# Florida Network for Youth and Family Services
# Compliance Monitoring Report for

**Youth and Family Alternatives, Inc.**

YFA- George W. Harris Jr. Runaway and Youth Crisis Shelter
1060 US Hwy 17 South
Bartow, Florida 33830

December 6-7, 2023

**Compliance Monitoring Services Provided by**

## EXECUTIVE SUMMARY

Forefront LLC conducted a Quality Improvement (QI) monitoring visit on behalf of the Florida Network of Youth and Family Services (FNYFS) for the YFA- George W. Harris Jr. Runaway and Youth Crisis Shelter for the FY 2023-2024 at its program office located at 1060 US HWY 17 South, Bartow, FL 33830. Forefront LLC (Forefront) is an independent compliance monitoring firm that is contracted by FNYFS to perform onsite program reviews to assess the agency's adherence to fiscal, programmatic and overall contract requirements. YFA- George W. Harris Jr. Runaway and Youth Crisis Shelter is contracted with the Florida Network of Youth and Family Services (FNYFS) to provide direct services to Children/Families in Need of Services (CINS/FINS). The services to be provided are identified in Contract Section A - Descriptions and Specifications and Section B - Delivery and Performance and are funded with General Revenue Funds effective from July 1, 2023 through June 30, 2024.

The review was conducted by Andrea Haugabook, Consultant for Forefront LLC, Kara Brown, DJJ (Department of Juvenile Justice), Amy Loomis, Safe Children Coalition, McKenzie Tomaski, Family Resources, and Sheryl Kincy, Youth Advocate Program. Agency representatives from YFA- George W. Harris Jr. Runaway and Youth Crisis Shelter present for the entrance interview were: Michelle Almand (Quality Improvement Coordinator), Jovia Dukes (Program Director), Kelly Scott (Program Director), and Shelly Gress (Residential Supervisor). The last onsite QI visit was conducted February 1-2, 2023.

In general, the Reviewer found that YFA- George W. Harris Jr. Runaway and Youth Crisis Shelter is in compliance with specific contract requirements. YFA- George W. Harris Jr. Runaway and Youth Crisis Shelter **received an overall compliance rating of 92% for achieving full compliance with 11 of 12 indicators** of the CINS/FINS Monitoring Tool. Two indicators were not applicable due to the fact that; 1) the agency did not have any corrective actions cited by external funders and 2) the agency does not purchase equipment with FNYFS funds. There was one corrective action from the monitoring visit, due to one indicator being rated as conditionally acceptable.

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

# 2023-2024 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
# Report Number: CM 12-6-7-202324

| | |
|---|---|
| **Agency Name:** YFA- George W. Harris Jr. Runaway and Youth Crisis Shelter | **Monitor Name: Andrea Haugabook, Lead Reviewer** |
| **Contract Type : CINS/FINS** | **Region/Office: 1060 US HWY 17 South, Bartow, FL 33830** |
| **Service Description: Comprehensive Onsite Compliance Monitoring** | **Site Visit Date(s): December 6-7, 2023** |

| **Major Programmatic Requirements** | **Explain Rating** | | | | | **Ratings Based Upon:**<br>**I = Interview**<br>**O = Observation**<br>**D = Documentation**<br>**PTV = Submitted Prior To Visit**<br>**(List Who and What)** | **Notes**<br>**Explain Unacceptable or Conditionally Acceptable:** |
|---|---|---|---|---|---|---|---|
| | **Unacceptable** | **Conditionally Unacceptable** | **Fully Met** | **Exceeded** | **Not Applicable** | | |
| **I. Administrative and Fiscal** | | | | | | | |
| **DJJ Quality Improvement Peer Reviewer**<br>a. Provider shall demonstrate that a minimum of two (2) staff members have been trained to be certified as DJJ QI Peer reviewers. Provider shall participate in a minimum of one (1) on-site quality assurance review of a similar type of program in another judicial circuit during each 12-month period of the contract, if requested. | ☐ | ☐ | ☒ | ☐ | ☐ | Documentation: The agency provided a list of certified peer reviewers to exceed the required contractual minimum number. There are currently six staff members trained as certified DJJ QI Peer reviewers. Five of the six reviewers are currently certified, and one needs to be recertified. Program staff reported an upcoming peer review assignment the week following this review, therefore fulfilling this programmatic requirement. | No recommendations and/ or corrective actions required. |
| **Additional Contracts**<br>a. Provider shall provide a listing of all current federal, state, or local government contracts, as well as other contracts entered into with for profit and not-for-profit organizations. Such a listing shall identify the awarding entity and contract start & end dates. **PTV** | ☐ | ☐ | ☒ | ☐ | ☐ | Documentation: A list of current federal, state, or local government contracts, and other contracts was uploaded. The list included the following funders, (Heartland for Children, Basic Centers Grant and Department of Health) with current funding periods and amounts. | No recommendations and/ or corrective actions required. |

# 2023-2024 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
# Report Number: CM 12-6-7-202324

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|---|---|
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| | Explain Rating | | | | | | |
|---|---|---|---|---|---|---|---|
| **Major Programmatic Requirements** | **Unacceptable** | **Conditionally Unacceptable** | **Fully Met** | **Exceeded** | **Not Applicable** | **Ratings Based Upon:**<br>**I = Interview**<br>**O = Observation**<br>**D = Documentation**<br>**PTV = Submitted Prior To Visit**<br>**(List Who and What)** | **Notes**<br>**Explain Unacceptable or Conditionally Acceptable:** |
| **Limits of Coverage**<br>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: A current certificate of insurance coverage from Marsh & McLennan Agency was provided to show evidence of all required coverage with sufficient limits and effective dates within this contract period.<br><br>Insurers listed: Alliance of Nonprofits for Insurance and Benchmark Company.<br><br>Commercial General liability coverage from 01/01/2023 - 07/01/2024 with limits of $1,000,000 per occurrence, $500,000 damage to rented premises, $20, 000 medical expense, $1,000,000 personal and adv injury, $3,000,000 general aggregate, $3,000,000 products – comp/op AGG. Automobile Liability coverage from 07/01/2023 - 07/01/2024 with limits of $1,000,000 combined single limit (ea. | No recommendations and/ or corrective actions required. |

# 2023-2024 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
# Report Number: CM 12-6-7-202324

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| **Service Description: Comprehensive Onsite Compliance Monitoring** | **Site Visit Date(s): December 6-7, 2023** |

| | Explain Rating | | | | | | |
|---|---|---|---|---|---|---|---|
| **Major Programmatic Requirements** | **Unacceptable** | **Conditionally Unacceptable** | **Fully Met** | **Exceeded** | **Not Applicable** | **Ratings Based Upon:**<br>**I = Interview**<br>**O = Observation**<br>**D = Documentation**<br>**PTV = Submitted Prior To Visit**<br>**(List Who and What)** | **Notes**<br>**Explain Unacceptable or Conditionally Acceptable:** |
| | | | | | | Accident), umbrella liability from 07/01/2024 - 07/01/2024 with limits of $3,000,000 for each occurrence and $3,000,000 aggregate<br><br>Worker's Compensation and Employer's liability from 07/01/2024 - -07/01/2024 with limits of $1,000,000 E.L. each accident, $1,000,000 E.L Disease – E.A. Employee, and $1,000,000 E.L. Disease – Policy Limit.<br><br>Professional Liability 07/01/2023 - 07/01/2024 $1,000,000/ $3,000,000<br><br>Abuse /Molestation 07/01/2023 - 07/0/2024 $1,000,000/ $3,000,000<br><br>Proof of coverage provided for GWH Youth Shelter and FNYFS as certificate holders. | |

# 2023-2024 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
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| **Major Programmatic Requirements** | **Explain Rating** | | | | | **Ratings Based Upon:**<br>**I = Interview**<br>**O = Observation**<br>**D = Documentation**<br>**PTV = Submitted Prior To Visit**<br>**(List Who and What)** | **Notes**<br>**Explain Unacceptable or Conditionally Acceptable:** |
|---|---|---|---|---|---|---|---|
| | **Unacceptable** | **Conditionally Unacceptable** | **Fully Met** | **Exceeded** | **Not Applicable** | | |
| **External/Outside Contract Compliance**<br>a. Provider has corrective action item(s) cited by an external funding source (Fiscal or Non-Fiscal). **ON SITE** | ☐ | ☐ | ☐ | ☐ | ☒ | Documentation: The written program update submitted indicated there were no corrective action items cited by external funding sources. | No recommendations and/ or corrective actions required. |
| **Fiscal Practice**<br>a. Agency must have employee and fiscal policy/procedures manuals that are in compliance with GAAP and provide sound internal controls. Agency maintains fiscal files that are audit ready. **PTV** | ☐ | ☐ | ☒ | ☐ | ☐ | Documentation: The agency submitted policies and procedures that comply with GAAP and provides sound internal controls allowing fiscal files to be audit ready. | No recommendations and/ or corrective actions required. |
| b. Agency maintains a general ledger and the corresponding source documents. A general ledger must be set up to track the activity of the grant separately (standard account numbers / separate funds for each revenue source, etc.). **PTV** | ☐ | ☐ | ☒ | ☐ | ☐ | Documentation: The agency submitted the current general ledger which shows the tracking of activity for this grant/ contract. General ledger does document and tracks funds separately for each revenue source. | No recommendations and/ or corrective actions required. |
| c. Petty cash ledger system is balanced and all cash disbursements are compliant with financial policies and allowable under the contract. (Disbursements/invoices are approved & monitored by management.) –**ON SITE** | ☐ | ☐ | ☒ | ☐ | ☐ | Documentation of petty cash policy and procedures were provided. Policy and procedures indicate use of petty for occasional purchase limited to $25 or less. Policy and procedure addresses who is responsible, how it is maintained, where it is kept and | No recommendations and/ or corrective actions required. |

# 2023-2024 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
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| | Explain Rating | | | | | | |
|---|---|---|---|---|---|---|---|
| **Major Programmatic Requirements** | **Unacceptable** | **Conditionally Unacceptable** | **Fully Met** | **Exceeded** | **Not Applicable** | **Ratings Based Upon:**<br>**I = Interview**<br>**O = Observation**<br>**D = Documentation**<br>**PTV = Submitted Prior To Visit**<br>**(List Who and What)** | **Notes**<br>**Explain Unacceptable or Conditionally Acceptable:** |
| | | | | | | how it is to be reconciled. No review of the petty cash practice was observed on-site. | |
| d. Financial records and reports are current. Includes bank statements reconciled within 6 weeks of receipt. Vendor invoices past 6 months. Invoices are submitted on a monthly basis with supporting documentation. (Disbursements/invoices are approved & monitored by management). **ON SITE** | ☐ | ☐ | ☒ | ☐ | ☐ | Documentation: prior 6 months of bank reconciliations provided for review and documentation in compliance. All bank statements reviewed are reconciled on the last day of the month. There are no outstanding vendor invoices and/or payments at the end of the reconciliation period. Statements are locked after reconciliation. | No recommendations and/ or corrective actions required. |
| e. Agency maintains inventory in accordance with a written policy and FNYFS contractual requirements. If over $1,000 inventory has DJJ Property Inventory Number/Tag. In the event the provider has purchased computer equipment an Informational Resources Request (IRR) has been submitted to DJJ. **PTV/ON SITE** | ☐ | ☐ | ☒ | ☐ | ☐ | Documentation: The agency provided policy and procedures for asset inventory control, equipment, real property and inventory and inventory management.<br><br>A letter dated December 1, 2023, from the VP of Finance was provided as additional documentation that | No recommendations and/ or corrective actions required. |

# 2023-2024 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
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| | Explain Rating | | | | | | |
|---|---|---|---|---|---|---|---|
| **Major Programmatic Requirements** | **Unacceptable** | **Conditionally Unacceptable** | **Fully Met** | **Exceeded** | **Not Applicable** | **Ratings Based Upon:**<br>**I = Interview**<br>**O = Observation**<br>**D = Documentation**<br>**PTV = Submitted Prior To Visit**<br>**(List Who and What)** | **Notes**<br>**Explain Unacceptable or Conditionally Acceptable:** |
| | | | | | | FNYFS funds are not used for asset purchases.<br><br>Interview: Agency staff reported no purchases have been made with FNYFS/ DJJ funds. | |
| f. Agency submits payroll taxes and deposits (and retirement deposits as applicable), Employee IRS Form W-2 and<br>Independent Contractors IRS Form 1099 forms prior to federal requirements. **ON SITE** | ☐ | ☐ | ☒ | ☐ | ☐ | Documentation: Proof of Payroll tax payments was provided in compliance with the requirement of submission of employee payroll taxes and deposits. | No recommendations and/ or corrective actions required. |
| g. Budget to actual reports prepared and reviewed by appropriate management. Variance from the budget are investigated and explained. **PTV/ON SITE** | ☐ | ☐ | ☒ | ☐ | ☐ | Documentation: Fiscal year 23-24 July-October, budget to actual report was submitted for the current year to date budget cycle. | No recommendations and/ or corrective actions required. |
| 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 | ☐ | ☐ | ☒ | ☐ | ☐ | Documentation: In compliance with the requirement to perform an annual audit, the agency provided the most recent audit report completed by Reeder & Associates, PA, CPA on December 7, 2023, for period ending | No recommendations and/ or corrective actions required. |

# 2023-2024 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
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| | Explain Rating | | | | | | |
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| **Major Programmatic Requirements** | **Unacceptable** | **Conditionally Unacceptable** | **Fully Met** | **Exceeded** | **Not Applicable** | **Ratings Based Upon:**<br>**I = Interview**<br>**O = Observation**<br>**D = Documentation**<br>**PTV = Submitted Prior To Visit**<br>**(List Who and What)** | **Notes**<br>**Explain Unacceptable or Conditionally Acceptable:** |
| the Network unless and extension has been requested and approved in writing. Copy of Audit is submitted to the FNYFS by December 31st. **Can obtain from FNYFS** | | | | | | June 30, 2022. The audit was completed within the required timeframe and done in accordance with government auditing standards and no findings were reported. | |
| i. Agency maintains confidentiality policy with written policies and procedures to ensure the security and privacy of all employee and client data. Personal information is not easily accessible. Agency maintains a backup system in case of accidental loss of financial information. Security procedures are in place to protect laptops. Obsolete documents are shredded and computer hard drives are wiped prior to discarding. **ON SITE** | ☐ | ☐ | ☒ | ☐ | ☐ | Documentation: Policy and procedures pertaining to security of confidential information, records management, and retention schedules were submitted and in compliance with contractual requirements | No recommendations and/ or corrective actions required. |
| j. Agency provided evidence that every direct care staff employee, as of October 1, 2023, is being paid at least $19.00 per hour. This also includes funding for additional staff as approved by the Department. **ON SITE** | ☐ | ☒ | ☐ | ☐ | ☐ | Documentation: Agency provided list of all direct care staff for YFA – GWH, which included current salaries.<br><br>Interview: Director indicated salary changes for all direct care staff (Shelter only) was made effective July | All direct care staff should be paid at least $19.00 per hour. |

# 2023-2024 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
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| **Service Description: Comprehensive Onsite Compliance Monitoring** | **Site Visit Date(s): December 6-7, 2023** |

| | Explain Rating | | | | | | |
|---|---|---|---|---|---|---|---|
| **Major Programmatic Requirements** | **Unacceptable** | **Conditionally Unacceptable** | **Fully Met** | **Exceeded** | **Not Applicable** | **Ratings Based Upon:**<br>**I = Interview**<br>**O = Observation**<br>**D = Documentation**<br>**PTV = Submitted Prior To Visit**<br>**(List Who and What)** | **Notes**<br>**Explain Unacceptable or Conditionally Acceptable:** |
| | | | | | | 29, 2023. Additional funds were amended into the agency's contract effective September 1, 2023. No additional SNAP funds were provided, and the agency did not make changes to SNAP employees. | |

## CONCLUSION

YFA- George W. Harris Jr. Runaway and Youth Crisis Shelter met the CINS/FINS contract requirements due to full compliance with 11 of 12 applicable indicators of the Administrative and Fiscal Contract Monitoring Tool. Two indicators were not applicable because YFA- George W. Harris Jr. Runaway and Youth Crisis Shelter did not have any corrective actions from any external funding sources and the agency does not use FNYFS to purchase equipment. Consequently, **the overall compliance rate for this contract monitoring visit is 92%.** There is one corrective action cited and no additional recommendations made as a result of the contract monitoring visit. The conditionally unacceptable rating is based on contract language/ requirement to pay every direct care staff $19.00 per hour as of October 1, 2023, and YFA- George W. Harris Jr. Runaway and Youth Crisis Shelter did not include direct care employees paid under the SNAP contract. An interview with the Sr. VP of Operations indicated that Youth and Family Alternatives – George W. Harris, Jr. Runaway and Youth Crisis Shelter did not receive an increase in SNAP funding for FY23-24, therefore did not apply the wage increase to direct care employees under the agency's SNAP contract. Overall, the provider is performing satisfactorily in meeting the fiscal and administrative terms of its contract. In addition, the majority of indicators reviewed were carried out in a manner which meets the standard described in the report findings.

### SUMMARY OF RECOMMENDATIONS

YFA- George W. Harris Jr. Runaway and Youth Crisis Shelter must ensure every direct care staff person is paid a minimum of $19.00 per hour per contract requirement effective October 1, 2023.

