Florida Network for Youth and Family Services
Compliance Monitoring Report for

Youth and Family Alternatives, Inc.
New Beginnings
18377 Sheriff Mylander Way
Brooksville, Florida 34601

Date: May 25-26, 2023

Compliance Monitoring Services Provided by

FOREFRONT

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, Inc. (YFA) New Beginnings for the FY 2022-2023 at its program office located at 18377 Sheriff Mylander Way, Brooksville, Florida 34601. 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. YFA New Beginnings 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 from July 1, 2022 through June 30, 2023.

The review was conducted by Keith Carr, Consultant for Forefront LLC and Peer Reviewer Alexis Sapp, Operations Coordinator Department of Juvenile Justice. Agency representatives from YFA New Beginnings present for the entrance interview were Jason Thomas, Senior Vice President of Operations; Tomi Steinruck, Program Director; Michelle Almand, Quality Improvement; Kialima Sharmetta Tzliah, Residential Supervisor. The last QI program review was conducted on March 9-10, 2022.

The Reviewer found 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 four 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.

2022-2023 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 05-25-26-2022-2023

Agency Name: YFA New Beginnings	**Monitor Name: Keith Carr, Lead Reviewer**
Contract Type : CINS/FINS	**Region/Office: 18377 Sheriff Mylander Way, Florida 34601**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): May 25-26, 2023**

Major Programmatic Requirements	Explain Rating: Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable	Ratings Based Upon: I = Interview; O = Observation; D = Documentation; PTV = Submitted Prior To Visit; (List Who and What)	Notes: Explain Unacceptable or Conditionally Acceptable: (Attach Supportive Documentation)
I. Administrative and Fiscal							
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 on file: General Liability through Alliance of Nonprofits for Insurance, for limits of coverage $1,000,000 each $3,000,000 aggregate, and $20,000 medical expenses, effective 7/01/22-7/01/23. Automobile insurance through Alliance of Nonprofits for Insurance for combined limits of liability/property damage for $1,000,000. Policy effective for 7/01/22-7/01/23. Abuse/Molestation coverage through Alliance of Nonprofits for Insurance for limits of coverage of $1,000,000 each $2,000,000 aggregate effective 7/01/22-7/01/23. Professional Liability through Alliance of Nonprofits for insurance for limits of coverage of $1,000,000 each	**No Recommendation or Corrective Action.**

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	Explain Rating						
Major Programmatic Requirements	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable	Ratings Based Upon: I = Interview O = Observation D = Documentation PTV = Submitted Prior To Visit (List Who and What)	Notes Explain Unacceptable or Conditionally Acceptable: (Attach Supportive Documentation)
						$3,000,000 aggregate effective 7/01/22-7/01/23. Workers Compensation through American Liberty Insurance Co for limits of coverage of $1,000,000 each accident effective 12/20/22-7/1/23. Umbrella Liability Insurance through Alliance of Nonprofit for insurance for limits of coverage of $3,000,000 each/aggregate effective 7/1/22-7/1/23. Florida Network is listed on the Certificate of Insurance 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 under “Financial Management” in the agency’s policy and procedure manual. The policies are divided into 43 sections labeled FM400-FM499. The fiscal procedures reviewed appear to be consistent with generally accepted accounting principles (GAAP) and provide for sound internal controls. Procedures	**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		
						are included for general ledger, bank reconciliations, purchasing, invoicing, payroll, petty cash, computer backup, and other relevant financial processes. Policies last revised and approved February 2019 and are updated as needed.	
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 Procedures FM482. The Petty Cash fund does not exceed the established minimum total amount of $100 and is used for purchases of $25 or less. Petty cash is stored by the Program Director in a secure locked location in the building. Petty cash is reconciled on a consistent basis (monthly) by the Residential Supervisor. Disbursements and invoices are approved by the Program Director and Residential Supervisor. Petty cash reconciliations from November 2022 through April 2023 were submitted for review. All were reconciled for $100 each month.	**No Recommendation or Corrective Action.**
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	☐	☐	☐	☐	☒	N/A – The Program Director reported they have not used FNYFS funds for any of any property inventory related	**No Recommendation or Corrective Action.**

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	Explain Rating					Ratings Based Upon:	Notes
Major Programmatic Requirements	Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable	I = Interview O = Observation D = Documentation PTV = Submitted Prior To Visit (List Who and What)	Explain Unacceptable or Conditionally Acceptable: (Attach Supportive Documentation)
equipment an Informational Resources Request (IRR) been submitted to DJJ. **PTV/ON SITE**						items with FNYFS funds in fiscal year 2022-2023.	
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: The agency Financial Audit was conducted for year ending June 30, 2022 was completed by Reeder & Associates, PA December 7, 2022. A separate Management Letter requiring a Corrective Action Plan was not issued by the auditor. A copy of the audit is on file with the FNYFS.	**No recommendation or Corrective Action.**

CONCLUSION

YFA New Beginnings has met the requirements for the CINS/FINS contract as a result of full compliance with all four applicable indicators of the Modified Administrative and Fiscal Contract Monitoring Tool. A fifth indicator was not applicable because the provider does not have any current inventory purchased with Florida Network 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 conducted 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

Youth and Family Alternatives - New Beginnings
CINS/FINS Program

May 25-26, 2023

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CINS/FINS Rating Profile

Standard 1: Management Accountability

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

Percent of indicators rated Satisfactory: 33.33 %
Percent of indicators rated Limited: 33.33 %
Percent of indicators rated Failed: 33.33 %

Standard 2: Intervention and Case Management

2.03 Case/Service Plan	**Satisfactory**

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

Standard 3: Shelter Care & Special Populations

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

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

Standard 4: Mental Health/Health Services

4.02 Suicide Prevention	**Limited**
4.03 Medications	**Limited**

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

Overall Rating Summary
Percent of indicators rated Satisfactory: 37.5 %
Percent of indicators rated Limited: 37.5 %
Percent of indicators rated Failed: 25 %

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

Keith Carr, Lead Reviewer Consultant - Forefront LLC/Florida Network of Youth and Family Services
Alexis Sapp, Operations Coordinator, Florida Department of Juvenile Justice

Methodology

This review was conducted in accordance with FDJJ-2000 (Quality Assurance Policy and Procedures), and focused on the 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 September 1, 2022).

