Florida Network for Youth and Family Services
Compliance Monitoring Report for

Youth and Family Alternatives, Inc.
New Beginnings Youth Shelter

18377 Sheriff Mylander Way,
Brooksville, FL 34601

February 7-8, 2024

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 Youth and Family Alternatives, New Beginnings (YFA New Beginnings) for the FY 2023-2024 at its program office located at 18377 Sheriff Mylander Way, Brooksville, Florida. 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 New Beginnings is contracted with the Florida Network of Youth and Family Services (FNYFS) to provide direct services to Children/Families in Need of Services (CINS/FINS). The services to be provided are identified in Contract Section A - Descriptions and Specifications and Section B - Delivery and Performance, and are funded with General Revenue Funds effective from July 2023 through June 30, 2024.

The review was conducted by Marcia Tavares, Consultant for Forefront LLC and Peer Reviewer(s): Melissa Johnson, Regional Monitor, Department of Juvenile Justice; Ophelia Ciesicki, Youth Advocate Program Inc; Shanda Hope – Arnette House; and Jarma Morgan – Family Resources Clearwater. Agency representatives from YFA New Beginnings present for the entrance interview were Amanda Kilian, Vice President of Quality Improvement and Compliance, Felicia Jones, Program Director; Autumn Gillespie, Residential Supervisor; and Michele Almand, Quality Improvement Prevention. The last onsite QI visit was conducted May 25-26,2023.

In general, the Reviewer found that YFA New Beginnings is in compliance with specific contract requirements. **YFA New Beginnings received an overall compliance rating of 100% for achieving full compliance with all 12 applicable indicators** of the CINS/FINS Monitoring Tool. There were no corrective actions or recommendations made as a result of the monitoring visit.

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

2023-2024 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 02-07-2023-2024

Agency Name: YFA- New Beginnings	**Monitor Name: Marcia Tavares, Lead Reviewer**
Contract Type : CINS/FINS	**Region/Office: 18377 Sheriff Mylander Way, Brooksville, FL 34601**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): February 7-8, 2024**

Major Programmatic Requirements	**Explain Rating**					**Ratings Based Upon:** **I = Interview** **O = Observation** **D = Documentation** **PTV = Submitted Prior To Visit** **(List Who and What)**	**Notes** **Explain Unacceptable or Conditionally Acceptable:**
	Unacceptable	**Conditionally Unacceptable**	**Fully Met**	**Exceeded**	**Not Applicable**		
I. Administrative and Fiscal							
DJJ Quality Improvement Peer Reviewer a. Provider shall demonstrate that a minimum of two (2) staff members have been trained to be certified as DJJ QI Peer reviewers. Provider shall participate in a minimum of one (1) on-site quality assurance review of a similar type of program in another judicial circuit during each 12-month period of the contract, if requested.	☐	☐	☒	☐	☐	The provider currently has two certified peer reviewers namely: Michele Almand and Kelley Scott. Both are scheduled to participate in a QI review for the current FY.	No recommendations and/ or corrective actions required.
Additional Contracts a. Provider shall provide a listing of all current federal, state, or local government contracts, as well as other contracts entered into with for profit and not-for-profit organizations. Such a listing shall identify the awarding entity and contract start & end dates. **PTV**	☐	☐	☒	☐	☐	Documentation: The provider submitted a list of 4 additional funders for FY2023-2024 as follows: DHHS Basic Center Grant, Department of Health, and Kids Central. The program also maintains interagency agreements and Memorandums of Agreement (MOUs) with schools, mental health, and other local providers.	No recommendations and/ or corrective actions required.
Limits of Coverage a. Provider shall provide and maintain during this contract, the following minimum kinds of insurance: Worker's	☐	☐	☐	☒	☐	Documentation: A current certificate of insurance coverage from Marsh & McLennan Agency was provided to show evidence of all required	No recommendations and/ or corrective actions required.

2023-2024 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
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Compensation and Employer's liability insurance as required by Chapter 440, F.S. with a minimum of $100,000 per accident, $100,000 per person and $500,000 policy aggregate. Commercial General Liability with a limit of $500,000 per occurrence, and $1,000,000 policy aggregate. Automobile Liability Insurance shall be required and shall provide bodily injury and property damage liability covering the operation of all vehicles used in conjunction with performance of this contract, with a minimum limit for bodily injury of $250,000 per person; with a minimum limit for bodily injury of $500,000 per accident; with a minimum limit for property damage of $100,000 per accident and with a minimum limit for medical payments or $5,000-$10,000 per person. Florida Network is listed as payee or co-payee. **PTV**						coverage with sufficient limits and effective dates within this contract period. Insurers listed: Alliance of Nonprofits for Insurance for commercial, umbrella, and auto insurance. Commercial General liability coverage from 07/01/2023 - 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. Accident), Umbrella liability from 07/01/2023 - 07/01/2024 with limits of $3,000,000 for each occurrence and $3,000,000 aggregate Worker's Compensation and Employer's liability with Benchmark Insurance Company for	

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						07/01/2023 - -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. Professional Liability 07/01/2023 - 07/01/2024 $1,000,000/ $3,000,000 Abuse /Molestation 07/01/2023 - 07/0/2024 $1,000,000/ $3,000,000. The Florida Network is listed as certificate holder.	
External/Outside Contract Compliance a. Provider has corrective action item(s) cited by an external funding source (Fiscal or Non-Fiscal). **ON SITE**	☐	☐	☐	☐	☒	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 a. Agency must have employee and fiscal policy/procedures manuals that are in compliance with GAAP and provide sound internal controls. Agency maintains fiscal files that are audit ready. **PTV**	☐	☐	☒	☐	☐	Documentation: Fiscal Policies and Procedures are contained under "Fiscal Management" in the agencies policy and procedure manual and were last reviewed September 2023. The procedures reviewed appear to be consistent with GAAP and provide for	No recommendations and/ or corrective actions required.

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						sound internal controls. Procedures are included for general ledger, payroll, petty cash, computer backup, and other relevant financial processes.	
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**	☐	☐	☒	☐	☐	YFA provided a General Ledger for the current FY. The agency maintains a detailed general ledger that is structured to track all funding sources as well as activities for the CINS/FINS program.	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 how it is to be reconciled.	No recommendations and/ or corrective actions required.
d. Financial records and reports are current. Includes bank statements reconciled within 6 weeks of receipt. Vendor invoices past 6 months. Invoices are submitted on a monthly basis with supporting documentation.	☐	☐	☒	☐	☐	Documentation and Observation. Reviewed Bank Statements and Bank Reconciliations for July-December 2023 for operating bank account held with PNC bank. Financial Statements	No recommendations and/ or corrective actions required.