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 responsible staff. 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 - GWH
CINS/FINS Program

Date: December 6-7, 2023

**Compliance Monitoring Services Provided by**

FOREFRONT

# CINS/FINS Rating Profile

Standard 1: Management Accountability

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

**Percent of indicators rated Satisfactory: 85.71 %**
**Percent of indicators rated Limited: 0 %**
**Percent of indicators rated Failed: 14.29 %**

Standard 2: Intervention and Case Management

| | |
|---|---|
| 2.01 Screening and Intake | Satisfactory |
| 2.02 Needs Assessment | Satisfactory |
| 2.03 Case/Service Plan | Satisfactory |
| 2.04 Case Management & Service Delivery | Satisfactory |
| 2.05 Counseling Services | Satisfactory |
| 2.06 Adjudication/Petition Process | Satisfactory |
| 2.07 Youth Records | Satisfactory |
| 2.08 Special Populations | Satisfactory |
| 2.09 Stop Now and Plan (SNAP) | 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 | Satisfactory |
| 3.02 Program Orientation | Satisfactory |
| 3.03 Youth Room Assignment | Satisfactory |
| 3.04 Log Books | Satisfactory |
| 3.05 Behavior Management Strategies | Satisfactory |
| 3.06 Staffing and Youth Supervision | Satisfactory |
| 3.07 Video Surveillance System | 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

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

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

## Overall Rating Summary

**Percent of indicators rated Satisfactory: 96.43 %**
**Percent of indicators rated Limited: 0 %**
**Percent of indicators rated Failed: 3.57 %**

## Rating Definitions

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

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

## Reviewers

Members

Andrea Haugabook - Lead Reviewer Forefront LLC/Florida Network of Youth and Family Services
Kara Brown – Regional Monitor, Department of Juvenile Justice
Amy Loomis, M.A. – Safe Children Coalition
Makenzie Tomaski, LCSW – Family Resources
Sheryl Kincey, BS – Youth Advocate Program

# 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 July 1, 2023).

## Persons Interviewed

| | | | | | |
|---|---|---|---|---|---|
| | Chief Executive Officer | | Case Manager | | Nurse – Full time |
| | Chief Financial Officer | | Counselor Non-Licensed | | Nurse – Part time |
| | Chief Operating Officer | | Advocate | | # Case Managers |
| | Executive Director | X | Direct – Care Full time | 1 | # Program Supervisors |
| X | Program Director | | Direct – Part time | | # Food Service Personnel |
| X | Program Manager | | Direct – Care On-Call | | # Healthcare Staff |
| | Program Coordinator | | Intern | | # Maintenance Personnel |
| | Clinical Director | | Volunteer | 1 | # Other (listed by title): Sr. VP of Operations |
| | 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 | X | Grievance Process/Records | 7 | # Health Records |
| X | Logbooks | X | Key Control Log | 2 | # MH/SA Records |
| | Continuity of Operation Plan | X | Fire Drill Log | 4 | # Personnel /Volunteer Records |
| X | Contract Monitoring Reports | X | Medical and Mental Health Alerts | 14 | # Training Records |
| | Contract Scope of Services | | Precautionary Observation Logs | 5 | # Youth Records (Closed) |
| X | Egress Plans | X | Program Schedules | 5 | # Youth Records (Open) |
| | Fire Inspection Report | X | List of Supplemental Contracts | 4 | # Other: Special Populations ___ |
| | 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 |
| | Recreation | X | Toxic Item Inventory & Storage | X | First Aid Kit(s) |
| X | Searches | | Discharge | | Group |
| X | Security Video Tapes | | Treatment Team Meetings | X | Meals |
| | Social Skill Modeling by Staff | X | Youth Movement and Counts | X | Signage that all youth welcome |
| | Medication Administration | X | Staff Interactions with Youth | X | Census Board |

## Surveys

| | | | | | | |
|---|---|---|---|---|---|---|
| 11 | # of Youth | 8 | # of Direct Staff | | # of Other | |

# Comments

A Quality Improvement Program Review was conducted for FY 2023-2024.

**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**

Youth and Family Alternatives - George W. Harris Runaway and Youth Crisis Center was granted the RHY Basic Center grant effective September 30, 2023. This funding allowed them to increase medical personnel to include two part-time RN/LPN positions, hire a full-time Outreach Coordinator and two FT YDS. The program is currently working to staff some of those positions including the RN/ LPN position. As of the date of the onsite visit Youth and Family Alternatives - George W. Harris is currently without a nurse on staff. There is one individual currently participating in the onboarding process to fill this vacancy. Additionally, the Leadership Council is actively working to provide funding for needed projects within the shelter. Planned projects include: a pole barn over the outside basketball court, and an upgraded video surveillance and phone system. One recent upgrade at the facility since the last site visit, was the installation of a new fence in May 2023.

**The following programmatic updates were provided by the agency:**

***Residential/ Shelter program updates:*** Youth and Family Alternatives - George Harris Shelter is located at 1060 US Hwy 17 South, Bartow, FL 33830 and serves Circuit 10 which includes: Polk, Highlands and Hardee counties. The shelter serves both males and female youths aged 10-17. The shelter has a current COA accreditation is valid through October 2024 and DCF license through 12/19/2023 with 24 licensed beds. The current census if 11 youth in shelter at the time of this review.

**Governance and Community**: The shelter currently has mental health agreements with Peace River Counseling Services and Crisis Unit.

**Major Challenges**: Mindshare electronic record system is used for all youth files at Youth and Family Alternatives - George W. Harris shelter. This system replaces the previous system (Celerity) on 07/01/2023. The staff reported major challenges during the transition of Electronic record systems and have maintained some level of paper files as Mindshare has not been completely built out as expected. Achieving full staffing continues to be a challenge for the residential program.

**Staffing**: The residential shelter management structure consists of: one Senior VP of Operations, one Senior Program Director, one Program Director, and one Residential Supervisor. There are several vacancies at this time. Seven vacant positions consist of: three FT YDS, one FT Shift Lead, one FT RN and 2 PT YDS positions. Four individuals were currently in onboarding status to fill various available shelter positions.

***Community Counseling program updates:*** The community counseling program serves youth that are legally truant from school or who are displaying ungovernable behavior outside of involvement with DCF or on Probation with DJJ. The community counseling program covers the following counties: Hardee, Highlands, and Polk.

**Staffing:** The program is fully staffed. Their team consists of one Master's level Program Director, one Team Supervisor/ Case Manager in Polk County, one Bachelor's level Case Manager in Polk County, two Bachelor's Level Case Managers in Highlands County, one additional Bachelor's Level Case Manager in Polk/ Hardee County and one Office Specialist. The entire team is fully remote, working in the community and meeting with youth and families in schools on a daily basis. The George Harris shelter serves as an anchor location as necessary. The New Port Richey location is used to house closed files and complete housekeeping items (i.e., copying, printing, picking up supplies). The address of the New Port Richey Location is 7524 Plathe Road, New Port Richey, FL 34653

**Narrative Summary**

Youth and Family Alternatives - George W. Harris Shelter has made several changes in management and leadership team members since the last site visit. Team members from three shelter positions have been moved into management and leadership positions (i.e., the prior Senior Program Director has been promoted to Sr. Program Director over all three shelters and community counseling, the prior Shift Lead was promoted to Training Coordinator and the prior Office Specialist was promoted to Quality Improvement Coordinator). The positions of Chief Executive Officer, Chief Operations Officer, Vice President of Prevention and Residential Shelter remain the same. There is currently no nurse or cook on staff at the shelter. Various staff members are trained in medication management and a list of approved staff members who can pass medications is maintained and made available during this review. Various direct care staff assist with meal preparation for shelter youth. The program has not reported any critical incidents, administrative review, or current external investigation. Additionally, there were no board changes reported as well.

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

**Standard 1:**
There are seven indicators for Standard 1.
Indicator 1.01 Background Screening of Employees/Volunteers was rated **Satisfactory**.
Indicator 1.02 Provision of an Abuse Free Environment was rated **Satisfactory with Exception** due to grievances not being recorded consistently in the daily log book nor proof of 2 grievances not being reviewed by a supervisor within 24 hours nor any documented reason for the supervisor not reviewing the grievance within 24 hours.
Indicator 1.03 Incident Reporting was rated **Satisfactory with Exception** due to 24 of 29 incident forms not being reviewed and signed off by a supervisor.
Indicator 1.04 Training Requirements was rated **Failed**.
Indicator 1.05 Analyzing and Reporting Information was rated **Satisfactory.**
Indicator 1.06 Client Transportation was rated **Satisfactory with Exception** due to one single transport that was made without prior approval from the supervisor and missing information for the transportation logs (i.e., # of youth transported, youth initials, and location).
Indicator 1.07 Outreach Services was rated **Satisfactory with Exception** due to lack of documentation of attending or conducting outreach activities being maintained.

**Standard 2**: There are nine indicators for Standard 2.
Indicator 2.01 Screening and Intake was rated **Satisfactory with Exception** due to two files not containing a referral for service.
Indicator 2.02 Needs Assessment was rated **Satisfactory with Exception** due to two of seven files reviewed missing a NIRVANA assessment and one file reviewed missing a supervisor signature on the NIRVANA.
Indicator 2.03 Case/Service Plan was rated **Satisfactory with Exception** due to one of seven files reviewed did not contain a parent signature of the service plan (file indicated "virtual consent") and showed no documentations of attempts to obtain a parent signature on the service plan, one file did not contain a youth signature on the service plan (file indicated "mx felt youth to young to sign") and one file did not identify the "person responsible" on the youth's comprehensive treatment plan.
**I**ndicator 2.04 Case Management and Service Delivery was rated **Satisfactory with Exception** due to one file reviewed not containing case terminations notes.
Indicator 2.05 Counseling Services was rated **Satisfactory.**
Indicator 2.06 Adjudication/Petition Process was rated **Satisfactory.**
Indicator 2.07 Youth Records was rated **Satisfactory.**
Indicator 2.08 Specialized Additional Program Services was rated **Satisfactory with Exception** due to one of two ICM files reviewed not containing evidence of minimum collateral contacts or evidence of completion of collateral contacts.
Indicator 2.09 Stop Now and Plan (SNAP) was rated **Satisfactory with Exception** due to five SNAP youth files containing no TRF's, two closed SNAP in school files reviewed which did not contain teacher and facilitator's signature as well as Teacher Pre Evaluation forms and Fidelity Adherence Checklists.

**Standard 3**: There are seven indicators for Standard 3.
Indicator 3.01 Shelter Environment was rated **Satisfactory with Exception** due to the absence of a chemical log at each area where chemicals where located. Two of three chemical locations had weekly logs present and the kitchen log began November 2023. Perpetual logs were not kept in the laundry room not the kitchen.
Indicator 3.02 Program Orientation was rated **Satisfactory.**
Indicator 3.03 Youth Room Assignment was rated **Satisfactory.**
Indicator 3.04 Log Books was rated **Satisfactory with Exception** due to absence of dates for review by the Program Director. Two instances were observed in the logbook with voided items that were not dated or initials by a staff member.
Indicator 3.05 Behavior Management Strategies was rated **Satisfactory.**
Indicator 3.06 Staffing and Youth Supervision was rated **Satisfactory with Exception.**
Indicator 3.07 Video Surveillance System was rated **Satisfactory with Exception** due to the absence of supervisory review of videos documented in the logbook and inconsistencies of reviews being conducted once every 14 days.

**Standard 4**: There are five indicators for Standard 4.
Indicator 4.01 Healthcare Admission Screening was rated **Satisfactory.**
Indicator 4.02 was rated **Satisfactory with Exception** due to two youth files indicating the clinical assessments were not completed within 24 hours of youth being placed on constant sight and sound following an evaluation of imminent danger of suicide screening tool being completed upon admission.
Indicator 4.03 was rated **Satisfactory with Exception** due to a mis-documentation of the number of tablets a youth/family received upon discharge versus the number of remaining tablets on youth's medication distribution log and daily shift medication count sheet. The program is in the process of recruiting a nurse with a projected hire date of December 18, 2023.
Indicator 4.04 Medical/Mental Health Alert Process was rated **Satisfactory.**
Indicator 4.05 Episodic/Emergency Care was rated **Satisfactory**.

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

**Standard 1:**
**Indicator 1.04** was rated a **Failed** due to the following reasons:

The agency's policy and practice were not sufficient to meet the requirements identified in 1.04 Training. 100% of training logs reviewed did not include Staff name, Position, and Hire date. Training logs do not reflect total training hours and trainings the individual may have completed above the required trainings. Two of six new hire training files did not contain any training certificates. Three of six new hire training files did not have documentation of completion of all 90-day training requirements. One of five new hire training files reviewed was still within the 90-day period.
One of five training files reviewed did not complete NetMis training and Adolescent Development and behavior Training. Six of six training files reviewed did not show evidence of completion of Chapter 948 training. Staff reports the DJJ attorney has not scheduled this particular training. Overall practice did not show any improvement since the date of the last review and sufficient documentation was not provided to support the requirements of this indicator.

# CINS/FINS QUALITY IMPROVEMENT TOOL

| **Quality Improvement Indicators and Results:** Please select the appropriate outcome for each indicator for each item within the indicator. | **Summary/Narrative Findings:** Narrative guidelines: The narrative write-up is a thorough summary of each assigned QI indicator worksheet, explain how you came to your finding(s). | **Deficiencies/Exceptions:** Please add additional detailed explanations for any items that have any deficiencies or exceptions. |
|---|---|---|

## Standard One – Management Accountability

| **1.01: Background Screening of Employees, Contractors and Volunteers** | | **Satisfactory** |
|---|---|---|
| **Provider has a written policy and procedure that meets the requirement for Indicator 1.01** | **YES** | |
| | If NO, explain here: | |
| | RSC 1.02 Provision of an Abuse Free Environment Org. Date 2/13/2016, Revised Date11/17/2023, Reviewed Date 9/15/2023, Approved Date 10/13/2023 by the CEO | |

**Document Source: Please provide a detailed explanation of any sources used to complete this indicator.** *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*

**Total number of New Hire Employee/Intern/Volunteer Files: 4 New Hire Employee files reviewed**
**Total number of 5 Year Re-screen Employee Files: N/A - The agency did not have any eligible (5 year re-screen) files to review.**
**Staff Position(s) Interviewed *: Training Coordinator, Quality Improvement Coordinator,***
**Type of Documentation(s) Reviewed: Suitability assessment summaries, Agency for Healthcare Administration (AHCA) - Department of Juvenile Justice (DJJ) Background Screening Results,**

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| All positions providing direct services to youth has successfully passed pre-employment suitability assessment on the initial attempt. | **Compliance** | Four out of four files reviewed contained evidence of completion of pre-employment suitability assessment. | |
| For any applicant that did not pass the initial suitability assessment, there was evidence that the applicant retook the assessment and passed within five (5) business days of the initial attempt, not exceeding three (3) attempts within thirty (30) days. | **No eligible items for review** | Four out of four files reviewed contained evidence of passing the suitability assessment on the first try, eliminating the need for re-assessment. | |
| Agency has evidence for employees who have had a break in service for 18 months or more, and/or when the agency had a change or update in the suitability assessment tool used was different from the employee's original assessment, that a new suitability assessment and background screening was completed as required. | **No eligible items for review** | The agency has no employees at the George W. Harris Shelter who have had a break in service for 18 months or more. | |
| 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 | **Compliance** | Four out of four employee files reviewed contained proof of completion of background screening prior to hire/start date. | |
| Five-year re-screening is completed every 5 years from initial date of hire or prior to retained fingerprints expiration date. | **No eligible items for review** | At the time of the review, the agency did not have any employees eligible for five year rescreening. | |

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| Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st? | **Compliance** | Email confirmation of the annual affidavit dated 01/18/2023 was submitted along with a receipt response from DJJ BSU. | |
| Proof of E-Verify for all new employees obtained from the Department of Homeland Security | **Compliance** | Proof of E-verify was present in all four employee files reviewed. | |
| ***Additional Comments:*** **There are no additional comments for this indicator.** | | | |
| **1.02: Provision of an Abuse Free Environment** | | | **Satisfactory with Exception** |
| **Provider has a written policy and procedure that meets the requirement for Indicator 1.02** | | **YES** | |
| | | If NO, explain here: | |
| | | RSC 1.02 Provision of an Abuse Free Environment Org. Date 2/13/2016, Revised Date11/17/2023, Reviewed Date 9/15/2023, Approved Date 10/13/2023 and Approved by President/CEO and COO. | |
| **Document Source: Please provide a detailed explanation of any sources used to complete this indicator.** *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.* | | | |
| **Staff Position(s) Interviewed: Residential Supervisor**<br>**Type of Documentation(s) Reviewed: Abuse Log and Grievance Folder.**<br>**Describe any Observations: Code of Conduct Signs were observed posted in conspicuous places throughout the common areas. Observed locked grievance boxes in two locations on the walls in the hallway of each youth dorm area. Surveys completed by the youth disclosed that 11 out of 11 youth knew how to report abuse or an incidents.** | | | |
| Agency has a code of conduct of policy and there is evidence that staff are aware of agency's code of conduct. | **Compliance** | Four out of the four files reviewed all contained agency code of conduct with staff's signature. | |
| The agency has a process in place for reporting and documenting child abuse hotline calls. | **Compliance** | YFA has policy, RSC 1.02 Provision of an Abuse Free Environment, last reviewed 9/15/2023 and approved 10/13/2023 by the CEO, which follows the FL Network Standards. This policy outlines the process for reporting and documenting child abuse hotline calls. This process was evident upon review of the agency's child abuse hotline calls log. | |
| Youth were informed of the Abuse and Contact Number | **Compliance** | Youth are informed at intake of the abuse and contact number as well it is posted in the common area and dorm area. | |

| Grievance | | | |
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| Grievances are maintained on file at minimum for 1 year. | **Compliance** | Interview with the Residential Supervisor indicated that all grievances filed are maintained by the agency for a minimum of one year. Grievance logs reviewed contained grievances from January 2023 to November 2023. There were no grievances filed in the months of March and April 2023. | |
| 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** | There are locked grievance boxes attached to the walls on both the boys and girls side of the dorms. A stack of grievance forms printed in English and Spanish are available above each grievance box. | |
| There is evidence that grievance boxes are checked by management or a designated supervisor at least daily as evidenced in the program logbook. | **Exception** | The grievance box key is held by supervisors only. Their is a clear policy in place that states that the grievance box should be checked daily; excluding the weekends and holidays. | In reviewing the daily log book for 30 days (8/31/23 to 10/2/23), 11 out of 30 days did not have evidence of a daily log entry by the supervisor indicating that a review of the grievance box was conducted. |
| All grievances are resolved within 72 hours and documented by program director/supervisor or escalated to higher leadership if grievance involves them directly. | **Exception** | 42 out of 44 grievances were reviewed by supervisor within 24 hours. Residential Supervisor verbally acknowledged that grievances are required to be addressed by supervisor within 72 hours but is not aware of why those two where not completed within the timeframe. | Two out of the 44 grievances (filed by youth) reviewed were not reviewed within 72 hours and not signed off my the program director. There was no documented reason indicated in the logbook as to why there was no review of the two grievances. |

| 1.03: Incident Reporting | | | Satisfactory with Exception |
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| **Provider has a written policy and procedure that meets the requirement for Indicator 1.03** | | **YES** | |
| | | If NO, explain here: | |
| | | RM760, Incident Reporting, Org date 4/1/04, Revision Date 9/1/23, Rev. Date 2/4/08. Approved by CEO and Board Chair. | |
| **Document Source: Please provide a detailed explanation of any sources used to complete this indicator.** *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.* | | | |
| **Staff Position(s) Interviewed: Residential Supervisor**<br>**Type of Documentation(s) Reviewed: Incident Log and Central Communication Center (CCC) report** | | | |
| During the past 6 months, the program notified the Department's CCC (Central Communication Center) no later than two hours after any reportable incident occurred or within two hours of the program learning of the incident | **Compliance** | 29 incidents were reviewed for the months of June-November 2023. All Central Communication Center (CCC) calls were made within two hours of occurrence or being made aware of incident. | |
| The program completes follow-up communication tasks/special instructions as required by the CCC | **Compliance** | All of the CCC calls reported for the past six months, had all follow-ups completed or special instructions completed. | |
| Agency internal incidents are documented on incident reporting forms and all CCC reportable incidents were consistently reported to CCC as required. | **Compliance** | All 29 Incidents were recorded on the agency review log, and all that were reportable where reported to the CCC and verified on the CCC report. | |
| Incidents are documented in the program logs and on incident reporting forms | **Compliance** | All incidents reported were documented in the program log and on incident reporting forms. | |
| All incident reports are reviewed and signed by program supervisors/ directors | **Exception** | Five of 29 incident forms were reviewed (2023: June, August, September, October, and November) and signed by program supervisor. | 24 out of the 29 incident forms reviewed (2023: June, August, September, October, and November) were not reviewed and signed off by supervisor. |

| **1.04: Training Requirements** (*Staff receives training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions*) | | **Failed** |
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| **Provider has a written policy and procedure that meets the requirement for Indicator 1.04** | **YES** | |
| | If NO, explain here: Agency Policy does not reflect the FL Network Policy on training logs. Training logs do not meet required standards such as Name, Position, Hire Date, and Training Hours. | |
| | RGC1.04:Training- Org Date 9/13/13, Revision Date 9/15/23, Reviewed Date 1/15/18, Approved Date 10/13/23 and Approved by the CEO and COO. | |

