Florida Network for Youth and Family Services
Compliance Monitoring Report for

Youth and Family Alternatives – RAP House
7522 Plathe Road,
New Port Richey, FL 34653

Compliance Monitoring Services Provided by

EXECUTIVE SUMMARY

Forefront LLC conducted a joint Modified Quality Improvement (QI) and Florida Network of Youth and Family Services (FNYFS) monitoring visit for Youth and Family Alternatives for the FY 2021-2022 at its program office located at 7522 Plathe Road, New Port Richey, FL 34653. Forefront LLC (Forefront) is an independent compliance monitoring firm contracted by the FNYFS to perform onsite program reviews to assess the agency's adherence to fiscal, programmatic, and overall contract requirements. Youth and Family Alternatives – RAP House is contracted with 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 1, 2021 through June 30, 2022.

The review was conducted by Baldwin Davis, Consultant for Forefront LLC and DJJ Peer Reviewer. Agency representatives from Youth and Family Alternatives – RAP House present for the entrance interview were Mark Wickham(CEO); Amanda Killian (VP QI); Jess Sternthal (VP Prevention and Residential); Rebecca Kaputo (COO); Kelly Scott (Program Director); Cayse Houston (Program Manager); Ryan Pettit (Residential Supervisor). The last QI visit was conducted February 3-4, 2021.

In general, the Reviewer found Youth and Family Alternatives (RAP House) is in compliance with specific contract requirements. Youth and Family Alternatives received an overall compliance rating of **100% for achieving full compliance with all four applicable indicators** of the Modified Administrative and Fiscal Contract Monitoring Tool. There were no corrective actions as a result of the monitoring visit and no recommendation was made.

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

2021-2022 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 05-23-2021-2022

Agency Name: Youth and Family Alternatives RAP House	**Monitor Name: Baldwin Davis, Lead Reviewer**
Contract Type: CINS/FINS	**Region/Office: 7522 Plathe Road, New Port Richey, FL 34653**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): May 4-5, 2022**

Major Programmatic Requirements	**Explain Rating**					**Ratings Based Upon:** **I = Interview** **O = Observation** **D = Documentation** **PTV = Submitted Prior To Visit** **(List Who and What)**	**Notes** **Explain Unacceptable or Conditionally Acceptable:** **(Attach Supportive Documentation)**
	Unacceptable	**Conditionally Unacceptable**	**Fully Met**	**Exceeded**	**Not Applicable**		
I. Administrative and Fiscal							
Limits of Coverage a. Provider shall provide and maintain during this contract, the following minimum kinds of insurance: Worker's Compensation and Employer's liability insurance as required by Chapter 440, F.S. with a minimum of $100,000 per accident, $100,000 per person and $500,000 policy aggregate. Commercial General Liability with a limit of $500,000 per occurrence, and $1,000,000 policy aggregate. Automobile Liability Insurance shall be required and shall provide bodily injury and property damage liability covering the operation of all vehicles used in conjunction with performance of this contract, with a minimum limit for bodily injury of $250,000 per person; with a minimum limit for bodily injury of $500,000 per accident; with a minimum limit for property damage of $100,000 per accident and with a minimum limit for medical payments or $5,000-$10,000 per person. Florida Network is listed as payee or co-payee. **PTV**	☐	☐	☒	☐	☐	Documentation: General Liability through Alliance of Nonprofits for Insurance for limits of coverage $1,000,000 each $3,000,000 aggregate, and $20,000 medical expense, effective 7/01/21-7/01/22. Workers Compensation Insurance is through Bridgefield Casualty Insurance Company for limits of coverage $1,000,000 each accident, effective 6/1/2021 – 6/1/2022. Automobile insurance through Alliance of Nonprofits for Insurance for combined limits of liability/property damage for $1,000,000 each and aggregate. Policy effective for 7/01/2021-7/1/2022. Professional Liability Claims insurance through Alliance of Nonprofits for	**No recommendation or Corrective Action.**