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	Explain Rating						
Major Programmatic Requirements	**Unacceptable**	**Conditionally Unacceptable**	**Fully Met**	**Exceeded**	**Not Applicable**	**Ratings Based Upon:** **I = Interview** **O = Observation** **D = Documentation** **PTV = Submitted Prior To Visit** **(List Who and What)**	**Notes** **Explain Unacceptable or Conditionally Acceptable:**
(Disbursements/invoices are approved & monitored by management). **ON SITE**						are reported on a monthly basis and were found to be current. Bank reconciliations are conducted typically at the end of each month for the activities and bank statements for the preceding month. Invoices are submitted on a monthly basis with supporting documentation.	
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**	☐	☐	☐	☐	☒	A letter dated December 1, 2023 from the VP of Finance was provided as documentation that FNYFS funds are not used for asset purchases.	No recommendations and/ or corrective actions required.
f. Agency submits payroll taxes and deposits (and retirement deposits as applicable), Employee IRS Form W-2 and Independent Contractors IRS Form 1099 forms prior to federal requirements. **ON SITE**	☐	☐	☒	☐	☐	Documentation: The provider contracts with Paylocity for payroll services. Proof of bi-weekly payroll tax payments made by Paylocity was provided in compliance with the requirement of submission of employee payroll taxes and deposits.	No recommendations and/ or corrective actions required.

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g. Budget to actual reports prepared and reviewed by appropriate management. Variance from the budget are investigated and explained. **PTV/ON SITE**	☐	☐	☒	☐	☐	Documentation: Agency provided a Statement of Revenues and Expenditures report to show year-to-date budget to actual activities for the CINS/FINS program for the current FY through 12/31/2023. Variances in budget are monitored on a regular basis and are discussed with the Board.	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 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**	☐	☐	☒	☐	☐	Documentation: The agency provided the most recent audit report completed by Reeder & Associates, PA, CPA for period ending June 30, 2022. A letter was also provided by the auditors stating the current audit as of June 30, 2023, has been delayed due to extended delays by the State of Florida. It is anticipated the audit will be completed no later than March 15, 2024	No recommendations and/ or corrective actions required.

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i. Agency maintains confidentiality policy with written policies and procedures to ensure the security and privacy of all employee and client data. Personal information is not easily accessible. Agency maintains a backup system in case of accidental loss of financial information. Security procedures are in place to protect laptops. Obsolete documents are shredded and computer hard drives are wiped prior to discarding. **ON SITE**	☐	☐	☒	☐	☐	Documentation: Policies and procedures for MIS Backup Procedures, MIS Security Procedures, Risk Management, and Agency Records were reviewed. A daily back-up is performed on all information saved on various servers throughout the agency. All laptops and computers were protected with up-to-date antivirus software.	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 positions for YFA – New Beginnings, which included current salaries. Documentation indicated salary changes for all shelter direct care staff was a minimum $19/hour effective July 29, 2023. Counseling staff's salary was previously above $19/hour.	No recommendations and/ or corrective actions required.

CONCLUSION

YFA New Beginnings has met the requirements for the CINS/FINS contract as a result of full compliance with 12 applicable indicators of the Administrative and Fiscal Contract Monitoring Tool. Two of the 14 indicators were not applicable because 1) the program does not have any corrective actions with any external funding source, and 2) Florida Network funds is not used to purchase inventory. Consequently, **the overall compliance rate for this contract monitoring visit is 100%.** There are no corrective actions cited or recommendations made as a result of the contract monitoring visit. Overall, the provider is performing satisfactorily in meeting the fiscal and administrative terms of its contract. In addition, the majority of indicators reviewed were carried out in a manner which meets the standard described in the report findings.

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

Florida Network of Youth and Family Services Quality Improvement Program Report

Review of Youth and Family Alternatives, Inc. - New Beginnings, Brooksville
CINS/FINS Program

February 7-8, 2024

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	Satisfactory
1.05 Analyzing and Reporting Information	Satisfactory
1.06 Client Transportation	Satisfactory
1.07 Outreach Services	Satisfactory

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

Standard 2: Intervention and Case Management

2.01 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)	Not Applicable

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

Rating Definitions

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

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

Reviewers

Members

Marcia Tavares - Lead Reviewer Consultant-Forefront LLC/Florida Network of Youth and Family Services
Melissa Johnson – Regional Monitor, Department of Juvenile Justice
Ophelia Ciesicki – Youth Advocate Program Inc
Shanda Hope – Arnette House
Jarma Morgan – Family Resources Clearwater

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

Documents Reviewed

	Accreditation Reports	X	Table of Organization		Visitation Logs
X	Affidavit of Good Moral Character	X	Fire Prevention Plan	X	Youth Handbook
X	CCC Reports	X	Grievance Process/Records	3	# Health Records
X	Logbooks		Key Control Log	5	# MH/SA Records
	Continuity of Operation Plan	X	Fire Drill Log	15	# Personnel /Volunteer Records
X	Contract Monitoring Reports	X	Medical and Mental Health Alerts	8	# Training Records
	Contract Scope of Services	X	Precautionary Observation Logs	6	# Youth Records (Closed)
X	Egress Plans	X	Program Schedules	4	# Youth Records (Open)
X	Fire Inspection Report	X	List of Supplemental Contracts		# Other: ___
	Exposure Control Plan	X	Vehicle Inspection Reports		

Observations During Review

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

Surveys

5	# 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 (YFA) Inc. operates three crisis shelters in the State of Florida that are contracted with Florida Network of Youth & Family Services, Inc. New Beginnings, located in Brooksville, Florida serves Hernando, Sumter, and Citrus Counties. The shelter is licensed for 18 beds and offers 24-hour availability, youth supervision, food and clothing, life skills education, crisis counseling, individual and family counseling, recreation and leisure activities, and case management services. Educational services are provided by the local school district, in the county in which the shelter is located. The community counseling north team for CINS/FINS also serves youth and families in the same counties and coordinate the delivery of community services to families and children in care. Funding through CINS/FINS allows the agency to serve both male and female youth up to seventeen years old that are locked out, runaway, ungovernable and/or truant, homeless, abuse, neglected, or at-risk. The agency also provides specialized services to youth who meet the criteria for Staff Secure shelter, Domestic Minor Sex Trafficking, and youth referred by the Juvenile Justice Court System for domestic violence, probation respite, and Family/Youth Respite Aftercare Services (FYRAC). The youth census during the QI visit was 16 youth (4 DCF, 12 CINS). YFA is currently accredited by the Council of Accreditation (COA) and was recently re-accredited through October 31, 2024.