**Document Source: Please provide a detailed explanation of any sources used to complete this indicator.** *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*

**Total number of New Hire Staff Files: Six new hire staff files were selected for review, three residential staff and three community counseling staff (including two SNAP staff). Two community counseling training files no contents, no evidence of any completed trainings.**
**Total number of Annual In-Service Staff Files: Four files were selected for review, three of the four met requirements.**
**Total number of Non-Licensed Mental Health Clinical Shelter Staff Files: Zero**
**Annual Training Plan Timeframe: All new hires have one year from hire date to complete all trainings. Staff that have been employed more than one year are placed on the agency's fiscal year training plan thereafter. The agency's fiscal year is July 1 to June 30.**
**Staff Position(s) Interviewed: Training Coordinator, Quality Improvement Coordinator**
**Type of Documentation(s) Reviewed: Community Counseling Training Folders and Residential Training Folders**
**Describe any Observations: Community Counseling/SNAP training folders did not include training plans and logs related to required trainings. A total of 15 training folders in order to gauge overall scope of compliance.**

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| **First Year Direct Care Staff** | | | |
| All direct care staff have completed new hire pre-service training requirements for safety and supervision as required. | **Exception** | One of six training files are still within the 90-day period in which to complete this training requirement. | Five out of the six training files reviewed did not have the completed new hire pre-service training requirements for safety and supervision. |
| All staff completed the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days from date of hire. | **Exception** | A review of three out of six training files reviewed did have the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days from date of hire. One of six files is within the first 30 day period and still has time to complete this required training. | Two out of the six training files reviewed did not have the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days from date 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. | **Compliance** | Six new hire direct care staff are within the first full year of employment and have time to demonstrate a minimum of 80 hours of training. Current training hours of all files reviewed range from 2-64 hours training completed as of the date of this on-site review. | |
| All staff receives all mandatory training during the first 90 days of employment from date of hire. | **Exception** | One of the six pre-service training files reviewed had evidence of staff completing all mandatory training due within the first 90 days of employment. One of the six files is still within the 90 day period and has time to complete all mandatory trainings. | Four of five applicable new hire training files did not contain evidence of completion of all mandatory training during the first 90 days of employment. Certificate of completion for Confidentiality 101 for Runaways and Homeless is missing in one training file. |
| **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. | **Compliance** | Two of six files reviewed enter NIRVANA assessments and complete data entry into the Florida Department of Juvenile Justice Information System (JJIS). Both files have evidence of completion of training for NIRVANA or access to JJIS . | |
| **Staff Participating in Case Staffing & CINS Petitions (within first year of employment)** | | | |
| Documentation of instructor led FL Statute 984 CINS Petition Training by a local DJJ Attorney. *Effective for staff hired after 7/1/23* | **No eligible items for review** | Local DJJ attorney canceled the FL Statute 984 CINS Petition Training on 11/16/2023. Reviewer was able to see documented proof from the attorney stating the training would take place in early 2024. | |

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| **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). | **Compliance** | One residential counselor completed the required Assessment of Suicide Risk Training with supporting documentation. | |
| **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** | One employee training file demonstrated compliance with 24 hours of mandatory refresher Florida Network, SkillPro, and job related training. | Three of four employee training files contained no documentation of completion of Youth Suicide Prevention, Fire Safety, and Managing Aggressive Behavior. |
| **Required Training Documentation** | | | |
| The agency has a training plan that includes all of the required training topics including the pre-service and in-service. | **Compliance** | The agency has a standard training plan but it is not job class specific nor does it list due dates. The agency training plan does not include all pre-service trainings or in-service trainings but has a training policy in place. | |
| The agency has a designated staff member responsible to manage all employee's individual training files and completes routine tracking and reviews of staff files to ensure compliance. | **Exception** | The agency has recently promoted a staff member to the position of training coordinator. The training coordinator reported that he is responsible for collecting all employee's individual trainings. Employee's are responsible for submitting evidence of completed training. | There is currently no routine tracking and review of training files to ensure compliance. Community Counseling and SNAP staff maintain their own individual training records and do not have a designated staff member completing reviews to ensure compliance. |
| The program maintains an individual training file or employee file AND a FLN Training Log (or similar document that includes all requirements) 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** | The agency does have a training file folder for each individual employee. The training files are kept in a secure location at George W. Harris shelter in a locked room where only staff has access. | The agency has a training log but it does not meet the FL Network Standards. The agency log is missing staff name, staff position, required trainings, due dates, and a list of total number of training hours completed. |
| ***Additional Comments:*** **There are no additional comments for this indicator.** | | | |

| 1.05 - Analyzing and Reporting Information | | | Satisfactory |
|---|---|---|---|
| **Provider has a written policy and procedure that meets the requirement for Indicator 1.05** | | **YES**<br>If NO, explain here:<br>QI300: Continuous Quality Improvement Process/CQI Teams-Org Date 2/5/00, Revision Date 9/5/18, Review Date 10/13/22; QI310: Data Collection and Evaluation- Org Date 12/1/15, Revision Date 9/1/18, Reviewed Date 10/13/22; QI320: Quality Improvement Review of Agency Files- Org Date 3/10/00, Revision Date 7/31/18, Reviewed Date 10/13/22; QI330 CQI Worksheet- Org Date 7/1/13, Revision Date 9/4/18, Reviewed Date 10/13/22; QI340 Stakeholders Feedback- Org Date4/5/04, Revision Date 9/5/18, Reviewed Date 10/13/22. Approved by CEO and Board Chair | |
| **Document Source: Please provide a detailed explanation of any sources used to complete this indicator.** *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.* | | | |
| **Staff Position(s) Interviewed: Quality Improvement Coordinator, Program Director**<br>**Type of Documentation(s) Reviewed: Meeting Notes, Binders with Reports and Graphs** | | | |
| Case record review reports demonstrate reviews are conducted quarterly, at a minimum | **Compliance** | 4th Qtr. CQI Stakeholders Involvement Team Meetings were held on 7/13/23 and 10/19/23 which discussed customer satisfaction, outreach involvement, suggestions placed in the suggestion boxed, surveys for HR, CBC, Non-residential/residential and CINS/FINS. | |
| The program conducts reviews of incidents, accidents, and grievances quarterly, at a minimum | **Compliance** | A Risk Prevention and Management Team meetings were held on 8/28/23 and 12/5/23 which discussed the reviewing of accidents, incidents, and grievances in order to identify trends and patterns that could be improved through corrective action, training, or other educational opportunities. | |
| The program conducts an annual review of customer satisfaction data | **Compliance** | Annual review of the customer satisfaction data is discussed at the Board and Stakeholder annual meeting. | |
| The program conducts an annual review of outcome data and (if applicable) there is evidence of annual reconciliation that occurs through communication from the Florida Network via email or phone call when corrections are needed and the information is corrected and submitted within the requested timeframes. | **Compliance** | Community Counseling Team meeting held on 6/8/2023 which discussed how to conduct and improve the following: reviewing of file forms, case staffing process, shelter processes, suicide assessment procedures, communication, and discharging. Agency FLN Report Cards are discussed monthly with supervisors and then discussed monthly at team meetings which was evident by meeting agendas. | |
| The program has a process in place to review and improve accuracy of data entry & collection | **Compliance** | Monthly data reviews were conducted on 8/23/23, 9/19/23 and 10/20/23 and sent via email which included July, August, and October data evidence reports, graphs, CMO reports, and PowerPoints. | |
| There is documentation that findings are regularly reviewed by management and communicated to staff and stakeholders. | **Compliance** | The past four months of scoring tools, continuous quality improvement worksheets, and annual reviews were emailed to supervisors monthly for their review. Corrective action plans were attached with desired outcomes, areas to improves, actions steps, parties responsible, and timeframes of completion. | |

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| There is evidence the program demonstrates that critical performance data reports are shared with the Board of Directors frequently. All final reports that include a Limited or Failed score is submitted electronically or by mail to the providers Executive Committee on the Board of Directors. | **Compliance** | The agency presented evidence of monthly emails sent by Vice-President of Quality and Compliance to the board and CEO about quality improvement updates and compliance. | |
| There is evidence that strengths and weaknesses are identified, improvements are implemented or modified, and staff are informed and involved throughout the process. | **Compliance** | Scoring Tools, CQI Worksheets, and Annual Reviews are emailed to supervisors monthly for their review. As reviewed on 6/19/23 and 10/9/23, CAP was attached with desired outcomes, areas to improves, actions steps, parties responsible, and timeframe of completion. Peer Mock reviews were documented on 11/8/23 and 11/15/23 where the Senior Director of Residential and Community Counseling, Program Manager RAP, Program Manager NBYS, and QI Coordinator Prevention reviewed all training documents, transport logs, treatment plans, shift checklist, grievances, daily walks, med room, chemical counts, and files. During this meeting weaknesses were addressed and new procedures were put in place. | |
| ***Additional Comments:*** **There are no additional comments for this indicator.** | | | |
| **1.06: Client Transportation** | | | **Satisfactory with Exception** |
| **Provider has a written policy and procedure that meets the requirement for Indicator 1.06** | | **YES**<br>If NO, explain here:<br>The agency has a policy, 1.06 Client Transportation, which was reviewed by the chief executive officer on October 13, 2023 and the chief operating officer on October 12, 2023. | |
| **Document Source: Please provide a detailed explanation of any sources used to complete this indicator.** *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.* | | | |
| **Dates or Timeframe Reviewed: June 1- December 7, 2023**<br>**Staff Position(s) Interviewed: Program Director, Human Resources**<br>**Type of Documentation(s) Reviewed: Single Party Transportation Log, Monthly Trip and Mileage Log, Insurance Cards, Approved Driver List, Driver's Licenses, Checked records for five staff.** | | | |
| Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle | **Compliance** | The agency provided a copy of their approved driver's list. The program director indicated they receive information from human resources regarding if a staff is eligible to provide transportation or not. Checkr records were reviewed for five staff showing an in depth check was done on each. Transportation is done in agency vehicles. | |
| Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy | **Compliance** | A copy of valid Florida driver's licenses were provided for the agency's approved drivers. Insurance cards for the vehicles were reviewed. Human resources staff indicated all driver's are covered under the company's 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 program's policy indicates staff are to take an approved third party on all situations that involve the transportation of a youth whenever possible. It indicates when this is not possible, they will notify the program director and receive consent. | |

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| 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** | The program's policy indicates the youth's history and recent behaviors will be considered prior to transport. | |
| The 3rd party is an approved volunteer, intern, agency staff, or other youth | **Compliance** | Reviewed Monthly Trip and Mileage Logs found all transports included either two youth or two staff. | |
| The agency demonstrated evidence via logbook or other written verification that supervisor approval was obtained prior to all single youth transports. | **Exception** | The program had four total single youth transports during the review period. Three of four transports had documented supervisor approval prior to transport. | One of the four transports had no documentation of supervisor approval prior to transport. |
| 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** | There is documentation of use of vehicles that notes name or initials of driver, date and time, mileage, number of passengers, purpose of travel, and location; however, there are some entries missing one or more fields, including the number of youth going to the destination or the number of youth coming back from the destination. | |
| ***Additional Comments:*** **There are no additional comments for this indicator.** | | | |
| **1.07 - Outreach Services** | | | **Satisfactory with Exception** |
| **Provider has a written policy and procedure that meets the requirement for Indicator 1.07** | **YES**<br>If NO, explain here: Policy and Procedures from Agency do not reflect FL NetMis policy and procedures for documenting outreach (entry into NetMis). Outreach is being kept in a binder.<br>CS580:Community Outreach and Education- Org Date 5/1/00, Revision Date 12/14/18, Reviewed date 9/19/22. Approved by the CEO and Board Chair. | | |
| **Document Source: Please provide a detailed explanation of any sources used to complete this indicator.** *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.* | | | |
| **Staff Position(s) Interviewed: Program Director**<br>**Type of Documentation(s) Reviewed: Outreach Binder and NetMis Excel Outreach Spreadsheet**<br>**Describe any Observations: Outreach that is being conducted is not being kept in one central location as eight documents were handed in and not placed in binder.** | | | |
| The program has a lead staff member designated to participate in local DJJ board, Circuit and Council meetings with evidence that includes minutes of the event or other verification of staff participation. | **Compliance** | The Program Director is designated to participate in the local DJJ board, council and circuit meetings. Documentation of meeting agendas were provided and the Program Director was able to report on different topics discussed at the meetings. | |
| The program maintains written agreements with other community partners which include services provided and a comprehensive referral process. | **Compliance** | A binder is kept with all interagency agreements with community partners. The agreements detail services provided and procedures for referrals processes. | |

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| The program will maintain documentation of outreach activities and enter into NetMIS the title, date, duration (hours), zip code, location description, estimated number of people reached, modality, target audience and topic. | **Exception** | There has been a newly designated staff member in charge of outreach. The Program Director presented some evidence of outreach activities and attendance at various events. | Outreach activities have not been entered into NetMis as required. |
| The program has designated staff that conducts outreach which is defined in their job description. | **Compliance** | Agency identified three staff members whom can conduct outreach. Supervisors and lead counselors can attend outreach events. | |
| ***Additional Comments:*** **There are no additional comments for this indicator.** | | | |
| **2.01 - Screening and Intake** | | | **Satisfactory with Exception** |
| **Provider has a written policy and procedure that meets the requirement for Indicator 2.01** | | **YES**<br>If NO, explain here:<br>Policy # RGC 2.01 Eligibility Screening and Intake Last Reviewed on 9/15/23 Last Approve by CEO 0n 10/13/23 | |
| **Document Source: Please provide a detailed explanation of any sources used to complete this indicator.** *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.* | | | |
| **Total number of Open (Residential & Community) Files: Three Open Community Counseling Youth Files and 2 Open Residential Youth files**<br>**Total number of Closed (Residential & Community) Files: Four Closed Community Counseling Youth Files and 1 Closed Residential Youth File**<br>**Staff Position(s) Interviewed: Program Director (Community Counseling), Program Director (Residential), Residential Supervisor**<br>**Type of Documentation(s) Reviewed: Youth's file, NetMIS, MindShare** | | | |
| **Shelter youth:** Eligibility screening is completed immediately for all shelter placement inquiries. | **Compliance** | All files reviewed indicated that three of three Residential youth were screened for eligibility immediately. | |
| **Community counseling:** Eligibility screening is completed within 3 business days of referral by a trained staff using the Florida Network screening form. | **Compliance** | All files reviewed indicated that seven of seven Community Counseling youth were screened for eligibility within three days of referral by a trained staff using the Florida Network screening form | |
| There is evidence all referrals for service is screened for eligibility and is logged in NetMIS within 72 hours of screening completion. | **Exception** | All files reviewed indicate that eight of ten referrals for service were screened for eligibility and logged in NetMIS within 72 hours of screening completion. | Two of ten files reviewed did not contain a referral for service. |
| Youth and parents/guardians receive the following in writing:<br>a. Available service options<br>b. Rights and responsibilities of youth and parents/guardians | **Compliance** | All files reviewed indicate that ten of ten youth and their parents/guardians received an information form that described the available service options and a copy of the family's Rights and responsibilities. Signatures of youths and parents receipt of the documents were present in each youth's files. | |

