Florida Network for Youth and Family Services
Compliance Monitoring Report for

Youth and Family Alternatives, Inc.
New Beginnings Shelter

18377 Clinton Blvd.
Brooksville, FL 34601

Compliance Monitoring Services Provided by

FOREFRONT

EXECUTIVE SUMMARY

Forefront LLC conducted a joint Quality Improvement (QI) and Florida Network of Youth and Family Services (FNYFS) monitoring visit for YFA New Beginnings for the FY 2020-2021 at its program office located at 18377 Clinton Blvd., Brooksville, Florida. Forefront LLC (Forefront) is an independent compliance monitoring firm that is contracted by the FNYFS to perform onsite program reviews to assess the agency's adherence to fiscal, programmatic and overall contract requirements. YFA New Beginnings is contracted with the Florida Network of Youth and Family Services (FNYFS) to provide direct services to Children/Families in Need of Services (CINS/FINS). The services to be provided are identified in Contract Section A - Descriptions and Specifications and Section B - Delivery and Performance and are funded with General Revenue Funds effective for July 2020 through June 30, 2021.

The review was conducted by Marcia Tavares, Consultant for Forefront LLC and Peer Reviewer(s). Agency representatives from YFA New Beginnings present for the entrance interview were: Melissa Atkinson, VP of Child Welfare and Residential; Amanda Killian, VP Quality Improvement; Tammy Holcombe, Program Manager; Jana Paulk, Executive Assistant; Shannon Martin, VP Prevention and Behavior Health; Kelly Scott, Non-Residential Supervisor; Tara Shock, Residential Supervisor; Sherry Higerdorn, HR; and Tracy Pfeiffer, HR. The last onsite QI visit was conducted on December 4 - 5, 2019.

In general, the Reviewer found that YFA New Beginnings is in compliance with specific contract requirements. **YFA New Beginnings received an overall compliance rating of 100% for achieving full compliance with all eleven applicable indicators** of the CINS/FINS Monitoring Tool. There were no corrective actions or recommendations made as a result of the monitoring visit.

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

2020-2021 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 02-17-2020-2021

Agency Name: YFA New Beginnings	**Monitor Name: Marcia Tavares, Lead Reviewer**
Contract Type : CINS/FINS	**Region/Office: 18377 Clinton Blvd., Brooksville, FL**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): February 17-18, 2021**

Major Programmatic Requirements	**Explain Rating**					**I = Interview** **O = Observation** **D = Documentation** **PTV = Submitted Prior To Visit** **(List Who and What)**	**Explain Unacceptable or Conditionally Acceptable:** **(Attach Supportive Documentation)**
	Unacceptable	**Conditionally Unacceptable**	**Fully Met**	**Exceeded**	**Not Applicable**		
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.	☐	☐	☒	☐	☐	Interview: The program currently has at least two staff members Tammy Holcombe and Tara Shock certified as DJJ QI Peer reviewers. Both staff members have participated as peer reviewer during the current FY.	
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 a list of seven additional contracts for FY2020- 2021. The list includes: the funder, amount, and contract period and includes: Kids Central, Eckerd, Heartland for Children, HHS Basic Center, USDA Department of Health, Food, and Nutrition, United Way, and CNSWFL. The program also maintains interagency agreements and Memorandums of Agreement (MOUs) with schools, mental health, and substance abuse providers. All of the agreements reviewed had current agreements.	
Limits of Coverage a. Provider shall provide and maintain during this contract, the following minimum kinds of insurance: Worker's	☐	☐	☐	☒	☐	Documentation: General Liability through Alliance of non-profit for Insurance, for limits of coverage $1,000,000 each $3,000,000	

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Compensation and Employer's liability insurance as required by Chapter 440, F.S. with a minimum of $100,000 per accident, $100,000 per person and $500,000 policy aggregate. Commercial General Liability with a limit of $500,000 per occurrence, and $1,000,000 policy aggregate. Automobile Liability Insurance shall be required and shall provide bodily injury and property damage liability covering the operation of all vehicles used in conjunction with performance of this contract, with a minimum limit for bodily injury of $250,000 per person; with a minimum limit for bodily injury of $500,000 per accident; with a minimum limit for property damage of $100,000 per accident and with a minimum limit for medical payments or $5,000-$10,000 per person. Florida Network is listed as payee or co-payee. **PTV**						aggregate, and $20,000 medical, effective 6/01/20-6/01/21. Automobile insurance through North American Elite Insurance for combined limits of liability/property damage for $1,000,000. Policy effective for 6/01/20-6/01/21 Abuse/Molestation coverage through Alliance of non-profit for Insurance for limits of coverage of $1,000,000 each $2,000,000 aggregate effective 6/1/20-6/1/21. Professional Liability through Alliance of non-profit for insurance for limits of coverage of $1,000,000 each $3,000,000 aggregate effective 6/1/2020-6/1/2021 Workers Compensation through Bridgefield Employers Ins Co for limits of coverage of $1,000,000 each accident effective 6/1/2020-6/1/2021. Umbrella Liability Insurance through Alliance of non-profit for insurance for limits of coverage of $3,000,000 each/aggregate effective 6/1/2020-6/1/2021. Florida Network is listed on the Worker's Compensation certificate as certificate holder.	
External/Outside Contract Compliance a. Provider has corrective action item(s) cited by an external funding source (Fiscal or Non-Fiscal). **ON SITE**	☐	☐	☐	☐	☒	N/A – During the Entrance Conference, the provider indicated that there are no	

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						outstanding corrective action item(s) cited by an external funding source.	
Fiscal Practice a. Agency must have employee and fiscal policy/procedures manuals that are in compliance with GAAP and provide sound internal controls. Agency maintains fiscal files that are audit ready. **PTV**	☐	☐	☒	☐	☐	Documentation: Fiscal Policies and Procedures are contained under "Financial Management" in the agencies policy and procedure manual. The policies are divided into ten sections with subsections in each one. The procedures reviewed appear to be consistent with GAAP and provide for sound internal controls. Procedures are included for general ledger, bank reconciliations, purchasing, invoicing, payroll, petty cash, computer backup, and other relevant financial processes. Policies last revised in 2018 and signed in 2019.	
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: Detailed General Ledger for the current FY, July 1-December 31, 2020. Agency maintains a detailed general ledger that is structured to track all funding sources as well as activities for the CINS/FINS program.	
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/Documentation: Reviewed petty cash Policy and Procedure. The Petty Cash fund does not exceed the established minimum and is used for purchases of $25 or less. Petty cash is stored in a secure locked location in the building. The	

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						agency produced past documentation of monthly petty cash reconciliations. Petty cash is reconciled on a consistent basis (monthly/quarterly) by designated staff and reviewed by the Supervisor. Disbursements and invoices are approved by the Program Supervisor as 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 and Observation: Reviewed Bank Statements and Bank Reconciliations for the past six months for operating account held with PNC. Financial Statements are reported on a monthly basis and were found to be current. Bank reconciliations are conducted each month for the activities and bank statements for the preceding month. Invoices are submitted on a monthly basis with supporting documentation. The agency maintains individual vendor files.	
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**	☐	☐	☐	☐	☒	N/A – Per the Executive Assistant, the agency has not purchased any property with FNYFS funds.	
f. Agency submits payroll taxes and deposits (and retirement deposits as applicable), Employee IRS Form W-2 and	☐	☐	☒	☐	☐	Documentation: Agency contracts with Paylocity for payroll services and provided evidence of payroll taxes being paid to the IRS	

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Independent Contractors IRS Form 1099 forms prior to federal requirements. **ON SITE**						as reported on 941s submitted for the 3rd and 4th quarter 2020. The 941s document the amount of payroll taxes that were submitted for Federal and FICA taxes with no balances due.	
g. Budget to actual reports prepared and reviewed by appropriate management. Variance from the budget are investigated and explained. **PTV/ON SITE**	☐	☐	☒	☐	☐	Documentation: Agency provided a Budget to Actual statement, for the current FY through December 31, 2020. A review of these documents was conducted. Report shows program budget and variances with YTD Total Budget net surplus. Variances in budget are monitored on a regular basis and approved by management.	
h. A Single Audit is performed as part of the annual audit if expenses are greater than $750,000. The agency must submit a Corrective Action Plan for findings cited in the management letter and single audit. An annual financial audit was completed within 120 days after the previous fiscal year/calendar year and that a copy was provided to the Network unless and extension has been requested and approved in writing. Copy of Audit is submitted to the FNYFS by December 31st. **Obtain from FNYFS**	☐	☐	☒	☐	☐	Documentation: Financial audit conducted for year ending June 30, 2020 was completed by Reeder & Associates, PA November 19, 2020. A separate Management Letter requiring a Corrective Action Plan was not issued by the auditor. A copy of the audit was provided to Forefront LLC for this review.	
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	☐	☐	☒	☐	☐	Documentation: Policies and procedures for MIS Backup Procedures, MIS Security Procedures, Risk Management, and Agency Records were reviewed. A daily back-up is performed on all information saved on various servers	

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documents are shredded and computer hard drives are wiped prior to discarding. **ON SITE**						throughout the agency. All laptops and computers were protected with up-to-date antivirus software. The agency has recently installed a new server that securely stores all data and email in the Cloud. Policies last revised in 2018 and signed in 2019.	

