exception:** Fire Drills Evacuation Times on 12/4/20 (4 minutes), 12/7/20 (3 Minutes) and 1/19/21 (6 Minutes). All fire drill times exceeded the evacuation time of two minutes.
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. e. Daily programming schedule is publicly posted and accessible to both staff and youth.	**X**					The program's daily and weekend schedules reflect meaningful and structured activities, which includes education, recreation, counseling services, life and social skill trainings. The schedule also depicts indoor and outdoor activities. Youth are provided the opportunity to attend faith-based opportunities twice a week, with an alternate activity to those who wish not to participate in the faith-based activity. Faith-Based Activities were verbally stated that they take place in the shelter on Wednesday & Friday evenings. A review of the daily activity schedule found that there is no definitive "faith-based activity" nor time noted on the daily schedule. Reviewer was able to determine through logbook entries and staff schedules when the pastor/church representative entered and exited facility after faith-based service for clients. Homework times and reading times are also reflected on the program's schedules.	

Quality Improvement Review

Youth and Family Alternatives, Inc. (George W. Harris) – April 21-22, 2021
Lead Reviewer: Nitara LaTouche

Provider has a written policy and procedure that meets the requirement for Indicator 3.02						**YES X NO (explain)** The agency policy RGC 3.02 meets the requirement of the indicator and was last approved 5/15/19 and signed by the President/CEO and the COO signed and approved the policy on 5/9/19.	
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	**X**					Five youth records were reviewed for this indicator. Each youth received a comprehensive orientation and handbook within 24 hours of admission. All files contained thorough documentation of the program orientation process.	
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 awareness of others having suicidal thoughts	**X**					Five youth records were reviewed for this indicator. Client orientation is completed within twenty-four (24) hours and includes the following topics: explanation of disciplinary actions, grievance procedure, contraband rules, information on shelter admission requests, shelter admissions, abuse hotline, youth room assignment, shelter orientation, correspondence, grooming, laundry/linens/bedding, BMS (6 Pillars) & Youth Level Advancement, youth supervision, and the alert system. Youth admitted to the shelter go through a new client orientation process, which encompasses all the required areas found on the Client Orientation Check List.	
Documentation of each component of orientation, including orientation topics and dates of presentation, as well as signatures of the youth and staff	**X**					The program's orientation component for new admissions is properly documented to include all topics, signatures and dates of the Admitting Staff and new client.	

involved is maintained in the individual youth record							
Provider has a written policy and procedure that meets the requirement for Indicator 3.03						**YES X NO (explain)** The agency has a written policy and procedure, RGC 3.03 - Youth Room Assignment that meets the requirement of the indicator and was last approved 5/15/19 and signed by the President CEO and the COO.	
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 j. Sexual orientation gender identity/ expression k. Acute health symptoms requiring quarantine or isolation	**X**					The Team Lead or Youth Development Staff on duty is responsible for reviewing the youth's intake packet and case file to assess youth's history, status and exposure to trauma. Youth who are deemed to be a potential threat will be separated from other youth. Room assignments are documented on the Admission Sleeping Assignment Form which takes into consideration the following criteria: age, gender, history of violence, medical or physical disabilities, physical size and strength, gang affiliation, suicide risk, sexually aggressive or predatory behavior, sexual orientation, gender identification/expression, maturity level, individual needs, acute health symptoms requiring quarantine or isolation, or other special needs noted. There were five residential files (1 open, 4 closed) reviewed for this indicator. All five youth files contained documentation of the youth's history, age, gender, history of violence, medical or physical disabilities, physical size and strength, gang affiliation, suicide risk, sexually aggressive or predatory behavior, sexual orientation, gender identification/expression, maturity level, individual needs, acute health symptoms requiring quarantine or isolation, alerts, collateral contacts, and initial interactions/observations. Youth room assignments are made with consideration of various tools and data compiled during intake and orientation. Youth determined to be a potential threat to staff, other youth, or themselves are assigned in bedrooms closer to the staff monitoring station and are separated from other youth.	