The following programmatic updates were provided by the agency:

Staffing

Significant changes have occurred since the last onsite review. The Program Director position has been filled as of 09/25/23. Two Residential Supervisors' positions were filled in August 2023. One Residential Supervisor transferred within the company to another position January 2024. A fulltime cook started in September 2023. The fulltime Counselor position is on hold at this time. A new training coordinator position was added to increase compliance with training requirements. The training coordinator is responsible for maintaining training records and facilitate some of the required trainings. At the time of the review, there was one residential youth care lead and a fulltime youth care staff position vacant.

Program Updates

Groups are provided five times per week via interactions with counselors, staff and volunteer groups. Youth are supported through life skills enhancements via laundry, dishes and daily chores. A reward system was put in place for making their bed, keeping their living space clean, and yard work. Youth are taken on group outing that pertain to team building skills.

The agency recently changed its electronic file system from Solarity to Mindshare. Files are maintained both electronically in and hard copy format.

The program implemented weekly meetings with shelter leadership staff who gather to conduct mock reviews of selected indicators and support each other through team building.

Facility

The facility was recently painted inside in the common areas and dorms. A new stove was recently installed as well. The shelter recently received a donation of two dryers and one washer. The shelter also received living room desk chairs, new office chairs, lamp and table. New ceiling tiles were replaced in needed areas of the shelter.

Funding/Finance

New Beginnings has continued to operate in a deficit this fiscal year due to carrying over a deficit from FY2022-2023. However, it is projected that we will break even in March 2024. The shelter has increased its youth intake to 18 max along with staffing. The number of filled positions have increased over the past couple of months which allows the shelter to slowly increase its census with the goal of being at 80% licensed capacity by the end of the current fiscal year. New Beginnings has received $7,532.72 in donations from various community organizations, including the Philippine-American Association, the Rotary Club of Brooksville, Saint Thomas Clinic, the Rotary Club of Spring Hill, Lake Lindsey Methodist Church, and Symphony Salvage.

Governance and Community

The program is continuing to increase its local collaboration and engagement by hosting a monthly leadership meeting with other providers in the community. Mental Health agreements in place include BayCare, Hernando Sheriff Department, and Mobile Response Team that conducts Suicide Assessments. Recent Board of Directors changes include the addition of Melanie Waxler (Pasco County Schools) and Amanda Hart 12/2023 (Blackjack Media Group).

Major Challenges

A major challenge within New Beginnings is employee knowledge retention from agency required trainings. Filling the Program Director along with the Residential Supervisor role was difficult at first but now those positions are filled, and the program can move on track with goals set forth. YFA has transitioned its electronic healthcare record to Mindshare in 2023; some challenges exist but the team is working hard to learn the system.

Narrative Summary

New Beginnings is under the leadership of a management team that consists of a Senior Director, a residential Program Director, two residential Shelter Supervisors, a Community Counseling Program Director, a Training Specialist, a licensed counselor, and four residential team leads. Additional program staff include a registered nurse, an outreach coordinator, and an office specialist.

Standard 1: There are seven indicators for Standard 1. Indicator 1.01 Background Screening of Employees/Volunteers was rated **Satisfactory with Exception**, Indicator 1.02 Provision of an Abuse Free Environment was rated **Satisfactory,** Indicator 1.03 Incident Reporting was rated **Satisfactory with Exception,** Indicator 1.04 Training Requirements was rated **Satisfactory with Exception**, Indicator 1.05 Analyzing and Reporting Information was rated **Satisfactory,** Indicator 1.06 Client Transportation was rated **Satisfactory**, and Indicator 1.07 Outreach Services was rated **Satisfactory.**

Standard 2: There are nine indicators for Standard 2. Indicator 2.01 Screening and Intake was rated **Satisfactory with Exception**, Indicator 2.02 Needs Assessment was rated **Satisfactory with Exception**, Indicator 2.03 Case/Service Plan was rated **Satisfactory with Exception**, Indicator 2.04 Case Management and Service Delivery was rated **Satisfactory with Exception**, 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**, and Indicator 2.09 Stop Now and Plan (SNAP) was rated **Not Applicable**.

Standard 3: There are seven indicators for Standard 3. Indicator 3.01 Shelter Environment was rated **Satisfactory with Exception**, 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**, Indicator 3.05 Behavior Management Strategies was rated **Satisfactory**, Indicator 3.06 Staffing and Youth Supervision was rated **Satisfactory**, and Indicator 3.07 Video Surveillance System was rated **Satisfactory with Exception**.

Standard 4: There are five indicators for Standard 4. Indicator 4.01 Healthcare Admission Screening was rated **Satisfactory with Exception**, Indicator 4.02 was rated **Satisfactory**, Indicator 4.03 was rated **Satisfactory**, Indicator 4.04 Medical/Mental Health Alert Process was rated **Satisfactory with Exception**, and 4.05 Episodic/Emergency Care was rated **Satisfactory with Exception**.

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

None of the indicators reviewed received a Limited or Failed rating.

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:** The narrative write-up is a thorough summary of each assigned QI indicator, explaining how finding(s) are determined.	**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 with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 1.01	**YES** If NO, explain here: The provider has multiple policies and procedures, RGC - 1.01 - Background Screening of Employees/Volunteer, Interns, Contracted Providers, and HR 230 - Recruitment and Hiring. Both policies were approved on 10/13/2023 by the Chief Executive Officer (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: 14 new hires files
Total number of 5 Year Re-screen Employee Files: 1 re-screened employee file
Staff Position(s) Interviewed (No Staff Names): Vice President of Quality Improvement and Compliance
Type of Documentation(s) Reviewed: Staff roster, Department of Juvenile Justice Background Screening results, Pre-Employment assessment tool, E-Verify, Annual Affidavit of Compliance with Level 2 Screening Standards

All positions providing direct services to youth has successfully passed pre-employment suitability assessment on the initial attempt.	**Exception**	The agency uses the Criteria Basic Skills Test (CBST) pre-assessment tool, that was implemented December 19, 2019, to determine eligibility for employment. An eligible pass rate is a minimum raw score of 25. The tool was utilized to screen all 14 applicable new hires. All 14 new staff successfully passed the CBST; however, one of the 14 staff did not complete the pre-employment assessment tool prior to hire.	Criteria pre-assessment tool was completed on 1/29/2024, after the hire date of 11/27/2023 for one new staff.
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**	All 14 new staff received passing scores.	