CONCLUSION

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

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

Florida Network of Youth and Family Services Quality Improvement Program Report

Review of YFA New Beginnings
CINS FINS Program

February 17-18, 2021

Compliance Monitoring Services Provided by

FOREFRONT

Quality Improvement Review

YFA New Beginnings – February 17-18, 2021
Lead Reviewer: Marcia Tavares

CINS/FINS Rating Profile

Standard 1: Management Accountability

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

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

Standard 2: Intervention and Case Management

2.01 Screening and Intake	Satisfactory
2.02 Needs Assessment	Satisfactory
2.03 Case/Service Plan	Satisfactory
2.04 Case Management & Service Delivery	Satisfactory
2.05 Counseling Services	Satisfactory
2.06 Adjudication/Petition Process	Satisfactory
2.07 Youth Records	Satisfactory
2.08 Sexual Orientation, Gender Identity, Gender Expression	Satisfactory
2.09 Special Populations	Limited
2.10 Stop Now and Plan (SNAP)	N/A

Percent of indicators rated Satisfactory: 88.89%
Percent of indicators rated Limited: 11.11%
Percent of indicators rated Failed: 0.00%

Standard 3: Shelter Care & Special Populations

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

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

Standard 4: Mental Health /Health Services

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

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

Overall Rating Summary

Percent of indicators rated Satisfactory: 96.43%
Percent of indicators rated Limited: 3.57%
Percent of indicators rated Failed: 0.00%

Rating Definitions

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

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

Reviewer

Members

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

Renette Crosby - Department of Juvenile Justice

Melissa Boeing - Orange County Youth Shelter

Rochelle Davis - Boy's Town of Central Florida

Kimberly Stone - SMA Healthcare

Quality Improvement Review

YFA New Beginnings – February 17-18, 2021
Lead Reviewer: Marcia Tavares

Methodology

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

Surveys

- **8** # Youth
- **11** # 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 **virtually**.

Quality Improvement Review

YFA New Beginnings – February 17-18, 2021
Lead Reviewer: Marcia Tavares

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.

Strengths and Innovative Approaches

Youth and Family Alternatives (YFA) Inc. operates three crisis shelters in the State of Florida that are contracted with Florida Network of Youth & Family Services, Inc. New Beginnings, located in Brooksville, Florida serves Hernando, Sumter, and Citrus Counties. The shelter is licensed for 18 beds and offers 24-hour availability, youth supervision, food and clothing, life skills education, crisis counseling, individual and family counseling, recreation and leisure activities, and case management services. Educational services are provided by the local school district, in the county in which the shelter is located. The Community Counseling North Team of CINS/FINS also serves youth and families in the same counties and coordinate the delivery of community services to families and children in care. Funding through CINS/FINS allows the agency to serve both male and female youth up to seventeen years old that are locked out, runaway, ungovernable and/or truant, homeless, abuse, neglected, or at-risk. The agency also provides specialized services to youth who meet the criteria for Staff Secure shelter, Domestic Minor Sex Trafficking, and youth referred by the Juvenile Justice Court System for domestic violence, probation respite, and Family/Youth Respite Aftercare Services (FYRAC). The youth census during the QI visit was 8 CINS/FINS and 4 DCF youth. YFA is currently accredited by the Council of Accreditation (COA) and was recently re-accredited through October 31, 2024.

The following programmatic updates and highlights since the last Quality Improvement review in December 2019 were reported to the QI team during the visit:

- Staffing: New Beginnings has a new YDS Team Lead, a new LMH counselor, and a full-time Outreach/Aftercare Coordinator and fulltime RN. The Outreach and .5 FTE of the RN position is funded with the Basic Center Grant that was awarded in October 2020 for three years.
- New Beginnings Leadership Council has grown to include school board personnel, a member of the City Council, local business owners, Assistant State Attorney, Hernando County Sheriff, and others.
- Hernando County Sherriff's office continues to be a huge partner to New Beginnings
- The Community Counseling North Team has a new Vice President of Prevention and Behavioral Services and has run at full capacity for the past year. There have been no new hires and no resignations. The program facilitates intakes on the

virtual platform and has found it helpful in assisting families and affording more time and attention to families as opposed to including travel time. Many case managers are supporting families during the evening hours as well as on the weekends.

Narrative Summary

New Beginnings is under the leadership of a management team that consists of a Vice President of Operations, a shelter Program Manager, a Residential Supervisor, and a licensed mental health counselor. New Beginnings currently has 12 full-time YDS. There are 2 part-time YDS positions open. One became vacant in December 2020 and one became vacant in January 2021. The program has not reported any major challenges, critical incidents, administrative review, or current external investigation.

The overall findings for the QI review for YFA New Beginnings are summarized as follows:

Standard 1 has a total of seven indicators regarding Management Accountability. Two of the seven indicators in Standard 1 were rated satisfactory with no exceptions (1.02 and 1.07) and five were rated satisfactory with exceptions (1.01, 1.03, 1.04, 1.05, 1.06).

Standard 2 has a total of ten indicators that relate to intervention and case management. One of the indicators, SNAP, is not applicable as YFA New Beginnings is not a SNAP provider. Five of the nine applicable indicators were rated satisfactory with no exceptions (2.03, 2.04, 2.06, 2.07, and 2.08), three were rated satisfactory with exceptions (2.01, 2.02, and 2.05), and one received a Limited rating (2.09).

Standard 3 has a total of seven indicators regarding shelter care. Four of the seven indicators were rated satisfactory with no exceptions (3.02, 3.03, 3.05, and 3.07) and three were rated satisfactory with exceptions (3.01, 3.04, and 3.06).

Standard 4, Mental Health and Health Services, is comprised of five indicators. All five indicators were rated satisfactory with no exceptions (4.01 - 4.05).

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

Standard 2:
Indicator 2.09 – Limited

- NetMIS data entry lag was observed in all four youth records reviewed i.e., three domestic violence (DV) and one probation respite file.
- Documentation of transition to CINS/FINS was not maintained in the file of one applicable DV youth record reviewed.
- Provider did not obtain FN approval for one applicable probation respite referral.

CINS/FINS QUALITY IMPROVEMENT TOOL

Quality Improvement Indicators:	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable	Review Based Upon Document Source *For example: Interview/Surveys, Observation, and/or Type of Documentation*	Notes Explain any items that have any deficiencies, exceptions or are not applicable.
Standard One – Management Accountability							
1.01: Background Screening and compliance with DJJ OIG statewide procedures regarding BS of employees, contractors and volunteers							
Provider has a written policy and procedure that meets the requirement for Indicator 1.01						**YES X NO (explain)** The agency has required policy and procedure in place RGC 1.01 that was last revised on March 26, 2019 and approved by the Chief Executive Officer (CEO) on September 9, 2019.	
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					The agency uses the Criteria Basic Skills Test (CBST) pre-assessment tool to determine eligibility for employment that was implemented December 19, 2019. An eligible pass rate is a minimum raw score of 30. The tool was utilized to screen 5 applicable new hires one of whom received a sub-score of 29; however, the results summary of the CBST indicated staff was recommended for role.	
Background screening completed prior to hire/start date or exemption obtained prior to working with youth (if rated ineligible) for new hires, volunteers/interns, and contractors		X				A total of six new staff were hired since the last onsite QI visit. Five of six background screenings were initiated prior to DJJ hire dates with eligibility documented on the Clearinghouse results. No exemptions were applicable. There were no eligible volunteers in the program during the review period.	**Exception** One staff was hired in another agency program and was initially screened by DCF. Staff was transferred to CINS/FINS Outreach position on 6/29/20; however, DJJ background screening was not done until 2/11/21.
Five-year re-screening completed every 5 years from initial date of hire			X			The program did not have eligible staff who met the criteria for 5-year re-screening during the review period.	
Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed	X					The program had a signed and notarized Annual Affidavit of Compliance with Level 2 Screening Standards that was completed and notarized on January 11, 2021 and sent to the	

and sent to BSU by January 31st?						Background Screening Unit on January 26, 2021, prior to the January 31st deadline.	
Proof of E-Verify for all new employees obtained from the Department of Homeland Security	**X**					Proof of E-Verify work authorizations were maintained in all six new hire files.	
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 agency has required policy and procedure in place RGC 1.02 that was last revised on March 26, 2019 and approved by the CEO on May 9, 2019.	The policy and procedures do not indicate grievance procedure timelines for resolution within 72 hours of submission. Policy does not indicate guidelines regarding program director and supervisor management of grievances that are 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**					Per policy and procedures staff are required to adhere to a code of conduct policy that forbids physical abuse, profanity, threats and intimidation and they follow the American Counseling Association (ACA) code. This is evidenced by review of the Employee Code of Conduct and Work Rules effective 10/1/2018. Employee acknowledgement of Employee Professionalism and Conduct was evidenced by observation of the Residential Shelter Site Orientation Acknowledgement form. Three staff documents, with signatures, were verified.	
Child Abuse Registry telephone number is visible to youth and posted common areas of the facility	**X**					Florida Abuse Hotline signs are visible to youth. This was evidenced during Peer Reviewer tour of the facility. The signs were observed to be laminated and posted throughout the facility. At least four signs were observed. One sign is in the recreational room and another sign visible to youth is located at the staff desk.	
Youth were informed of the Abuse and Contact Number (see youth survey results)	**X**					Youth are informed of the Abuse Reporting contact numbers as evidenced by observation of Facility Client Orientation Checklist form. The checklist outlines that there is a review of how to contact the Florida Abuse Hotline.	