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	X					All alerts referencing a youth's special needs and risks such as risk of suicide, mental health, substance abuse, physical health or security risk factors are documented accordingly in the client files.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.04						**YES X NO (explain)** The agency has a written policy and procedure, RGC 3.04 Log Books, that meets the requirement of the indicator and was last approved 5/21/19 and signed by the President/CEO and the COO.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Log book entries that could impact the security and safety of the youth and/or program are highlighted		X				There were numerous Safety/Security Issues not highlighted in the log book entries that could impact the security and safety of the youth and/or program.	**Exceptions:** Numerous Safety/Security Issues not highlighted: Youth taken to Urgent Care due to High Fever (Intake Delayed). Program notified by parent that youth with severe allergies and in need of an Epi-Pen. Two (2) areas where clients medication times were changed, one of which medication was placed in another location (other than pyxis). Youth threatened to stab staff member.

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		**X**				The policy dictates that logbooks in the shelter are to document all daily activities, events, and incidents in the program. Furthermore, the operating procedure requires highlighted logbook entries that could impact security and safety of the program, date and time of incident, event or activity, names of youth and staff involved, brief statement of pertinent information, and staff making entry with date and time of signature. The program confirmed logbooks are retained for a period of no less than three years. The Program Director or designee shall review the logbook every week and make a note in the logbook as to any corrections, recommendations, and follow up required. The oncoming supervisor and YDS staff shall review the logbook for the previous two shifts. A total of six weeks (1 week a month for 6 months) was uploaded into the portal for this review. All entries reviewed were brief and legibly written in ink. The staff did not follow the logbook requirement that safety and security issues that could impact the youth and/or program are highlighted. There were multiple incidents reviewed through the course of the six weeks of entries reviewed that should have been highlighted but were not. All entries included dates and times of incidents/activities/events, names of youth and staff involved, a brief statement containing pertinent information, and signature and/or initials of staff making the entry. There were no noticeable uses of white-out, nor erasure use. The staff did follow the log book requirement to strike out the error and initial. The Program Director and/or Designee (Res. Supervisor) did not follow the requirement to review the facility logbook weekly and note any follow-ups needed. Of the six weeks of entries reviewed only 1 entry on 10/2/20 depicted the Res. Supervisor weekly review. There are no Security Surveillance Reviews by PM or Designee depicted in the logbook as stated in agency policy (Indicator 3.04). However, a separate Surveillance Log is utilized. Practice described by PM is that an entry is entered in logbook depicting date and time to coincide with the Surveillance Log, but after review this practice could not be verified.	**Exceptions:** After review of 6 weeks of logbook entries, there was only one (1) entry on 10/2/20 depicting a Res. Supervisor Weekly Review. No PM reviews noted. The agency does not have consistent weekly evidence in the logbook that documents the review period the Program Manager or shelter supervisor reviews the logbook to become aware of any general activities, unusual occurrences or problems.

						Entries that were made contained shift-to-shift turn-over inputs which detail the census, medical count, key exchange, and any significant issues from the previous shift. Throughout the logbooks there were annotations of intakes, discharges, snack and meal times, 15-minute checks and headcounts. Logbook Entries Reviewed: 10/1/20 - 10/7/20, 11/7/20 - 11/13/20, 12/21/20 - 12/28/21, 1/21/21 - 1/28/21, 2/1/21 - 2/7/21, 3/8/20 - 3/14/21	
Recording errors are struck through with a single line. The staff person must initial and date the correction. The use of whiteout and erasures is prohibited.	**X**					The program's logbook reflects recording errors are struck through with a single line, with the staff initials and date of correction included. There were no areas reviewed that depicted the use of whiteout and/or erasures usage.	
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		**X**				After review of 6 weeks of logbook entries, there was only one (1) entry on 10/2/20 depicting a Res. Supervisor Weekly Review.	**Exception:** Program manager and residential supervisor reviews were not documented in the logbook weekly as required.
All staff review the logbook of the previous two shifts and makes an entry signed and dated into the logbook indicating the dates reviewed	**X**					After review of the program's logbook entries, the staff when signing in for their shift include the review of two previous shifts and signed & dated.	
At the beginning of their shift, oncoming supervisor and shelter counselor reviews the logbook of all shifts since their last log entry and makes a signed and dated entry and into log book indicating the dates reviewed.	**X**					The Team Leads and/or residential supervisor review the logbook at the beginning of their shifts, signed and dated.	
Logbook entries include: a. Supervision and resident counts b. Visitation and home visits	**X**					Client counts and client visitation and home visits are documented accordingly.	