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**	None of the new staff were prior agency employees.	
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. *(Employees who have had a break in service and are in good standing may be reemployed with the same agency without background screening if the break is less than 90 days.)*	**Compliance**	All 14 new hire background screenings were initiated prior to DJJ hire dates with eligibility documented on the Clearinghouse results. No exemptions were applicable. There were no eligible volunteers in the program during the review period.	
Five-year re-screening is completed every 5 years from the date of last screening.	**Compliance**	The program had one staff who met the criteria for 5-year re-screening. The staff was re-screened on time and had valid retained prints in the clearinghouse.	
Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?	**Compliance**	The program had a signed and notarized Annual Affidavit of Compliance with Level 2 Screening Standards that was completed, notarized, and emailed to the Background Screening Unit (BSU) on December 29, 2023, prior to the January 31st deadline.	
Proof of E-Verify for all new employees obtained from the Department of Homeland Security	**Exception**	The program provided E-verify documentation from the Department of Homeland Security for 13 of the 14 new staff, verifying authorization to work.	The program did not have the required proof of E-Verify for one new staff hired; however, a copy of Form I-9 verifying identity and eligible work documents was maintained in the staff's file.
Additional Comments: **There are no additional comments for this indicator.**			
1.02: Provision of an Abuse Free Environment			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 1.02	**YES**		
	If NO, explain here:		
	The provider has the required policy and procedure RGC 1.02 - Provision of an Abuse Free Environment that was approved 10/12/2023 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.*

Staff Position(s) Interviewed (No Staff Names): Shelter Program Director, Residential Supervisor
Type of Documentation(s) Reviewed: client handbook, client grievance file, code of conduct,
Describe any Observations: abuse hotline postings, grievance box, grievance forms

Agency has a code of conduct of policy and there is evidence that staff are aware of agency's code of conduct.	**Compliance**	Agency has a code of conduct policy that is included in training and posted in a common area.	
The agency has a process in place for reporting and documenting child abuse hotline calls.	**Compliance**	Employees are required to report all known or suspected cases of abuse and/or neglect and youth have unimpeded access to self-report. The program documents child abuse hotline calls on a report form which is maintained in the youth's file. A total of three non-institutional abuse calls were reported during the review period.	
Youth were informed of the Abuse and Contact Number	**Compliance**	All youth are told about the abuse and contact number and have full access to that information. This is completed during orientation and documented on the Client Orientation checklist.	
Grievance			
The program must have an accessible and responsive grievance process for youth to provide feedback and address complaints. Program director/ supervisor will have access to and manage grievances unless it is towards themselves.	**Compliance**	The program has an accessible and responsive grievance process for youth to provide feedback and address complaints. Agency supervisor has access to and manages grievances.	
Shelter only: Grievances are maintained on file at minimum for 1 year.	**Compliance**	The shelter program director maintains a record of grievances for a minimum of one year.	
Shelter only: 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**	Agency has formal grievance procedures for youth including grievance forms, and a locked box which are accessible to youth in a common area.	
Shelter only: There is evidence that grievance boxes are checked by management or a designated supervisor at least daily as evidenced in the program logbook.	**Compliance**	Agency has evidence that grievance boxes are checked by supervisor daily and logged in a log box daily. Grievance box checks, and documentation in the program logbook, for six randomly selected 2-week periods each month from August 2023-January 2024 was conducted. Evidence supported the grievance boxes were checked daily resulting in 67 documented grievance box checks for 65 days reviewed.	

Shelter only: All grievances are resolved within 72 hours and documented by program director/supervisor or escalated to higher leadership if grievance involves them directly.	**Compliance**	Agency has evidence that all grievances were resolved within 72 hours and are documented by supervisor and signed by director	
1.03: Incident Reporting			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 1.03		**YES** If NO, explain here: The provider has the required policy and procedure RM760 - Incident Reporting, that was approved 9/25/2023 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.*			
Staff Position(s) Interviewed (No Staff Names): Shelter Director, Residential Specialist **Type of Documentation(s) Reviewed CENTRAL COMMUNICATIONS CENTER (CCC) Incidents Detail Report and agency Internal Reports** **Describe any Observations: CCC number posted in facility**			
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	**Exception**	DJJ CCC Summary report with 25 incidents between 8/7/2023 and 2/7/2024 was reviewed and compared to the agency's CCC report submission. Twenty-one of the 25 CCC incidents were reported within the required 2- hour timeline.	Four of the 25 incidents were not reported to CCC within the 2 hour timeframe required. Dates of the four incidents are: 9/23/23,10/4/23, 12/14/23, and 1/15/24.
The program completes follow-up communication tasks/special instructions as required by the CCC	**Exception**	All applicable follow up tasks were completed as requested with the exception of one incident on 9/23/2023.	No follow-up tasks were evident for DJJ's instructions to the program for an incident that occurred on 9/23/23. CCC does not mark the incident as closed and documentation supporting receipt of the information requested by CCC was not present.
Agency internal incidents are documented on incident reporting forms and all CCC reportable incidents were consistently reported to CCC as required.	**Compliance**	All incidents reported to CCC were found to be documented on an agency incident reporting form.	

Incidents are documented in the program logs and on incident reporting forms	**Exception**	A review was conducted of eight randomly selected CCC incidents to determine if incidents are documented in the program log. Evidence supported three of the eight CCC incidents were recorded in the program logbook.	Five of the eight incidents were not noted in the logbook (four were related to missed medication and/or were medication related and one was due to inappropriate sexual activity between 2 youth).
All incident reports are reviewed and signed by program supervisors/ directors	**Compliance**	All 25 incidents were reviewed and signed by the program director. The reportable incidents were classified as follows: 5 – Mental Health 15 – Medical 3 - program disruption 2 – complaint against staff	
1.04: Training Requirements (*Staff receives training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions*)			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 1.04		**YES** If NO, explain here: The provider has the required policy and procedures RGC 1.04 - Training, that was approved 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 Staff Files: 4 **Total number of Annual In-Service Staff Files:4** **Annual Training Plan Timeframe** (*Program timeframe for annual trainings*)**: staff's anniversary date** **Staff Position(s) Interviewed** *(No Staff Names)* **: Quality Improvement Specialist** **Type of Documentation(s) Reviewed: Staff training records, annual training plan**			
First Year Direct Care Staff			
All direct care staff have completed new hire pre-service training requirements for safety and supervision as required.	**Compliance**	All four direct care staff members have completed the required new hire pre-service safety and supervision training. Two of the four completed some of the pre-service trainings outside of the 90 days required; however, neither staff worked independently with youth in the interim.	
All staff completed the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days from date of hire.	**Exception**	Three of four direct care staff completed new hire pre-service training requirements for Justice (DOJ) Civil Rights & Federal Funds training within 30 days from date of hire.	One of four staff, a community counseling case manager hired 6/28/23, did not complete the Civil Rights training until 1/2/24.