Persons Interviewed

	Chief Executive Officer	X	Case Manager		Nurse – Full time
	Chief Financial Officer		Counselor Non-Licensed	X	Nurse – Part time
X	Chief Operating Officer		Advocate	2	# Case Managers
	Executive Director	X	Direct – Care Full time	1	# Program Supervisors
X	Program Director	X	Direct – Part time		# Food Service Personnel
	Program Manager		Direct – Care On-Call	1	# Healthcare Staff
	Program Coordinator		Intern		# Maintenance Personnel
	Clinical Director		Volunteer	4	# Other (listed Direct Care and Human Resources staff me
X	Counselor Licensed	X	Human Resources		

Documents Reviewed

	Accreditation Reports	X	Table of Organization		Visitation Logs
X	Affidavit of Good Moral Character	X	Fire Prevention Plan	X	Youth Handbook
X	CCC Reports	X	Grievance Process/Records	4	# Health Records
X	Logbooks	X	Key Control Log	4	# MH/SA Records
X	Continuity of Operation Plan	X	Fire Drill Log	8	# Personnel /Volunteer Records
X	Contract Monitoring Reports	X	Medical and Mental Health Alerts	8	# Training Records
X	Contract Scope of Services	X	Precautionary Observation Logs	5	# Youth Records (Closed)
X	Egress Plans	X	Program Schedules	7	# Youth Records (Open)
X	Fire Inspection Report		List of Supplemental Contracts		# Other: ___
X	Exposure Control Plan	X	Vehicle Inspection Reports		

Observations During Review

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

Surveys

8	# of Youth	14	# of Direct Staff		# of Other

Comments

Due to the systemic staffing issues which impact the availability for member agencies to participate in the QI Peer Review team review, this review was conducted using the Modified QI Review Tool.

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/or community counseling services.

Strengths and Innovative Approaches

The following programmatic updates were provided by the agency:

The agency reported the Program Director resigned in July 2022 and a Program Supervisor resigned in December 2022. Both Program Supervisor positions were filled in February 2023. The agency reported the new Registered Nurse started on May 8, 2023. In addition, a Quality Specialist position has been added, which started on May 2, 2023. A Training Specialist position has been created and is scheduled to start in June 2023.

The agency reported the facility was recently painted inside in the common area and a new stove was recently installed. The agency reported Leadership Hernando has partnered with the program and installed an inground basketball hoop as well as some sail shade near some pine trees and some new picnic tables for the youth to enjoy. This organization is also interested in funding the installation of a fence in the back of the property.

The youth census during the Quality Improvement (QI) visit was seven CINS/FINS residents. The YFA is currently accredited by the Council of Accreditation (COA) and was recently re-accredited through October 31, 2024. Since the last QI visit, the YFA agency has a new leadership team with a new Chief Operations Officer coming on board within the last 30 days. The Vice President of Prevention reports to the Chief of Operations and a New Senior Director position which will report to the Vice President of Prevention. The agency has each Program Director position at each residential youth shelter reporting to the Senior Residential Director. Each of the three service locations will have a Program Director and all have two Residential Supervisors, and residential and non-residential direct care staff members which report to them accordingly.

Narrative Summary

Youth and Family Alternatives (YFA) Inc. operates three crisis shelters in the State of Florida that are contracted with the Florida Network of Youth & Family Services, Inc (FNYFS). The YFA New Beginnings youth shelter is in Brooksville, Florida and serves judicial circuit 5, which includes Citrus, Hernando, and Sumter Counties. The YFA agency serves additional counties including Pasco, Hardee, Highlands and Polk. The New Beginnings youth 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 YFA Children in Need of Services/ Families in Need of Services (CINS/FINS) Community Counseling team serves youth and families in the counties and coordinates the delivery of community services to families and children in care in these areas. CINS/FINS provides the ability to serve both male and female youth ages from six to seventeen year olds for community counseling services and ten to seventeen year olds for residential services for youth that are locked out, runaway, ungovernable and/or truant, homeless, abused, neglected, or at-risk. The agency also provides specialized services to youth who meet the criteria for Domestic Violence, 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 overall findings for the QI Review for YFA New Beginnings are summarized as follows:

Standard 1: Three indicators were reviewed for Standard 1: 1.01 Background Screening of Employees/Volunteers, 1.04 Training Requirements, and 1.06 Client Transportation. Indicator 1.01 Background Screening was rated Satisfactory with exceptions. Indicator 1.06 Transportation was rated Limited. Indicator 1.04 Training was rated Failed.

Standard 2: One indicator was reviewed for Standard 2, Indicator 2.03 Case/Service Plan. Indicator 2.03 was rated Satisfactory with exceptions.

Standard 3: Two indicators were reviewed for Standard 3: 3.01 Shelter Environment, and 3.06 Staffing and Youth Supervision. Indicator 3.01 was rated Failed. Indicator 3.06 was rated Satisfactory with exceptions.

Standard 4: Two indicators are reviewed for Standard 4: 4.02 Suicide Prevention and 4.03 Medications. Indicator 4.02 Suicide Prevention was rated Limited. Indicator 4.03 Medications was rated Limited.