Quality Improvement Review

Youth and Family Alternatives, Inc. (George W. Harris) – April 21-22, 2021
Lead Reviewer: Nitara LaTouche

Provider has a written policy and procedure that meets the requirement for Indicator 3.05						**YES X NO (explain)** The agency has a written policy and procedure, RGC 3.05- Behavioral Management, that meets the requirement of the indicator and was last approved 5/15/19 and signed by the President/CEO and COO.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
The program has a detailed written description of the BMS, and it is explained during program orientation	**X**					The agency utilizes a proactive behavioral management system that highlights positive and preventative measures in the managing of the youth behaviors. The program uses a tiered system which consists of four levels of advancement within the Advancing Youth Development (AYD) curriculum. Advancement for eligibility to leveling up consists of a baseline time period for each level; Orientation (3 days), Educations (4 days), Graduation (7 days) and then final level of the program is Collegiate. Each level instructs the youth to achieve multiple goals, which promotes positive behavioral choices and healthy decisions among program clients. Each level during the youth's placement at the residential facility will focus on twelve key areas to promote positive youth development. There are five areas with specific targeted behavioral goals that are consistent with the six identified character development issues from the Character Counts Curriculum. The BMS offers an array of awards and incentives to inspire member participation and completion of the program. Each youth's pace for advancement is ultimately based on the youth's behavior, commitment, goal-oriented, and compliance.	
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	**X**					The program is a Staff Secure "Hands Off" Facility so the utilization of mechanical restraints is not allowed. The staff utilize de-escalation strategies to manage difficult situations. Staff are trained in Managing Youth Behavior (MAB) and Why Try curriculums to training staff on de-escalation tactics. The BMS focuses on six pillars of character (Trustworthiness, Respect, Responsibility, Fairness, Caring and Citizenship) to instill within each member that they are responsible and accountable for his/her actions, encouraging them to think before they act and be aware of consequences. There were five residential files (4 closed, 1 open) reviewed for this indicator. Documentation was evident in all 5 residential files that thorough orientation is conducted and documented for each youth. The documentation reviewed	

encourage participation and completion of the program d. Appropriate consequences and sanctions are used by the program and consequences for behavior are logical and designed to promote skill-building for the youth e. Counseling, verbal intervention and de-escalation techniques are used prior to physical intervention (Only techniques approved by the Florida Network and DJJ are used if physical intervention is required) f. Only staff discipline youth. Group discipline is not imposed g. Room restriction is not used as part of the system or for youth who are physically and/or emotionally out of control h. Youth should never be denied basic rights such as meals, clothing, sleep, services, exercise, or correspondence privileges						is detailed and reflected the fulfillment of BMS educational, consent, and feedback mechanisms which are available for the youth.	
Program's Use of the BMS							
All staff are trained in the theory and practice of administering BMS rewards and consequences	**X**					Staff training records reflect that they are trained in the BMS practice and administration.	
There is a protocol for providing feedback and evaluation of staff regarding their use of BMS rewards and consequences	**X**					The PM provided documentation, as well as how feedback and evaluation of staff's execution of the program's BMS.	

Supervisors are trained to monitor the use of rewards and consequences by their staff	**X**					The PM provided documentation, as well as how feedback and evaluation from Supervisors monitoring their staff's execution of the program's BMS.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.06						**YES X NO (explain)** The agency has a written policy and procedure RGC 3.06 which details Staffing levels and On-Call/Scheduling that addresses all the key elements of the QI indicator and was approved by the President/CEO and COO on 5/15/19.	
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	**X**					The procedures address staff-to-client ratios, On-call duties, and Youth Supervision. The staff-to-client ratios section discusses the following topics: the need for both male and female staff working at all times with a staff awake ratio of 1:6 and an asleep ration of 1:12, utilization of part-time employees, documentation requirements for staff in the log, and On-Call procedures. All shifts maintain a minimum of two (2) staff present. The program staff schedule is provided to staff and is posted in the staff command center. The program utilizes cameras to provide surveillance coverage of both the interior & exterior of the facility. There are a total of 22 cameras which provide adequate monitoring of the facility and youth. The surveillance system records and stores data on a back-up device for 30 days. A random selection of overnight checks was conducted and verified staff's observation and documentation of bed checks every 15 minutes. The selection consisted of 3 days with 6.5 hours of video review consisting of varying blocks of time. This allowed for verification of the awake and asleep ratio and staffing requirements. Staffing ratios of 1:6 during wake hours and 1:12 during sleep hours were observed to be in compliance. Video surveillance and logbook entries coincide with one another.	
All shifts must always provide a minimum of two staff present	**X**					The representation of two or more staff on each shift was verified with the staff schedules reviewed.	