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| The following is also available to the youth and parents/guardians:<br>a. Possible actions occurring through involvement with CINS/FINS services (case staffing committee, CINS petition, CINS adjudication)<br>b. Grievance procedures | **Compliance** | All files reviewed indicate that parents receive a "Parent Brochure in which the Grievance process is explained. A list of possible actions that can occur through the family's involvement with CINS/FINS services are also included in the brochure. | |
| During intake, all youth were screened for suicidality and assessed as required if needed. | **Compliance** | All files reviewed indicate that ten of ten youth were screened for suicidality. Four of the youths screened required further assessing and were assessed by a licensed mental health professional or an unlicensed mental health professional under the supervision of a licensed mental health professional. | |
| ***Additional Comments:*** **There are no additional comments for this indicator.** | | | |
| **2.02 - Needs Assessment** | | | **Satisfactory with Exception** |
| **Provider has a written policy and procedure that meets the requirement for Indicator 2.02** | | **YES**<br>If NO, explain here:<br>Policy # RGC 2.02 NIRVANA (formerly Needs Assessment) Origination Date 2/1/22, 9/15/23 Last Approved on 10/13/23 by the CEO. | |
| **Document Source: Please provide a detailed explanation of any sources used to complete this indicator.** *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.* | | | |
| **Total number of Open (Residential & Community) Files: Three Open Community Counseling Youth files and two Open Residential Youth Files**<br>**Total number of Closed (Residential & Community) Files: Four Closed Community Counseling Youth Files and 1 Closed Residential Youth File**<br>**Staff Position(s) Interviewed Program Director (Community Counseling), Program Director (Residential), Residential Supervisor**<br>**Type of Documentation(s) Reviewed: NIRVANA interview guide, NetMIS** | | | |
| Shelter Youth: NIRVANA is initiated within 72 hours of admission | **Compliance** | Three of three residential youth files indicate that a NIRVANA was initiated within 72 hours of admission. | |
| Non-Residential youth: NIRVANA is initiated at intake and completed within 2 to 3 face-to-face contacts after the initial intake **OR** updated, if most recent assessment is over 6 months old | **Compliance** | Seven of seven Community Counseling files indicate that the NIRVANA was initiated at intake and completed within two to three face to face contacts after the initial intake. | |
| Supervisor signatures is documented for all completed NIRVANA assessments and/or the chronological note and/or interview guide that is located in the youths' file. | **Exception** | All ten youths' files reviewed contained a completed NIRVANA assessment interview guide | One open community counseling youth file contained a re-assessment that did not have a supervisor's signature. Signature line shows "reviewed with X by phone" on 11/6. |
| (Shelter Only) NIRVANA Self-Assessment (NSR) is completed within 24 hours of youth being admitted into shelter. If unable to complete, there must be documentation in NetMIS and the youth's file explaining the barriers to completion. | **Compliance** | Three of three Residential youth files reviewed indicate that all three youth completed a NIRVANA Self Report (NSR) within 24 hours of being admitted into the shelter | |

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| A NIRVANA Post-Assessment is completed at discharge for all youth who have a length of stay that is greater than 30 days. | **Compliance** | Four of the five closed youth's files reviewed indicate that a NIRVANA Post-Assessment was completed for any youth with a length of stay greater than 30 days. One closed file did not contain a completed NIRVANA Post Assessment due to the youth's length of stay being less than 30 days | |
| A NIRVANA Re-Assessment is completed every 90 days excluding files for youth receiving SNAP services. | **Exception** | One open Community Counseling youth file contained a NIRVANA Re-Assessment. | One file contained a NIRVANA Re-Assessment completed at day 96. |
| All files include the interview guide and/or printed NIRVANA. | **Compliance** | Ten of ten youth's files reviewed contained an interview guide and/or printed NIRVANA. | |
| ***Additional Comments:*** **There are no additional comments for this indicator.** | | | |
| **2.03 - Case/Service Plan** | | | **Satisfactory with Exception** |
| **Provider has a written policy and procedure that meets the requirement for Indicator 2.03** | | **YES**<br>If NO, explain here:<br>Policy #RGC 2.03 Service Plan Development and Service Monitoring Last Reviewed on 10/05/21 Last Approved on 10/13/23 by the CEO | |
| **Document Source: Please provide a detailed explanation of any sources used to complete this indicator.** *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.* | | | |
| **Total number of Open (Residential & Community) Files: Three open community counseling youth files and 2 open residential youth files**<br>**Total number of Closed (Residential & Community) Files: Four closed community counseling youth files and 1 closed residential youth file**<br>**Staff Position(s) Interviewed: Program Director (community counseling), Program Director (residential), Program Supervisor**<br>**Type of Documentation(s) Reviewed: Service/ Case Plan, Youth files** | | | |
| The case/service plan is developed on a local provider-approved form or through NETMIS and is based on information gathered during the initial screening, intake, and NIRVANA. | **Compliance** | Ten of ten files reviewed contained a case/service plan that was developed on a local provider-approved form and is based on information gathered during the initial screening, intake and NIRVANA. | |
| Case/Service plan is developed within 7 working days of NIRVANA | **Compliance** | Ten of ten files reviewed contained a Case/Service Plan that was developed within seven working days of the NIRVANA. | |
| **Case plan/service plan includes:**<br>1. Individualized and prioritized need(s) and goal(s) identified by the NIRVANA<br>2. Service type, frequency, location<br>3. Person(s) responsible<br>4. Target date(s) for completion and Actual completion date(s)<br>5. Signature of youth, parent/ guardian, counselor, and supervisor<br>6. Date the plan was initiated | **Exception** | Seven of ten files reviewed had Case/Service plans that included: individualized and prioritized need(s) and goal(s) identified by the NIRVANA, Service type, frequency and location; person(s) responsible; target date(s) for completion and actual completion date(s); Signature of youth, parent/guardian, counselor and supervisor and the Date the plan was initiated | One closed community counseling file's service plan was not signed by the youth or parent; signature lines showed "virtual consent". One open community counseling file's service plan was not signed by the youth; signature line showed "mx felt too young to sign" and was initialed by the Program Supervisor. One closed Residential file service plan did not identify the person responsible. |

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| 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** | Seven of ten files reviewed were reviewed for progress/revised by counselor and parent every 30 days for the first three months and every six months after. Two open Residential files were for youth that were admitted to the program less than 30 days at the time of review. A closed Community Counseling file was for a youth who spent less than 30 days in the program. | |
| ***Additional Comments:*** **There are no additional comments for this indicator.** | | | |
| **2.04 - Case Management and Service Delivery** | | | **Satisfactory with Exception** |
| **Provider has a written policy and procedure that meets the requirement for Indicator 2.04** | | **YES**<br>If NO, explain here:<br>Policy # RGC 2.04 Traditional and Intensive Case Management and Service Delivery Last Reviewed 9/16/21 Last Approved 10/13/23 by the CEO. | |
| **Document Source: Please provide a detailed explanation of any sources used to complete this indicator.** *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.* | | | |
| **Total number of Open (Residential & Community) Files: Three open community counseling youth files and two open residential youth files**<br>**Total number of Closed (Residential & Community) Files: Four closed community counseling youth files and one closed residential youth file**<br>**Staff Position(s) Interviewed: Program Director, (community counseling), Program Director (residential), Residential Supervisor**<br>**Type of Documentation(s) Reviewed: Referrals, Service Plans, Case Notes, NetMIS** | | | |
| Counselor/Case Manager is assigned | **Compliance** | Ten of ten youth's files reviewed contained an intake form that identified the Counselor/Case Manager assigned. | |
| The Counselor/Case Manager completes the following as applicable:<br>1. Establishes referral needs and coordinates referrals to services based upon the on-going assessment of the youth's/family's problems and needs<br>2. Coordinates service plan implementation<br>3. Monitors youth's/family's progress in services<br>4. Provides support for families<br>5. Monitoring of progress for court ordered youth in shelter<br>6. Makes referrals to the case staffing to address problems and needs of the youth/family<br>7. Accompanies youth and parent/guardian to court hearings and related appointments<br>8. Refers the youth/family for additional services when appropriate<br>9. Provides case monitoring and reviews court orders<br>10. Provides case termination notes<br>11. Provides follow-up after 30 days of exit<br>12. Provides follow-up after 60 days of exit | **Exception** | All files reviewed indicates that the Counselor/Case Manager establishes referral needs and coordinates referrals to services based upon the on-going assessment of the youth's/family's problems and needs and coordinates service plan implementation, monitors the youth's/family's progress in services and provides support for families. All files reviewed indicate that the Counselor/Case Manager provides case monitoring. Five files indicated a need for additional services and of those five files, all indicate that the Counselor/Case Manager referred the youths/family for additional services. Four of the five Closed youth files indicate that the Counselor/Case Manager completed case termination notes. Three of five closed youth files indicates that the Counselor/Case Manager provided follow-ups after 30 and 60 days of exits. The remaining two closed files were recently closed and follow-ups were not applicable. Ten of ten youth files indicate that no youth were court ordered to the program for services. | One closed Residential youth file did not contain case termination notes. |
| The program maintains written agreements with other community partners that include services provided and a comprehensive referral process | **Compliance** | Ten of ten youth files reviewed indicates the program maintains written agreements with other community partners that include services provided and a comprehensive referral process. | |

***Additional Comments:*** **There are no additional comments for this indicator.**

| 2.05 - Counseling Services | | | Satisfactory |
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| **Provider has a written policy and procedure that meets the requirement for Indicator 2.05** | | **YES**<br>If NO, explain here:<br>Policy # RGC 2.05 Community Counseling and Residential Group Care Services Last Reviewed on 11/17/21 Last Approved on 10/13/23 by the CEO. | |
| **Document Source: Please provide a detailed explanation of any sources used to complete this indicator.** *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.* | | | |
| **Total number of Open Files: Three open community counseling youth files and two open residential youth files**<br>**Total number of Closed Files: Four closed community counseling youth files and one closed Residential youth file**<br>**Staff Position(s) Interviewed: Program Director (community counseling), Program Director (residential), Residential Supervisor**<br>**Type of Documentation(s) Reviewed: Case Notes, Service Plans, NIRVANA, Group Attendance Log** | | | |
| **Shelter Program** | | | |
| Shelter programs provides individual and family counseling | **Compliance** | Three of three residential youth files indicate that the program provides individual and family counseling. | |
| Group counseling sessions held a minimum of five days per week | **Compliance** | The group attendance log indicates that group counseling sessions are being held at least five times per week. | |
| Groups are conducted by staff, youth, or guests and group counseling sessions consist of :<br>1. A clear leader or facilitator<br>2.Relevant topic - educational/informational or developmental<br>3. Opportunity for youth to participate<br>4. 30 minutes or longer | **Compliance** | A review of the group attendance logs indicates that groups are being conducted by staff and that group counseling sessions consist of a clear facilitator, a relevant topic that is educational/informational and or developmental, gives youth the opportunity to participate and are 30 minutes or longer. | |
| Documentation of groups must include date and time, a list of participants, length of time, and topic. | **Compliance** | A review of the group attendance logs indicates the date, time, participants, length of time and topic for each group session conducted. | |
| **Community Counseling** | | | |
| Community counseling programs provide therapeutic community-based services designed to provide the intervention necessary to stabilize the family. Services are provided in the youth's home, a community location, the local provider's counseling office or virtually if written documentation is provided in the youth's file for reasons why it is in the best interest of the youth and family. | **Compliance** | Seven of seven community counseling youth files reviewed, indicate that the program provides therapeutic community based services that are designed to provide the necessary intervention to stabilize the family. These files also indicate that services are provided at the youth's home, program's counseling office or community location. Virtual counseling services are provided on an as needed basis with documentation in the youth's file for reasons why it is in the best interest of the youth and family to received services virtually. | |

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| **Counseling Services** | | | |
| Reflect all case files for coordination between presenting problem(s), psychosocial assessment, case/service plan, case/service plan reviews, case management, and follow-up | **Compliance** | All files reviewed reflect a coordination between presenting problem(s), NIRVANA assessment, case/service plan, case/service plan reviews, case management and follow-up | |
| Maintain individual case files on all youth and adhere to all laws regarding confidentiality | **Compliance** | All files reviewed indicates that program staff maintain individual case files and the files adhere to all laws regarding confidentiality | |
| Case notes maintained for all counseling services provided and documents youth's progress | **Compliance** | All files reviewed contained case notes that are maintained for all counseling services provided and documents the youths' progress. | |
| On-going internal process that ensures clinical reviews of case records and staff performance | **Compliance** | All files reviewed contained case notes that are maintained for all counseling services provided and documents the youths' progress. | |
| ***Additional Comments:*** **There are no additional comments for this indicator.** | | | |
| **2.06 - Adjudication/Petition Process** | | | **Satisfactory** |
| **Provider has a written policy and procedure that meets the requirement for Indicator 2.06** | | **YES** | |
| | | If NO, explain here: | |
| | | RGC 2.06 Adjudication/ Petition process, last reviewed 9/15/2023 by the CEO | |
| **Document Source: Please provide a detailed explanation of any sources used to complete this indicator.** *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.* | | | |
| **Total number of Open (Residential & Community) Files: No eligible files for review**<br>**Total number of Closed (Residential & Community) Files: No eligible files for review**<br>**Staff Position(s) Interviewed: Quality Improvement**<br>**Type of Documentation(s) Reviewed: Agency Policy** | | | |
| Must include:<br>a. DJJ rep. or CINS/FINS provider<br>b. Local school district representative | **No eligible items for review** | The agency's policy includes all requirements of this standard and each of its indicators. The agency has no current adjudication/ petition cases and has not had any back to the date of the last review. | |
| Other members may include:<br>a. State Attorney's Office<br>b. Others requested by youth/ family<br>c. Substance abuse representative<br>d. Law enforcement representative<br>e. DCF representative<br>f. Mental health representative | **No eligible items for review** | The agency's policy includes all requirements of this standard and each of its indicators. The agency has no current adjudication/ petition cases and has not had any back to the date of the last review. | |
| The program has an established case staffing committee, and has regular communication with committee members | **No eligible items for review** | The agency's policy includes an established case staffing committee however, the agency has no current adjudication/ petition cases and has not had any back to the date of the last review. | |

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| The program has an internal procedure for the case staffing process, including a schedule for committee meetings | **No eligible items for review** | The agency's policy includes internal procedures for the case staffing process. The agency has no current adjudication/ petition cases and has not had any back to the date of the last review. | |
| The youth and family are provided a new or revised plan for services | **No eligible items for review** | The agency's policy includes all requirements of this standard and each of its indicators. The agency has no current adjudication/ petition cases and has not had any back to the date of the last review. | |
| Written report is provided to the parent/guardian within 7 days of the case staffing meeting, outlining recommendations and reasons behind the recommendations | **No eligible items for review** | The agency has no current adjudication/ petition cases and has not had any back to the date of the last review. | |
| If applicable, the program works with the circuit court for judicial intervention for the youth/family | **No eligible items for review** | The agency has no current adjudication/ petition cases and has not had any back to the date of the last review. | |
| Case Manager/Counselor completes a review summary prior to the court hearing | **No eligible items for review** | The agency has no current adjudication/ petition cases and has not had any back to the date of the last review. | |
| ***Additional Comments:*** **There are no additional comments for this indicator.** | | | |

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| **2.07 - Youth Records** | | **Satisfactory** |
| **Provider has a written policy and procedure that meets the requirement for Indicator 2.07** | **YES** | |
| | If NO, explain here: | |
| | Policy #RGC 2.07 Youth Records was last reviewed on 09/15/2023 and signed by the CEO 10/13/2023 | |

**Document Source: Please provide a detailed explanation of any sources used to complete this indicator.** *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*

**Staff Position(s) Interviewed: Quality Improvement Coordinator**
**Describe any Observations: File Storage Location, Mobile file Boxes**

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| All records are clearly marked 'confidential'. | **Compliance** | All records (youth files, employee training files, other) observed during this on-site review were clearly marked confidential. | |
| All records are kept in a secure room or locked in a file cabinet that is marked "confidential" | **Compliance** | An observation was made of all records are kept in a secure room where only facility staff has access and file cabinets containing records are all marked confidential. | |
| When in transport, all records are locked in an opaque container marked "confidential" | **Compliance** | The staff transport records in locked opaque file boxes with "confidential" marked on each box. | |
| All records are maintained in a neat and orderly manner so that staff can quickly and easily access information | **Compliance** | All records were observed in the file room in a neat and orderly fashion. Records are easily accessible to staff. | |
| ***Additional Comments:*** **There are no additional comments for this indicator.** | | | |

| 2.08 - Specialized Additional Program Services | | | Satisfactory with Exception |
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| **Provider has a written policy and procedure that meets the requirement for Indicator 2.08** | | **YES**<br>If NO, explain here:<br>RGC 2.08 Specialized Additional Program Services was last reviewed on 09/15/2023 and signed by the CEO. | |
| **Staff Secure** | | | |
| **Document Source: Please provide a detailed explanation of any sources used to complete this indicator.** *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.* | | | |
| **Total number of Open Files: Zero**<br>**Total number of Closed Files: Zero**<br>**Staff Position(s) Interviewed: Program Director (community counseling), Quality Improvement Coordinator**<br>**Type of Documentation(s) Reviewed: Review of the agency's policy for Specialized Additional Program Services was last reviewed on 09/15/2023 and signed by the CEO and is sufficient to meet the requirements of this Standard and each of it's indicators.** | | | |
| Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted?<br>**(If no, select rating "No eligible items for review")** | **No eligible items for review** | The agency has no current staff secure cases and has not had staff secure cases since the date of the last review. | |
| Staff Secure policy and procedure outlines the following:<br>a. In-depth orientation on admission<br>b. Assessment and service planning<br>c. Enhanced supervision and security with emphasis on control and appropriate level of physical intervention<br>d. Parental involvement<br>e. Collaborative aftercare | **No eligible items for review** | The agency has a policy that is compliant with the indicator. The policy and procedure outlines the following: in-depth orientation on admission; assessment and service planning; enhanced supervision and security with emphasis on control and appropriate level of physical intervention; parental involvement and collaborative aftercare. There are no current staff secure cases and none since the date of the last review. | |
| Program only accept youth that meet legal requirements of F.S. 984 for being formally court ordered in to Staff Secure Services | **No eligible items for review** | The agency's policy states the program only accepts youth that meet legal requirements of F.S. 984 for being formally court ordered into staff secure services, however there are no current staff secure cases and has not been any staff secure cases since the date of the last review. | |
| Staff Assigned:<br>a. One staff secure bed and assigned staff supervision to one staff secure youth at any given time<br>b. Program assign specific staff during each shift to monitor location/ movement of staff secure youth<br>c. Agency clearly documents the specific staff person assigned to the staff secure youth in the logbook or any other means on each shift | **No eligible items for review** | The agency has a policy that is indicates one staff secure bed and assigned staff supervision to one staff secure youth at any given time; program assigns specific staff during each shift to monitor location/ movement of staff secure youth; and agency clearly documents the specific staff person assigned to the staff secure youth in the logbook or any other means on each shift. There is no practice to review at this time due to the agency having no current staff secure cases and has not had any staff secure cases since the date of the last review. | |
| Agency provides a written report for any court proceedings regarding the youth's progress | **No eligible items for review** | There is no written report for court proceedings regarding youth's progress because the agency has no current staff secure cases and has not been any staff secure cases since the date of the last review. | |