Summary of Deficiencies resulting in Limited or Failed Rating:

Standard 1: Indicator 1.04 Training– Failed

Three out of four new hire staff members were each missing various trainings that were not completed within the required timeframe.
Five in-service staff member training records were reviewed. Two staff members completed the minimum hours of required training. The program was unable to provide the number of hours completed for the remaining staff, and the hours of training completed are not able to be verified at this time. Unable to find documentation of most trainings for in-service staff members. Of nine staff training records reviewed, one staff did not have an individual training record at all. It was indicated by program staff the employee transferred from another facility, however, the former program did not have the training record either.

Indicator 1.06 – Limited
Dates of transportation events missing prior approval were identified in the travel log only and failed to demonstrate supervisor approval was obtained prior to the single transportation event nor was it documented in program logbook by the agency. A sample of staff were interviewed about the staff's understanding of the agency's policy and none of the staff were able to identify the requirement of obtaining supervisor approval prior to single transport events.

Standard 3:
Indicator 3.01 – Failed

Water pooling near exit door on screened patio was observed. The agency submitted a work order on the same day and the company arrived onsite to start repair to stop pooling work on Day 2 of the review. The trash bin was missing a lid and trash was exposed and observed around the bin. Agency reported, on Day 2 of review, trash company is scheduled to replace bin in June 2023. Weekly and perpetual chemical checks were not found in five of the six previous months (end of November 2022, December 2022, January 2023, February 2023, March 2023 and April 2023). A pipe near the water heater located in the kitchen was leaking. There is a hole in the drywall near the floor hot water heater in laundry room and is exposed and requires repair. The floor board of each transportation van needed to be cleared of items (boxes of masks, mosquito spray, large containers of wipes) and the vans needed to be vacuumed. There is no evidence of several Fire and Mock Drills across multiple work shifts.

Prepared food in three plastic containers located in the refrigerator are not marked as required. All three containers do not indicate the current date when food was prepared and placed in the refrigerator as required. Documented evidence of chemicals check were found for May 2023 on a weekly basis. At the time of this onsite program review, the perpetual use of chemicals, when used by staff members is not being documented.

No evidence of multiple drills being conducted over the last six months. Fire Drills and Mock drills practice were both reviewed and there was no evidence of documented fire drills over the last six months on each shift for the following months: First Shift – December 2022, January 2023, February 2023, March 2023, April 2023; Second Shift: November 2022, December 2022, February 2023, March 2023, and Third Shift: November 2022, December2022, January 2023, February 2023, March 2023, and April 2023. Mock Drills missing included: First Shift: None documented between November 2022 and January 2023; Second Shift: None documented between November 2022 and January 2023; and Third Shift: None documented between November 2022 and January 2023.

At the time of this onsite program review, grievance boxes checked over the last six month between November 2022 through May 2023 by supervisors are not documented in the program logbook as required.

Standard 4:

Indicator 4.02 - Limited

No documentation of youth being placed on Sight and Sound on one client. Documentation of the date the youth is taken off supervision is found, but the entry is not written correctly on one client. The CINS/FINS Intake form for one client was not found. A logbook entry is a late entry on one client being placed on sight and sound. One client is missing two forms on the second day of observations being conducted. This client's case file is missing the Close Supervision Observation Checks form and Behavior 30-Minute Checks Observation Log and log entries on day two between 3:30pm and 5:00pm. Further, this client's case does not have evidence of documentation of youth being taken off Sight and Sound status. Third youth case is missing six 30 minute observation check log entries. A client being taken off Sight and Sound is found in the logbook, but not documented correctly. This entry fails to document the actual time of entry is logged. There is no evidence of the third client case being taken off Sight and Sound status in logbook.

Indicator 4.03 - Limited

Three end of shift counts did not have a signature from a witness associated with the medication count.
The RN reported no medication distribution-related reports are currently being pulled from the Pyxis medication cabinet due to the prolonged vacancy which the RN only recently filled. Discrepancies are not being cleared after each shift as the RN is not on site full time. The medication discrepancy form was reviewed and does not include a section for a response, or indication of the resolution to the discrepancy. A report was generated for the medication discrepancies for the previous six months, and there were several uncleared discrepancies due to a vacancy in the nurse position.

CINS/FINS QUALITY IMPROVEMENT TOOL

Quality Improvement Indicators and Results: Please select the appropriate outcome for each indicator.		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			**Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 1.01		**YES** If NO, explain here: The program policy and procedure policy number is RGC 1.01, and was reviewed and approved by the President/CEO on November 17, 2021.	
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.	**Compliance**	Background screening documentation was reviewed for twenty one staff members. Seventeen staff records contained a pre-employment suitability assessment with a passing score, which was completed before the employee's hire date. The remaining four records did not require them due to the employees being hired prior to the agency mandating that all program staff complete suitability assessments before their hire date.	There was no documentation of a pre-employment assessment being completed for three staff members, and documentation for one staff members indicated the pre-employment assessment was completed after the staff's hire date.
Background screening completed prior to hire/start date (or exemption obtained prior to working with youth if rated ineligible) for new hires, volunteers/interns, and contractors	**Exception**	Twenty-one staff employment records were reviewed. Seventeen staff records contained a pre-employment suitability assessment with a passing score, which was completed before the employee's hire date. The remaining four records did not require them due to the employee being hired before the program staff were required to complete one before hire date. The remaining twenty staff had documentation to indicate a background check was completed with eligible results prior to hire date.	The program was unable to provide a pre-employment background screening for one staff member. One record did not contain the background screening for one staff member, only the five year re-screen for this staff.