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	Explain Rating					Ratings Based Upon: I = Interview O = Observation D = Documentation PTV = Submitted Prior To Visit (List Who and What)	Notes Explain Unacceptable or Conditionally Acceptable: (Attach Supportive Documentation)
Major Programmatic Requirements	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable		
						Insurance for limits of coverage $1,000,000 each/$3,000,000 aggregate effective 7/01/2021-7/01/2022. Florida Network is listed on the Worker's Compensation certificate as certificate holder.	
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 in the Financial Services Policy and Procedures Manual. The manual is divided into eight sections with subsections in each. The procedures reviewed appear to be consistent with GAAP and provide for sound internal controls. All policies have a revision date of May 2019.	**No recommendation or Corrective Action.**
b. 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: No change in practice was reported for the agency since the last site program review in February 2021. Reviewed petty cash Policy and Procedure FS030. The Petty Cash fund does not exceed the established minimum of $225. Petty cash is stored in a secure locked location in the building and is	**No recommendation or Corrective Action.**

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Major Programmatic Requirements	Explain Rating: Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable	Ratings Based Upon: I = Interview O = Observation D = Documentation PTV = Submitted Prior To Visit (List Who and What)	Notes: Explain Unacceptable or Conditionally Acceptable: (Attach Supportive Documentation)
						reconciled and reviewed on a consistent basis (monthly/quarterly) by the Program Manager, disbursements and invoices are also approved by the Program Manager as required. Reconciliation of Petty Cash funds was conducted by the Program Manager as part of this review.	
c. 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 – The agency has not purchased any items with FNYFS monies since the last time on-site.	**No recommendation or Corrective Action.**
d. A Single Audit is performed as part of the annual audit if expenses are greater than $500,000. The agency must submit a Corrective Action Plan for findings cited in the management letter and single audit. An annual financial audit was completed within 120 days after the previous fiscal year/calendar year and that a copy was provided to the Network unless and extension has been requested and approved in writing. Copy of Audit is submitted to the FNYFS by December 31st. **Obtain from FNYFS**	☐	☐	☒	☐	☐	Documentation: Financial audit conducted for year ending June 30, 2021, and 2020 was completed by Beeder and Associates, C.P.A. and dated December 1, 2021. Per the audit report, a separate Management Letter is not required and was not issued by the auditor. A copy of the audit was submitted to the FNYFS.	**No recommendation or Corrective Action.**

CONCLUSION

Youth and Family Alternatives (RAP House) has met the requirements for the CINS/FINS contract as a result of full compliance with four of the five applicable indicators of the Modified Administrative and Fiscal Contract Monitoring Tool. One of the five indicators was not applicable because the provider 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 indicators reviewed were carried out in a manner which meets the standard as described in the report findings.

SUMMARY OF RECOMMENDATIONS

Recommendation
There were no recommendations as a result of this review.

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

Florida Network of Youth and Family Services
Quality Improvement Program Report

Review of Youth and Family Alternatives, Inc. (RAP House)
CINS/FINS Program

DATE: May 4-5, 2022

Compliance Monitoring Services Provided by

FOREFRONT

CINS/FINS Rating Profile

Standard 1: Management Accountability

1.01 Background Screening	**Satisfactory**
1.04 Training Requirements	**Satisfactory**
1.06 Client Transportation	**Satisfactory**

Percent of Indicators rated Satisfactory: 100 %
Percent of Indicators rated Limited: 0 %
Percent of Indicators rated Failed: 0 %

Standard 2: Intervention and Case Management

2.03 Case/Service Plan	**Satisfactory**

Percent of Indicators rated Satisfactory: 50 %
Percent of Indicators rated Limited: 0 %
Percent of Indicators rated Failed: 0 %

Standard 3: Shelter Care & Special Populations

3.01 Shelter Environment	**Satisfactory**
3.06 Staffing and Youth Supervision	**Satisfactory**

Percent of Indicators rated Satisfactory: 100 %
Percent of Indicators rated Limited: 0 %
Percent of Indicators rated Failed: 0 %

Standard 4: Mental Health/Health Services

4.02 Suicide Prevention	**Satisfactory**
4.03 Medications	**Satisfactory**

Percent of Indicators rated Satisfactory: 100 %
Percent of Indicators rated Limited: 0 %
Percent of Indicators rated Failed: 0 %

Overall Rating Summary
Percent of indicators rated Satisfactory: 100 %
Percent of indicators rated Limited: 0 %
Percent of indicators rated Failed: 0 %

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.