| Domestic Minor Sex Trafficking (DMST) | | | |
|---|---|---|---|
| **Document Source: Please provide a detailed explanation of any sources used to complete this indicator.** *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.* | | | |
| **Total number of Open Files: Zero**<br>**Total number of Closed Files: Zero**<br>**Staff Position(s) Interviewed: Program Director (community counseling), Quality Improvement Coordinator**<br>**Type of Documentation(s) Reviewed: No eligible files to review** | | | |
| Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted?<br>(If no, select rating "No eligible items for review") | **No eligible items for review** | There are no current Domestic Minor Sex Trafficking (DMST) cases and has not been any DMST cases since the date of the last review. | |
| Agency has evidence that the FNYFS was contacted for approval prior to admission for all Domestic Minor Sex Trafficking (DMST) placements. | **No eligible items for review** | The agency's policy indicates that the Florida Network of Youth and Family Services (FNYFS) will be contacted for approval prior to admission for all DMST placements. There are no current DMST cases and has not been any DMST cases since the date of the last review. | |
| There is evidence the youth was entered into NetMIS as a Special Populations youth at admission and a Human Trafficking Screening Tool (HTST) was completed. | **No eligible items for review** | The agency has a policy regarding entering youth into NetMIS as a special populations youth at admission and a Human Trafficking Tool shall be completed, however, there is currently no DMST cases and has not been any DMST cases since the date of the last review. | |
| Services provided to these youth specifically designated services designed to serve DMST youth | **No eligible items for review** | The agency has a policy that is compliant with the indicator however has no current practice. There are no current DMST cases and has not been any DMST cases since the date of the last review. | |
| Did the placement of DMST youth require additional supervision for the safety of the youth or the program? If so, did the agency provide the appropriate level of supervision and safety measures? | **No eligible items for review** | The agency has a policy that is compliant with the indicator regarding additional supervision for the safety of the youth or the program, however there are no current DMST cases and has not been any DMST cases since the date of the last review. | |
| Length of Stay:<br>a. Youth in program do not have length of stay in DMST placement that exceeds seven (7) days<br>b. Agency has approval for stays and support beyond seven (7) days for DMST placements that are obtained on a case-by-case basis? (If applicable.) | **No eligible items for review** | The agency has a policy that is compliant with the indicator however has no current practice. There are no current DMST cases and has not been any DMST cases since the date of the last review. | |
| Agency has evidence that staff assigned to DMST youth under this provision are to enhance the regular services available through direct engagement in positive activities designed to encourage the youth to remain in shelter | **No eligible items for review** | The agency has a policy that is compliant with the indicator however has no current practice. There are no current DMST cases and has not been any DMST cases since the date of the last review. | |
| All other services provided to DMST youth are consistent with all other general CINS/FINS program requirements | **No eligible items for review** | The agency's policy indicates that services provided to DMST youth are consistent with all other general CINS/FINS program requirements. There are no current DMST cases and has not been any DMST cases since the date of the last review. | |

| Domestic Violence | | | |
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| **Document Source: Please provide a detailed explanation of any sources used to complete this indicator.** *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.* | | | |
| **Total number of Open Files: Zero**<br>**Total number of Closed Files: One**<br>**Staff Position(s) Interviewed: Program Director (community counseling), Quality Improvement Coordinator**<br>**Type of Documentation(s) Reviewed: Youth Case File** | | | |
| Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted?<br>(If no, select rating "No eligible items for review") | **Yes** | The agency has one Domestic Violence case in the last six months. The youth was admitted 08/31/2023 and discharged 09/11/2023. | |
| Youth admitted to DV Respite placement have evidence in the file of a pending DV charge | **Compliance** | Evidence of a pending DV charge was present in the one youth file reviewed. | |
| Data entry into NetMIS within (3) business days of intake and discharge | **Compliance** | NetMis entry occurred within 3 days of intake and discharge in the youth file reviewed. | |
| Youth length of stay in DV Respite placement does not exceed 21 days. If more than 21 days, documentation exists in youth file of transition to CINS/FINS or Probation Respite placement, if applicable. | **Compliance** | The length of stay did not exceed 21 days in the youth file reviewed. Youth was admitted 08/31/2023 and discharged on 09/11/2023. | |
| Case plan in file reflects goals for aggression management, family coping skills, or other intervention designed to reduce propensity for violence in the home | **Compliance** | The case plan reviewed reflected goals for family coping skills and managing aggression. Additional goals pertained to youth getting along with parents. | |
| All other services provided to Domestic Violence Respite youth are consistent with all other general CINS/FINS program requirements | **Compliance** | The file reviewed contained evidence of other services that are consistent with all other general CINS/ FINS program requirements. | |
| **Probation Respite** | | | |
| **Document Source: Please provide a detailed explanation of any sources used to complete this indicator.** *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.* | | | |
| **Total number of Open Files: Zero**<br>**Total number of Closed Files: One**<br>**Type of Documentation(s) Reviewed: One residential youth file** | | | |
| Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted?<br>(If no, select rating "No eligible items for review") | **Yes** | One probation respite file reviewed that was served in the last six months or since the date of the last review. | |
| All probation respite referrals are submitted to the Florida Network. | **Compliance** | One of one file reviewed showed evidence of probation referral submitted to the Florida Network | |
| All Probation Respite Referral come from DJJ Probation and there is evidence that the youth is on Probation regardless of adjudication status. | **Compliance** | One of one file reviewed showed evidence of a DJJ referral and came from DJJ probation and that the youth was on probation regardless of adjudication status | |

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| Data entry into NetMIS and JJIS within (3) business days of intake and discharge | **Compliance** | One of one file reviewed showed evidence of NetMis within 3 business days of intake and discharge | |
| Length of stay is no more than fourteen (14) to thirty (30) days. Any placement beyond thirty (30) days contains evidence in the file that the JPO was contacted in writing to request the need of an extension no later than the 25th day the youth was admitted into the program. | **Compliance** | One of one file reviewed was in compliance with a length of stay that was 14 to 30 days (admission was 08/27/2023 and discharge was 09/07/2023). | |
| All case management and counseling needs have been considered and addressed | **Compliance** | Evidence of case management and counseling needs were addressed in one of one files reviewed. | |
| All other services provided to Probation Respite youth are consistent with all other general CINS/FINS program requirements | **Compliance** | Evidence of other services provided to probation respite youth were consistent with the other general CINS/FINS program requirement was present in the file reviewed. | |
| **Intensive Case Management (ICM)** | | | |
| **Document Source: Please provide a detailed explanation of any sources used to complete this indicator.** *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.* | | | |
| **Total number of Open Files: Two**<br>**Total number of Closed Files: Zero**<br>**Type of Documentation(s) Reviewed: Youth Files** | | | |
| Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted?<br>(If no, select rating "No eligible items for review") | **Yes** | The agency has two open ICM youth files. | |
| Youth receiving services were deemed chronically truant and/or runaway and require more intensive and lengthy services. The youth was determined to be eligible because they have gone through petition and/or case staffing and was in need of case management services. | **Compliance** | Both youth files contained evidence of the eligibility to be deemed in need of case management services. | |
| Services for youth and family include:<br>a. Two (2) direct contacts per month<br>b. Two (2) collateral contacts per week<br>c. Direct and collateral contacts not obtained must have documentation to support attempts made to obtain them. All reasonable attempts (at minimum of three) must be made to reach all contacts (direct and collateral) and documented in the case file and NetMIS. | **Exception** | Both youth files demonstrated evidence of two direct contacts per month. One file demonstrated two collateral contacts per week. | One youth file did not demonstrate evidence of collateral contacts nor the attempts to obtain them. |
| Assessments include<br>a. NIRVANA at intake<br>b. NIRVANA Re-Assessment every 90 days<br>c. Post NIRVANA at discharge as aligned with timeframe requirements | **Exception** | Both youth files reviewed included NIRVANA assessment at intake. One youth file contained a NIRVANA re-assessment at 90 days. Both youth files are still open. There were no eligible closed ICM youth files for review. | One youth file did not contain a NIRVANA re-assessment at 90-days. |

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| Service/case plan demonstrates a strength-based, trauma-informed focus | **Compliance** | Both youth cases reviewed demonstrated a strength-based, trauma-informed focus. | |
| For any virtual services provided, there is written documentation in the youths' file as to why virtual contact is in the best interest of the youth and family | **No eligible items for review** | No virtual services were provided in either of the two cases reviewed. | |
| **Family and Youth Respite Aftercare Services (FYRAC)** | | | |
| **Document Source: Please provide a detailed explanation of any sources used to complete this indicator.** *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.* | | | |
| **Total number of Open Files: Zero**<br>**Total number of Closed Files: Zero**<br>**Staff Position(s) Interviewed: Program Director (Community Counseling), Quality Improvement Coordinator**<br>**Type of Documentation(s) Reviewed: Review of the agency's policy for Specialized Additional Program Services was last reviewed on 09/15/2023 and signed by the CEO and is sufficient to meet the requirements of this Standard and each of it's indicators.** | | | |
| Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted?<br>(If no, select rating "No eligible items for review") | **No eligible items for review** | The agency has no FYRAC cases and has not had any FYRAC cases since the date of the last review. | |
| Youth is referred by DJJ for a domestic violence arrest on a household member, and/or the youth is on probation regardless of adjudication status and at risk of violating. | **No eligible items for review** | The agency's policy is compliant with the indicator. There is currently no FYRAC cases and has not been any FYRAC cases since the date of the last review. | |
| Agency has evidence that all FYRAC referrals have documented approval from the Florida Network office | **No eligible items for review** | The agency's policy indicates FYRAC referrals have documented approval from the Florida Network office. Currently there are no FYRAC cases and has not been any FYRAC cases since the date of the last review. | |

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| Intake and initial assessment sessions meets the following criteria:<br>a. Services shall be documented through the signature of the youth and his/her parent/guardian as well as orientation to the program which is kept in the youths file.<br>b. The initial assessment shall be face-to-face, in person or through virtual means, to include a gathering of all family history and demographic information, as well as the development of the service plan.<br>c. For youth on probation, a copy of the youths Community Assessment Tool (CAT) to assist with development of the family service plan. | **No eligible items for review** | The agency has a policy on intake and initial assessment meets the criteria outlined in the indicator however there are no FYRAC cases and has not been any FYRAC cases since the date of the last review. | |
| Life Management Sessions meets the following criteria:<br>a. Sessions are face-to-face, sixty (60) minutes in length and focus on strengthening the family unit<br>b. Services are highly supportive, individualized, and flexible and require a "whole family" approach to dealing with the problems affecting the youth and family. | **No eligible items for review** | The agency has a policy addresses life management session and is compliant with the measures of the indicator. There are no FYRAC cases to review and has not been any FYRAC cases since the date of the last review. | |
| Individual Sessions:<br>a.The program conducted sessions with the youth and family to focus on work to engage the parties and identify strengths and needs of each member that help to improve family functioning.<br>b. Issues to be covered through each session include but are not limited to:<br>Identifying emotional triggers; body cues; healthy coping strategies through individual, group and family counseling; understanding the cycle of violence and the physical and emotional symptoms of anger; developing safety plans; and educating families on the legal process and rights. | **No eligible items for review** | The agency has a policy covers Individual sessions and is compliant with the indicator. There are no current FYRAC cases and has not been any FYRAC cases since the date of the last review. | |
| Group Sessions:<br>a. Focus on the same issues as individual/family sessions with application to youth pulling on similar experiences with other group members with the overall goal of strengthening relationships and prevention of domestic violence.<br>b. Shall be no more than eight (8) youth at one (1) time and shall be for a minimum of sixty (60) minutes per session | **No eligible items for review** | The agency has a policy addresses group sessions and is compliant with the indicator however there are no current FYRAC cases and has not been any FYRAC cases since the date of the last review. | |
| There is evidence of completed 30 and/or 60 day follow-ups and is documented in NetMIS following case discharge. | **No eligible items for review** | The agency has a policy that is compliant with the indicator however has no current practice. There are no FYRAC cases and has not been any FYRAC cases since the date of the last review. | |
| Youth and family participate in services for thirteen (13) sessions or ninety (90) consecutive days of services, or there is evidence in the youth's file that an extension is granted by DJJ circuit Probation staff | **No eligible items for review** | The agency has a policy that is compliant with the indicator however has no current practice. There are no FYRAC cases and has not been any FYRAC cases since the date of the last review. | |

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| Any service that is offered virtually, is documented in the youth's file why it was in the youth and families best interest. | **No eligible items for review** | The agency's policy covers virtual services, however the agency has no current FYRAC cases and has not been any FYRAC cases since the date of the last review. | |
| All data entry in NetMIS is completed within 3 business days as required. | **No eligible items for review** | The agency has a policy indicated all data entry in NetMIS is completed within three business days. There are no FYRAC cases and has not been any FYRAC cases since the date of the last review. | |
| ***Additional Comments:*** **There are no additional comments for this indicator.** | | | |
| **2.09- Stop Now and Plan (SNAP)** | | | **Satisfactory with Exception** |
| **Provider has a written policy and procedure that meets the requirement for Indicator 2.09** | | **YES**<br>If NO, explain here:<br>Policy #RGC 2.09 Stop Now And Plan Last Reviewed 9/15/23 Last Approved 10/13/23 by the CEO | |
| **Document Source: Please provide a detailed explanation of any sources used to complete this indicator.** *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.* | | | |
| **Total number of Open Files: Four Open youth's files**<br>**Total number of Closed Files: One Closed youth's file; Two closed SNAP In Schools files**<br>**Staff Position(s) Interviewed: Program Director (community counseling)**<br>**Type of Documentation(s) Reviewed: NIRVANA, Child Behavior Checklist, Teacher Report Form, SNAP Discharge Summary, SNAP Child Evaluation Form, SNAP Parent Evaluation Form, SNAP In School attendance Sheets, SNAP In School Class Goal, MoCE** | | | |
| **SNAP Clinical Groups Under 12** | | | |
| Youth are screened to determine eligibility of services. | **Compliance** | Five of five youth files reviewed contained a Brief Intake Screening form used to determine eligibility of services | |
| The NIRVANA was completed at initial intake, or within two sessions. | **Compliance** | Five of five youth files reviewed contained a NIRVANA Assessment that was completed at initial intake, or within two sessions. | |
| There is evidence of the completed Child Behavior Checklist (CBCL) by the caregiver (pre and post) and is located within the file. | **Compliance** | Five of five youth files reviewed contained a Pre Child Behavior Checklist by the caregiver. | |
| There is evidence of the completed Teacher Report Form (TRF) is completed by the teacher (pre and post) and is located within the file. | **Exception** | Five of five youth files were reviewed for this indicator. | Five of five youth files reviewed did not contain a Pre and Post Teacher Report Form completed by a teacher. |
| **SNAP Clinical Groups Under 12 - Discharge** | | | |

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| There is evidence of the completed SNAP Discharge Report located within the file for any discharged youth. | **Compliance** | One closed youth file contained a completed SNAP Discharge Report | |
| There is evidence of the completed SNAP Discharge Report located within the file for any discharged youth. | **Compliance** | One closed youth file contained a completed SNAP Discharge Report | |
| There is evidence of the SNAP Boys/SNAP Girls Child Group Evaluation Form located in the file. | **Compliance** | Five of five youth files reviewed contained a Child Group Evaluation form. | |
| There is evidence of the SNAP Boys/SNAP Girls Parent Group Evaluation Form located in the file. | **Compliance** | Five of five youth files reviewed contained a Parent Group Evaluation form. | |
| **SNAP Clinical Groups for Youth 12-17** | | | |
| Youth are screened to determine eligibility of services. | **Not Applicable** | This indicator is not applicable because the agency does not serve this population as it pertains to SNAP Clinical groups for youth ages 12-17. | |
| The Consent to Treatment and Participation in Research Form is completed and located within the file. | **Not Applicable** | This indicator is not applicable because the agency does not serve this population as it pertains to SNAP Clinical groups for youth ages 12-17. | |
| The NIRVANA was completed at initial intake, or within two sessions. | **Not Applicable** | This indicator is not applicable because the agency does not serve this population as it pertains to SNAP Clinical groups for youth ages 12-17. | |
| There is evidence of the completed 'How I Think Questionnaire' (HIT) form located within the file or evidence of at least three (3) documented attempts in the youths' file to obtain this information. | **Not Applicable** | This indicator is not applicable because the agency does not serve this population as it pertains to SNAP Clinical groups for youth ages 12-17. | |
| There is evidence of the completed Social Skills Improvement System (SSIS) Student form located within the file or evidence of at least three (3) documented attempts in the youths' file to obtain this information. | **Not Applicable** | This indicator is not applicable because the agency does not serve this population as it pertains to SNAP Clinical groups for youth ages 12-17. | |
| There is evidence of the completed Social Skills Improvement System (SSIS) Teacher/Adult form located within the file or evidence of at least three (3) documented attempts in the youths' file to obtain this information. | **Not Applicable** | This indicator is not applicable because the agency does not serve this population as it pertains to SNAP Clinical groups for youth ages 12-17. | |
| **SNAP for Schools & Communities** | | | |