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.	**No eligible items for review**	Twenty-one staff hiring records were reviewed, and none were applicable.	
Five-year re-screening completed every 5 years from initial date of hire	**Compliance**	Staff member records were reviewed for this indicator. Three staff records were applicable for five year background screening. Each applicable staff member had a completed five year re-screen.	
Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?	**Compliance**	The affidavit of compliance with level two screening standards was reviewed, as well as an email submission to the Florida Department of Juvenile Justice (DJJ) background screening. The affidavit was completed and emailed to the appropriate parties before the January 31, 2023 due date.	
Proof of E-Verify for all new employees obtained from the Department of Homeland Security	**Compliance**	Twenty-one staff member employment records were reviewed. Each record contained proof of E-Verify being obtained from the Department of Homeland Security for that staff member.	
1.04: Training Requirements (Staff receives training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions)			**Failed**
Provider has a written policy and procedure that meets the requirement for Indicator 1.04		**YES** If NO, explain here: The agency policy number is RGC 1.04 and called Training. The policy was reviewed and signed by the President/CEO on February 11, 2022.	
First Year Direct Care Staff			
All direct care staff have completed new hire pre-service training requirements for safety and supervision as required.	**Exception**	Four staff training records were reviewed to assess the agency's adherence to the requirements of this indicator. Training records were reviewed for four staff members who have been employed at the program for less than a year, but more than ninety days. One staff had completed new hire pre-service training requirements.	Three of the four staff members did not have evidence of completing all pre-service trainings within the required timeframe.

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)*	**Compliance**	Four staff training records were reviewed to assess the agency's adherence to the requirements of this indicator. Training records were reviewed for four staff who have been employed at the program for less than a year, but more than ninety days. Each staff member completed Civil rights and federal funds training within the first thirty days of hire.	
All direct care CINS/FINS staff (full time, part time, or on-call) demonstrated a minimum of 80 hours of training or more for the first full year of employment.	**Exception**	One of the reviewed staff member training records was applicable.	This record contained documentation to indicate the staff member did not complete eighty hours of training within the first year of employment.
All staff receives all mandatory training during the first 90 days of employment from date of hire.	**Exception**	Four staff training records were reviewed for this indicator. One of three staff members completed all required trainings within the first ninety days of hire.	One first year staff member that completed their first full year of training showed evidence or late and/or missing trainings. One staff member did not complete Cultural Humility training. The second staff member did not complete the following trainings: Provider Orientation, Cultural Humility, Behavior Management, Understanding Youth/Adolescent Development, Child Abuse Reporting, CPR, First Aid, Confidentiality, Managing Aggressive Behavior, Florida Network Suicide Prevention, CINS/FINS Core Training, Signs and Symptoms of Mental Health and Substance Abuse, Skillpro Suicide Awareness, Fire Safety Equipment, or SOGIE. The third remaining staff members did not complete Cultural Humility trainings, and completed Managing Aggressive Behavior training late.
Staff Required to Complete Data Entry for NIRVANA or access the Florida Department of Juvenile Justice Information System (JJIS)			
Any designated staff that is responsible for entering NIRVANA or ensuring accurate and complete data entry in the Florida Department of Juvenile Justice Information System (JJIS) have completed all of the required trainings.	**No eligible items for review**	None of the reviewed staff member records were applicable for these trainings.	

Non-licensed Mental Health Clinical Shelter Staff (within first year of employment)			
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).	**No eligible items for review**	None of the program staff members were applicable for review for this item.	
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).*	**Exception**	Five in-service staff member training records were reviewed to assess the agency's adherence to the requirements of this indicator. Two staff members completed the minimum hours of required training. One staff completed all required trainings.	The program was unable to provide the number of hours completed for the remaining staff, and the hours of training completed are not able to be verified at this time. One staff member is missing the following in-service trainings: Florida Network suicide prevention, CPR, first aid, SkillPro PREA, SkillPro sexual harassment, SkillPro human trafficking 101, SkillPro child abuse reporting, SkillPro information security awareness, SkillPro trauma informed care. Another staff is missing CPR and first aid training. A third staff is missing Florida network suicide prevention. The remaining staff did not complete Florida Network suicide prevention, CPR, first aid, SkillPro PREA, SkillPro sexual harassment, SkillPro human trafficking 101, SkillPro child abuse reporting, SkillPro information security awareness, SkillPro trauma informed care. Unable to find documentation of most trainings for in-service staff members.
Required Training Documentation			
The agency has a designated staff member responsible for managing all employee's individual training files and completes routine reviews of staff files to ensure compliance.	**Compliance**	An informal interview was conducted to obtain information regarding the agency's ability to meet this requirement. Program staff were interviewed informally during the Entrance Interview and reported there is one person who is responsible for managing training files.	
The program maintains an individual training file for each staff, which includes an annual employee training hours tracking form and related documentation, such as electronic record/transcript, training certificates, sign-in sheets, and agendas for each training attended.	**Exception**	A total of nine staff member training records were reviewed to assess the agency's adherence to this requirement. Eight out of the nine files reviewed included the individual training record for staff.	Of nine staff training records reviewed, one staff did not have an individual training record. It was indicated by program staff the employee was transferred from another facility, however, the former program did not have the training record either.