						Youth are required to initial next to the line item and youth and staff signatures are required at the bottom of the form. Eight youth surveys were completed. All eight youth indicated staff is respectful towards them and they feel safe in the program. Seven of the eight youth stated they were aware of the abuse hotline number and its location in the facility.	
Management takes immediate action to address any incidents of threats or abuse	**X**					Interview with Program Manager revealed there have been no staff incidents in the last 6 months.	
Grievance Process							
Agency has a formal grievance process	**X**					Youth are informed of the grievance process as evidenced by observation of Facility Client Orientation Checklist form. The checklist outlines review of Rights and Responsibility and grievance procedure. Youth are required to initial next to the line item and youth and staff signatures are required at the bottom of the form. The youth orientation handbook details the grievance process and indicates a Residential Supervisor and or Program Manager will have 24 hours after receiving the grievance to discuss with the youth and come to a resolution.	
Locked box accessible to only management and available to youth in a common area	**X**					One grievance lockbox was observed during the virtual tour. A lock was observed on the box and blank forms are located next to the box.	
Direct care does not handle the complaint/grievance unless assistance is asked for by the youth. Program director/supervisor will have access to and manage grievances unless it is towards themselves.	**X**					The policy indicates that direct care staff do not handle grievances unless assistance is requested by a youth. Interview with Program Manager revealed direct care only assist youth in locating the box or additional forms if needed. If a grievance is directed to a supervisor, the Program Manager will address the grievance. If a grievance is directed toward Program Manager, then the VP will address the grievance.	
72-hour resolution requirement by management. If this does NOT	**X**					Six grievances were reviewed and five were resolved within the 72-hour timeline. One	

occur within the 72 hour period, there is sufficient documentation explaining the cause for the delay in resolution.						grievance was not resolved due to youth discharge prior to the resolution. The grievance is dated 8/9/2020 and the youth was discharged on 8/11/2020. It was observed that the youth handbook states the timeline is 24 hours for resolution after receipt. An interview with the Program Manager indicated timeline is 72 hours to address the issue with the youth, but goal is to address grievance the same day. The written handbook resolution timeline of 24 hours after receipt and the practice timeline of 72 hours do not align. The resolution is written from a perspective of intent to resolve the grievance rather than as documentation of the actions taken to resolve the grievance.	
1.03: Incident Reporting							
Provider has a written policy and procedure that meets the requirement for Indicator 1.03						**YES X NO (explain)** The agency has required policy and procedure in place RM760 and RGC 1.03 which were last revised 12/4/18. The policies were approved by the CEO on 2/26/2019.	
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**					A DJJ CCC Summary report with 21 incidents between 8/17/2020 and 2/18/2021 was provided and compared to the YFA CCC report submission. All twenty-one incidents were reported within the required 2- hour timeline. DJJ Incident Classifications: 4 – Public Health Emergencies (COVID) 2 – Nonconsensual sexual acts Youth on Youth 1 – Contraband 2 – Improper Supervision 1 – Medical other 2 – Other Agency Investigation 4 – Medical Transport 3 – Policy Violations 10- Medication Errors 1 – Improper Search 1 – Weapon	

						*Note: Some incidents have more than one classification. Three CCC reports documentation: 12/10/2020, 10/18/2020, 8/21/2020 are not clear on when staff were notified of the med errors. On-call supervisor notification was used to determine compliance with the CCC 2-hour reporting timeline.	
The program completes follow-up communication tasks/special instructions as required by the CCC	**X**					Three of the twenty-one incidents required follow-up tasks. These tasks were completed as evidenced of submission of the follow-up documentation. Two incidents required counseling and one required a written reprimand.	
Incidents are documented in the program logs and on incident reporting forms		**X**				Five of 21 CCC reports were documented in the program logbook. Eleven medication errors were documented on medication logs instead of in the logbook. There were 4 COVID reports were not documented in the logbook due to confidentiality. Per Program Manager, the program does not have CCC incident report forms for 12/15/2020 and 12/29/2020 as those were emailed to the COVID reporting email. CCC reports documentation confirm that reporting was done via email communication.	**EXCEPTION** One CCC report dated 2/10/2020 and 11 CCC medication error related reports were not documented in the program logs as required.
All incident reports are reviewed and signed by program supervisors/directors	**X**					All incidents were reviewed and signed by program supervisors/directors.	
1.04: Training Requirements (Staff receives training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions)							
Provider has a written policy and procedure that meets the requirement for Indicator 1.04						**YES** **NO (explain) X** The agency has required policy and procedure RGC 1.04 in place which was last revised 1/29/2021 and approved by the CEO on 2/1/2021.	Training policy was updated on 2/1/2021. However, it is missing several requirements of the updated FL Network Policy: • Training policy does not indicate which trainings are required for all staff vs direct care staff or indicate the requirement for individual training files. • The agency's policy indicates that DJJ SkillPro trainings are to be taken within one year of employment. The FL Network Policy requires all FL

							Network and DJJ training be completed within 90 days of hire. • Suicide Prevention 1 & 2, Child Abuse: Recognition, Reporting and Prevention and DJJ Civil Rights and Federal Funds trainings are missing from new hire SkillPro trainings list. • DJJ Civil Rights deadline of 30 days from hire is missing. • Annual trainings list is missing Suicide Prevention 1& 2. • Every two-year training list is missing Managing Aggressive Behavior**.**
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**					All three new staff files reviewed have documentation that demonstrated completion of the training prior to the 12/31/2020 Florida Network deadline.	
All staff receives all mandatory training during the first 90 days of employment from date of hire.		**X**				Staff training was rated based on the prior 120-day training completion rule due to eligible new staff's hire prior to the January 1, 2021 new policy updates. Three first year staff files were reviewed. One of three staff met all of the 120-day new hire requirements. One staff had two trainings completed after 120 days that were attributed late due to COVID 19 (MAB and CPR/First Aid). The third staff had one training missing due to COVID, CPR and First Aid missed (this was not taken when training resumed) and 2 late trainings that could not be found in Katniss training documentation.	**EXCEPTION** Two of 3 new hire staff did not complete all required training on time during the first 120 days of hire. Two training topics (Managing Aggressive Behavior and CPR/First Aid) were completed late for one staff as a result of COVID 19 and in-person training not being offered. Additionally, one of the two staff had 2 other trainings completed late, Suicide Prevention and CINS/FINS Core also missing documentation that was not found in Katniss. This staff had also not completed CPR/First Aid when the training resumed in October 2020.

All staff completes all mandatory Florida Network and SkillPro training during the first-year employment.		X				Two of three staff met all 1st year training requirements.	**EXCEPTION** One of three staff did not complete LGBTQ annual training required during the first year; training documentation could not be located in Katniss.
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 eligible first year non-licensed mental health clinical shelter staff	
Documentation of non-licensed mental health clinical staff person's training in Assessment of Suicide Risk form or written confirmation by a licensed mental health professional of training (includes date, signature and license number of the licensed mental health professional supervisor).			X			No eligible first year non-licensed mental health clinical shelter staff	
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				Three staff met mandatory training hours. Two of three staff completed all mandatory annual training requirements.	**EXCEPTION** One staff did not complete CPR training prior to certificate expiring on 1/16/2021. The agency resumed CPR/First Aid training in October 2020.
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					The program has training files for each staff that contain training hours tracking forms, certificates, sign-in sheets and other training material.	
Provider has a written policy and procedure that meets the requirement for Indicator 1.05						**YES X NO (explain)** The agency has required policy and procedure RGC 1.05 in place which was approved by the CEO on 2/26/2019. Additionally, the agency has a CQI Plan for 2020-2021 that was last reviewed 6/26/2020.	