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| The program demonstrated all of the required weekly attendance sheets that included youth names and/or identifying numbers completed with the teacher and trained SNAP Facilitator signatures. (*This must include a total of 13 attendance sheets for a full cycle*) | **Exception** | Two of two SNAP In Schools closed files contained 13 completed attendance sheets. | Each file contained an attendance sheet that was missing the Teacher's and Facilitator's signatures. |
| The program maintained evidence of a completed "Class Goal" Document for the class reviewed. | **Compliance** | Two of two SNAP In Schools files contained a class goal that was reviewed by the class. | |
| The program maintained evidence of both pre AND post Measure of Classroom Environment (MoCE) completed documents for the class reviewed. | **Compliance** | Two of two SNAP In Schools files contained evidence of a pre and post Measure of Classroom Environment completed for the class. | |
| The program maintained evidence of completed pre and post evaluation documents for the class reviewed. | **Exception** | Two of two SNAP In Schools files reviewed contained post evaluation documents for the class. | Two of two SNAP In Schools files did not contain a pre evaluation document for the class review. |
| There is evidence of the fidelity adherence checklist maintained in the file for each class reviewed. | **Exception** | There were a total for two SNAP in school files reviewed. Both files had completed all 13 week sessions. | Two of two SNAP In Schools files did not contain a fidelity adherence checklist for class review. |

***Additional Comments:*** **There are no additional comments for this indicator.**

| **3.01 - Shelter Environment** | | **Satisfactory with Exception** |
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| **Provider has a written policy and procedure that meets the requirement for Indicator 3.01** | **YES** | |
| | If NO, explain here: | |
| | Policy #RGC3.01 - Titled: Residential Group Care Environment was last reviewed on September 15, 2023. It was approved by the CEO on October 12, 2023 and COO on October 13, 2023. | |

**Document Source: Please provide a detailed explanation of any sources used to complete this indicator.** *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*

**Staff Position(s) Interviewed: The program director and shelter supervisor were interviewed regarding the shelter environment.**
**Type of Documentation(s) Reviewed: The indicated documentation below was reviewed throughout various placements in the shelter. Daily schedules and logs were also reviewed.**
**Describe any Observations: Twelve bedrooms were observed in the shelter (Six in the girls dorm and six in the boys dorm). The dorms are on separate hallways with a common staff station in the center. Observations were also made of the full shelter to include: kitchen, dining area, main living room, hallways, dorm hallways, bathrooms and other common areas.**

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| **Facility Inspection:**<br>a. Furnishings are in good repair.<br>b. The program is free of insect infestation.<br>c. Bathrooms and shower areas are clean and functional, free of foul odors, leaks, dust, and mildew and in good working order.<br>d. There is no graffiti on walls, doors, or windows.<br>e. Lighting is adequate for tasks performed there.<br>f. Exterior areas are free of debris; grounds are free of hazards.<br>g. Dumpster and garbage can(s) are covered.<br>h. All doors are secure, in and out access is limited to staff members and key control is in compliance.<br>i. Detailed map and egress plans of the facility, general client rules, grievance forms, abuse hotline information, DJJ Incident Reporting Number and other related notices are posted.<br>j. Interior areas (bedrooms, bathrooms, common areas) do not contain contraband and are free from hazardous unauthorized metal/foreign objects. | **Exception** | Twelve of twelve bedrooms were observed on the tour of the facility. Other areas of the shelter environment were observed included the: entryway, main hallways, common area or "living room," conference room, dining area, kitchen, and all bathrooms located in the facility. Located within the facility there are seven bathrooms. Four of the seven bathrooms included a shower. Four of the seven bathrooms were located in the dorm hallways. Three of the seven bathrooms were located in a common area. One of the seven bathrooms is designated for staff use only. Seven of seven bathrooms were observed clean, functional, free of foul odors, leaks, dust, mildew and in good working condition. The program was observed free of insect infestation. There was no graffiti on the walls, doors or windows. To deter youth from putting graffiti on the walls, twelve of twelve bedrooms had a portion of the wall painted in chalk paint, allowing the youth to use chalk to draw on the walls appropriately. Throughout the shelter and offices, lighting was appropriate. Dumpster and garbage cans were observed covered, there was one large dumpster located outside. Exterior areas were observed to be clear and neat. Four doors facing the outside of the shelter were checked and were locked. The front entrance to the shelter also was locked, controlling access to the building. Twelve of twelve dorm rooms were observed to have an egress map within the room. Six other locations throughout the shelter were also noticed to have the maps at an accessible location for easy reading. General client rules, Florida Abuse Hotline were posted in three observed locations to include the girls' dorm, boys' dorm and in the common area/"living room." Grievance boxes were also located in three areas accessible to youth as well. The DJJ incident reporting number was also observed posted in the both dorms - boys and girls. The DJJ incident reporting number is also available to staff and observed in two locations: the clipboard being carried by staff throughout the shelter and on the overtime call list located at the staff bubble. | Two of twelve bedrooms observed, contained unauthorized foreign objects. Both bedrooms were located on the girls dorm. One bedroom had string lights hanging from the ceiling, the other had loose nails in the wall holding up a framed picture with glass. The Residential Supervisor and Program Director immediately removed the items from the dorm rooms upon observation during the facility walk-thru. |
| **Facility Inspection:**<br>a.All agency and staff vehicles are locked.<br>b. Agency vehicles are equipped with major safety equipment including first aid kit, (all items in the first aid kit are current and do not have expired items; all expired items should be replaced regularly), fire extinguisher, flashlight, glass breaker and, seat belt cutter. | **Exception** | The agency has two operating staff vehicles. Two of two vans are Chrysler Voyagers 2022 - White. Two of two agency vehicles are equipped with all major safety equipment to include: first aid kid (all items are current and do not have expired items), fire extinguishers, flashlights, glass breakers and seat belt cutters. Two of two agency vans appeared clean, well-maintained and have active registrations. | During a random check on December 7, 2023 of two agency vehicles, one of the two vans was found unlocked on shelter premises. The staff immediately locked the vehicle. |

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| **Facility Inspection:**<br><br>All chemicals are listed, approved for use, inventoried weekly and perpetually, stored securely and Material Safety Data Sheets (MSDS) are maintained on each item (minimum 1 time per week or per agency policy).<br><br>A perpetual inventory will be the primary means of maintaining a current and real-time inventory.<br><br>The weekly inventory will be conducted weekly at a minimum to ensure that a perpetual inventory is being maintained consistently and accurately. If more than one location is used to store chemicals, there is an inventory wherever chemicals are stored that is current and well maintained unless previously approved by the Network. | **Exception** | Three of three locations of chemicals appeared to be organized and clean. All chemicals were easily accessible and labeled. The agency has a MSDS maintained in a MSDS binder for all chemicals. Chemicals are stored in more than one location throughout the shelter. There are chemicals stored in three locations as observed during the site tour: kitchen, chemical closet and laundry room. All three locations of the chemicals were locked. There is a binder for perpetual inventories that is kept at the staff station in the dorms. Weekly inventories were completed as required for two of the three locations. Weekly inventories were completed for the chemical closet and laundry room. | Weekly inventories were started for the kitchen in November of 2023. The perpetual inventories for the chemicals is located at all three locations, however, all of the perpetual inventory sheets for the kitchen and laundry chemicals are not filled out. |
| **Facility Inspection:**<br><br>Washer/dryer are operational & general area/lint collectors are clean.<br>Agency has a current DCF Child Care License which is displayed in the facility.<br>Each youth has own individual bed with clean covered mattress, pillow, sufficient linens and blanket.<br>Youth have a safe, lockable place to keep personal belongings, if requested. | **Compliance** | Two of two dryers were observed and appeared to be clean, operable and clear of lint. Two of two washers were observed and appeared operational and clean. Twenty-four (24) of twenty-four (24) beds were observed. All appeared clean and supplied with appropriate bedding to include: pillows, sufficient linens and blankets. In a storage area located in the dorm hall, there was an abundant of extra blankets, pillows and other linens available. It was also identified by the shelter supervisor in an interview that if a youth requests to lock something up, they would inform staff and utilize a storage area in the med room, which has it's own lock. | |
| **Additional Facility Inspection Narrative (if applicable)** | | | |

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| **Fire and Safety Health Hazards:**<br>a. Annual facility fire inspection was conducted, and the facility is in compliance with local fire marshal and fire safety code within jurisdiction.<br>b. Agency completes a minimum of 1 fire drill per month within 2 minutes or less.<br>c. Completes 1 mock emergency drill per shift per quarter.<br>d. All annual fire safety equipment inspections are valid and up to date (extinguishers, sprinklers, alarm system and kitchen overhead hood, including fire extinguishers in all vehicles). | **Compliance** | The annual facility fire inspection was conducted on September 26, 2023. This notice was observed posted in the facility, near the fire alarm box located in the front lobby. As observed in records produced in the binder "Fire Safety" there is a certificate identifying the completion of annual facility fire inspection as well. The fire inspection indicated having a result of" Passed, Satisfactory and Approved. No violations were identified. The inspection was completed by the City of Bartow Fire Department. During the last six months, there have been fire drills that have taken place at every shift throughout the month. 1st Shift: The dates for the fire drills on first shift are as follows: 11/7/23, 10/29/23, 9/28/23, 8/6/23, 7/21/23 and 6/16/23. Of the six fire drills that have taken place on first shift, the evacuations take place in less than two (2) minutes for all of the drills.<br>2nd Shift: The dates for the fire drills on second shift are as follows: 11/22/23, 10/15/23, 9/27/23, 8/30/23, 7/17/23 and 6/1/23. Of the six fire drills that have taken place on second shift, the evacuations take place in less than two (2) minutes for all of the drills.<br>As applicable 3rd Shift: The dates for the fire drills on third shift are as follows: 11/3/23, 10/23/23, 9/2/23, 8/15/23, 7/1/23 and 6/17/23. Of the six fire drills that have taken place on third shift, the evacuations take place in less than two minutes for all of the drills. As observed in the binder titled "Fire Safety," the annual alarm, hydrant and sprinkler inspection was completed on March 10, 2023. As observed in the binder titled "Fire Safety," there was an annual check for the fire alarms was completed on March 6, 2023. As observed in the binder titled "Fire Safety," there was an annual inspection of the fire extinguishers on January 31, 2023.<br>Twelve fire extinguishers were observed throughout the premises. Six of twelve fire extinguishers are located in the dormitory. Two of twelve fire extinguishers were observed in the kitchen. One of twelve fire extinguishers were found in the living room/"great room." Three of twelve fire extinguishers were observed in other common walkways/areas with easy accessibility. Twelve of twelve fire extinguishers were all noted to have placard cards that also indicate the last check of them being completed on June of 2023. Two of two fire extinguishers were located in each site van and were within compliance. | |

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| **Fire and Safety Health Hazards:**<br>a. Agency has a current Satisfactory Residential Group Care inspection report from the Department of Health.<br>b. Agency has a current Satisfactory Food Service inspection report from the Department of Health and food menus are posted, current and signed by Licensed Dietician annually.<br>c. All cold food is properly stored, marked and labeled and dry storage/pantry area is clean and food is properly stored.<br>d. Refrigerators/Freezers are clean and maintained at required temperatures and all small and medium sized appliances are operable and clean for use as needed. | **Compliance** | As observed on a print off on the wall near the fire alarm in the main lobby, there is a Group Care inspection Report. The results yielded on the form are: satisfactory. The inspection took place on October 3, 2023. The agency also has a Satisfactory Food Service inspection report dated for October 3, 2023 with the results of satisfactory. The food items that are not in their original container are in plastic containers that are labeled with the date they were opened and their expiration date. Two refrigerators were observed in the kitchen area. Two of two refrigerators were observed to be clean, maintained and operable. One of two operating refrigerators was at 36 degrees F and the other refrigerator was at 33 degrees F. There are three freezers observed in the kitchen area. One of the three freezers is not operable at this time. There is no food in that freezer. Two of the three freezers were observed to clean, maintained and operable. One of the two freezers was operating at -8 degrees F and one of two operating freezers was operating at -6 degrees F. Posted on the wall in dining area was a posted food menu that was signed by a Licensed Dietician. Two of two food menus were produced by the shelter supervisor for the dates of October 2023 and August 2023, both were signed by a licensed dietician and the license was prominently displayed and current. | |
| **Additional Fire and Safety Health Hazards Narrative (if applicable)** | | | |

| Youth Engagement | | | |
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| 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.<br>b. At least one hour of physical activity is provided daily.<br>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.<br>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.<br>e. Daily programming schedule is publicly posted and accessible to both staff and youth. | **Compliance** | Throughout shelter observation of the days of the audit, December 6 and December 7, 2023, the youth were observed to be engaged in meaningful, structured activities. All youth appeared to be kept busy and were responsive to the changing scheduled. An observation was made of the daily schedule posted in the "living room" or main common area of the shelter. Of the schedule, it was observed that the youth have a blocked hour at least daily for physical activity. On the posted schedules, there was also designated time for youth to participate in a faith-based activity. Two of two daily schedules were posted in the living area, both reflecting calendars for when the youth are in school and when they are out of school. Two of two daily schedules were also observed in both the boys' and girls' dorm hallways. All schedules were posted, legible and easily accessible to the youth. Each hour of the day had a specific activity or structure | |
| ***Additional Comments:*** **There are no additional comments for this indicator.** | | | |
| **3.02 - Program Orientation** | | | **Satisfactory** |
| **Provider has a written policy and procedure that meets the requirement for Indicator 3.02** | | **YES**<br>If NO, explain here:<br>Policy # RGC 3.02 titled Program Orientation was last reviewed on 9/15/2023. It was approved on October 13, 2023 by the President/CEO and on October 12, 2023 by the COO. | |
| **Document Source: Please provide a detailed explanation of any sources used to complete this indicator.** *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.* | | | |
| **Total number of Open Files: 2**<br>**Total number of Closed Files: 5**<br>**Type of Documentation(s) Reviewed: Seven youth charts were reviewed in their electronic health record system. Various components of the youth's intake documentation was reviewed to include the orientation page which indicated that they had received all of the information identified below. A physical copy of the orientation packet was also received and reviewed.**<br>**Describe any Observations: Observations were made of the youth charts as well as the physical orientation packet form in a printed version.** | | | |
| Youth received a comprehensive orientation and handbook provided within 24 hours | **Compliance** | Seven of seven youth charts were reviewed and noted to have received a comprehensive orientation and handbook within 24 hours. This was observed by the entry date of signatures in their electronic health record system showing they have received the orientation and handbook. | |

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| Orientation includes the following:<br>a. Youth is given a list of contraband items<br>b. Disciplinary action is explained<br>c. Dress code explained<br>d. Review of access to medical and mental health services<br>e. Procedures for visitation, mail and telephone<br>f. Grievance procedure<br>g. Disaster preparedness instructions<br>h. Physical layout of the facility<br>i. Sleeping room assignment and introductions<br>j. Suicide prevention- alerting staff of feelings or awareness of others having suicidal thoughts | **Compliance** | The shelter program director indicated that all youth are given the same orientation packet at admission. Seven of seven youth charts showed evidence of receipt of the orientation packet. The orientation packet outlined the following: contraband items, disciplinary actions, dress code, access to medical and mental health services, procedures for mail, visitation and telephone, grievance procedure, room assignments, addressing suicide prevention and disaster preparedness instructions. The physical layout of the facility is notated by the maps located throughout the shelter as well as by the tour the youth is provided. Seven of seven youth signed and acknowledged having received the orientation packet and a tour of the facility. | |
| Documentation of each component of orientation, including orientation topics and dates of presentation, as well as signatures of the youth and staff involved is maintained in the individual youth record | **Compliance** | Seven of seven youth charts were observed to have signatures confirming that each had received the orientation, reviewed the orientation presentation and topics. Seven of seven youth charts also had staff signatures present. | |
| ***Additional Comments:*** **There are no additional comments for this indicator.** | | | |
| **3.03 - Youth Room Assignment** | | | **Satisfactory** |
| **Provider has a written policy and procedure that meets the requirement for Indicator 3.03** | | **YES**<br>If NO, explain here:<br>Policy # RGC 3.03 titled Youth Room Assignment was last reviewed on September 15, 2023. It was approved by the CEO/President on October 13, 2023 and the COO on October 12, 2023. | |
| **Document Source: Please provide a detailed explanation of any sources used to complete this indicator.** *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.* | | | |
| **Total number of Open Files: 2**<br>**Total number of Closed Files: 5**<br>**Staff Position(s) Interviewed: Residential Supervisor**<br>**Type of Documentation(s) Reviewed: Seven youth charts were reviewed as well as the a shelter census that is available to all staff via a shared drive.**<br>**Describe any Observations: Observations were also made of a board indicating all room assignments with some minimal youth demographics and alerts.** | | | |

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| **A process is in place that includes an initial classification of the youths, to include:** | | | |
| a. Review of available information about the youth's history, status and exposure to trauma<br>b. Initial collateral contacts,<br>c. Initial interactions with and observations or the youth<br>d. Separation of younger youth from older youth,<br>e. Separation of violent youth from non-violent youth<br>f. Identification of youth susceptible to victimization<br>g. Presence of medical, mental or physical disabilities<br>h. Suicide risk<br>i. Sexual aggression and predatory behavior<br>j. Acute health symptoms requiring quarantine or isolation | **Compliance** | Seven of seven charts were reviewed for this standard. Of the seven charts, seven had appropriate room assignments notated in each file. Within all seven files, it was observed that the following items were taken into consideration when choosing room assignments: youth's history and exposure to trauma, collateral contacts with family members/guardians, initial interaction with youth, presence of medical, mental or physical disabilities, suicide risk, sexual aggression and predatory behavior as well as acute health symptoms requiring quarantine or isolation. Such items were determined by the completion of the Nirvana with the youth as well as the safety, suicide screenings. Interviews with the shelter program director also indicated the need to keep youth separated by age differences. The program director further explained and identified how she interprets the data that was present in the youth chart to determine an appropriate room assignment. A census log was reviewed as provided by the shelter program director that is available on a shared drive for all staff. | |
| An alert is immediately entered into the program's alert system when a youth is admitted with special needs and risks such as risk of suicide, mental health, substance abuse, physical health or security risk factors | **Compliance** | Seven of seven youth charts were reviewed and noted to have alerts placed on all of the charts appropriate to the youth's needs. The shelter program director also shared in what ways the information is shared immediately across the program and that is through emails sent upon the arrival of an intake, in the log book and on the census kept in a shared drive. Two youth intakes were noted in the log book between the dates of October 10, 2023 and November 10, 2023 with appropriate notifier's of alerts next to their names. | |
| ***Additional Comments:*** **There are no additional comments for this indicator.** | | | |
| **3.04 - Log Books** | | | **Satisfactory with Exception** |
| **Provider has a written policy and procedure that meets the requirement for Indicator 3.04** | | **YES**<br>If NO, explain here: The agency policy does not reflect that staff need to date corrections as identified in the standard.<br>Policy # RGC 3.04, titled: Log Books was last reviewed on September 15, 2023. It was approved the CEO on October 13, 2023 and the COO on October 12, 2023. | |
| **Document Source: Please provide a detailed explanation of any sources used to complete this indicator.** *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.* | | | |
| **Dates or Timeframe Reviewed: Between two log books, the following dates were covered: April 26, 2023 - August 10, 2023 and August 10, 2023 through November 10, 2023.**<br>**Staff Position(s) Interviewed: Residential Supervisor**<br>**Type of Documentation(s) Reviewed: Two log books were provided and reviewed.**<br>**Describe any Observations: Two shelter log books were observed in good condition with legible writing throughout them.** | | | |
| Log book entries that could impact the security and safety of the youth and/or program are highlighted | **Compliance** | Two of two log books were observed and reviewed. Both log books presented with a system for highlighting important facts pertaining to security and safety as shared by the shelter supervisor. This was also observed by reviewing both log books. | |