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		**X**				A review of the program staff included in staff-to-youth ratio were background screened. There were five out of nine staff that completed the proper training.	**Exception:** There were four out of nine staff files that had evidence of one or more missing trainings.
The staff schedule is provided to staff or posted in a place visible to staff	**X**					The schedule is provided to each staff by the PM, as well as posted in a visible place in the staff command center.	
There is a holdover or overtime rotation roster which includes the telephone numbers of staff who may be accessed when additional coverage is needed	**X**					A rotation roster including staff contact information is posted in the staff command center.	
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	**X**					All bed checks were completed accordingly in real time. Physical layout of sleeping arrangements: There are two separate dorm hallways (boys & girls), where a staff command center sits between the two.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.07						**YES X NO (explain)** The agency has a written policy and procedure, RGC 3.08- Video Surveillance that addresses all the key elements of the QI indicator and was approved by the President/CEO and COO on 8/21/19.	
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	**X**					The policy ensures that the shelter provides a secure environment, protects its facilities, and enhances the safety of youth, staff, and visitors. Cameras are in the interior (e.g. Intake Office, Counseling Office, dining/kitchen area, day room) and exterior (e.g. entrance/exit, recreation area, parking lot) general locations of the shelter where youth and staff congregate and where visitors enter and exit. There is a written notice displayed at the front entrance of the facility which	

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 and where visitors enter and exit. Cameras are never placed in bathrooms or sleeping quarters. f. All cameras are visible						indicates video surveillance in the building. Staff maintain 2 logbooks: 1 for the girls and 1 for the boys. The surveillance system is equipped with 22 cameras. The system can capture and retain video photographic images for a minimum of 30 days. Video surveillance is only accessible by designated personnel (Residential Supervisor, Program Director) and is to be reviewed a minimum of every 14 days and noted in a logbook and the Video Surveillance Log Binder. Observation of the video surveillance noted that data was available up to 30 days. A random selection of overnight checks was conducted and verified staff's observation and documentation of bed checks every 15 minutes. The selection consisted of 3 days with 6.5 hours of video review consisting of varying blocks of time.	
A list of designated personnel who can access the video surveillance system is maintained (includes off-site capability per personnel)?	**X**					The PM and Res. Supervisors are designated to access the video surveillance 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		**X**				Video surveillance is only accessible by designated personnel (Residential Supervisor, Program Director) and is to be reviewed a minimum of every 14 days and noted in a logbook and the Video Surveillance Log Binder. There are no Security Surveillance Reviews by PM or Designee depicted in the logbook as stated in agency policy (Indicator 3.07).	**Exception:** The agency uses a separate video Surveillance Log to document all video surveillance reviews. Practice described by PM is that an entry is entered in logbook depicting date and time to coincide with the Surveillance Log, but after review this practice could not be verified. There is no consistent evidence that the surveillance review is conducted by a supervisor.

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	**X**					Reflective in the program's P&P and practiced accordingly when warranted.	
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	**X**					Reflective in the program's P&P and practiced accordingly when warranted.	
Provider has a written policy and procedure that meets the requirement for Indicator 4.01						**YES X NO (explain)** The provider's policy and procedure for Healthcare Screening, #RGC 4.01 fully meets the requirements for this indicator and was approved on May 15, 2019 by the CEO.	
Rating 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 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	**X**					Five residential youth files were reviewed, to include two open and three closed. Each of the files contained the required healthcare admission screening form which included information on the youth's current medications, existing medical conditions, allergies, recent injuries or illnesses, and observations. There were no medical follow-ups or scheduling needed by any of the youth in the files reviewed, however the program staff explained that any such necessary medical follow-up or scheduling is coordinated with the child's parent or guardian. The program highlights entries in the daily log with any medically relevant issues, allergies, and medical alerts on the file(s) as applicable and on the kitchen board. The program nurse reviewed the health screenings of all five of the new intake files reviewed within the required five days.	
Referral and Follow-up							
Youth with chronic medical conditions have a referral to ensure medical care (e.g. diabetes, pregnancy, seizure					**X**		