1.06: Client Transportation			Limited
Provider has a written policy and procedure that meets the requirement for Indicator 1.06		**YES** If NO, explain here: The agency policy number is RGC 1.06 and called Client Transportation. The policy was reviewed and signed by the COO on January 24, 2022.	
Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	**Compliance**	The agency requires all direct care staff members to be utilized as drivers and be listed as approved to drive all official transportation vehicles. The agency provided documentation from its automobile insurance carrier indicating all staff members with a valid drivers license are permitted to drive all agency vehicles.	
Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	**Compliance**	A review of a sample of six staff member personnel files indicated staff members have valid driver's licenses. The agency submitted documented evidence of automobile insurance coverage which includes provisions stipulating employees with valid drivers licenses are covered under its automobile insurance policy.	
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	**Compliance**	The agency protocol for single transportation events states in the event a single client needs to be transported, and no staff or youth are available to be the third person, staff members must obtain authorization from the Shelter Supervisor or a manager prior to transport. Documentation of prior approval must be documented in the shelter log book.	
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	**Compliance**	A review of the agency's policy describes a third party participant as a staff member, intern, volunteer, or youth that has been preapproved. The agency assesses the past history and current behavior of clients in order to approve them as eligible for single client transport events.	
The 3rd party is an approved volunteer, intern, agency staff, or other youth	**Compliance**	The agency has a policy that states 3rd parties are an approved volunteer, intern, agency staff, or other youth.	

The agency demonstrated evidence via logbook or other written verification that supervisor approval was obtained prior to all single youth transports.	**Exception**	A total of 187 transportation events were documented on the agency's Monthly Trip and Mileage Log. None of the eight had evidence of supervisor approval prior to transport for single youth transports.	Of the 187 transportation events, a total of eight documented events included one driver and one passenger and had no proof of prior approval from a program supervisor. The five single transport events which are not documented in the program logbook occurred on April 27, 2023, and May 1, 3, 8, 10, 2023 and no supporting evidence to demonstrate supervisor gave prior approval. There were three single transport events which were documented in the logbook but without prior approval of a supervisor (February 16, 17, 22, 2023). Dates of transportation events missing prior approval were identified in the travel log only and failed to demonstrate supervisor approval was obtained prior to the single transportation event nor was it documented in program logbook by the agency. A sample of staff were interviewed about the staff's understanding of the agency's policy and none of the staff were able to identify the requirement of obtaining supervisor approval prior to single transport events.
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.	**Compliance**	All areas of the form are listed for employees to document in the agency's monthly trip and mileage log. A review of logged transportation events completed in the last six months from November 2022 to May 2023 was conducted and verified the driver completing the travel log as required.	
2.03 - Case/Service Plan			**Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 2.03		**YES** If NO, explain here: The agency policy number is RGC 2.03 and called Service Plan Development and Service Monitoring. The policy was reviewed and signed by the COO on February 3, 2022.	
The case plan is developed based on information gathered during the initial screening, intake, suicide screening and NIRVANA.	**Compliance**	A random sample of eight (open and closed) client residential and community counseling records which received services in the last six months starting in November 2022 through May 2023 was conducted to assess the agency adherence to the case file requirements of this indicator. A total of eight out of eight client files reviewed contained a service plan developed from information gathered at the initial general screening, intake, suicide screening and NIRVANA assessment. The agency uses an electronic client file records system.	

Case/Service plan is developed within 7 working days of NIRVANA	**Compliance**	Eight out of eight client file case records contained evidence of service plans which were developed within seven days of completion of the NIRVANA assessment.	
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	**Exception**	Agency staff members are trained to conduct screenings. Once collected the findings which included presenting problems are used to determine the client's eligibility status. A service plan is developed for each eligible client. The service plan is created with information and observations collected by staff members during the screening process. The presenting problems collected by the agency are used to build the number of goals and objectives for each client's service plan. Six of the eight client files contain documentation for each case which includes multiple goals and objectives, service type, frequency, location, the person responsible for completing the goals and objectives, target dates for completion, and actual completion date. One client file contains evidence of all of the aforementioned case file requirements except target dates and completion dates. Eight of the eight client files all have evidence of the signatures of the youth and counselor on the initial plan. There was evidence of a signature of the parent/guardian in four community counseling client files. Signatures of supervisors were found in four non-residential cases. Eight out of eight client files have documented evidence indicating the date the service plan was initiated. At the time of the QI program review, the agency has one fulltime counselor that is a Licensed Mental Health Counselor.	One residential case is missing documented evidence of target dates. One client case file is missing evidence of completion dates for assigned goals. The reviewer observed missing parent and supervisor signatures on initial Treatment Plan sessions of four residential client files. The current method in which the residential counselor documents the initial plan review is not being captured in the electronic client case file system.
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	**Compliance**	Client file records were assessed to determine if the files contain documentation of service plan review sessions which track the status of completion of goals and objectives. The current status of client files contains evidence of completed plan review sessions between the counselor and the client and parent/guardian at the required interval for all four community counseling cases. Four community counseling client cases reviewed were applicable for 30, 60 and 90 day case reviews. All cases contained documented evidence confirming plan review sessions at the required intervals.	

3.01 - Shelter Environment			Failed
Provider has a written policy and procedure that meets the requirement for Indicator 3.01		**YES** If NO, explain here: The agency policy number is RGC 3.01 and called Residential Group Care Environment. The policy was reviewed and signed by the COO on February 3, 2022.	
Facility Inspection	**Exception**	A tour of the youth shelter was conducted to determine the agency's adherence to the requirements of this indicator. The DCF license was current and effective and enforced through August 9, 2023. The agency is licensed as a child care agency (CCA) emergency shelter for a capacity of 18 residents. The YFA agency youth shelters have a similar layout across all three facilities. The New Beginnings youth shelter is a one story landscape dwelling with a modern siding and a metal roof. The facility has a foyer, multipurpose room, full kitchen with commercial grade appliances and an eat-in dining area with multiple high-top tables and chairs. The facility also includes a large dayroom for numerous functions for daily activities and events. The facility has separate male and female sleeping quarters with two bathrooms on each of the wings of the dorm sleeping areas. The facility also includes an utility room which is equipped with a washer and dryer and room for storage and laundry supplies. This area also includes a separate room for medication distribution. All furnishings are in good order and no graffiti was found in the interior areas. The exterior of both agency SUV transportation vehicles were clean. Both transportation vans have van logs, fire extinguishers, seat belt cutters and window punches to break the glass in case of an emergency. One van was not equipped with a light and one had a flashlight which was not working properly. The agency placed working flashlights in each van during the review. The agency utilizes a key control system for all direct staff which requires keys to be passed down from shift to shift.	Water pooling near exit door on screened patio was observed. The agency submitted a work order on same day and company arrived onsite to start repair to stop pooling work on Day 2 of review. The trash bin is missing a lid and trash is exposed and observed around bin. Agency reported, on Day 2 of review, trash company is scheduled to replace bin in June 2023. Weekly and perpetual chemical checks were not found in 5 of the 6 previous months (end of November 2022, December 2022, January 2023, February 2023, March 2023, April 2023). A pipe near the water heater located in the kitchen was leaking. There is a hole in the drywall near the floor next to the hotwater heater piping in the laundry room and is exposed and the dry wall requires repair. The floor board of each transportation van needed to be cleared of items (boxes of masks, mosquito spray, large containers of wipes) and the vans needed to be vacuumed.