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				Peer record reviews were conducted in August and December 2020 for a total of 9 cases in the residential program quarter using the Shelter Review Tool. An additional 17 cases were reviewed in December 2020 using the YFA Residential Scoring Tool. The non-residential CINS/FINS program conducted a review of 24 cases in June 2020 using the Scoring Tool. No other peer record review was conducted since then for the non-residential program. Areas of improvement are documented on the CQI Worksheet and followed up by QI.	**Exception** Quarterly peer record reviews have not been conducted by the non-residential program since June 2020
The program conducts reviews of incidents, accidents, and grievances quarterly, at a minimum	X					The program reviews incidents and accidents quarterly in the Risk Prevention and Management Team Meeting (held July and October 2020) as well as Compliance Committee meetings (held August and November 2020). Incidents/accidents are tracked monthly on the Incident Reports tracking form by type of incident and a roll-up report is emailed by the VP of Quality Improvement to management staff. Emails sent in October 2020 and January 2021 were reviewed.	
The program conducts an annual review of customer satisfaction data	X					Client satisfaction surveys for the 1st quarter FY2020-2021 (November 2020) and 4th quarter (July 2020) FY2019-2020 (192 responses) were reviewed. Survey results are reviewed at the Stakeholder Involvement Team (SIT) meetings held quarterly.	
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					Outcomes data for the program is monitored and included on the agency's Scoring Tool quarterly. Documentation and discussion of outcomes is included on the quarterly QMC meeting agenda as well as management meetings. An annual review of outcomes was conducted at the compliance committee meeting held August 2020 but the residential and non-residential programs conduct their own quarterly reviews of outcomes.	

The program conducts a monthly review of NetMIS data reports.	X					Netmis data is reviewed monthly upon receipt from the Florida Network and the information is compiled into quarterly Florida Network Comparison reports that reviews the agency's performance of contracted units compared to five top performers.	
The Florida Network conducts monthly reconciliation by comparing NetMIS data to JJIS data. Agency has evidence that they have reconciled any differences noted.	X					Data reconciliation is monitored by the VP of Technology who, upon receipt from the Florida Network, emails the file and instructions to corresponding managers to resolve. Emails sent to managers were submitted documenting process of reconciliation.	
The program has a process in place to review and improve accuracy of data entry & collection	X					Data entered into JJIS and NETMIS is reviewed, compared, and assessed with contract compliance outputs, outcomes, and target populations. Program managers are responsible for ensuring data reconciliation is done upon receipt of information from the FN and the VP of Technology.	
There is documentation that findings are regularly reviewed by management and communicated to staff and stakeholders.	X					The Compliance Committee meets to review all data areas including safety trends, evaluation trends, program updates, peer record review, data collection, and committee updates. Corrective actions plans are implemented to address areas of concern and documented as a result of the scoring tool. The program tracks performance using a weekly dashboard that includes outcomes, incidents/accidents, and HR data.	
There is evidence that strengths and weaknesses are identified, improvements are implemented or modified, and staff are informed and involved throughout the process.	X					Evidence of CAPs were observed on the CQI Worksheets as well as SIT meeting minutes, with assigned parties and follow up documented.	
Provider has a written policy and procedure that meets the requirement for Indicator 1.06						**YES X NO (explain)** The agency has required policy and procedure RGC 1.06 in place which was revised 4/18/19 and approved by the CEO on 5/9/2019.	
Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	X					The agency maintains a list of approved drivers. The list was submitted for review.	

Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	**X**					All drivers named on the approved drivers' list have current driver's licenses and are covered under the agency's insurance policy. The program provided a list of staff driver's license status and two actual driver's licenses. The insurance policy was also provided for review.	
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 the importance of avoiding single youth transports. It also specifies that in the event of a single transport supervisor pre-approval is required, youth should be sitting in the back and an open line should be maintained.	
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**					The agency policy includes that single transports require that staff take into consideration the youth's history and recent behaviors prior to transporting.	
The 3rd party an approved volunteer, intern, agency staff, or other youth	**X**					The agency only allows staff to act as approved third parties for transport. However, the agency's documentation does not list the names of staff who acted as third parties in the transportation log so this is not verifiable via documentation.	
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**				The agency uses two transportation logs. One for general transportation and another detailed log that includes supervisor pre-approval for single transports. The general transportation log documents when one youth is being transported but does not include the name of the second staff in the vehicle as evidence that it is not a single transport.	**EXCEPTION** The transportation logs do not include time entries as required by the FL Network policy. The general transportation log does not include the name of the second staff in the vehicle as evidence that it is not a single transport.
Provider has a written policy and procedure that meets the requirement for Indicator 1.07						**YES** **NO X** The agency has required policy and procedure RGC 1.07 in place which was revised 3/27/2017 and approved by the CEO on 3/14/2020.	Policy and procedures RGC 1.07 do not include: 1) a requirement to maintain documentation of outreach activity and 2) updated language regarding compliance with FL Statue 984 with is administered by DJJ.

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 agency's DJJ board and council meeting agendas, minutes, and electronic sign in sheets were reviewed. Meeting information for August 2020 is missing. However, there is email documentation that this information was requested from DJJ and August minutes are included in the documents reviewed. The agency has a designated Outreach Coordinator position.	
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 NetMIS Outreach Activities show approximately 40 plus outreach activities in the last 6 months. These include outreach planning meetings that are outreaches for a target audience. NetMIS Outreach documentation does not include details of the activities. Two entries include additional information although it is noted that "0" is filled in for target audience. It was noted that most of the logged outreach are meetings and not outreach activities that provide community education, prevention and access to services. Program manager submitted the FL Network of Youth and Family Services Outreach Events Forms as supporting documentation for outreach activities. It was noted that the forms are missing the number of attendees.	
The program maintains written agreements with other community partners which include services provided and a comprehensive referral process.	X					The agency has nine active interagency agreements. In addition to a list, each interagency agreement was provided for inspection. These include agreements with school boards, agencies that provide services to person with disabilities, United Way and more.	

Provider has a written policy and procedure that meets the requirement for Indicator 2.01						**YES** **NO (explain) X** The agency has required policy and procedure RGC 2.01 in place which was revised 3/26/2019 and approved by the CEO on May 15, 2019.	The agency's policy (last revised in March 2019) does not reflect the current requirement for the initial screening for eligibility to occur within 3 business days of referral by a trained staff member. The policy currently indicates "an initial eligibility screening is begun at the time of the first contact, and no later than 7 days of a youth being referred for services."
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					A total of ten files were reviewed which included five residential files and five nonresidential files. Of the five residential files, two were opened and three were closed. Of the five nonresidential files, two were opened and three were closed. Five out of five residential files had an eligibility screening that were completed immediately for all inquiries into shelter placement.	
Community counseling: Eligibility screening is completed within 3 business days of referral by a trained staff using the NetMIS form	X					Five out of 5 nonresidential files had the initial screening for eligibility that occurred within 3 business days of the referral.	
Youth and parents/guardians receive the following in writing: a. Available service options b. Rights and responsibilities of youth and parents/guardians		X				Five out of 5 residential files indicated that the families received the required information (available service options and rights and responsibilities of the youth and parents/guardians) in writing. All five nonresidential files had forms which indicated that the required information was reviewed with the family via phone (no signatures were present for this reason).	**Exception** None of the five nonresidential files indicated that families were given available service options and rights and responsibilities in writing as required by the indicator although it was noted that the required information was reviewed with the family via phone.
The following is also available to the youth and parents/guardians: a. Possible actions occurring through involvement with CINS/FINS services (case staffing	X					All ten files reviewed provided information to support the required information (possible actions occurring through involvement with CINS/FINS services and grievance procedures) was reviewed with/provided to the families.	

committee, CINS petition, CINS adjudication) b. Grievance procedures							
Provider has a written policy and procedure that meets the requirement for Indicator 2.02						**YES X NO (explain)** The agency has required policy and procedure RGC 2.02 in place which was revised 3/26/2019 and approved by the CEO on May 15, 2019.	
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**					Five out of 5 residential files reviewed had the Needs Assessment 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**					Five out of 5 nonresidential files had the Needs Assessment completed within 2 to 3 face to face contacts after the initial intake.	
Needs Assessment is conducted by a bachelor's or master's level staff member	**X**					All ten files reviewed had the Needs Assessment completed by a Bachelor's or Master's level staff member.	
Needs Assessment includes a supervisor's review signature upon completion		**X**				All five nonresidential files had a Needs Assessment which included a supervisor review signature upon completion. There seems to be a pattern in the nonresidential files where there is a delay in obtaining the supervisor review signature after completion of the Needs Assessment. After interviewing staff it was explained that this is due to COVID-19 and no one meeting in person. Staff further explained that files include a separate chart supervision form which indicates when files and document requirements have been reviewed by a supervisor via phone or in person.	**Exception** Four out of 5 residential files were missing a supervisor's signature for the completed Needs Assessment. The files indicated that a supervisor was consulted with but were missing signatures.