All direct care CINS/FINS staff (full time, part time, or on-call) demonstrated a minimum of 80 hours of training or more for the first full year of employment.	**Exception**	All four first year staff are within their first year of hire. Three of the four records showed training hours between 52-62 hours with adequate time remaining to complete the 80 hours required.	One community counseling staff record did not include a training log that documents all trainings completed and the number of hours.
All staff receives all mandatory training during the first 90 days of employment from date of hire.	**Exception**	Two of four first year staff completed all mandatory trainings during the first 90 days of employment.	Two of four new staff did not complete all mandatory trainings due within the 90 days required. One residential staff was late completing seven trainings and a second staff (community counseling) was late completing 17 trainings due within the 90 days and was missing motivational interviewing training that is scheduled for 4/4/24. Email provided by Human Resources indicated the staff was out for FMLA from 7/31/23-8/22/23 which contributed to missing the 90 day timeframe.
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**	One applicable staff member responsible for entering NIRVANA completed the NIRVANA.	
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**	Training Coordinator provided proof that CIN/FINS training has been postponed due to resignation of DJJ attorney and no rescheduled date has been provided. One applicable staff has four months remaining to complete the training.	
Non-licensed Mental Health Clinical Shelter Staff (within first year of employment)			
Documentation of non-licensed mental health clinical staff person's training in Assessment of Suicide Risk form or written confirmation by a licensed mental health professional of training (includes date, signature and license number of the licensed mental health professional supervisor).	**No eligible items for review**	The program has not hired any new non-licensed mental health clinical shelter staff person during the review period.	

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).*	**Compliance**	Four annual staff training records reviewed revealed all direct care staff completed and/or is on target to complete the 40 hours of mandatory refresher Florida Network, SkillPro, and job-related training annually.	
Required Training Documentation			
The agency has a training plan that includes all of the required training topics including the pre-service and in-service.	**Exception**	The agency has a training plan that covers all of the mandatory training topics, including pre-service and in-service. Six of the eight training records reviewed included a training plan/log that shows all required and completed trainings.	The two community counseling training records included training certificates and transcripts but were missing a training plan and/or training log.
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.	**Compliance**	The agency has a designated staff member responsible for managing all employee's training files and completes routine tracking and reviews of staff files 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**	Six of the eight training records reviewed were maintained in a training file which included 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.	The two community counseling training records were not maintained in a dedicated training file.
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** If NO, explain here: The provider has multiple policies and procedures that fulfill the requirement of the indicator as follows: QI300-Continuous Quality Improvement Process/CQI Teams; QI310-Data Collection and Evaluation; QI320-Quality Improvement Review of Agency Files; QI330-CQI Worksheet; and QI340-Stakeholder Feedback. All of the policies were approved 10/19/22 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.*

Staff Position(s) Interviewed (No Staff Names): Vice President of Quality Improvement and Compliance (VPQI), Quality Improvement Specialist (QIS) **Type of Documentation(s) Reviewed: CQI Plan FY2023-2024, CQI Policy and Procedures, Residential/Community Counseling Scoring Tool, quarterly risk management score card reports, Stakeholder Involvement Team (SIT) reviews consumer satisfaction surveys board of director meeting minutes, program committee/staff meeting agendas/minutes, and NetMIS data reports.**			
Case record review reports demonstrate reviews are conducted quarterly, at a minimum	**Compliance**	Quarterly prevention reviews, led by the QI coordinator, are conducted to review youth files for shelter and Community Counseling (CINS FINS) program, utilizing experienced staff within each program. Case record reviews are documented on the Residential/Community Counseling Scoring Tool and were conducted for 26 residential and 18 community counseling records for the first and second quarters, FY2023-2024.	
The program conducts reviews of incidents, accidents, and grievances quarterly, at a minimum	**Compliance**	The agency's Risk Prevention and Management Team - CQI Committee convene quarterly to aggregate data and assess for any trends. Data reviewed by the committee is documented on score cards including facility safety issues, types of incidents, medication errors, transportation incidents, contraband, restrictive behavior management, service modalities, workers compensation, legal issues, and grievances. Evidence of quarterly data collected and reviews were observed for the 1st quarter (8/28/23) and 2nd quarter (12/5/23) of the current FY.	
The program conducts an annual review of customer satisfaction data	**Compliance**	The Stakeholder Involvement Team (SIT) reviews consumer satisfaction surveys received from YFA programs, including from youth and their families served by Prevention programs and caregivers of CBC children. The SIT Team Lead compiles surveys for review and discussion at the SIT quarterly meeting. Results of these surveys are evaluated for trends and patterns and recommendations are made to strengthen practices if needed. Evidence of quarterly surveys was observed for the 1st quarter (10/19/23) and 2nd quarter (1/22/24) of the current FY.	
The program demonstrates a monthly review of the statewide End-of-Month ("EOM") report generated by the Florida Network Office. This includes monthly data, fiscal year to date data, benchmarks for residential and community counseling, screening data, report card measures, follow-up reporting measures.	**Compliance**	EOM reports are emailed from the VP of Technology to the leadership staff. Monthly outcomes reports include a link to share with staff and includes the Florida Network report card, bed days, medication passes, % medication errors, cumulative number of medication errors, and bed utilization rate. Copies of monthly reports for September-December were reviewed and verified this practice.	

The program has a process in place to review and improve accuracy of data entry & collection	**Compliance**	The YFA Data Analyst is responsible for verifying timely submission and accuracy of program data that is captured in NetMIS. The Data Analyst communicates with programs to reconcile any discrepancies and maintains data tracking systems to ensure contractual requirements are met, and generates data reports for distribution to management and to analyze data for trends and patterns.	
There is documentation that findings are regularly reviewed by management and communicated to staff and stakeholders.	**Compliance**	Compliance issues or areas of concern noted in any performance reviews and reports are reviewed by management and an internal plan is developed to address areas that need improvement. The program also conducts mock reviews of specific QI indicators each month to identify current issues. Documentation supported the agency regularly reviews findings and implements corrective actions that are monitored by the QI team. Communication to management and staff is verified through emails sent.	
There is evidence the program demonstrates that program performance is routinely reviewed with the Board of Directors. 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 VPQI provided minutes of board meetings held during the review period. Meeting minutes include a CQI report, operations data, strategic planning, and COA update to support program performance data reports are shared with the Board of Directors.	
There is evidence that strengths and weaknesses are identified, improvements are implemented or modified, and staff are informed and involved throughout the process.	**Compliance**	CQI teams and management review all findings on a regular basis and communicates them to staff and stakeholders. Strengths and weaknesses are identified, improvements are implemented or modified and staff are informed and involved throughout the process. A CQI Worksheet (corrective action plan) is used to remediate negative trends, identified either through the routine review process or through regular review of data and performance by program management.	
Additional Comments: **There are no additional comments for this indicator.**			