Reviewers

Members

Baldwin Davis - Lead Reviewer Consultant-Forefront LLC/Florida Network of Youth and Family Services
Brenda Comadore – Regional Monitor, Department of Juvenile Justice

Methodology

This modified review was conducted in accordance with FDJJ-2000 (Quality Assurance Policy and Procedures), and focused in particular areas of (1) Management Accountability, (2) Intervention and Case Management, (3) Shelter Care/Health Services, and (4) Mental Health/Health Services, which are included in the Children/Families in Need of Services (CINS/FINS) Standards (effective January 2022).

Persons Interviewed

X	Chief Executive Officer	X	Case Manager		Nurse – Full time
	Chief Financial Officer	X	Counselor Non-Licensed	X	Nurse – Part time
X	Chief Operating Officer		Advocate		# Case Managers
	Executive Director		Direct – Care Full time		# Program Supervisors
X	Program Director		Direct – Part time		# Food Service Personnel
	Program Manager		Direct – Care On-Call	1	# Healthcare Staff
X	Program Coordinator		Intern		# Maintenance Personnel
	Clinical Director		Volunteer		# Other (listed by title): ___
	Counselor Licensed	X	Human Resources		

Documents Reviewed

	Accreditation Reports	X	Table of Organization		Visitation Logs
X	Affidavit of Good Moral Character		Fire Prevention Plan	X	Youth Handbook
X	CCC Reports		Grievance Process/Records		# Health Records
	Logbooks		Key Control Log		# MH/SA Records
	Continuity of Operation Plan	X	Fire Drill Log	14	# Personnel /Volunteer Records
X	Contract Monitoring Reports	X	Medical and Mental Health Alerts	6	# Training Records
	Contract Scope of Services	X	Precautionary Observation Logs	4	# Youth Records (Closed)
X	Egress Plans	X	Program Schedules	4	# Youth Records (Open)
X	Fire Inspection Report		List of Supplemental Contracts		# Other: ___
	Exposure Control Plan		Vehicle Inspection Reports		

Observations During Review

	Intake	X	Posting of Abuse Hotline	X	Staff Supervision of Youth
X	Program Activities		Tool Inventory and Storage	X	Facility and Grounds
X	Recreation	X	Toxic Item Inventory & Storage		First Aid Kit(s)
	Searches		Discharge		Group
X	Security Video Tapes		Treatment Team Meetings	X	Meals
	Social Skill Modeling by Staff		Youth Movement and Counts	X	Signage that all youth welcome
X	Medication Administration	X	Staff Interactions with Youth	X	Census Board

Surveys

7	# of Youth	7	# of Direct Staff		# of Other		

Comments

Due to COVID-19, this review was conducted **on-site using the Modified QI Review Plan.**

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

The Youth and Family Alternatives - Runaway Alternatives Project (RAP) House program provided a brief program update on major operations, staffing, funding, and other changes since the last Quality Improvement review conducted on February 3-4, 2021. The agency reported it has added new personnel in several positions including a Registered Nurse (RN) as RAP House has been without a Registered Nurse from October 2021 until late April 2022. RAP House hired a new Residential Supervisor, who works closely with the Program Manager and other program staff, and they hired a new Counselor. The agency promoted two staff members, one to a Team Lead position, and promoted the other staff to the position of Office Specialist. Due to the COVID-19 pandemic and loss of staffing, RAP House was temporarily housed at New Beginnings Youth Shelter to help stabilize staff and focus on recruitment, which was from the period of October 2021 and November 2021. The agency communicated this significant program change to the Florida Network, via a series of hardship letters and updates between the Chief Executive Officer (CEO) Mark Wickham and Stacey Gromatski, CEO of Florida Network. RAP House has held a lower census due to staffing shortages, as well as a few COVID Quarantines that restricted staff movements. RAP House is currently working on staff recruitment and training to bring in processes to increase the youth census. The Community Counseling Team of CINS/FINS Non-Residential has run at full capacity for the past year, despite the COVID 19 challenges of the past year. There have been no new hires and no resignations within the community counseling team over the past year. The agency's community counseling program reports that they are running at a high capacity of referrals and are continuing to work with all assigned school districts.

Narrative Summary

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

The overall findings for the Modified QI Review for YFA RAP House are summarized as follows:
Standard 1: Management Accountability Standard had three (3) indicators reviewed; 1.01 - Background Screening, 1.04 - Training, and 1.06 Transportation. Indicator 1.01 and 1.04 were rated Satisfactory with exceptions and Indicator 1.06 was rated Satisfactory with no exceptions noted.