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| All entries are brief, legibly written in ink and include:<br>• Date and time of the incident, event or activity<br>• Names of youth and staff involved<br>• Brief statement providing pertinent information<br>• Name and signature of person making the entry | **Compliance** | Two of two log books were observed and reviewed. Both log books included writing that was brief, legibly written and in ink. For the entries observed in both books, they included date and times of the incidents that took place, staff and youth involved, name and signature of who made the entry and a brief statement. | |
| Recording errors are struck through with a single line. The staff person must initial and date the correction. The use of whiteout and erasures is prohibited. | **Exception** | The use of whiteout and erasure was not utilized or observed in two log books were reviewed for the dates of April 26, 2023 through August 10, 2023 (logbook # one) and August 10, 2023 through November 10, 2023 (logbook # two). | In log book number one: there were at least two identified lines in which items were crossed through in the book but there was no date or initials next to the voided items. This was observed on dates: July 26, 2023 (end of shift notation) and August 9, 2023 (2:45 p.m.). In log book number two there were at least two identified lines in which items were crossed through in the book and there was no date or initials next to the voided items. This was observed on dates: September 1, 2023 (between times of 8:31 p.m. and 10:39 p.m.) and November 2, 2023 (at 6:45 a.m.). For all identified errors above, there were no initials and dates. |
| The program director or designee reviews the facility logbook(s) every week and makes a note chronologically in the logbook indicating the dates reviewed and if any correction, recommendations and follow-up are required and sign/date the entry | **Exception** | Two log books were reviewed and observed. Log book number one was dated for April 26, 2023 through August 10, 2023 and log book number two was dated for August 10, 2023 through November 10, 2023. From the dates checked, log books indicate that weekly checks are being completed by the program director or designee as indicated in purple. | The program director reviews present in the logbook do not indicate the dates that are being reviewed. |
| All staff review the logbook of the previous two shifts and makes an entry signed and dated into the logbook indicating the dates reviewed | **Compliance** | Two of two log books were reviewed and observed. One (1) of two (2) log books was dated for April 26, 2023 through August 10, 2023. From July 7, 2023 through July 14, 2023 and August 2, 2023 through August 10, 2023, there were clear notations indicating that staff were reviewing the log book of the previous two shifts that included entries that were signed, dated and included the dates they reviewed. One (1) of two (2) log books was dated for August 10, 2023 through November 10, 2023. From September 1, 2023 through September 5, 2023 and November 5, 2023 through November 9, 2023, there were clean notations indicating that staff were reviewing the log book of the previous two shifts which included entries in the books that were signed, dated and included the dates reviewed. | |
| At the beginning of their shift, oncoming supervisor and shelter counselor reviews the logbook of all shifts since their last log entry and makes a signed and dated entry and into log book indicating the dates reviewed. | **Exception** | Two of two log books were reviewed and observed. One log book dated for April 26, 2023 through August 10, 2023. One log book dated for August 10, 2023 through November 10, 2023. In two of two log books, it was observed that the counselors and oncoming supervisors were indicating that they are conducting a review of the shelter log. | Several entries in both logbooks reviewed had no date that indicated the dates of when counselors and oncoming supervisors are reviewing the logbooks. |

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| Logbook entries include:<br>a. Supervision and resident counts<br>b. Visitation and home visits | **Compliance** | Both log books produced examples of appropriate notations of supervision and resident counts throughout the various shifts. Visitations and home visits were also indicated through highlights. | |
| ***Additional Comments:*** **There are no additional comments for this indicator.** | | | |
| **3.05 - Behavior Management Strategies** | | | **Satisfactory** |
| **Provider has a written policy and procedure that meets the requirement for Indicator 3.05** | | **YES**<br>If NO, explain here:<br>Policy # RGC 3.05 titled Behavior Management was last reviewed on September 15, 2023. It was approved by the CEO on October 13, 2023 and COO on October 12, 2023. | |
| **Document Source: Please provide a detailed explanation of any sources used to complete this indicator.** *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.* | | | |
| **Staff Position(s) Interviewed** *(No Staff Names)* **: The shelter supervisor and one shelter staff member were interviewed.**<br>**Type of Documentation(s) Reviewed: Documentation outlining the parameters of their Behavior Management System (BMS) program were reviewed. These documents were formulated from the client handbook, teaching material for the staff and posters or signage posted throughout the shelter environment.**<br>**Describe any Observations: The material that was reviewed as it relates to the shelter's behavior management strategies was clear, concise and easily obtained and reviewed.** | | | |
| The program has a detailed written description of the BMS and it is explained during program orientation | **Compliance** | A review of the program orientation packet contained all information pertaining to the BMS system. It was easily legible and understandable for youth and adults to read. | |
| **Behavior Management Strategies must include:** | | | |
| a.BMS is designed to teach youth new behaviors and help youth understand the natural consequences for their actions<br>b.Behavioral interventions are applied immediately, with certainty, and reflect the severity of the behavior<br>c.BMS uses a wide variety of awards/incentives to encourage participation and completion of the program<br>d.Appropriate consequences and sanctions are used by the program and consequences for behavior are logical and designed to promote skill-building for the youth<br>e.Counseling, verbal intervention and de-escalation techniques are used prior to physical intervention (Only techniques approved by the Florida Network and DJJ are used if physical intervention is required)<br>f.Only staff discipline youth. Group discipline is not imposed<br>g.Room restriction is not used as part of the system or for youth who are physically and/or emotionally out of control<br>h.Youth should never be denied basic rights such as meals, clothing, sleep, services, exercise, or correspondence privileges | **Compliance** | Rooms restrictions and denial of basic rights was not an indicated outcome of the BMS system. One of one staff interview indicated that they do not use this as a part of their behavior management system. Three of three placements throughout the shelter were observed to have the BMS system posted to include: in the girls' dorm, in the boys' dorm and in the common area known by staff as the "living room" or "main room." Upon review of teaching material provided to staff, appropriate consequences are identified for staff to learn. There is not anything that documents the timeline in which behavioral interventions are applied. From a staff interview, it is reported that behavioral interventions are applied immediately and then documented in the client chart by documenting the severity of the behavior, which was observed. Two of two youth charts were observed and reviewed that had pages in their chart that documented the youth's behavior, a grading level and potential rewards or consequences for the youth. | |

| Program's use of the BMS | | | |
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| All staff are trained in the theory and practice of administering BMS rewards and consequences | **Compliance** | Two of two employee training charts were observed and all charts presented with a check-list that indicated that they were trained on BMS. From a staff interview, the program director indicated that she teaches all staff about the BMS rewards and consequences at time of on-boarding. | |
| There is a protocol for providing feedback and evaluation of staff regarding their use of BMS rewards and consequences | **Compliance** | The staff interviewed indicated that she holds one on ones (individual supervisions) with staff to address and coach staff regarding these topics. A review of staff meeting minutes showed the staffs' use of positive and negative consequences during the following meetings the took place on: August 11, 2023 and October 13, 2023. | |
| Supervisors are trained to monitor the use of rewards and consequences by their staff | **Compliance** | One of one supervisory staff files were reviewed and included training regarding the use of behavior interventions. | |
| ***Additional Comments:*** **There are no additional comments for this indicator.** | | | |

| 3.06 - Staffing and Youth Supervision | | | Satisfactory with Exception |
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| **Provider has a written policy and procedure that meets the requirement for Indicator 3.06** | | **YES**<br>If NO, explain here:<br>Policy # RGC 3.06 - Staffing and Youth Supervision was last reviewed on September 15, 2023 and was approved by the President/CEO on October 13, 2023 and the COO on October 12, 2023. | |
| **Document Source: Please provide a detailed explanation of any sources used to complete this indicator.** *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.* | | | |
| **Dates or Timeframe Reviewed: The following timeframes were reviewed of documentation in the "staff schedule book" to include four (4) weekly schedules: August 19 - August 25, 2023, October 7-13, 2023, November 4-10, 2023 and November 18-24, 2023. When reviewing the cameras, an observation of November 1, 2023 and December 6, 2023 were made to complete the bed checks.**<br>**Staff Position(s) Interviewed: Residential Supervisor**<br>**Type of Documentation(s) Reviewed: The following documents were reviewed: the staff schedule book, the holdover and overtime rotation roster, a schedule located in a shared drive, and the log book dated from August 2023 through November 2023.**<br>**Describe any Observations: Observations of all of the above documents were completed as well as observations of the shelter cameras.** | | | |
| The program maintains minimum staffing ratios as required by Florida Administrative Code and contract.<br>• 1 staff to 6 youth during awake hours and community activities<br>• 1 staff to 12 youth during the sleep period | **Compliance** | While touring the facility on December 6-7, 2023, a minimum of two staff members were present with the youth during the first shifts. The "staff schedule book" indicated that there were two staff scheduled for the following weeks of all shifts (1st, 2nd and 3rd shift): August 19 - 25, 2023, October 7-13, 2023, November 4-10, 2023 and November 18-24, 2023. | |
| All shifts must always provide a minimum of two direct care staff present that have met the minimum training requirements | **Compliance** | Four of four weekly schedules were observed in the "Staff Schedule Book." Four of four weekly schedules observed presented with having enough staff members scheduled during all of the shifts. Weekly schedules were observed for the following dates: August 19 - 25, 2023, October 7-13, 2023, November 4-10, 2023 and November 18-24, 2023. From an interview with the program director, she indicated that staff are not placed on rotation until they have met all minimum training requirements implying that all staff on the schedules are trained. | |
| 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** | From reviews completed of the employee training charts, staff had the appropriate background screenings completed. | |
| The staff schedule is provided to staff or posted in a place visible to staff | **Compliance** | The staff schedule book was reviewed. It is available for all staff to observe the schedule. From reports from the shelter supervisor, there are a series of text messages to staff that also include the schedule. It was also observed on an employee laptop that is on a shared drive that is accessible to all staff members. | |

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| There is a holdover or overtime rotation roster which includes the telephone numbers of staff who may be accessed when additional coverage is needed | **Compliance** | There were two locations observed in which there was a holdover or overtime rotation roster for staff to assist in locating additional coverage. The first location observed was a piece of paper taped down in the "staff bubble" of the dormitory. The second location observed was a clipboard that was being carried by the staff that were working the unit with the youth. Both locations contained the same form that included a list of all contacts available to cover shifts with appropriate phone numbers to reach the staff. | |
| 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** | As observed on the cameras, random checks were made throughout the last month to observe the cameras and times of bed checks. An observation of November 1, 2023 was made from 12:00 a.m. until 3:00 a.m. and 4:00 a.m. - 6:00 a.m. The majority of bed checks were done appropriately and at least every fifteen (15) minutes as evidenced by comparing the time on the timestamp of the video to the time documented in the book. An observation of December 6, 2023 was made from 12:00 a.m. until 2:30 a.m. All documented times of bed checks were appropriate while the youth were in their room. | One bed check observed to be completed outside of the required timeframe. In the females dorm, there was one bed check completed on December 6, 2023 at 12:13 a.m. and then the next bed check was completed at 12:30 a.m. - 17 minutes apart. |
| ***Additional Comments:*** **There are no additional comments for this indicator.** | | | |
| **3.07 - Video Surveillance System** | | | **Satisfactory with Exception** |
| **Provider has a written policy and procedure that meets the requirement for Indicator 3.07** | | **YES** | |
| | | If NO, explain here: | |
| | | Policy # RGC 3.07 titled Video Surveillance was last reviewed on September 15, 2023. It was approved on October 13, 2023 by the CEO/President and on October 12, 2023 by the COO. | |
| **Document Source: Please provide a detailed explanation of any sources used to complete this indicator.** *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.* | | | |
| **Dates or Timeframe Reviewed: Reviews of the cameras and accompanying log book was reviewed between the dates of November 2023 - December 2023.**<br>**Staff Position(s) Interviewed: The program director was interviewed to obtain information to support what was documented below.**<br>**Type of Documentation(s) Reviewed: Logs dated for August 2023 - December 2023 were reviewed.**<br>**Describe any Observations: Observation was made of the cameras throughout the building on the tour.** | | | |

| Surveillance System | | | |
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| The agency, at a minimum, shall demonstrate:<br>a. A written notice that is conspicuously posted on the premises for the purpose of security<br>b. System can capture and retain video photographic images which must be stored for a minimum of 30 days<br>c. System can record date, time, and location; maintain resolution that enables facial recognition<br>d. Back-up capabilities consist of cameras' ability to operate during a power outage<br>e. Have cameras placed in interior and exterior general locations of the shelter where youth and staff congregate and where visitors enter and exit. Cameras are never placed in bathrooms or sleeping quarters.<br>f. All cameras are visible | **Compliance** | At the front entry of the facility, there was a written notice on the front of the building indicating that there is a surveillance system in use. As observed walking through the facility and on the video, there are twenty-one (21) active cameras on site. There are six (6) outside cameras, you are able to observe all areas of the building through observing the cameras. There are fifteen (15) cameras located within the shelter. All appear operable at this time. The shelter cameras capture the following locations as observed on the screen: all of the hallways in the dorms, staff station, outside patio, main common hallway, food pantry, kitchen, living room, dining area, med room, conference room and main entryway. All areas of the shelter are able to be observed. No cameras were observed in the bathrooms or sleeping quarters. On the camera system, two dates were checked to see that camera video was stored throughout the last 30 days. Video was able to be produced for November 9, 2023 and November 28, 2023. The Program Director shared that the camera system is not set up to operate during a power outage. It was observed that the camera system is plugged into a surge protector outlet and not the battery backup outlet. The Program Director immediately moved the plug to the outlet indicated as battery backup. It was also reported and observed that the agency does have a generator that powers the facility in the event of a power outage. | |
| A list of designated personnel who can access the video surveillance system is maintained (includes off-site capability per personnel)? | **Compliance** | The program director reports that the program director, senior director and residential supervisor all have access to video surveillance system on their work cell phones. | |
| Supervisory review of video is conducted a minimum of once every 14 days and timeframes reviewed are noted in the logbook. | **Exception** | The shelter maintains a regular log book and a separate video surveillance logbook. The shelter log books are well-written and legible. | A review of the logbook revealed no clear documentation of supervisory review of video cameras as advised by the standard. A review and observation of shelter "Video Surveillance Log" provided by the shelter program director revealed that reviews were not conducted once every 14 days and time frames reviewed were not reflected in the log. Discrepancies of the timeline were noticed on the following dates: log review completed on July 19, 2023 and then again on August 10, 2023 (22 days in between), on October 25, 2023 and then on November 15, 2023 (21 days in between) and again on November 15, 2023 and then on December 5, 2023 (20 days in between). |

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| The reviews assess the activities of the facility and include a review of random sample of overnight shifts | **Exception** | The shelter log books includes clear descriptions of what is taking place in the shelter. | Most reviews notated in the log also were reviewing the overnight shifts and not assessing overall other daily activities of the shelter. |
| Grant the requesting of video recordings to yield a result within 24-72 hours from program quality improvement visits and when an investigation is pursued after an allegation of an incident | **Compliance** | From a staff interview, it was identified that there has not been a request to yield a result of a video recording within 24-72 hours. The staff indicated that there is a risk improvement team that meets quarterly consisting of the following staff members: Human Resources representative, Information Technology person, Vice President of quality improvement and program staff. The purpose of this meeting is to review incidents that have taken plan and to discuss how to improve on how to handle the situation. It was indicated that they meet quarterly. The policy does not indicate the need for a process for third party review of video records and supplying the video within 24-72 hours. | |
| Camera service order/requests will be made within 24 hours of discovery of camera malfunctioning or being inoperable. All efforts made to obtain repairs are documented and maintained | **Compliance** | In July 29, 2023, there was an incident that was reported by the program director involving the cameras. On the identified date, the Information Technology department was informed that the cameras were down and inoperable at that time as evidenced by reviewing and observing an email sent to information technology from the program director. | |
| ***Additional Comments:*** **There are no additional comments for this indicator.** | | | |
| **4.01 - Healthcare Admission Screening** | | | **Satisfactory** |
| **Provider has a written policy and procedure that meets the requirement for Indicator 4.01** | | **YES**<br>If NO, explain here:<br>The agency has a policy, 4.01 Healthcare Admission Screening, which was reviewed by the chief executive officer on October 13, 2023 and the chief operating officer on October 12, 2023. | |
| **Document Source: Please provide a detailed explanation of any sources used to complete this indicator.** *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.* | | | |
| **Total number of Open Files: Two**<br>**Total number of Closed Files: Five**<br>**Staff Position(s) Interviewed: Residential Supervisor**<br>**Type of Documentation(s) Reviewed: Healthcare Screening forms, Monitoring Notes, TB Screening forms** | | | |