Additional Facility Inspection Narrative (if applicable)	All keys were accounted for during the two-day review. The agency has three grievance boxes. The agency has youth shelter egress plan map listings in all areas of the building. The youth shelter egress plans are located in the entry area, dayroom, kitchen, dorm halls, and program multi-purpose room. The youth has a knife-for-life, wire cutters and a metal wand detector. The client rules, incident and abuse reporting information, and important contact numbers are posted on the general bulletin board in the dayroom. The daily activity schedule is posted and includes other client-related shelter information. At the time of this review, the interior areas were clean as required, including resident bedrooms, bathrooms, dayroom, kitchen, and the eating areas. At the time of the review, there were no leaks, dust, grime, or mildew observed in each of the bathrooms. At the time of this onsite program review, the shelter kitchen, pantry, oven, refrigerator and sinks are clean and in working order. Current kitchen built-in commercial refrigerator thermometer read 37 degrees. The commercial kitchen freezer has a temperature of 5 degrees. The dietitian's menu is posted in the kitchen and the dietician's license is valid. A review of Material Safety Data Sheets (MSDS) was conducted on chemicals stored at the agency. Chemicals observed onsite did contain MSDS sheets. There is a MSDS binder on each chemical and chemical inventory binder at each location where chemicals are housed. The agency is conducting weekly chemical inventory checks for all chemicals listed and approved for use but there is not consistent documentation. There are currently three locations where chemicals are maintained including kitchen pantry, utility hall closet and laundry room. Laundry related detergents, softeners and cleaning chemicals are stored in a locked laundry room.	Prepared food in three plastic containers located in the refrigerator are not marked as required. All three containers do not indicate current date when food was prepared and placed in the refrigerator as required. Documented evidence of chemicals check were found for May 2023 on a weekly basis. At the time of this onsite program review, the perpetual use of chemicals, when used by staff members is not being documented.

Fire and Safety Health Hazards	**Exception**	A facility fire inspection was conducted by the Brooksville Fire Department on July 18, 2022. No infractions noted. Piper Fire Protection conducted an Alarm System Test on December 13, 2022. Piper Fire Protection conducted a Wet Based Fire Protection - Sprinkler and Hydrant System Test on December 13, 2022. The most recent Department of Health County Health Department Food Inspection was conducted on January 3, 2023. The First shift is 8am to 4pm. First Shift fire drill on May 23, 2023, with 13 participants and an exit on 1:30 seconds at 3:31pm. First Shift fire drill on November 7, 2022, with nine participants and an exit time of 1 minute at 10:30am; The Second Shift is 4pm to 12am. Second Shift fire drill on May 22, 2023, with 11 participants and an exit time is not legible at 8:24pm. The Second Shift fire drill on April 20, 2023, with 13 participants and an exit time of 2 minutes at 5:15pm; Second Shift on May 28, 2023 12 participants and an exit time of 2 minutes at 5:54pm; Second Shift on January 13, 2023 with 6 participants, exit time of 1 minute at 5:04pm. The Third shift is 12am to 8pm. Third Shift on May 23, 2023 with 8 participants, exit time of 1:11 seconds at 7:36am.	Fire drills and mock drills practice were both reviewed and there was no evidence of documented fire drills over the last six months on each shift for the following months: First Shift – December 2022, January 2023, February 2023, March 2023, April 2023; Second Shift: November 2022, December 2022, February 2023, March 2023, and Third Shift: November 2022, December 2022, January 2023, February 2023, March 2023, and April 2023. Mock drills missing included: First Shift: None documented between November 2022 and January 2023; Second Shift: None documented between November 2022 and January 2023; and Third Shift. None documented between November 2022 and January 2023.
Additional Fire and Safety Health Hazards Narrative (if applicable)			
Grievance			
There are formal grievance procedures for youth, including grievance forms, and a locked box which are easily accessible to youth in a common area.	**Compliance**	The agency has grievance forms and boxes which are accessible to all residents. The agency's grievance boxes are located in the day room and in the hall leading to the dorm sleeping rooms. All blank grievance forms are accessible in a slot built into the grievance box. The grievance box is locked and only accessible to the Residential Supervisor and Program Director. The agency also has a grievance box for staff members.	