						One of 5 residential files had a Needs Assessment which included a supervisor review signature upon completion.	
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**					Five of 5 residential files had a youth that was identified with an elevated risk of suicide as a result of the Needs Assessment. This does not applicable to the nonresidential files because none of those youth were identified with an elevated risk of suicide as a result of the 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**					The five applicable residential files were referred for an Assessment of Suicide Risk conducted by or under the direct supervision of a licensed mental health professional.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.03						**YES** **NO (explain) X** The agency has required policy and procedure RGC 2.03 in place which was revised 3/26/2019 and approved by the CEO on May 15, 2019.	The agency's policy RGC 2.03 does not include "completion dates" in the list of components that will be included in the service plan as stated in the QI Standard 2.03.
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**					All ten files reviewed had a Case/Service Plan that was developed within 7 working days of the Needs Assessment.	
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**					All ten files reviewed had Case/Service Plans that included individualized and prioritized needs and goals identified by the Needs Assessment, service type, frequency, location, person(s) responsible, and target dates for completion. Three out of 5 nonresidential files included actual completion dates. The remaining files were not applicable due to target dates not yet occurring or the youth was not in the facility long enough. Five out of 5 residential files and 1 out of 5 nonresidential files included the signature of the youth; however, 4 out of 5 nonresidential files indicated that the youth provided verbal consent on the Case/Service Plan. Two out of 5	

						residential files and 0 out of 5 non-residential files included the signature of the parent/guardian. The records missing signatures included notes indicating that the parent/guardian provided verbal consent on the Case/Service Plan. All ten files included the counselors' signatures and the supervisors' signature. All ten files included a form which indicated the date the Case/Service Plan was initiated.	
Case/service plans are reviewed for progress/revised by counselor and parent (if available) every 30 days for the first three months and every 6 months after	**X**					A total of ten files were reviewed which included five residential files and five nonresidential files. Of the five residential files, two were opened and three were closed. Of the five nonresidential files, two were opened and three were closed. All applicable files (0 out of 5 nonresidential and 5 out of 5 residential) included a Case/Service Plan that was reviewed for progress/revised by the counselor or parent (if available) every 30 days for the first 3 months and every 6 months after. The remaining files were not applicable due to cases not being open long enough.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.04						**YES** **NO (explain)** **X** The agency has required policy and procedure RGC 2.04 in place which was revised 3/26/2019 and approved by the CEO on May 15, 2019.	The agency's policy (last revised in March 2019) does not include maintaining written agreements with other community partners that include services provided and a comprehensive referral process as part of the case management process.
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Counselor/Case Manager is assigned	**X**					All ten files had a Counselor/Case Manager assigned.	
The Counselor/Case Manager completes the following as applicable:	**X**					All ten files had a Counselor/Case Manager who established referral needs and coordinated referrals to services based upon the on-going	

1. Establishes referral needs and coordinates referrals to services based upon the on-going assessment of the youth's/family's problems and needs 2. Coordinates service plan implementation 3. Monitors youth's/family's progress in services 4. Provides support for families 5. Monitors out-of-home placement (if necessary) 6. Makes referrals to the case staffing to address problems and needs of the youth/family 7. Accompanies youth and parent/guardian to court hearings and related appointments 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						assessment of the youth's/family's problems and needs, coordinated service plan implementation, monitored youth's/family's progress in services, and provided support for families. Out-of-home placement was monitored in the five residential cases. One out of 5 applicable nonresidential file included a referral by the case manager to case staffing to address problems and needs of the youth/family. The remaining files were not applicable due to lack of need for this resource. None of the files required the Counselor/Case Manager to accompany the youth and parent/guardian to court hearings or related appointments. All applicable files (4 out of 5 residential and 2 out of 5 nonresidential) included Counselors/Case Managers who referred the youth/family for additional services when appropriate. resources/services. None of the files required the Counselor/Case Manager to provide case monitoring and review of court orders. All applicable files (3 out of 5 residential and 3 out of 5 nonresidential) included a Counselor/Case Manager who provided case termination notes, follow-up after 30 days of exit, and follow-up after 60 days of exit. The remaining files were not applicable due to cases not yet being closed.	
The program maintains written agreements with other community partners that include services provided and a comprehensive referral process	**X**					The agency provided documentation to indicate that they maintain written agreements with other community partners (such as the School Board of Hernando County and the Sumter County School Board) that include services provided and a comprehensive referral process.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.05						**YES X NO (explain)** The agency has required policy and procedure RGC 2.05 in place which was revised 3/26/2019 and approved by the CEO on May 15, 2019.	

Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
Youth and families receive counseling services, in accordance with the youth's case/service plan, to address needs identified during the assessment process	X					All files (5 out of 5 residential and 5 out of 5 nonresidential) included counseling services provided to youth and families in accordance with the youth's Case/Service Plan to address needs identified during the assessment process.	
Shelter Program							
Shelter programs provides individual and family counseling	X					Evidence of individual and family counseling services was observed in the 5 residential files reviewed.	
Group counseling sessions held a minimum of five days per week		X				All of the residential files indicated that youth participated in group counseling sessions. After interviewing staff members, it was explained that the number of groups participated in weekly by youth varied based on factors such as individual need, willingness, and availability. The agency's group log and group meeting notes for a 6-month period (August 2020 to January 2021) was also reviewed. It was observed that group counseling sessions were not always held a minimum of 5 days per week but were held five or more days per week the majority of the time. This requirement is not applicable to the five nonresidential files.	**Exception** It was noted that in a total of 4 weeks (one week in each of the months of October 2020, November 2020, December 2020, and January 2021) out of the 6 months of groups observed, groups were provided but were provided less than 5 days per week as required by the QI Standard 2.05.
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					The agency's group log and group meeting notes for a 6-month period (August 2020 to January 2021) was reviewed. The documentation reviewed indicated that group counseling sessions consisted of a length of at least 30 minutes, opportunity for youth engagement, clear and relevant topics (informational/developmental/educational), and a clear leader or facilitator.	
Community Counseling							
Community counseling programs provide therapeutic community-based services designed to provide the intervention necessary to stabilize the family.	X					The 5 nonresidential files indicated that the community counseling program provided therapeutic community-based services designed to provide the intervention necessary to stabilize the family. They also indicated that	

Services are provided in the youth's home, a community location, or the local provider's counseling office.						services were provided in the youth's home, a community location, or the local provider's counseling office.	
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**					All ten files reviewed reflected coordination between presenting problem(s), psychosocial assessment, case/service plans, case/service plan reviews, case management, and follow-up when applicable.	
Maintain individual case files on all youth and adhere to all laws regarding confidentiality	**X**					All ten youth records were maintained in individual case files with adherence to all laws regarding confidentiality.	
Case notes maintained for all counseling services provided and documents youth's progress	**X**					Case notes were maintained in all ten files indicating the youth's progress.	
On-going internal process that ensures clinical reviews of case records and staff performance	**X**					All ten files demonstrate an on-going internal process that ensures clinical reviews of case records and staff performance through review of documentation of staff meetings and quarterly file reviews lead by supervisors provided by the agency.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.06						**YES X NO (explain)** The agency has required policy and procedure RGC 2.06 in place which was revised 3/26/2019 and approved by the CEO on May 15, 2019.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Case Staffing Initiation and Notifications							
If parent/guardian initiates, staffing is held within 7 days			**X**			A total of three Case Staffing files were reviewed. Two were opened and one was closed. All three were nonresidential files. None of the files had Case Staffing meetings that were initiated by parents/guardians. Upon interviewing staff members, it was explained that all three files were initiated by the agency.	

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					Staff members were interviewed and provided documentation (e-mails sent to families and the committee) which showed that 3 out of 3 files provided notification to youth/family and the committee no less than 5 working days prior to staffing.	
Case Staffing Committee							
Must include: a. DJJ rep. or CINS/FINS provider b. Local school district representative	X					Case Staffing meetings held for all 3 youth included a DJJ representative/CINS/FINS provider and a local 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					All applicable files included law enforcement representatives and others requested by the family. None of the files included participation of the State Attorney's Office, substance abuse representative, DCF representative, or mental health representative. These files did not indicate a specific need for the participation of these individuals and are also not required.	
The program has an established case staffing committee, and has regular communication with committee members	X					The program has an established case staffing committee and has regular communication with committee members.	
The program has an internal procedure for the case staffing process, including a schedule for committee meetings	X					The program has an internal procedure for the case staffing process. Staff members were interviewed and provided documentation that indicated a schedule for committee meetings.	
As a result of the Case Staffing							
The youth and family are provided a new or revised plan for services	X					The family was provided a new plan of services in all three case staffings held.	
Written report is provided to the parent/guardian within 7 days of the case staffing meeting, outlining recommendations and	X					Two out of 3 files indicated that the parent/guardian was provided with a written report within 7 days of the case staffing meeting which outlined recommendations and reasons behind the recommendations. These	

reasons behind the recommendations						files documented that the families were sent these documents via mail. One out of 3 files reviewed did not include documentation to indicate that the parent/guardian was provided with a written report within 7 days of the case staffing meeting which outlined recommendations and reasons behind the recommendations. Staff members were interviewed and explained that this file has a case staffing that was held in person and that the parent/guardian was provided with the documents in person the day of the meeting.	
If applicable, the program works with the circuit court for judicial intervention for the youth/family			**X**			None of the files required that the program work with the circuit court for judicial intervention for the youth/family. This requirement is not applicable due to lack of need.	
Case Manager/Counselor completes a review summary prior to the court hearing			**X**			None of the files required that the Case Manager/Counselor completes a review summary prior to court hearings. This requirement is not applicable due to lack of need for court hearings. All files included case staffing summary reports within the files.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.07						**YES X NO (explain)** The agency has required policy and procedure RGC 2.07 in place which was revised 3/26/2019 and approved by the CEO on May 15, 2019.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
All records are clearly marked 'confidential'.	**X**					It was observed that all files (virtually uploaded) were marked confidential on papers within the file. The outside of files was not observed due to it being a virtual QI review.	
All records are kept in a secure room or locked in a file cabinet that is marked "confidential"	**X**					Staff provided photo evidence showing that records are kept in locked filing cabinets marked "confidential".	