disorder, cardiac disorders, asthma, tuberculosis, hemophilia, head injuries, etc.)							
When needed, the parent is involved with the coordination and scheduling of follow-up medical appointments					**X**		
All medical referrals are documented on a daily log.					**X**		
The program has a thorough referral process and a mechanism for necessary follow-up medical care as required and/or needed					**X**		
Provider has a written policy and procedure that meets the requirement for Indicator 4.02						**YES X NO (explain)** The provider's policy and procedure for Suicide Prevention, #RGC 4.02, fully meets the requirements for this indicator and was approved on February 1, 2021 by the CEO.	
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.	**X**					A total of five files were reviewed, two open and three closed. Each file evidenced completion of the suicide risk screening at intake and the results of the screenings were reviewed and signed by the supervisor in timely fashion. In one of the five files reviewed, the youth was placed on sight-and-sound supervision pending assessment by a licensed professional or a non-licensed professional under the direct supervision of a licensed professional. The program advises that it rotates YFA-employed licensed mental health counselors to cover this agency site from month to month to ensure reviews of suicide assessments within the required time frames (24 hours or morning of 1st business day fallowing the screening). The program advised that it may use telephonic and/or electronic reviews to expedite services and ensure timeliness. Each of the five files reviewed, contained the required assessment by a licensed professional or non-licensed professional under the direct supervision of the licensed professional within 24 hours from the completion of the	

						suicide risk screening or the morning of the 1st business day after completion of the screening (if performed between 5:00 pm Friday and 9:00 am Monday). In each of the files reviewed, the youth was placed on the appropriate level of supervision based on the results of the suicide risk assessment. The staff person assigned to monitor each applicable youths' files documented behavior at 30 minutes or less intervals. and included the time of day, behavioral observations, any warning signs observed and the observers' initials.	
The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	**X**					The program's suicide risk assessment has been 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.	**X**					All five of the files reviewed demonstrated youth were placed on the appropriate level of supervision based on the results of their suicide risk assessment.	
Staff person assigned to monitor youth documented youth's behavior at 30 minute or less intervals	**X**					Only one of the five files reviewed was eligible for a staff person to be assigned to monitor youth's behavior at 30 minute or less intervals. There is evidence in the file that the staff person assigned to monitor documented the youth's behavior at 5, 15 and 30 minute checks as required.	
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	**X**					One of the files reviewed contained evidence that the supervision level was not changed until a bachelor's level counselor under the supervision of licensed mental health counselor completed a further assessment (at 8:41am on 2/18/21).	
Provider has a written policy and procedure that meets the requirement for Indicator 4.03						**YES X NO (explain)** The provider's policy and procedure for Medication Control and Management, #RGC 4.03 fully meets the requirements for this indicator and was approved on April 23, 2020 by the CEO.	
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		**X**				The program uses the Pyxis Med-Station 4000 to store medication. It is in a locked room that is inaccessible to youth. It is a biometric locking cabinet that requires a	**Exceptions:** One youth file reviewed had two medication

inaccessible to youth (when unaccompanied by authorized staff) 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						combination of passcode and thumb print to open. The system keeps an inventory of all narcotics and controlled medications stored in the Med-Station. The program uses a Medication Distribution Log to track distribution of medication to youth by non-licensed and licensed staff. There were no refrigerated medications on site at the time of the review; however, there is a thermometer to monitor the temperature inside the designated medication storage refrigerator. It was at 42 degrees at the time of the review, which meets the required parameters for this standard. The program conducts monthly reviews of medication management via the Pyxis Med-Station report.	errors, which were discovered during the following shift's med pass. Razors for youth are kept in the medical station, but the weekly inventory logs are inconsistent. Three out of nine staff training files reviewed were missing updated Epi pen, CPR, and First Aid training.
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		**X**				The program has four Super Users, who are authorized to dispense medications and an additional seven General Users, who are also authorized to dispense medication. Medication Logs and inventories are maintained in the locked Med-Station room and checked daily by staff on each shift. It was observed there were a total of 19 medication errors since October 2020 as a result of direct care staff are passing meds two out of three times per day, as nurse is not at the facility during the hours of most med passes. One staff person has had eight med errors since October. Lancets are secured and logged in the nurse's office. These are only used for COVID testing at this time. Sharps in the kitchen are not being logged, however are secured in a locked wire container in the kitchen. The program stores oral medications separately from injectable and topical medications.	**Exceptions:** One staff member has had 8 medication errors since October. Staff was suspended on 1/25/21, however, she was assisting in the delivery of medications on 1/31/21, due to shortage. Nurse has started re-training this staff (three times on 2/9, 3/2, 3/16). Three out of nine staff training files reviewed were missing updated