There is evidence that grievance boxes are checked by management or a designated supervisor at least daily as evidenced in the program logbook. All grievances are resolved within 72 hours and documented by program director.	**Exception**	The agency has three grievance boxes. The agency has two youth grievance boxes and 1 staff grievance box. The agency provided copies of two grievances. Both were addressed within the 72 hours as required.	At the time of this onsite program review, grievance boxes checked over the last six month between November 2022 through May 2023 by supervisors are not documented in the program logbook as required.
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.	**Compliance**	The agency has a daily schedule which is posted in the youth shelter day rooms and is accessible to all residents. All residents are also informed of the daily schedule during the shelter orientation process. The reviewer observed youth participating in all activities listed on the program's daily schedule. The residents participated in groups. The residents were divided into teams to learn to work toward collective decision-making and to foster teamwork. The residents also participated in creative art work projects. The program followed the structured activities schedule. Several transport events to school were observed. The program was also observed providing meals and engaging children during free time on both days. Children also used the basketball court and green space for recreation events. Other physical activity consisted of volley ball. The schedule also provided residents with free time to read and also to make necessary telephone calls. The program does offer youth access to religious and faith-based activities. Youth that wish to not participate are offered non-faith based options.	
3.06 - Staffing and Youth Supervision			**Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 3.06		**YES** If NO, explain here: The agency has policy number 3.06 and the policy is called Staffing and Youth Supervision and policy number is reviewed and approved by President/CEO on February 8, 2022.	

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	**Compliance**	The staff schedule and youth census were reviewed for six days during the annual compliance review period. The program met the ratio requirements for each day reviewed. Dates of Staff Schedule and youth census Reviewed: 12/10/22-12/16/22 1/21/23- 1/27/23 1/28/23-2/3/23 3/25/23-3/31/23 4/15/23-4/21/23 5/6/23- 5/11/23	
All shifts must always provide a minimum of two direct care staff present that have met the minimum training requirements	**Exception**	The staff schedule was reviewed for six days of the annual compliance review period. Dates of Staff Schedule Reviewed: 12/10/22-12/16/22 1/21/23- 1/27/23 1/28/23-2/3/23 3/25/23-3/31/23 4/15/23-4/21/23 5/6/23- 5/11/23	The staff schedule was reviewed for six randomly selected days of the six month schedule within the review period. One of the reviewed days had documentation which indicated the program only had one direct care staff member present for one shift. All other days had a minimum of two staff on each 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	**Compliance**	Staff schedules were reviewed to assess this indicator. Only the appropriate staff were included on the staff schedule as direct care staff and included in ratio.	
The staff schedule is provided to staff or posted in a place visible to staff	**Compliance**	The staff schedule was observed posted on the inside of the door at the entrance to the secure shelter area.	
There is a holdover or overtime rotation roster which includes the telephone numbers of staff who may be accessed when additional coverage is needed	**Exception**	Informal interview with program director was conducted. A facility tour was conducted to assess the status of this requirement.	A facility tour was conducted, and a holdover or overtime rotation schedule was not observed. An informal interview was conducted with the program director, who indicated there is not currently a schedule due to staffing shortages.

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	**Exception**	Bed checks were reviewed via video surveillance and compared to the log books for the same dates and times. Five days were reviewed. Bed check dates/times Selected: 5/6/23 5/10/23 5/15/23 5/19/23 5/22/23 12:00am- 8:00am each day	A total of 160 bed checks performed over six randomly selected days were reviewed on video camera by the reviewer. Of the 160 bed checks, two bed checks documented in the log book contained documentation that these two checks were not documented in real time and were not consistent by three-five minutes compared to the remaining 158 bed checks. A bed check was conducted at 11:55pm, but 12:00am was written in the logbook. At a different time, the reviewed bed check occurred at 7:27am, but 7:30am was written in the logbook. An additional bed check indicated a staff member signed off on a ten minute check on behalf of the staff member that actually conducted the bed check. Regarding an additional bed check, one fifteen minute check was ten minutes late. On the third day, two fifteen minute checks were missed due to staff attempting to contain plumbing issues and contacting the Program Director. The missed checks were documented in the logbook and highlighted.
4.02 - Suicide Prevention			**Limited**
Provider has a written policy and procedure that meets the requirement for Indicator 4.02		**YES** If NO, explain here: The agency policy number is RGC 4.02 and called Suicide Prevention. The policy was reviewed and signed by the COO on February 3, 2022.	
Suicide Risk Screening and Approval (*Residential and Community Counseling*)			
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.	**Compliance**	Three randomly selected applicable client case files were reviewed to assess the agency's adherence to the requirements of this indicator. All youth files contained documentation verifying each case was screened for suicide risk during the initial intake process using the CINS/FINS Intake Assessment form. Each of the three client files screened indicated each youth was positive for suicide on at least one of the suicide risk screening questions. The suicide risk form was reviewed, signed and dated by the supervisor as required.	
The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	**Compliance**	The program's suicide risk assessment was previously approved by the Florida Network.	