Standard 2: Intervention and Case Management had one (1) indicator reviewed. Indicator 2.03 - Case/Service Plan was rated Satisfactory with no exceptions.

Standard 3: Shelter Care & Special Populations Standard had two (2) indicators reviewed; 3.01 Shelter Environment and 3.06 Staff and Youth Supervision. Indicator 3.01 was rated Satisfactory with no exceptions and indicator 3.06 was rated Satisfactory with exception.

Standard 4: For the Mental Health and Health Services Standard, there were two (2) indicators reviewed; 4.02 - Suicide Prevention and 4.03 Medication. Indicator 4.02 was rated Satisfactory with no exceptions and indicator 4.03 was rated Satisfactory with an exception.

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

There were no indicators resulting in a Limited or Failed rating.

CINS/FINS QUALITY IMPROVEMENT TOOL

Quality Improvement Indicators: Add an "**X**" in the applicable column *Satisfactory* *Non- Compliant (E.g. Exceptions)* ***No Eligible Items for Review*** ***No Practice*** ***Not Applicable***	**Satisfactory (S)**	**Non-compliant (E)**	**No Eligible Items for Review (N)**	**No Practice (NP)**	**Not Applicable (N/A)**	**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 (BS) 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** If NO, explain here: Policy # 1.01 Titled: Background Screening of Employees/Volunteers/Interns/Contracted Providers and was last reviewed on 10/17/2021 and signed by the CEO.	**Add any exceptions below:**
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 for staff hired with a non-passing/low score.	**X**					The Program Manager (PM) and Human Resource Director (HR) interviewed confirmed the facility uses the CBST (Criteria Basic Skills Test) to determine suitability and explained that the cut off score of less than 30 requires an additional review which is the same practice from the previous year. Thirteen (13) files were reviewed for this indicator. Eleven (11) of the thirteen (13) new hire files reviewed demonstrated all employees completed the assessment prior to the date of hire. Two (2) files were not applicable due to being existing agency staff who were in other positions and transferred into the CINS/FINS program.	
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**					Thirteen (13) new hire staff had background screenings that were deemed eligible prior to their individual date of hire.	

Agency has evidence for employees who have had a break in service and who are in good standing and reemployed with the same agency without an additional suitability assessment or background screening if the break is less than 90 days.			**X**			The agency has no employees who have had a break in service or were reemployed with the agency without an additional suitability assessment or background screening if the break is less than 90 days, at the time of this review.	
Five-year re-screening completed every 5 years from initial date of hire		**X**				There was one (1) five year rescreening file that met the requirement for review. The rescreening documentation was dated as eligible from the DJJ Background Screening Unit (BSU) on March 31, 2022. The screening should have been submitted prior to July 11, 2021, which is the employee's anniversary date. The Chief Operations Officer (COO) explained that due to agency disruptions it was overlooked and that the staff was administrative.	Exception: One (1) staff member had the re-screen completed outside of the employee's 5 year anniversary date.
Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?		**X**				The agency did not provide the Annual Affidavit of Compliance with Level 2 Screening Standards to the BSU before or by January 31st .	Exception: Annual Affidavit of Compliance was submitted late to the DJJ BSU on 02/28/2022.

Proof of E-Verify for all new employees obtained from the Department of Homeland Security	X					Proof of E-Verify was documented for all new employees files that were reviewed, these were obtained from the Department of Homeland Security.	
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** If NO, explain here: The agency has a policy for this standard #1.04 titled Training and which was last reviewed on 2/11/2022 and signed by the CEO.	**Add any exceptions below:**
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					Three (3) new hire staff files were reviewed for this requirement. All 3 staff completed their DJJ Civil Rights and Federal Funds training within 30 days of hire.	
All staff receives all mandatory training during the first 90 days of employment from date of hire.	X					Three (3) new hire staff files were reviewed for this requirement. All staff completed the mandatory training within the 90-day timeframe as required.	
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			There was no new non-licensed mental health clinical shelter staff hired at the time of the review.	
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			There was no new non-licensed mental health clinical shelter staff hired at the time of the review.	