When in transport, all records are locked in an opaque container marked "confidential"	X					Staff provided photo evidence showing that they have locked opaque containers marked "confidential" to use for the transportation of records.	
All records are maintained in a neat and orderly manner so that staff can quickly and easily access information	X					All files were observed to be clearly divided into sections which were consistent in their organization among residential and nonresidential files. Some files had papers that were out of order likely due to uploading issues. At times, it was somewhat difficult to read some entries due to the way that mistakes were redacted (scribbling out and/or writing over mistakes). Additionally, some forms were not filled out completely or were missing signatures in some of the files. Some files were inconsistent in the level of detail provided in the contact logs and progress notes which made it difficult to clearly determine what was completed and what was not (ex. some actions taken by supervisors and/or counselors detailed in interviewing are not reflected in writing within the file). Overall, all files indicated that records are maintained in a neat and orderly manner.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.08						**YES X NO (explain)** The agency has required policy and procedure RGC 2.08 in place which was revised 3/26/2019 and approved by the CEO on May 21, 2019.	
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					Three applicable closed residential youth records were reviewed for youth who met the criteria for SOGIE. Documentation in the logbook and outward-facing documents supported youth were addressed using preferred names and gender pronouns.	

Youth in need of specialized support is referred to qualified resources (as applicable)	X					One of the three youth required referral for specialized services; the referral was made and followed up by the case manager.	
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					It was observed one youth's room preference was not fulfilled; however, the program did not have a female bed available at the time of intake and was unaware of the youth's preferred gender status at the time of referral.	
Youth is provided hygiene products, undergarments and clothing that affirms their gender identity or gender expression	X					One of the 3 youth requested supplies that align with gender expression and was provided appropriate products as needed.	
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					Signage was observed posted in common areas throughout the facility during the tour. The program has the Zine provided by the Florida Network throughout the facility and has a minimum one in each room. All staff and volunteers sign the final page of the Zine acknowledging receipt of awareness of FN policy 5.08. The ZINE is located at the front reception desk. Per review of 3 new staff's training files, 1 of 3 did not provide documentation of LGBTQ training; however, documentation was provided to confirm staff reviewed and acknowledged FN policy 5.08 via ZINE.	
Provider has a written policy and procedure that meets the requirement for Indicator 2.09						**YES X NO (explain)** The agency has required policy and procedure RGC 3.07 in place which was revised 3/26/2019 and approved by the CEO on May 15, 2019.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Staff Secure							
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? **(If no, select rating "No eligible items for review")**	**YES**	**NO** **X**	**N/A**			The program has not served any Staff Secure youth since the last onsite QI visit and has no eligible items for 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 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			**X**				
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 has not served any DMST youth since the last onsite QI visit and has no eligible items for 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 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.)			X				
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**					Three applicable closed Domestic Violence (DV) Respite files were reviewed. All three files had pending DV charges, were screened by JAC, and did not meet criteria for secure detention.	
Data entry into NetMIS and JJIS within (3) business days of intake and discharge		**X**				Reviewed NetMIS data entry lag and JJIS prevention service record for 3 DV youth records reviewed. Data entry lags were observed.	**Exception** Per NetMIS data entry lag report, intake and discharge lags were observed for all 3 DV youth files reviewed. Discharge lag was 1, 3, and 17 days for 3 youth, respectively.
Youth in program do not have length of stay in DV Respite placement that exceeds 21 days. If more than 21 days, documentation exists in youth file of transition to CINS/FINS or Probation Respite placement, if applicable.		**X**				The length of stay exceeded 21 days in one of the three youth records reviewed. The youth was transitioned to CINS/FINS prior to the 21st day; however, there was no documentation in the file showing the youth was transitioned to CINS/FINS.	**Exception** Documentation of transition to CINS/FINS was not maintained in the file of one applicable DV youth record reviewed.
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**					All 3 case plans reflected goals that were appropriate such as aggression management, coping skills, and communication.	
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 DV youth were found to be consistent with general CINS/FINS program service requirement.	
Probation Respite							
Does the agency have any cases in the last 6 months or	**YES**	**NO**	**N/A**				

since the last onsite QI review was conducted? **(If no, select rating "No eligible items for review")**	**X**						
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 program served only one probation respite youth since the last onsite QI review. A review of the one closed record revealed the Florida Network was not contacted prior to accepting the referral.	**Exception** Provider did not obtain FN approval for one applicable probation respite referral.
Probation Respite Referral come from DJJ Probation and are all youth referred on probation regardless of adjudication status	**X**					Per the DJJ Face Sheet in the closed file, the youth was on probation and was referred by DJJ Probation.	
Data entry into NetMIS and JJIS within (3) business days of intake and discharge		**X**				NetMIS data entry lag and JJIS prevention service record for 1 probation respite youth record reviewed showed NetMIS data entry lags for intake and discharge.	**Exception** Per NetMIS data entry lag report, the youth record indicated 21 days lag for discharge entry.
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**					The length of stay did not exceed 30 days for youth record reviewed.	
All case management and counseling needs have been considered and addressed	**X**					The case plan reflected goals that were appropriate to address individualized needs identified for the youth and family.	
All other services provided to Probation Respite youth are consistent with all other general CINS/FINS program requirements	**X**					All other services provided to probation respite youth were found to be consistent with general CINS/FINS program service requirement.	
Intensive Case Management (ICM)							
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? **(If no, select rating "No eligible items for review")**	**YES**	**NO**	**N/A** **X**			This program location is not contracted to provide Intensive Case Management services.	
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		
Services for youth and family include: a. Four (4) direct contacts per month b. Four (4) collateral contacts per month					X		
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		
Case plan demonstrates a strength-based, trauma-informed focus					X		
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		
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**	**YES**	**NO** **X**	**N/A**			The program has not served any FYRAC youth since the last onsite QI visit and has no eligible items for review	

rating "No eligible items for review")							
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Youth is referred by DJJ for a domestic violence arrest on a household member, and/or the youth is on probation regardless of adjudication status and at risk of violating			**X**				
Agency has evidence that all FYRAC referrals have documented approval from the Florida Network office			**X**				
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			**X**				
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			**X**				
Group Sessions: a. Focus on the same issues as individual/family sessions with			**X**				

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			**X**				
2.10: STOP NOW AND PLAN (SNAP)							
Provider has a written policy and procedure that meets the requirement for Indicator 2.10						**YES NO (explain) N/A X**	YFA New Beginnings is not a contracted SNAP provider.
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**	YFA New Beginnings is not a contracted SNAP provider.	
Needs assessment is completed at initial intake, or within two face-to-face sessions					**X**		
SNAP Assessments a. Child Behavior Checklist (CBCL) is completed by the caregiver (pre & post) b. Teacher Report Form (TRF) completed by the teacher (pre & post) c. Tool for Parenting Self Efficacy (TOPSE) completed by the caregiver (pre & post) d. Prevention Assessment Tool (PAT) (pre & post)					**X**		
SNAP discharge report summary					**X**		

SNAP Boys/SNAP Girls **Parent** Group Evaluation Form					**X**		
SNAP Boys/SNAP Girls **Child** Group Evaluation Form					**X**		
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**		
"Class Goal" sheet					**X**		
Measure of Classroom Environment (MoCE) (Pre and Post) is used to identify baseline and treatment outcomes of reported classroom dynamics.					**X**		
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 has required policy and procedure RGC 3.01 in place which was revised 8/15/2019 and approved by the CEO on 8/20/2019.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Facility Inspection		**X**				The virtual tour of the facility showed a safe and well-maintained building and grounds. The shelter appeared clean and presentable. The	**Exception** The menu provided was last reviewed by a dietician on October 30, 2019.

						bedrooms were observed to be clean, organized, and free of graffiti and insect infestation. A detailed map/egress plan is posted in each bedroom. The bathrooms were clean, free of graffiti and appeared to be in working order. The grounds were free of debris and hazardous materials. The dumpster was equipped with lids, but the right side was observed to be open with trash visible during the tour. Laundry area was organized, free of lint and appliances appeared to be in working condition. Youth have a place to lock up personal belongings if requested. Vehicles were locked and equipped with all major safety equipment. Key control appeared to be enforced and in compliance. Chemicals used had MSDS sheets maintained for each and were kept in the utility closet and inventoried daily. Food was properly stored and labeled. The refrigerator and freezer were at the appropriate temperatures. The agency's DCF license is issued for 18 beds effective through August 8, 2021 and is displayed in the building.	Policy #RGC 3.01, food menus are posted and signed by a dietician annually; however, the program did not have an approved/signed menu for 2020 on file.
Fire and Safety Health Hazards	**X**					Fire inspection was completed on July 10, 2020. Fire drills were completed, three times per month, once on each shift, all within a two-minute time frame. Agency completed a mock emergency drill on 8/20/2020 and two mock emergency drills on 12/29/2020. All annual fire safety equipment inspections are valid and up to date. The most recent fire safety equipment inspection is dated 12/1/2020. Hood exhaust cleaning was last inspected on 02/10/2021. Upon initial review, the agency had posting of Department of Health Group Care Inspection and Food Inspection, dated 11/18/2019. Upon inquiry, the most recent inspection completed by DOH 1/26/21 was received listing several violations and an unsatisfactory inspection, requiring re-inspection scheduled for 4/20/21. The program manager provided an email	

						outlining how each item cited was subsequently fully addressed.	
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**					Daily programming schedule is publicly posted and accessible to both staff and youth. Youth are engaged in meaningful, structured activities seven days a week during awake hours. Youth are provided at least one hour of physical activity per day. Youth are given the opportunity to participate in faith-based activities. Daily programming does include the opportunity for youth to complete homework and access age appropriate, approved books for reading, and quiet time to read.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.02						**YES X NO (explain)** The agency has required policy and procedure RGC 3.02 in place which was revised 5/9/2019 and approved by the CEO on 5/15/2019.	
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**					Four youth records were reviewed, two open and two closed. All youth were provided with a comprehensive orientation and provided with a handbook at the time of intake.	