Supervision of Youth with Suicide Risk *(Shelter Only)*			
Youth are placed on the appropriate level of supervision based on the results of the suicide risk assessment.	**Exception**	All three applicable files are residential client files. Two of the three files contained evidence of documentation the youth was placed on sight and sound observation based on the suicide risk screening questions answered by the youth during the initial screening process.	No documentation of youth being placed on Sight and Sound on one client. Documentation of the date the youth is taken off supervision is found, but the entry is not written correctly on one client. The CINS/FINS Intake form for one client was not found. A logbook entry is a late entry on one client being placed on sight and sound.
Staff person assigned to monitor youth documented youth's behavior at 30 minute or less intervals	**Exception**	One of the three residential client files have the required forms documenting evidence of each youth being placed on sight and sound observation. The agency utilizes two Sight and Sound and Behavior documentation forms- Behavior 30-Minute Checks Observation Log and Close Supervision 15-Minute Checks form. Each client's form recorded the youth's status according to the requirements of the respective form.	One client is missing two forms on the second day of observations being conducted. This client's case file is missing the Close Supervision Observation Checks form and Behavior 30-Minute Checks Observation Log and log entries on day two between 3:30pm and 5:00pm. Further, this client's case does not have evidence of documentation of youth being taken off Sight and Sound status. Third youth case is missing six 30 minute observation check log entries.
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	**Exception**	All three residential client files contained a completed suicide risk screening and suicide risk assessment. Three of the three client files contain an assessment completed by the Licensed Mental Health Counselor (LMHC).	A client being taken off Sight and Sound is found in the logbook, but not documented correctly. This entry fails to document the actual time of entry is logged. There is no evidence of the third client case being taken off Sight and Sound status in logbook.
Youth with Suicide Risk *(Community Counseling Only)*			
Youth identified for suicide risk during intake was immediately assessed by a licensed professional or non-licensed professional (under the direct supervision of a licensed mental health professional) and the parents and supervisor were both notified of the results.	**No eligible items for review**	There were no community counseling youth identified with suicide risk for the review period timeframe.	
During the intake, if the appropriate staff is unavailable, youth identified for suicide risk was immediately referred by the provider and the parent/guardian is notified of the suicide risk findings disclosed and advised that an Assessment of Suicide Risk should be completed ASAP by a licensed professional.	**No eligible items for review**	There were no community counseling youth identified with suicide risk for the review period timeframe.	

Information on resources available in the community for further assessment was provided to the parent/guardian and is documented in the youth's file and signed by the parent/guardian OR a written follow-up notification was sent by certified mail if the parent/guardian was not present during the screening and was notified by telephone.	**No eligible items for review**	There were no community counseling youth identified with suicide risk for the review period timeframe.	
If the parent/guardian cannot be contacted, all efforts to contact them are documented in the case file.	**No eligible items for review**	There were no community counseling youth identified with suicide risk for the review period timeframe.	
When the screening was completed during school hours on school property, the appropriate school authorities were notified.	**No eligible items for review**	There were no community counseling youth identified with suicide risk for the review period timeframe.	
4.03 - Medications			**Limited**
Provider has a written policy and procedure that meets the requirement for Indicator 4.03		**YES** If NO, explain here: The agency policy number is RGC 4.03 and called Medication Control and Management. The policy was reviewed and signed by the President/CEO on February 8, 2022.	
The agency has a Registered Nurse (RN) and/or a Licensed Practical Nurse (LPN) that is being supervised by RN and all of their credentials have been verified.	**Compliance**	The program has a Registered Nurse on staff. Their credentials were also able to be located on the Department of Health Website, and are valid credentials at the time of the program review.	

Medication Storage			
a. All medications are stored in a Pyxis ES 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 Pyxis ES 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	**Compliance**	Medication storage practice was observed by the reviewer. The medication storage room was observed. All prescription, narcotic and controlled medication is stored in the Pyxis machine, which is not accessible to youth due to being stored in a locked room. The Pyxis machine is stored according to policy requirements. Oral medications are stored separate from topical medications, and the program does not have any injectable medications or Epi-Pens. The program does not currently have any medications requiring refrigeration on site. The program does have a locked medication fridge kept at the appropriate temperature. All controlled medications are stored in the Pyxis machine. There is a set of keys for the Pyxis machine labelled appropriately in case the machine malfunctions.	

Medication Distribution			
a. Agency maintains a minimum of 2 site-specific System Managers for the Pyxis ES 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 three methods listed in the FNYFS Policies & Procedures 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	**Compliance**	An informal interview was conducted with the registered nurse (RN). The reviewer also observed medication pass being conducted on youth and reviewed documentation logged on Medication distribution logs. An informal interview was conducted with the program's registered nurse. The nurse reported the program has two site specific managers for the Pyxis ES Station. The agency reported the two managers are the RN and the Program Director. The RN indicated only staff members with user permissions have access to secure medications, with limited access to controlled substances. Medication distribution is tracked on the individual medication logs for the youth. Staff initial and inventory the youth's medication log upon distributing medication to the youth. Medication is verified appropriately. When the RN is on duty, the RN conducts all medication processes. One medication distribution session was observed during the annual compliance review. The delivery process was consistent with the Florida Network Medication Management and Distribution Policy. The RN and Program Director reported none of the program staff are trained in the use of Epi-Pens.	

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	**Compliance**	The reviewer conducted observations of the agency's medication inventories and medication storage practices. In addition, Medication inventories were reviewed for controlled substances and over-the-counter medications. There is a perpetual inventory for over-the-counter medications, which is updated with a weekly inventory. The agency currently does not have any sharps on site, but does have a secure storage location for sharps, which was observed.	Three end of shift counts did not have a signature from a witness associated with the medication count.
There are monthly reviews of the Pyxis reports to monitor medication management practice.	**Exception**	An informal interview was conducted with the program's registered nurse. At the time of this QI program review, reports are not being produced. The nurse plans to pull weekly reports when they are established enough in their position to do so.	The RN reported no medication distribution-related reports are currently being pulled from the Pyxis medication cabinet due to the prolonged vacancy which the RN only recently filled.
Medication discrepancies are cleared after each shift.	**Exception**	A medication discrepancy form and the medication discrepancy report for the past six months were reviewed. An informal interview was conducted with the RN. The RN explained the process for clearing medical discrepancies entails the staff member filling out a medication discrepancy form, and leaving it on the nurse's desk. The nurse then reviews the form and discrepancy, and clears the discrepancy upon the beginning of their next shift at the program.	Discrepancies are not being cleared after each shift as the RN is not on site full time. The medication discrepancy form was reviewed and does not include a section for a response, or indication of the resolution to the discrepancy. A report was generated for the medication discrepancies for the previous six months, and there were several uncleared discrepancies due to a vacancy in the nurse position.