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 (3) out of four (4) training files were reviewed for staff completing the required number of hours of Florida Network, SkillPro and job-related training, three (3) of which were shelter staff who completed their training hours and one (1) community counseling training file. The Community Counseling program staff was unable to provide the initial requested file for review as the staff was out of work, ill. Reviewer randomly requested another training file and the adhoc documentation was provided via several email attachments, however, not all training documentation was provided to demonstrate all training requirements were met at the time of the review. Three (3) out of four (4) staff training files reviewed demonstrated over 40 hours of annual training hours.	Exception: One community counseling staff training file was requested and lacked evidence of the following trainings being completed as required: PREA (incomplete since 2019), Suicide Prevention, CPR and First Aid Certification.
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 shelter program maintains a very robust and meticulously managed individual training file for all staff including each of the five shelter staff files reviewed from the seven (7) total that was reviewed. The files included the annual employee training hours tracking form and related supporting documentation. The tracking forms that are used breaks the training into individual and specific contract training requirements which are more specific to pre-service, orientation training, in-service annually and ninety (90) day training requirements. The community counseling staff do not maintain individual training files for each staff, instead each staff are responsible for completing and tracking their own CINS/FINS training documentation and individual hours. As a result of the current practice, this reviewer was unable to obtain the original requested training file due to staff being absent from work. A second request had to be made and there was not an organized training file maintained for that individual.	Exception: The community counseling staff do not maintain individual training files for each staff as required.

Provider has a written policy and procedure that meets the requirement for Indicator 1.06						YES If NO, explain here: The agency has a policy for this standard #1.06 titled Client Transportation which was last reviewed 01/24/2022 by the CEO.	Add any exceptions below:
Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	X					An up-to-date list of approved driver list was provided for YFA RAP House Staff to the reviewer.	
Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	X					The agency provided insurance documentation to meet the approved driver requirement.	
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 has a policy that provides guidance in the event that a single transport needs to occur if the 3rd party is not available. The policy states that in the event of a single transport staff must ensure that the Program Manager is aware and they factor in the client's history, evaluation, and recent behaviors.	
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					Reviewer reviewed three van logs with date ranges from October 2021 - April 2022. A random sample of logbook entries were reviewed for 12/7/21; 2/8/22; 3/1/22; 3/2/22; 3/28/22 and 4/5/22 all of which revealed Program Manager's approval to provide single transport.	
The 3rd party an approved volunteer, intern, agency staff, or other youth	X					The agency makes the effort to avoid single transport and documented these consistently when they occurred.	
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					There is transportation log documentation reviewed that includes the use of vehicle, name or initials of driver, date, time, mileage, number of passengers, purpose of travel, and location.	

Standard Two – Intervention and Case Management							
Provider has a written policy and procedure that meets the requirement for Indicator 2.03						**YES** If NO, explain here: The program has a Policy # 2.03 RGC that was last reviewed 10/05/2021 by the CEO.	**Add any exceptions below:**
Rating Criteria	Satisfactory	Non-compliant	No Eligible Items for Review	No Practice	Not Applicable		
Case/Service plan is developed within 7 working days of NIRVANA	X					Case/Service plans were developed within 7 working days of NIRVANA.	
Case plan service Plan includes: 1. Individualized and prioritized need(s) and goal(s) identified by the NIRVANA 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					Eight (8) youth records were reviewed; four (4) closed and four (4) open, with an equal representation from both residential and community counseling services. Documentation was reviewed and confirmed all eight (8) youth records contained a completed service plans, with all required elements completed at the required timelines. All completed youth Case/Service plans had evidence of being individualized and included prioritized needs and goals identified by the need's assessment. All 8 completed Case/Service Plans were found to have service type, frequency and location identified and also identified the person responsible. All Case/Service Plans had evidence of target dates for completion and documentation actual completion dates, as well as evidence of the youth's, parent's/guardian's and supervisor's signature. All Case/Service Plans were found to contain the signature of the counselor.	
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					Four (4) files were applicable for this review item. Each of the four records also contained an Aftercare Plan, with all documentation to support the required elements being met.	