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| **Preliminary Healthcare Screening** | | | |
| Screening includes :<br>a. Current medications<br>b. Existing (acute and chronic) medical conditions<br>c. Allergies<br>d. Recent injuries or illnesses<br>e. Presence of pain or other physical distress<br>f. Observation for evidence of illness, injury, physical distress, difficulty moving, etc.<br>g. Observation for presence of scars, tattoos, or other skin markings<br>h. Acute health symptoms requiring quarantine or isolation | **Compliance** | Five closed records and two open records were reviewed for healthcare screening. Each reviewed youth had a healthcare screening which included current medications, existing medical conditions, allergies, recent injuries or illnesses, presence of pain or other physical distress, observation for evidence of illness, injury, physical distress, difficulty moving, etc., observation for presence of scars, tattoos or other skin markings, and acute health symptoms requiring quarantine or isolation. | |
| **Referral and Follow-Up** | | | |
| Youth with chronic medical conditions have a referral to ensure medical care (e.g. diabetes, pregnancy, seizure disorder, cardiac disorders, asthma, tuberculosis, hemophilia, head injuries, etc.) | **Compliance** | The residential supervisor indicated the program does not provide referrals for medical care. It is the practice of the program to coordinate medical care with the parent/ guardian to ensure treatment for chronic medical conditions are addressed. One closed youth file reviewed showed evidence of need for treatment for chronic medical condition. | |
| When needed, the parent is involved with the coordination and scheduling of follow-up medical appointments | **Compliance** | One reviewed closed youth file required a medical appointment for the youth to receive a prescription for a chronic condition. The program worked with the parent/guardian to schedule an appointment and coordinate for the parent/guardian to pick the youth up and transport to the appointment. | |

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| All medical referrals are documented on a daily log. | **Compliance** | One reviewed closed record required a medical appointment for the youth to receive a prescription for a chronic condition. The program worked with the parent/guardian to schedule an appointment and coordinate for the parent/guardian to pick the youth up and transport to the appointment. A record of the youth appointment and subsequent medication is documented in the log. | |
| The program has a thorough referral process and a mechanism for necessary follow-up medical care as required and/or needed | **Compliance** | The residential supervisor indicated they have a process in place in which the parent/guardian is actively involved in the coordination and scheduling of follow-up medical appointments or care, as the program is unable to take youth to medical appointments. If the parent/guardian does not follow through, the program will continue to try to work with the parent/guardian, discharge the youth, or report the issue, if necessary. | |
| ***Additional Comments:*** **There are no additional comments for this indicator.** | | | |
| **4.02 - Suicide Prevention** | | | **Satisfactory with Exception** |
| **Provider has a written policy and procedure that meets the requirement for Indicator 4.02** | | **YES**<br>If NO, explain here:<br>The agency has a policy, 4.02 Suicide Prevention, which was reviewed by the chief executive officer on October 13, 2023 and the chief operating officer on October 12, 2023. | |
| **Document Source: Please provide a detailed explanation of any sources used to complete this indicator.** *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.* | | | |
| **Total number of Open (Residential & Community) Files: Two Residential**<br>**Total number of Closed (Residential & Community) Files: Five Residential and One Community (only one of eight community counseling records was applicable)**<br>**Staff Position(s) Interviewed: QI Specialist**<br>**Type of Documentation(s) Reviewed: Intake forms, Evaluation of Imminent Danger of Suicide screening tool, Suicide Assessment forms, Close Supervision 15-Minute Checks Logs, and Behavior 30-Minute Observation Logs** | | | |
| **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** | Eight youth records were reviewed, seven residential and one community. Each youth received a suicide risk screening completed during the initial intake and screening process. Four residential youth had at least one "Yes" answer on their initial screening; therefore, an Evaluation of imminent Danger of Suicide screening was completed for them. All screening results were signed by a supervisor and maintained in each youth's case file. | |
| The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services | **Compliance** | The program's QI Specialist indicated they have been using the Suicide Assessment form for several years and had prior approval by the Florida Network but indicated approval was no longer necessary. | |

| **Supervision of Youth with Suicide Risk *(Shelter Only)*** | | | |
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| Youth are placed on the appropriate level of supervision based on the results of the suicide risk assessment. | **Compliance** | Seven shelter youth were reviewed for suicide risk. Four of the youth required a suicide assessment be completed. Each youth was placed on constant sight and sound supervision upon completion of their suicide screening and remained on until a suicide risk assessment was completed indicating they could return to standard supervision. | |
| Staff person assigned to monitor youth maintained one-to-one supervision or constant supervision and documented his/her observations of the youth's behavior at 30 minute or less intervals | **Compliance** | Four reviewed youth were placed on constant supervision. Observations of each youth's behavior was documented on a Behavior 30-Minute Observation Log by staff at a minimum of every thirty minutes for the duration each youth was on constant supervision. | |
| Documentation includes the time of day, behavioral observations, any warning signs observed, and the observers' initials and was maintained in either an observation log or in the shelter daily log. | **Compliance** | Documentation on each youth's 30-Minute Observation Log included the time, behavior observations, any warning signs observed, and the staff's initials. | |
| 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** | Four youth required a suicide assessment be completed. Each youth was placed on constant sight and sound supervision upon completion of their suicide screening and remained on until a suicide risk assessment was completed by mental health staff and reviewed with licensed staff indicating they could return to standard supervision. Two out of four youth were assessed within 24 business hours of the initial screening. All youth remained on constant sight and sound until the supervision level was changed by the appropriate licensed professional. | Two youth did not receive a further assessment within 24 business hours of the initial screening. One youth was screened on November 1, 2023 and assessed on November 7th, 2023. Another youth was screened on November 16, 2023 and assessed on November 27, 2023 due to the licensed professional being unavailable to release the youth. |
| There was evidence that documentation was reviewed by supervisory staff each shift. If program uses an observation log, completed logs are maintained in the youth's file. | **Compliance** | Four reviewed youth were placed on constant supervision. Each youth had a Close Supervision 15-Minute Checks Log and a Behavior 30-Minute Observation Log completed for each shift. Each log was signed by a supervisor and maintained in the youth's file. | |

| **Youth with Suicide Risk *(Community Counseling Only)*** | | | |
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| 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. | **Compliance** | One community counseling file was reviewed for suicide risk, as they were the only youth applicable for a suicide assessment of eight files which were requested. A suicide assessment was immediately conducted with a licensed professional. The Suicide Assessment form indicated the parent/guardian and the supervisor were notified of the results. | |
| 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. | **Compliance** | One community counseling file was reviewed for suicide risk. A suicide assessment was immediately conducted with a licensed professional which satisfies the requirement of the indicator. The Suicide Assessment form indicated the parent/guardian and the supervisor were notified of the results. | |
| 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. | **Compliance** | The community counseling youth's completed Suicide Assessment form included information on resources available in the community. The form indicated the information was provided to the parent/guardian and was signed by the parent/guardian. | |
| If the parent/guardian cannot be contacted, all efforts to contact them are documented in the case file. | **Compliance** | Parent contact was made as evidenced by appropriate parent signatures present in one community counseling file reviewed. All parent contact was appropriately documented in the file. | |
| When the screening was completed during school hours on school property, the appropriate school authorities were notified. | **No eligible items for review** | One community counseling youth file reviewed showed the screening was not completed during school hours on school property. | |
| ***Additional Comments:*** **There are no additional comments for this indicator.** | | | |

| 4.03 - Medications | | | Satisfactory with Exception |
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| **Provider has a written policy and procedure that meets the requirement for Indicator 4.03** | | **YES**<br>If NO, explain here:<br>The agency has a policy, 4.03 Medications, which was reviewed by the chief executive officer on October 13, 2023 and the chief operating officer on October 12, 2023. | |
| **Document Source: Please provide a detailed explanation of any sources used to complete this indicator.** *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.* | | | |
| **Total number of Open Files: Two**<br>**Total number of Closed Files: Five**<br>**Staff Position(s) Interviewed: Program Direction, Residential Supervisor**<br>**Type of Documentation(s) Reviewed: Prescription Medication Log Sheets, Prescription Medication Verification Forms, Youth Medication Intake/Temporary Release/Discharge Forms, Daily Shift Medication Count forms, Sharps Inventories, First-Aid Kit Inventories, Over-the-Counter Medication Inventories, medication administration training**<br>**Describe any Observations: Medication Room, Pyxis Medication Cabinet, Sharps, Pyxis keys** | | | |
| 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. | **Exception** | The Program Director supervises med passes. | The program does not currently have a registered nurse (RN) or a licensed practical nurse (LPN) that is being supervised by an RN. The program has a RN in the hiring process with a projected hire date of December 18, 2023. |
| **Medication Storage** | | | |
| a. All medications are stored in a Pyxis ES Medication Cabinet that is inaccessible to youth (when unaccompanied by authorized staff)<br>b. Pyxis machine is stored in accordance with guidelines in FS 499.0121 and policy section in Medication Management<br>c. Oral medications are stored separately from injectable epi-pen and topical medications<br>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.)<br>e. Narcotics and controlled medications are stored in the Pyxis ES Station<br>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** | The agency maintains a Pyxis Medication Cabinet where they maintain all medications. The medication cabinet is located within a locked medication room in the facility. All oral medications, epi-pens, and topical medications are stored in separate compartments within the medication cabinet. There is a locked refrigerator in the medication room utilized only for medications requiring refrigeration. The temperature of the refrigerator was 43 degrees F. The agency did not currently have any narcotics or controlled medications at the time of the review; however, when they do, they are stored in the Pyxis. The agency maintains three Pyxis keys, with the proper labels, in the medication room in the event they need to access mediations if there is a Pyxis malfunction. | |
| **Medication Distribution** | | | |

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| a. Agency maintains a minimum of 2 site-specific System Managers for the Pyxis ES Station<br>b. Only designated staff delineated in User Permissions have access to secured medications, with limited access to controlled substances (narcotics)<br>c. A Medication Distribution Log shall be used for distribution of medication by non-licensed and licensed staff<br>d. Agency verifies medication using one of three methods listed in the FNYFS Policies & Procedures Manual<br>e. When nurse is on duty, medication processes are conducted by the nurse<br>f. The delivery process of medications is consistent with the FNYFS Medication Management and Distribution Policy<br>g. Agency does not accept youth currently prescribed injectable medications, except for epi-pens<br>h. Non-licensed staff have received training in the use of epi-pens provided by a registered nurse | **Compliance** | The agency has two site-specific mangers for the Pyxis Station, the program director and the residential supervisor. All agency staff are trained in the distribution of medication; therefore they all have access to medications. According to the program director, only they or the residential supervisor are able to place controlled substances in the Pyxis. Seven residential files were reviewed and five youth, four closed and one open, were prescribed medication. A Prescription Medication Log Sheet was utilized for each youth. Each youth's file included a Prescription Medication Verification Form, which was in line with one of the three methods listed in the FNYFS manual. A medication pass was not able to be observed, as they are scheduled at 6am and 7pm; however, the program's policy indicates when a medication is delivered staff will prepare the medication by checking alerts for allergies or other contradictions, removing the container from Pyxis and counting the medication, have the youth approach the area and verify the youth, verifying the five rights, verify allergies with the youth and ask if they are having any side effects, identify and verify the medication and compare it to the Prescription Medication Log Sheet, remove the exact dose from the container, and provide it to the youth. Youth will be observed while taking the medication and then open their mouth and will stick out their tongue in case there are any concerns. The distribution should be documented and signed by the youth and staff. The program director indicated the do not accept youth who are currently prescribed injectable medications, with the exception of epi-pens. Non-licensed staff receive training in the use of epi-pens during their medication administration training. | |
| The medication distribution log documentation includes:<br>a. the time of medication administration<br>b. evidence of youth initials that the dosage was given<br>c. evidence of staff initials that the dosage was given | **Exception** | Prescription medication log sheets were reviewed for five youth who were prescribed medication. Four youth's prescription medication log sheets included the date and time of medication administration, amount given, amount remaining, and youth and staff signature for each administration. | One youth's prescription medication log sheet was missing the name of medication, amount, date, staff signature and amount remaining on the last line. |
| There is evidence that staff provide youth with medications within one hour of the scheduled time of delivery as ordered by the medication. Documentation is provided for instances this does not occur within the required timeframe. | **Compliance** | None of the reviewed youth had a time specified in which they need to take their prescribed medication, aside from am or pm. The agency provides their am medications at 6am and their pm medications at 7pm. A review of the five applicable youth's Prescription Medication Log Sheets found the agency is providing medications within an hour of the scheduled times. | |
| During the review period, there were no instances where youth missed their medication due to failure to open the pyxis machine. | **Compliance** | The program director indicated there have been no instances in which a youth missed their medication due to failure to open the Pyxis machine. | |

| Medication Inventory | | | |
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| 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<br>b. Over-the-counter medications that are accessed regularly are inventoried weekly by maintaining a perpetual inventory<br>c. Syringes and sharps (needles, scissors, etc.) are secured, and counted and documented weekly | **Compliance** | The agency did not have any youth currently prescribed a controlled medication. One reviewed closed record was applicable for controlled medication. The youth's file included a perpetual inventory with a running balance maintained on the Prescription Medication Log Sheet. A shift-to-shift count was also conducted utilizing a Daily Medication Count Form where the medication is counted each shift and initialed by two staff. The agency's practice is to complete these forms for all prescribed medication. Over-the-counter medications are inventoried perpetually when they are dispensed and are also inventoried daily utilizing the Daily Medication Count Form. Sharps are secured within the medical room and are inventoried as they are used. The program director indicated the only sharps they maintain are razors and youth are only allowed to use them one day each week. | |
| There are monthly reviews of the Pyxis reports to monitor medication management practice. | **Compliance** | Monthly reviews are conducted to monitor medication management practices. | |
| Medication discrepancies are cleared after each shift. | **Compliance** | The program director indicated her or the shift supervisor go into the medical room to clear discrepancies each shift. If they are not on-site a staff member video calls them to complete this task. | |
| The agency has an internal quality assurance process to ensure appropriate medication management and distribution methods. | **Compliance** | Each youth record is reviewed monthly to ensure appropriate medication management and distribution methods. | |
| ***Additional Comments:*** **One medication distribution Log and daily medication count sheet indicated the youth had 78 doses remaining on the day they were discharged; however, the youth medication intake/temporary release/discharge form for the same day indicated they only left with 76 doses.** | | | |

| 4.04 - Medical/Mental Health Alert Process | | | Satisfactory |
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| **Provider has a written policy and procedure that meets the requirement for Indicator 4.04** | | **YES**<br>If NO, explain here:<br>The agency has a policy, 4.04 Medical and Mental Health Alert System, which was reviewed by the chief executive officer on October 13, 2023 and the chief operating officer on October 12, 2023. | |
| **Document Source: Please provide a detailed explanation of any sources used to complete this indicator.** *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.* | | | |
| **Total number of Open Files: Two**<br>**Total number of Closed Files: Five**<br>**Staff Position(s) Interviewed: Program Director (Residential), Residential Supervisor**<br>**Type of Documentation(s) Reviewed: Prescription Medication Log, Mindshare electronic records, youth files, Staff Training**<br>**Describe any Observations: Alert boards in kitchen and medication room** | | | |
| Youth with a medical, mental health, or food allergy was appropriately placed on the program's alert system | **Compliance** | All seven reviewed youth had a medical or mental health concern or a food allergy. The agency's process is to put a sticker on each youth file with codes for each type of alert. Alerts are also listed in the agency's electronic file system. Allergies are indicated on the alert board in medical and food allergies are indicated on the board in the kitchen. Each reviewed youth was appropriately place on the program's alert system. | |
| Alert system includes precautions concerning prescribed medications, medical/mental health conditions | **Compliance** | The program includes medical/mental health conditions, as well possible side effects/adverse reactions concerning prescribed medications on each youth's Prescription Medication Log Sheet. | |
| Staff are provided sufficient training, information and instructions to recognize/respond to the need for emergency care for medical/mental health problems | **Compliance** | Program staff receive training in first-aid and CPR. Two new shelter staff were reviewed for training and both received first-aid and CPR. | |
| A medical and mental health alert system is in place that ensures information concerning a youth's medical condition, allergies, common side effects of prescribed medications, foods and medications that are contraindicated, or other pertinent mental health treatment information, is communicated to all staff | **Compliance** | A current list of youth alerts is maintained by staff. Medical alerts include: medical condition, allergies, common side effects of prescribed medications, foods and medications that are contraindicated or other pertinent mental health treatment information. Lists are maintained in several locations including med room and kitchen. | |
| ***Additional Comments:*** **There are no additional comments for this indicator.** | | | |

| 4.05 - Episodic/Emergency Care | | | Satisfactory |
|---|---|---|---|
| **Provider has a written policy and procedure that meets the requirement for Indicator 4.05** | | **YES**<br>If NO, explain here:<br>The agency has a policy, 4.05 Episodic/Emergency Care, which was reviewed by the chief executive officer on October 13, 2023 and the chief operating officer on October 12, 2023. | |
| **Document Source: Please provide a detailed explanation of any sources used to complete this indicator.** *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.* | | | |
| **Total number of Open Files: One**<br>**Total number of Closed Files: One**<br>**Staff Position(s) Interviewed: Residential Supervisor**<br>**Type of Documentation(s) Reviewed: Incident/Complaint Report Form, Discharge Instructions, Logbook** | | | |
| **Off Site Emergency Care** | | | |
| a. If off-site emergency medical or dental care was provided, an incident report was submitted for the medical or dental care<br>b. Upon youth return, there is a verification receipt of medical clearance via discharge instructions with follow-up is present in file<br>c. Youth's parent/guardian was notified<br>d. A daily log is maintained for emergency care provided | **Compliance** | The residential supervisor indicated they had two youth during the review period who required off-site emergency medical or dental care. An Incident/Complaint Report Form was completed for both youth. There were discharge instructions for both youth indicating medical clearance and any required follow-up. Each youth's Incident/Complaint Report Form documents their parent/guardian was notified. The emergency care was documented in the logbook for both youth. | |
| All staff are trained on emergency medical procedures | **Compliance** | A review of three staff files contained training on emergency medical procedures. | |
| The program has a Knife-for-life and wire cutters accessible to staff in a secure location(s) | **Compliance** | The agency maintains four locked kits which include a knife-for-life and wire cutters. These are maintained in the copy room, kitchen, staff station in the dormitory area, and in the medication room. | |
| ***Additional Comments:*** **There are no additional comments for this indicator.** | | | |