1.06: Client Transportation			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 1.06		**YES** If NO, explain here: The provider has the required policy and procedure RGC 1.06-Client Transportation, that was approved 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.*			
Dates or Timeframe Reviewed: August 2023-January 2024 **Staff Position(s) Interviewed (No Staff Names): QIS** **Type of Documentation(s) Reviewed: transportation logs for Chrysler and Kia minivans, eligible drivers DMV Check, auto insurance policy** **Describe any Observations: single transport entries were observed**			
Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	**Compliance**	The provider has implemented a transportation policy with drivers approved by the administration. A list of 28 agency approved drivers is maintained by the program. The program has two vans used to transport youth.	
Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	**Compliance**	All drivers named on the approved drivers' list have current driver's licenses and are covered under the agency's insurance policy. The program provided a list of staff driver's license status based on DMV check conducted. The auto insurance policy was also provided for review.	
Agency's Transportation policy prohibit transporting a client without maintaining at least one other passenger in the vehicle during the trip and include exceptions in the event that a 3rd party is NOT present in the vehicle while transporting	**Compliance**	The provider's policy outlines the importance of avoiding single youth transports. It also specifies that in the event of a single transport supervisor pre-approval is required, youth should be sitting in the back and an open line should be maintained.	
In the event that a 3rd party cannot be obtained for transport, the agency's supervisor or managerial personnel consider the clients' history, evaluation, and recent behavior	**Compliance**	The provider's policy includes requirement for single transports to take into consideration the youth's history and recent behaviors prior to approval for transport.	
The 3rd party is an approved volunteer, intern, agency staff, or other youth	**Compliance**	The provider only allows staff to act as approved third parties for transport and transportation documentation lists the names of staff who act as third parties.	

The agency demonstrated evidence via logbook or other written verification that supervisor approval was obtained prior to all single youth transports.	**Compliance**	During the review period, it was observed the program made significant effort to avoid single transport. A total of 26 transport events included a single youth; however, 24 of those trips included a staff as third party. The two single youth transports evidenced prior approval by the supervisor.	
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**	The agency has two vans that have two separate transportation logs. Each log notes the names/ initials of the driver and 2nd party, the date & time of the trip, odometer start and end, number of passengers and purpose of travel along with the destination.	
Additional Comments: **There are no additional comments for this indicator.**			
1.07 - Outreach Services			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 1.07		**YES** If NO, explain here: The provider has the required policy and procedure CS550 - Community Outreach and Education that was approved 9/30/22 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.*			
Staff Position(s) Interviewed (No Staff Names): Quality Improvement Specialist, Outreach Coordinator **Type of Documentation(s) Reviewed: DJJ Meeting Agenda, partnership agreements, NetMIS Outreach report, flyers, pictures of the events, and meeting minutes.**			
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 provider has a designated staff defined by title and job description to conduct outreach activities. The Outreach Coordinator is also designated to participate in local DJJ board, Circuit and council meetings and provided evidence of attendance that includes minutes of the events.	
The program maintains written agreements with other community partners which include services provided and a comprehensive referral process.	**Compliance**	The Outreach Coordinator has written agreements for each community partner which include services provided and a comprehensive referral process.	
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.	**Compliance**	The Outreach Coordinator maintains documentation of outreach activities and enters into NetMIS the title, date, duration, zip code, location description, estimated number of people reached, modality, target audience and topic.	

The program has designated staff that conducts outreach which is defined in their job description.	**Compliance**	The Outreach Coordinator is the designated staff defined by title and job description to conduct outreach activities.	
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** If NO, explain here: The provider has the required policy and procedure RGC 2.01-Eligibility Screening and Intake, that was approved on 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 Open (Residential & Community) Files: 4 **Total number of Closed (Residential & Community) Files: 6** **Staff Position(s) Interviewed** *(No Staff Names)* **: Program Director, QI Specialist** **Type of Documentation(s) Reviewed: Youth records**			
Shelter youth: Eligibility screening form is completed immediately for all shelter placement inquiries.	**Compliance**	All five shelter records demonstrated prompt service accessibility. Screenings were completed on the day services were requested.	
Community counseling: Eligibility screening form is completed within 3 business days of referral by a trained staff using the Florida Network screening form.	**Compliance**	All five community counseling records demonstrated screening forms were completed on the day of service request or the next day of the initial request.	
There is evidence all referrals for service is screened for eligibility and is logged in NetMIS within 72 hours of screening completion.	**Exception**	Nine of ten records reviewed show referrals were screened for eligibility by review of the screening forms and then logged into NETMIS within 72 hours.	One of the ten records reviewed was screened on 12/7/23 but was not logged into Netmis until 12/11/23, beyond the 72 hours required.
Youth and parents/guardians receive the following in writing: a. Available service options b. Rights and responsibilities of youth and parents/guardians	**Compliance**	All records reviewed maintained a document signed by the parent and youth verifying they received information about available service options and their rights and responsibilities.	
The following is also available to the youth and parents/guardians: a. Possible actions occurring through involvement with CINS/FINS services (case staffing committee, CINS petition, CINS adjudication) b. Grievance procedures	**Exception**	During intake, all youth are provided information about the program's grievance procedures. Interview with the program director indicated during intake the parents/guardian are provided a copy of the Florida Network Parents Handbook that explains the possible actions occurring through involvement with CINS/FINS.	No documentation was maintained in the 10 records reviewed that parents/guardian are provided with the Florida Network Parents Handbook.

During intake, all youth were screened for suicidality and correctly assessed as required if needed.	**Compliance**	All records reviewed contained a suicide risk screening. All youth responses were documented and additional assessments were completed as needed,	
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** If NO, explain here: The provider has the required policy and procedure RGC - 2.02 Nirvana, that was approved on 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 Open (Residential & Community) Files: 4 **Total number of Closed (Residential & Community) Files: 6** **Staff Position(s) Interviewed (No Staff Names): Program Director, QI Specialist** **Type of Documentation(s) Reviewed: Youth records**			
Shelter Youth: NIRVANA is initiated within 72 hours of admission	**Exception**	The Nirvana Assessments for four of the five residential records reviewed were all completed within 72 hours of admission and was placed in the case file.	One of the five records reviewed was not in compliance with the indicator RGC 2.03. The youth intake was 10/5/2023 and the Nirvana was initiated on 10/15/2023.
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**	All community counseling records reviewed noted Nirvana assessments were completed within service days of initiation or two to three days after face to face contact.	
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.	**Compliance**	All records reviewed contained a Pre-Nirvana Assessment.	
(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**	All five shelter records reviewed contained a Nirvana Self-Assessment completed by the youth.	