Standard Three – Shelter Care							
Provider has a written policy and procedure that meets the requirement for Indicator 3.01						**YES** If NO, explain here: The agency has a policy titled RGC 3.01 Residential Group Care Environment and was last reviewed 02/03/2022 by the CEO.	**Add any exceptions below:**
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
Facility Inspection	X					On May 5, 2022, the reviewer was given a tour of the youth shelter conducted by the Program Manager. The agency informed the review team there were no further physical plant improvements since the last review. A tour of the entire shelter facility resulted in the facility appearing to be clean and well kept. The bedrooms were being adequately furnished, clean, and maintained the required bedding. Bathrooms appeared to be clean and all were in good working condition. The open design of the common area/day room allows natural light to enter. The youth have access to the facility's backyard which included basketball and volleyball courts.	
Additional Facility Inspection Narrative (if applicable)	The outside grounds were observed to be tidy and free of debris or unsafe items. The kitchen was organized and all stored food was clearly labeled and marked appropriately. The refrigerator and freezer temperature were within the required minimally acceptable range. Menus were posted and reviewed annually by a licensed dietician. The current menu is valid until 07/13/2022. The dietician's license is also posted and expires 05/31/2023. The agency has a current Department of Children and Families (DCF) childcare license on display that expires March 2023.						

Fire and Safety Health Hazards	X					12/21/2022	
Additional Fire and Safety Health Hazards Narrative (if applicable)	The agency provided evidence the fire inspection was conducted on 12/21/2021 by Pasco County Fire Department which identified 13 violations, however, a successful reinspection was completed on 02/15/2022. The agency has a fire certificate that addressed the previously issued corrective actions and, therefore, the agency met their annual fire inspection obligation. All fire drills were conducted as required 1 per shift each month over last 6 months. All mock emergency drills completed as required in the last 6 months. The Fire Extinguishers were inspected on 1/11/2022, the Kitchen Overhead Hood Suppression System was inspected on 02/02/2022, the Sprinkler System was documented as occurring on 12/08/2021, and the Fire Alarm System was inspected on 02/22/2022. The agency reports that since the COVID-19 pandemic the local Department of Health (DOH) only does a limited on-site selection of facilities to conduct kitchen/food inspections. A desk audit was conducted where they submitted documents to the DOH, dated 04/14/2022, confirmed via a memo from the DOH. Residential Group Home Inspection was conducted and deemed as satisfactory on 03/04/2022. Chemicals are appropriately stored in two specific locked areas inaccessible to youth. Material Safety Data Sheets are in place and a inventory of chemicals is updated weekly. The agency's chemical inventory is done weekly as required by the indicator, however, it is not a perpetual count and so the count was inaccurate when a review of chemical log was conducted with the assigned staff at the time of the review.						.
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					Youth are engaged in meaningful, structured activities seven days a week during awake hours. Idle time is minimal. At least one hour of physical activity is provided daily. Youth are provided the opportunity to participate in a variety of faith-based activities. Nonpunitive structured activities are offered to youth who do not choose to participate in faith-based activities. Daily programming includes opportunities for youth to complete homework and access a variety of age appropriate and program approved books for reading. Youth are allowed quiet time to read. A daily programming schedule is publicly posted and accessible to both staff and youth.	

Provider has a written policy and procedure that meets the requirement for Indicator 3.06						YES If NO, explain here: The agency has a policy titled RGC 3.06 and was last reviewed 11/17/2021 by the CEO.	Add any exceptions below:
Rating Criteria	**Satisfactory**	**Non-compliant**	**No Eligible Items for Review**	**No Practice**	**Not Applicable**		
The program maintains minimum staffing ratios as required by Florida Administrative Code and contract. • 1 staff to 6 youth during awake hours and community activities • 1 staff to 12 youth during the sleep period	X					The logbooks and staff schedules were reviewed from October 2021 to the date of the review. During the months of October- November 2021, the program was closed, and staff and youth were re-located to a sister property; New Beginnings. The logbook shows that there were eight (8) youth onsite and two staff as per contractual requirements at the date of the review. The program provided documentation, through a hardship letter, dated, September 2, 2021 from Mark Wickham, CEO of YFA, to Stacy Gromatski, President and CEO of Florida Network of Youth and Family Services, which provided notification of the program closure and alternate housing location for program youth and staff. Additional follow-up communication has continued through April 4, 2022 updating Florida Network of YFA program status.	
All shifts must always provide a minimum of two staff present	X					A review of the schedules over the last six (6) months while on-site found that all shifts had evidence a minimum of two (2) staff were present on all work shifts.	
Program staff included in staff-to-youth ratio includes only staff that are background screened and properly trained youth care workers, supervision staff, and treatment staff	X					The staff schedules for the last six months reflect the minimum number of staff needed to work each work shift meets the in staff-to-youth ratio requirement.	
The staff schedule is provided to staff or posted in a place visible to staff	X					Evidence of the staff schedule was provided during the onsite tour. The reviewer observed the staff schedule posted in the staff office which is visible to staff.	