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**					During the initial intake, orientation includes the program expectations and a description of the Behavior Management Plan. It outlines the dress code and includes a list of items considered to be contraband. Client rights and responsibilities are explained as well as the grievance procedures. Orientation also reviews access to medical and mental health services, procedures for visitation, mail, and visitation. Youth are made aware of the disaster preparedness instructions. Youth are made aware of their room assignments at the time of intake. Staff reviews suicide awareness and prevention protocols with youth during orientation.	
Documentation of each component of orientation, including orientation topics and dates of presentation, as well as signatures of the youth and staff involved is maintained in the individual youth record	**X**					The orientation checklist for all four youth records reviewed were initialed by staff and signed by youth and staff. Three of the four records were dated at the time of intake but one record reviewed was missing the date of signature.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.03						**YES X NO (explain)** The agency has required policy and procedure RGC 3.03 in place which was revised 5/9/2019 and approved by the CEO on 5/15/2019.	
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	**X**					Four youth records were reviewed, two open and two closed. All records reviewed indicated a review of youth's history/trauma, age, gender,	

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						history of violence, physical size, strength, gang affiliation, risk of suicide, and sexually aggressive behavior. Collateral contacts were listed and initial observations were noted by intake staff.	
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**					Alerts were clearly documented in all four records at intake.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.04						**YES X NO (explain)** The agency has required policy and procedure RGC 3.04 in place which was revised 3/36/2019 and approved by the CEO on 5/21/2019.	
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**					In reviewing the logbook entries for 6 randomly selected weeks during the review period, information that could have an impact on the safety and security of the youth and/or program were highlighted.	

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**					A review of the logbook entries for the following weeks were conducted: Week 1 – August 2020, Week 2 – September 2020, Week 3 – October 2020, Week 1 – November 2020, Week 4 – December 2020, and Week 2 – January 2021. Entries appeared to be written in ink and legible with a signature at the end of each entry. Dates and times of incidents/events/activities were listed with names of staff and youth involved. All pertinent information was provided.	
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**					Recording errors were struck through with a single line and initialed. There was no evidence of the use of white out.	
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**					In the review of the logbook entries for the selected weeks, the program director reviewed the logbook weekly and made chronological notes indicating the dates of the review, any corrections, recommendations or follow up that was required. The entries were signed and dated.	
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**				Direct care staff signed entries that they reviewed the logbook indicating the dates reviewed back to their previous shift.	**Exception** During the last six months, direct care staff have not been consistently reviewing the logbook at the beginning of every shift as required.
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 supervisor is reviewing the logbook regularly and indicating the dates reviewed.	
Logbook entries include: a. Supervision and resident counts b. Visitation and home visits	**X**					Logbook entries did indicate supervision and resident counts and indicated phone calls.	

Provider has a written policy and procedure that meets the requirement for Indicator 3.05						**YES X NO (explain)** The agency has required policy and procedure RGC 3.05 in place which was revised 3/36/2019 and approved by the CEO on 5/15/2019.	
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 program has a detailed written description of the Behavior Management System, which is explained to youth at intake including the program rules and expectations.	
Behavior Management Strategies MUST include: a. Supervisors are trained BMS is designed to teach youth new behaviors and help youth understand the natural consequences for their actions b. Behavioral interventions are applied immediately, with certainty, and reflect the severity of the behavior c. BMS uses a wide variety of awards/incentives to encourage participation and completion of the program d. Appropriate consequences and sanctions are used by the program and consequences for behavior are logical and designed to promote skill-building for the youth e. Counseling, verbal intervention and de-escalation techniques are used prior to physical intervention (Only techniques approved by the Florida Network and DJJ	**X**					Youth receives the handbook at intake explaining the Behavior Management/Level System (Youth Development System) and signs off on it at intake. The program's Behavior Management System consists of four different phases. (Orientation, Education, Graduation and Collegiate). Youth are placed on Orientation level for three days after being admitted to the program. While in the Orientation level, the emphasis is to become oriented to the program's core values (six pillars of character) and youth development strategies (twelve developmental outcomes). After completion of the Orientation level (which requires setting a weekly goal), the youth will advance to the Education Level. The Education level's emphasis is placed on the youth's ability to demonstrate what they have learned while on the Orientation level as well as actively participate in educational activities, groups, outings etc. At completion of the Education level, youth achieve the Graduate level. At the Graduate level, the expectation is to demonstrate an enhanced understanding of the skills learned while on the previous levels. Youth must exemplify the characteristics of a role model. The highest level of the program is the Collegiate level. At this level, youth are expected to be role models and serve as peer leaders. In addition, youth putting the Six Pillars of Character into practice gives them the	

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						opportunity to earn "New Beginning Bucks" to purchase items at the New Beginnings Store. The staff of the program do not impose group discipline and do not allow anyone else to discipline youth. The use of room restriction is not used as part of the Behavior Management System. Youth are never denied basic rights such as meals, clothing, sleep, services, exercise or correspondence privileges as part of a consequence.	
Program's Use of the BMS							
All staff are trained in the theory and practice of administering BMS rewards and consequences	**X**					All staff are trained on the Behavior Management System during new hire training; this was verified in the training records reviewed for 3 new staff.	
There is a protocol for providing feedback and evaluation of staff regarding their use of BMS rewards and consequences	**X**					There is policy in place explaining program protocol for feedback and evaluation of staff regarding their use of the Behavior Management System.	
Supervisors are trained to monitor the use of rewards and consequences by their staff	**X**					Supervisors are trained to monitor the use of awards and consequences by staff.	
Provider has a written policy and procedure that meets the requirement for Indicator 3.06						**YES X NO (explain)** The agency has required policy and procedure RGC 3.06 in place which was revised 3/36/2019 and approved by the CEO on 5/15/2019.	
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	**X**					The last six months of staff schedules were reviewed and cross-referenced with the logbooks. Appropriate staffing ratios (one staff to six youth during awake hours and one staff to twelve youth during asleep hours) were maintained.	

• 1 staff to 12 youth during the sleep period							
All shifts must always provide a minimum of two staff present	X					In the last six months, a minimum of two staff members were on duty at all times, even throughout the overnight shift.	
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					Shelter staff included in the staff-to-youth ratio included only properly trained youth care workers. Youth care workers in training were identified on the staff schedule with an asterisk (*) and were not included in the staff to youth ratio.	
The staff schedule is provided to staff or posted in a place visible to staff	X					The staff schedule is emailed to staff bi-weekly and if/when any changes have been made. The schedule is also posted in the staff office.	
There is a holdover or overtime rotation roster which includes the telephone numbers of staff who may be accessed when additional coverage is needed	X					The staff list, with staff phone numbers, is posted in the staff work area in the event additional coverage is needed.	
Staff observe youth at least every 15 minutes while they are in their sleeping room, either during the sleep period or at other times, such as during illness or room restriction		X				Video and logbook entries were checked and matched for the following dates and times randomly selected: January 21st 12am-2am; January 25th 2am -4am; January 30th 4am - 6am; February 7th 1am - 3am; and February 12th 3am - 5am. During review of the video surveillance system it was observed staff bed checks were being completed at least every fifteen minutes as required except for one documented observation on January 30, 2021 at 0400, where the observation was documented in the logbook; however review of video indicated that staff did not complete the observation. Physical layout of sleeping arrangements: there is a male's hall and a girl's hall identified as sleeping quarters for youth. Each bedroom is equipped to have two youth assigned if necessary. There is an identified area by the staff office for youth who require sight and sound supervision.	**Exception** On January 30, 2021 at 0400, there was a documented bed check in the logbook; however review of video surveillance determined that staff did not complete the check as documented. CCC was called by the program supervisor at 12:37pm on February 18, 2021 and was accepted. Report #2021-01587.