A NIRVANA Post-Assessment is completed at discharge for all youth who have a length of stay that is greater than 30 days.	**Compliance**	All records reviewed contained a post Nirvana-Assessment completed by the assigned counselor.	
A NIRVANA Re-Assessment is completed every 90 days excluding files for youth receiving SNAP services.	**Exception**	Two of the ten youth records reviewed had a length of stay (LOS) over 90 days.	The two community counseling youth records with LOS over 90 days did not have a Nirvana post-assessment completed at discharge.
All files include the interview guide and/or printed NIRVANA.	**Compliance**	All records reviewed contained a printed copy of the Nirvana assessment.	
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** If NO, explain here: The provider has the required policy and procedure RGC- 2.03 Service Development and Service Monitoring, that was approved on 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 Open (Residential & Community) Files: 4 **Total number of Closed (Residential & Community) Files: 6** **Staff Position(s) Interviewed (No Staff Names): Program Director, QI Specialist** **Type of Documentation(s) Reviewed: Youth records**			
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**	All records reviewed contained a treatment plan based on information gathered during the screening, intake and Nirvana.	
Case/Service plan is developed within 7 working days of NIRVANA	**Exception**	Nine of ten case plans reviewed were developed within 7 working days of the Nirvana as indicated by the service plan date.	One of the ten charts reviewed did not have a Case/Service plan developed within seven days of completion of the Nirvana. The youth's intake date was 10/5/2023 and the case plan was initiated on 10/16/2023.

Case plan/service plan includes: 1. Individualized and prioritized need(s) and goal(s) identified by the NIRVANA 2. Service type, frequency, location 3. Person(s) responsible 4. Target date(s) for completion and Actual completion date(s) 5. Signature of youth, parent/ guardian, counselor, and supervisor 6. Date the plan was initiated	**Exception**	All ten service plans reviewed included individualized and prioritized needs and goals identified by the Nirvana, service type, location of services, signature of youth, counselor and supervisor, actual completion dates, and date the plan was initiated. Signature of parent/ guardian was included on six of the case plans. Nine of the 10 case plans included target dates. Frequency of services were indicated on seven of the 10 case plans.	Four of the ten records reviewed did not have parent/ guardian signatures on the case plan. One of the ten records reviewed did not have a target completion date on the case plan. Three of the five residential records reviewed did not have the service frequency.
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**	Five applicable community counseling records reviewed demonstrated case/service plan reviews are completed every thirty days or less.	
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** If NO, explain here: The provider has the required policy and procedure RGC - 2.04 Traditional and Intensive Case Management, that was approved on 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 Open (Residential & Community) Files: 4 **Total number of Closed (Residential & Community) Files: 6** **Staff Position(s) Interviewed (No Staff Names): Program Director, QI Specialist** **Type of Documentation(s) Reviewed: Youth records**			
Counselor/Case Manager is assigned	**Compliance**	All 10 records reviewed included evidence of the counselor's name and credentials assigned to the case.	

The Counselor/Case Manager completes the following as applicable: 1. Establishes referral needs and coordinates referrals to services based upon the on-going assessment of the youth's/family's problems and needs 2. Coordinates service plan implementation 3. Monitors youth's/family's progress in services 4. Provides support for families 5. Monitoring progress of court ordered youth in shelter 6. Makes referrals to the case staffing to address problems and needs of the youth/family 7. Accompanies youth and parent/guardian to court hearings and related appointments 8. Refers the youth/family for additional services when appropriate 9. Provides case monitoring and reviews court orders 10. Provides case termination notes 11. Provides follow-up after 30 days post discharge 12. Provides follow-up after 60 days post discharge	**Exception**	As observed in the case files, the counselors established referrals and coordinated referrals based on the needs of the family, implemented and coordinated the service plans, provided support for the families, monitored the youth and family progress and documented it in the case notes, and provided case termination notes in the discharge summary and in the case notes for the clients that were terminated. Referrals were observed for nine applicable records reviewed. One applicable youth was monitored for progress due to being court ordered to the shelter. Four cases out of the 10 reviewed were due for a 30 day follow-up and three were completed. All three cases due for a 60-day follow-up showed they were completed.	One residential record closed on 9/22/23 was missing case termination notes. Also, one community counseling record closed on 1/4/24 did not have a 30 post discharge follow-up.
The program maintains written agreements with other community partners that include services provided and a comprehensive referral process	**Compliance**	The program has interagency agreements with local partners to include, but not limited United Way, Lighthouse for the Visual Impaired, Pasco Sheriff Office Special Victims, BayCare, and Youth and Family Alternatives.	
Additional Comments: **There are no additional comments for this indicator.**			
2.05 - Counseling Services			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.05		**YES** If NO, explain here: The provider has the required policy and procedure RGC 2.05 - Community Counseling and Residential Group Care Services, that was approved on 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 Open (Residential & Community) Files: 4 **Total number of Closed (Residential & Community) Files: 6** **Staff Position(s) Interviewed (No Staff Names): Program Director, QI Specialist** **Type of Documentation(s) Reviewed: Youth records**			
Shelter Program			
Shelter programs provides individual and family counseling	**Compliance**	Individual and family counseling was observed in the case file notes for the applicable shelter youth files reviewed.	
Group counseling sessions held a minimum of five days per week	**Compliance**	Group log books reviewed supported weekly groups are held five days a week.	

Groups are conducted by staff, youth, or guests and group counseling sessions consist of : 1. A clear leader or facilitator 2.Relevant topic - educational/informational or developmental 3. Opportunity for youth to participate 4. 30 minutes or longer	**Compliance**	The shelter provided group counseling sessions five days a week as evidenced by group sessions logged in the group log book.	
Documentation of groups must include date and time, a list of participants, length of time, and topic.	**Compliance**	It was observed that group sessions consisted of a leader/facilitator, relevant topic, opportunity for youth to participate and that the groups sessions lasted 30 minutes are longer.	
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**	All five community counseling records reviewed included a treatment plan tailored to stabilize the family while addressing the presenting problem.	
Counseling Services			
There is evidence the program completes review of 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 of the files reviewed reflected coordination between presenting problem(s), psychosocial assessment, case/service plans, case/service plan reviews, case management, and follow-up when applicable. The Program Director meets with staff monthly to discuss case concerns and progress.	
Maintain individual case files on all youth and adhere to all laws regarding confidentiality.	**Compliance**	The program maintains individual case files on each youth and adheres to the law regarding confidentiality. Each case file had confidential on the front and back.	
Case notes maintained for all counseling services provided and documents youth's progress.	**Compliance**	All records reviewed included chronological case notes of service delivery and youth's progress.	
On-going internal process that ensures clinical reviews of case records and staff performance.	**Compliance**	The program has an internal process that ensures clinical reviews of case records and staff performance. The Program Director meets monthly with staff.	