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					Evidence of the staff schedule was provided. The agency has a part-time, on-call, and holdover list. The agency supervisor refers to the list to manage and maintain the number of staff required to fill the staffing schedule when needed.	
Staff observe youth at least every 15 minutes while they are in their sleeping room, either during the sleep period or at other times, such as during illness or room restriction		X				A review of randomly selected dates on the overnight work shift were assessed to determine the agency's adherence to this bed check indicator. The area reviewed in the facility has a split floor plan with a male hallway and a female hallway. Video footage of three randomly selected dates for 15-minute bed checks was reviewed, for a total of nine time slots. During the video observations, it was noted some staff document bed checks in the logbook at the beginning of conducting bed checks and other staff record checks in the logbook after completion of 15-minute checks. This practice of recording bed checks was discussed with the Program Manager and the inconsistency of staff recording bed checks in the logbook. The Program Manger stated she would be notifying staff, today, of the best practice for all staff to follow; which will be to record bed checks in logbook after checks are completed. Program Manager provided reviewer a copy of the email sent to program staff, confirming the practice of documenting 15-minute checks in logbook after the completion of the checks.	Exception: Fifteen minute bed checks were observed on video by the reviewer. The observation of these checks revealed that some bed check tasks were documented prior to the staff actually completing the bed check task. Additional bed checks observed on video by the reviewer revealed that bed checks were documented after the check was done.
Standard Four – Mental Health/Health Services							
Provider has a written policy and procedure that meets the requirement for Indicator 4.02						**YES** If NO, explain here: The agency has both policy and procedure in place which meets the requirements. RGC 4.02 Reviewed 09/29/2021and approved by CEO.	**Add any exceptions below:**
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					The reviewer assigned to this indicator reviewed a total of four (4) client files. A total of two (2) open and two (2) closed client files were reviewed to determine the agency's adherence to the indicator. The agency's healthcare screening forms reviewed have evidence that they were all completed at the screening and intake phase. The four youth records reviewed, represented residential program youth. All four (4) youth records contained the required documentation of completed suicide screening at intake; each suicide screening results were signed by a licensed professional.	
The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	X					The agency continues to utilize a Suicide Assessment tool that has been submitted and approved by the Florida Network of Youth and Family Services.	
Supervision of Youth with Suicide Risk							
Youth are placed on the appropriate level of supervision based on the results of the suicide risk assessment.	X					One of four reviewed youth files for suicide risk assessment found the youth was applicable for sight and sound supervision, which was done by a licensed professional.	
Staff person assigned to monitor youth documented youth's behavior at 30 minute or less intervals	X					The single file reviewed for sight and sound had evidence that observations were conducted in thirty (30) minutes or less. Staff are documenting observation checks on a log that tracks the check completion on each shift.	
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					Evidence showed that the youth who was under observation supervision level was not stepped down from that level until the youth received a follow up Suicide Risk Assessment by the therapist working under the supervision of a licensed clinician.	

Provider has a written policy and procedure that meets the requirement for Indicator 4.03						YES If NO, explain here: The agency has both policy and procedure in place which meets the requirements. RGC 4.03 Reviewed on 09/29/2022 and approved by CEO.	Add any exceptions below:
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 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 f. Pyxis keys with the following labels are accessible to staff in the event they need to access medications if there is a Pyxis malfunction: a TOP COVER b BACK PANEL- LEFT TALL CABINET LOCK-LEFT, c BACK PANEL- RIGHT TALL CABINET LOCK- RIGHT	X					Program staff that included the Program Director and the Registered Nurse were interviewed to assess the agency's adherence to this medication indicator. All narcotics and controlled medications are stored in a Care Fusion Pyxis Med-Station 4000 Medication Cabinet. The medication cabinet is stored in the laundry room behind a locked door that is inaccessible to youth. Oral medications are stored in separate bins of the Medication Station, apart from topical or injectables. A refrigerator was observed to be secured with a lock in the medication storage room. At the time of the QI program review, the program does not have any prescription or other medications needing refrigeration nor did they have any narcotic medications. The agency's medication management practice indicates that narcotics and controlled medications are stored in the Pyxis Med-Station.	