f. The delivery process of medications is consistent with the FNYFS Medication Management and Distribution Policy 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						The facility does not use over-the-counter medications without a prescription. If a youth needs an over-the-counter medication, the parent/guardian is contacted and is to take the youth to see a doctor. The reviewer confirmed that the program staff verifies all medications are prescribed to, and current for, the youth at intake. The program will accept youth prescribed injectable medications; however, the youth must either be able to self-inject or have a family or other person able to come to the facility to administer the injection, as there is no full-time nurse on staff. All staff are required to receive Epi pen training along with their CPR and First Aid training.	Epi pen, CPR, and First Aid training.
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		**X**				Medication counts are performed by shift leads at the beginning of each shift. Over-the-counter medications that are accessed regularly are inventoried weekly by maintaining a perpetual inventory. Sharps in the kitchen are not being logged but are secured in the kitchen.	**Exceptions:** Razors for youth are kept in the medical station, but the weekly inventory logs are inconsistent. Sharps in the kitchen are not being logged.
There are monthly reviews of medication management practice via Knowledge Portal or Pyxis Med-Station Reports.	**X**					There are monthly reviews of the medication management practice via Knowledge Portal or Pyxis Med-Station Reports.	
Medication discrepancies are cleared after each shift.		**X**				The program staff clears all medication discrepancies after each shift.	**Exception:** Youth records had two reported med errors, both were found during the next shift's med count.

Quality Improvement Review

Youth and Family Alternatives, Inc. (George W. Harris) – April 21-22, 2021
Lead Reviewer: Nitara LaTouche

Provider has a written policy and procedure that meets the requirement for Indicator 4.04						**YES X NO (explain)** The provider's policy and procedure for Medical and Mental Health Alert System, #RGC 4.04, fully meets the requirements for this indicator and was approved on May 15, 2019 by the CEO.	
Rating 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	**X**					Five files were reviewed, two open and three closed. Each of the youth files had either a medical, mental health condition or food allergy (or a combination of these) noted on the label of their file. The reviewer confirmed that each youth was appropriately placed on the program's alert system based on the information gathered at intake on the NetMIS and Health Screening forms. The program maintains a medical alert board in the medication room and a special dietary needs board in the kitchen showing any allergies or special diet requirements of all youth in residence. Both boards are reviewed by staff at the beginning of each shift.	
Alert system includes precautions concerning prescribed medications, medical/mental health conditions	**X**					The alert system includes precautions concerning prescribed medications, medical/mental health conditions.	
Staff are provided sufficient training, information and instructions to recognize/respond to the need for emergency care for medical/mental health problems	**X**					All staff are required to complete training, which includes information and instruction on recognizing and responding to the need for emergency care for medical/mental health issues and/or food allergy reactions.	
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	**X**					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.	

Quality Improvement Review

Youth and Family Alternatives, Inc. (George W. Harris) – April 21-22, 2021
Lead Reviewer: Nitara LaTouche

Provider has a written policy and procedure that meets the requirement for Indicator 4.05						**YES X NO (explain)** The provider's policy and procedure for Episodic/Emergency Care, #RGC 4.05 fully meets the requirements for this indicator and was, approved on May 15, 2019 by the CEO.	
Rating 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		**X**				There were seven medical CCC reports related to emergency or episodic care during the reporting period commencing October 1, 2020 through April 21, 2021. Five files of youth involved in an episodic emergency care situation were reviewed. The program's incident reporting records were referenced to verify the reporting to CCC and parental notification requirement for this indicator. The discharge follow-up documentation was in each of the files reviewed and was also attached to the incident report stored separately by the program. The program documented each episodic emergency care incident in the program's daily log book, as well as in the chronological records of each youth's file.	**Exception:** One incident was not logged in the program's Episodic Care Log, but was reported to the CCC and was noted in the facility log.
All staff are trained on emergency medical procedures		**X**				Out of 9 files reviewed, six (6) staff training files reviewed contained updated CPR and First Aid training.	**Exception:** Three staff did not have updated CPR and First Aid training.
The program has a Knife-for-life and wire cutters accessible to staff in a secure location(s)	**X**					The facility has knife for life and wire cutters located in the Med Station, Kitchen, and Dorm station.	
First aid kit/supplies are fully equipped and inventoried		**X**				The facility has wall-mounted First Aid kits in the Med Station, Kitchen, Copy Room and Dorm station.	**Exception:** At the time of the review, the first aid kits had expired contents, which were replaced during the review.