Provider has a written policy and procedure that meets the requirement for Indicator 3.07						**YES X NO (explain)** The agency has required policy and procedure RGC 3.08 in place which was revised 7/10/2019 and approved by the CEO on 8/21/2019.	
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Surveillance System							
The agency, at a minimum, shall demonstrate: a. A written notice that is conspicuously posted on the premises for the purpose of security b. System can capture and retain video photographic images which must be stored for a minimum of 30 days c. System can record date, time, and location; maintain resolution that enables facial recognition d. Back-up capabilities consist of cameras' ability to operate during a power outage e. Have cameras placed in interior and exterior general locations of the shelter where youth and staff congregate and where visitors enter and exit. Cameras are never placed in bathrooms or sleeping quarters. f. All cameras are visible	**X**					The shelter has a video surveillance system that is operational twenty-four hours a day, seven days a week. There were written notices posted around the grounds of the program indicating there is recording in progress. Cameras were located in the interior and exterior of the shelter where youth and staff congregate and where visitors enter and exit. All cameras were visible. There were no cameras in the sleeping quarters or the bathrooms. The video surveillance system can retain video and photographic images for up to thirty days. The system captures date, time, location and maintains resolution for facial recognition. The cameras have the ability to operate during a power outage.	
A list of designated personnel who can access the video surveillance system is maintained (includes off-site capability per personnel)?	**X**					Camera review ability is limited to supervisory staff only.	

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					A supervisory review of video is conducted at least every fourteen days and documented in the logbook. The review includes a random sample of overnight shifts.	
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					The shelter has a policy in place that grants the requesting party video recordings within twenty-four to seventy-two hours from the time of the request.	
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					The shelter has a policy in place that states camera service orders will be made within twenty-four hours of discovery of malfunction or being inoperable. All efforts to obtain repairs are documented and maintained.	
Provider has a written policy and procedure that meets the requirement for Indicator 4.01						**YES X NO (explain)** The agency has required policy and procedure RGC 4.01 in place which was revised 3/36/2019 and approved by the CEO on 5/15/2019.	
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.	X					Five residential records reviewed, 3 closed and 2 open. Five of five included healthcare screening on date of admission. The screening included: current medications, existing medical conditions, allergies, recent injuries, physical distress or presence of pain, observations for evidence of illness, injury, or physical distress, presence of scars, tattoos, or other markings, and acute health symptoms requiring quarantine or isolation.	

g. Observation for presence of scars, tattoos, or other skin markings h. Acute health symptoms requiring quarantine or isolation							
Referral and Follow-up							
Youth with chronic medical conditions have a referral to ensure medical care (e.g. diabetes, pregnancy, seizure disorder, cardiac disorders, asthma, tuberculosis, hemophilia, head injuries, etc.)	**X**					Three of the five records reviewed showed applicable youth with chronic medical conditions with referrals to ensure medical care (e.g. diabetes, pregnancy, seizure 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**					One of five records was applicable for coordination and scheduling of follow-up of medical appointments and included documentation the parent was involved.	
All medical referrals are documented on a daily log.	**X**					Five out of five records included documentation supporting medical referrals are documented on a daily log.	
The program has a thorough referral process and a mechanism for necessary follow-up medical care as required and/or needed	**X**					The program has a thorough referral process and a mechanism for necessary follow-up medical care as required and/or needed**.**	
Provider has a written policy and procedure that meets the requirement for Indicator 4.02						**YES X NO (explain)** The agency has required policy and procedure RGC 4.02 in place which was revised 1/11/2021 and approved by the CEO on 2/01/2021.	
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**					Four applicable residential youth records were reviewed and all four youth had documentation suicide risk screening occurred during the initial intake and screening process. Suicide screening results were reviewed and signed by the supervisor and documented in the youth's case file.	

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					Three out of four youth were applicable. Three youth were placed on the appropriate level of supervision based on the results of the suicide risk assessment. One record was N/A due to results of suicide risk assessment.	
Staff person assigned to monitor youth documented youth's behavior at 30 minute or less intervals	X					Three of four youth were applicable and included documentation staff person assigned to monitor youth documented youth's behavior at 30 minute or less intervals.	
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					Three of four files were applicable, and documentation was available showing 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.	
Provider has a written policy and procedure that meets the requirement for Indicator 4.03						**YES X NO (explain)** The agency has required policy and procedure RGC 4.03 in place which was revised 4/3/2020 and approved by the CEO on 4/3/2020.	**Add any exceptions here:**
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Medication Storage							
a. All medications are stored in a Pyxis Med-Station 4000 Medication Cabinet that is inaccessible to youth (when unaccompanied by authorized staff) b. Pyxis machine is stored in accordance with guidelines in FS 499.0121 and policy section in Medication Management	X					All medications are stored in a Pyxis Med-Station 4000 Medication Cabinet that is inaccessible to youth (when unaccompanied by authorized staff). Pyxis machine is stored in accordance with guidelines in FS 499.0121 and policy section in Medication Management. Oral medications are stored separately from injectable epi-pen and topical medications. Medications requiring refrigeration are stored in a secure refrigerator that is used only for this purpose, at temperature range 2-8 degrees C	

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						or 36-46 degrees F. (If the refrigerator is not secure, the room is secure and inaccessible to youth). Narcotics and controlled medications are stored in the Med-Station. All medications are stored in a Pyxis Med-Station 4000 Medication Cabinet that is inaccessible to youth.	
Medication Distribution							
a. Agency maintains a minimum of 2 Super Users for the Med-Station b. Only designated staff delineated in User Permissions have access to secured medications, with limited access to controlled substances (narcotics) c. A Medication Distribution Log shall be used for distribution of medication by non-licensed and licensed staff d. Agency verifies medication using one of four methods listed in the FNYFS Operations Manual e. When nurse is on duty, medication processes are conducted by the nurse f. The delivery process of medications is consistent with the FNYFS Medication Management and Distribution Policy g. Agency does not accept youth currently prescribed	**X**					Agency maintains a minimum of 2 Super Users for the Med-Station. Only designated staff delineated in User Permissions have access to secured medications, with limited access to controlled substances (narcotics). A Medication Distribution Log is used for distribution of medication by non-licensed and licensed staff. Two open and one closed file was reviewed. All three youth had medications and a medication distribution log for each medication they received. In all three records the medication delivery process was consistent with the FNYFS medication management and distribution policy. When on site the nurse conducts medication processes. When not on-site trained staff dispense medication. Agency does not accept youth currently prescribed injectable medications, except for epi-pens. Epi-pen training of non-licensed staff by the registered nurse was verified in the 6 training records reviewed.	

injectable medications, except for epi-pens h. Non-licensed staff have received training in the use of epi-pens provided by a registered nurse							
Medication 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**					Three youth had controlled substances prescribed and all three had a perpetual inventory with running balances maintained. In all three records, shift-to shift counts were verified by a witness and documented. Over-the-counter medications are inventoried perpetually as accessed and are also inventoried weekly. A review of the sharps inventory for the past six months supported the program monitors the location and number of sharps weekly and ensures they are secured.	
There are monthly reviews of medication management practice via Knowledge Portal or Pyxis Med-Station Reports.	**X**					There are monthly reviews of medication management practice via Knowledge Portal or Pyxis Med-Station Reports.	
Medication discrepancies are cleared after each shift.	**X**					Medication discrepancies are cleared after each shift.	
Provider has a written policy and procedure that meets the requirement for Indicator 4.04						**YES X NO (explain)** The agency has required policy and procedure RGC 4.04 in place which was revised 3/26/2019 and approved by the CEO on 5/15/2019.	
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**					Four of four youth records reviewed were applicable and had documentation medical, mental health, or food allergy was appropriately placed on the program's alert system.	

Alert system includes precautions concerning prescribed medications, medical/mental health conditions	X					Four of four records were applicable and demonstrated 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					Staff are trained in CPR/First Aid to recognize/respond to the need for emergency care for medica/health problems. CPR/First Aid training was verified in 5 of the 6 training records reviewed with one new staff pending training due to the COVID 19 pandemic.	
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					The program has an alert board and when applicable alerts are documented including other essential information pertaining to the youth. The board is inaccessible to youth in the shelter. Observation of the alert board reflected all alerts were accurate and up to date. Alerts are also documented in the youth's file.	
Provider has a written policy and procedure that meets the requirement for Indicator 4.05						**YES X NO (explain)** The agency has required policy and procedure RGC 4.05 in place which was revised 3/26/2019 and approved by the CEO on 5/09/2019.	
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					Three closed files were reviewed. In one of the three files, the youth was taken off-site requiring medical care, and the incident report was submitted. Upon youth return, there is a verification receipt of medical clearance and discharge instructions with follow-up is present in the file. All three files did reflect instances of episodic care. All episodic care incidents were located on an episodic log. Parent/guardian notification occurred in two applicable incidents reviewed.	

All staff are trained on emergency medical procedures	X					Staff are trained in CPR/First Aid to recognize/respond to the need for emergency care for medica/health problems.	
The program has a Knife-for-life and wire cutters accessible to staff in a secure location(s)	X					The program has a Knife-for-life and wire cutters accessible to staff in a secure location.	
First aid kit/supplies are fully equipped and inventoried	X					First aid kit/supplies are fully equipped and inventoried weekly as documented by the monthly logs.	