Medication Distribution							
a. Agency maintains a minimum of 2 Super Users for the Med-Station b. Only designated staff delineated in User Permissions have access to secured medications, with limited access to controlled substances (narcotics) c. A Medication Distribution Log shall be used for distribution of medication by non-licensed and licensed staff d. Agency verifies medication using one of four methods listed in the FNYFS Operations Manual e. When nurse is on duty, medication processes are conducted by the nurse f. The delivery process of medications is consistent with the FNYFS Medication Management and Distribution Policy g. Agency does not accept youth currently prescribed injectable medications, except for epi-pens h. Non-licensed staff have received training in the use of epi-pens provided by a registered nurse	X					The agency has a documented list of super and regular users who are authorized to assist in the delivery of medication. The agency has a medication distribution log that tracks all of the medication provided to the youth during their shelter stay. Each youth's medication record is maintained in a combined binder. The agency practices the use of the 5 Rights method, (right dose, right route, right med, right patient, and right time) to assist in the delivery of medications to that it is consistent and limits mistakes. This method is listed and in alignment with the FNYFS Operations Manual and the delivery of medication is consistent with FN medication management policy. The agency has documentation that non-licensed direct care staff have received training in the use of Epi-pens provided by the program's RN during medication training which is provided during the on-boarding process. The agency's program director reported that the agency's newly employed RN provides the medication distribution and Pyxis training.	

Medication Inventory							
a. For controlled substances, a perpetual inventory with running balances is maintained as well as a shift-to shift count verified by a witness and documented b. Over-the-counter medications that are accessed regularly are inventoried weekly by maintaining a perpetual inventory c. Syringes and sharps (needles, scissors, etc.) are secured, and counted and documented weekly		X				All controlled substances are maintained in a perpetual running balance in order to maintain a shift-to-shift count. This is required to be completed by 2 direct care staff members and is documented on the youth's Medication Distribution Log (MDL). The reviewer conducted a shift count on the medication distribution logs for all clients and was found not to be consistent. All over-the-counter medications are inventoried on a weekly basis on a perpetual log. The medication log is reviewed by the designated personnel and signed by the RN who started in that role only a few weeks prior to the review. A perpetual inventory is maintained on the youth's MDL each time that youth receives assistance in the distribution of medication. Reviewer and nurse inventoried three OTC medications (Ibuprofen, Pepto Bismol, and Midol) and compared them for accuracy, using the perpetual OTC medication inventory log, medication log, and actual counts. Two of the three medication's inventory was confirmed as accurate. The medication log indicated one tablet had been given after-hours to a youth on 5/3/22 and was properly recorded; however, the staff did not record it in the perpetual OTC medication inventoy log as required by policy RCG 4.03; page 8, section 9(c). The nurse, who was hired, less than one month, stated she will be conducting re-training to staff regarding dispensing and logging dispensed medication in the OTC medication inventory log by unlicensed staff. The agency maintains sharps in the facility, securely. The inventory for sharps and all associated documentation indicates that the sharps are counted on a weekly basis. Review of the documentation indicate that the RN is reviewing the medication records of all residents when she is on duty. Currently, the program does not have any youth taking narcotics and controlled medications; therefore, no inventory of narcotics and controlled medications was conducted. However, the program has a policy and procedure to address the storage, inventory and dispensing of narcotics and controlled medications.	Exception: The documentation of over-the-counter (OTC) medication inventory was inaccurate when inventoried by the reviewer and nurse while on-site. One medication (Ibuprofen), stated on the medication log there were 33 tablets and the actual count was 33 tablets; however, the perpetual OTC medication inventory log listed 34 tablets.

There are monthly reviews of medication management practice via Knowledge Portal or Pyxis Med-Station Reports.	X					The RN conducts monthly reviews of medication management practice via knowledge portal reports from the med station. The outcome of these reports is then discussed during director's meetings.	
Medication discrepancies are cleared after each shift.	X					An interview with the RN indicates that all discrepancies are required to be cleared prior to the close of the current work shift. The RN confirms that she is required to submit weekly reviews of discrepancies and requests reports on these occurrences. A review of medication distribution practice indicates that the agency reported nine (9) CCC reportable medication related incidents since the last review. These incidents were either given late to the youth or were missed.	