When an intake is conducted through virtual means, consent is confirmed by the counselor, documented in the file, and reviewed with the supervisor during supervision/case review. There is written documentation provided in the youths file for reasons why virtual sessions are in the best interest of the youth and family.	**No eligible items for review**	None of the records reviewed were provided a virtual intake.	
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: The provider has the required policy and procedure RGC 2.06 - Adjudication/Petition Process, that was approved on 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 Open (Residential & Community) Files: 4 **Total number of Closed (Residential & Community) Files: 6** **Staff Position(s) Interviewed (No Staff Names): community counseling Program Director, QI Specialist** **Type of Documentation(s) Reviewed: Youth records**			
Must include: a. DJJ rep. or CINS/FINS provider b. Local school district representative	**Compliance**	Per interview with the community counseling Program Director, there were no case staffing requests since the last QI review. Per the policy and procedure, the case staffing committee consists of a DJJ Representative, the CINS/FINS provider, and a school district representative.	
Other members may include: a. State Attorney's Office b. Others requested by youth/ family c. Substance abuse representative d. Law enforcement representative e. DCF representative f. Mental health representative	**Compliance**	Per the program's policy and procedure, other members of the committee may include: State Attorney's Office; others requested by youth/ family; substance abuse representative; law enforcement representative; DCF representative; and mental health representative.	
The program has an established case staffing committee, and has regular communication with committee members	**Compliance**	Per the provider's policy and procedures, the program has a case staffing committee who will be contacted within five working days if a request for case staffing is made.	
The program has an internal procedure for the case staffing process, including a schedule for committee meetings	**Compliance**	Internal procedures for the case staffing are outlined in the provider's policy and procedures reviewed.	
The youth and family are provided a new or revised plan for services	**No eligible items for 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**		
If applicable, the program works with the circuit court for judicial intervention for the youth/family	**No eligible items for review**		
Case Manager/Counselor completes a review summary prior to the court hearing	**No eligible items for review**		
Additional Comments: **There are no additional comments for this indicator.**			
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:	
		The provider has the required policy and procedure RGC 2.07 - Youth Records, that was approved on 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 Open (Residential & Community) Files: 4 **Total number of Closed (Residential & Community) Files: 6** **Staff Position(s) Interviewed (No Staff Names): Program Director, QI Specialist** **Type of Documentation(s) Reviewed: Youth records**			
All records are clearly marked 'confidential'.	**Compliance**	All 10 case files reviewed were marked confidential on the front and back of the folders.	
All records are kept in a secure room or locked in a file cabinet that is marked "confidential"	**Compliance**	A tour of the facility was conducted to observe where the case files are kept. The files are kept in a secure room in a locked file cabinet with confidential marked on the file cabinet.	
When in transport, all records are locked in an opaque container marked "confidential"	**Compliance**	The program has a locked opaque containers marked "confidential" to use for the transportation of records.	

All records are maintained in a neat and orderly manner so that staff can quickly and easily access information	**Compliance**	All files are maintained electronically in Mindshare and a hard copy format. Records were observed to be clearly divided into sections which were consistent in their organization among residential and community counseling files.	
Additional Comments: **There are no additional comments for this indicator.**			
2.08 - Specialized Additional Program Services			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.08		**YES** If NO, explain here: The provider has the required policy and procedure RGC 2.08 - Specialized Additional Program Service that was approved on 10/13/2023 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.*			
Staff Position(s) Interviewed (No Staff Names): Program Director, QI Specialist			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? **(If no, select rating "No eligible items for review")**	**No eligible items for review**	The provider has not served any youth who meet the criteria for Staff Secure services since the last QI review.	
Staff Secure policy and procedure outlines the following: a. In-depth orientation on admission b. Assessment and service planning c. Enhanced supervision and security with emphasis on control and appropriate level of physical intervention d. Parental involvement e. Collaborative aftercare	**No eligible items for 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**		
Staff Assigned: a. One staff secure bed and assigned staff supervision to one staff secure youth at any given time b. Program assign specific staff during each shift to monitor location/ movement of staff secure youth c. Agency clearly documents the specific staff person assigned to the staff secure youth in the logbook or any other means on each shift	**No eligible items for review**		
Agency provides a written report for any court proceedings regarding the youth's progress	**No eligible items for 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.*			
Staff Position(s) Interviewed (No Staff Names): Program Director, QI Specialist			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	**No eligible items for review**	The provider has not served any youth who meet the criteria for Domestic Minor Sex Trafficking (DMST) services since the last QI 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**		
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**		
Services provided to these youth specifically designated services designed to serve DMST youth	**No eligible items for 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**		
Length of Stay: a. Youth in program do not have length of stay in DMST placement that exceeds seven (7) days b. Agency has approval for stays and support beyond seven (7) days for DMST placements that are obtained on a case-by-case basis? (If applicable.)	**No eligible items for 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**		
All other services provided to DMST youth are consistent with all other general CINS/FINS program requirements	**No eligible items for review**		
Domestic Violence			
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 opened Files: 1 Domestic Violence open file **Total number of Closed Files: Two (2) Domestic Violence closed files** **Staff Position(s) Interviewed (No Staff Names): Program director** **Type of Documentation(s) Reviewed: Case Files**			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	**Yes**	Three records (one open and two closed) were reviewed for Domestic Violence respite.	

Youth admitted to DV Respite placement have evidence in the file of a pending DV charge	**Compliance**	The domestic violence charges were observed on the client's face sheet in the three case files.	
Data entry into NetMIS within (3) business days of intake and discharge	**Compliance**	The data was entered into NETMIS within 3 days of intake as indicated in the NETMIS system and in the case file.	
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**	None of the three youth had a length of stay over 21 day as indicated on the discharge forms in two closed file and active days for open record.	
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**	All three case plans include goals to assist the youth with anger management and the family with coping skills.	
All other services provided to Domestic Violence Respite youth are consistent with all other general CINS/FINS program requirements	**Compliance**	All services provided to domestic violence youth are consistent with all other CINS/FINS services as evidenced in the case files.	
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.*			
Staff Position(s) Interviewed (No Staff Names): Program Director, QI Specialist			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	**No eligible items for review**	The provider has not served any youth who meet the criteria for Probation Respite since the last QI review.	
All probation respite referrals are submitted to the Florida Network.	**No eligible items for review**		
All Probation Respite Referral come from DJJ Probation and there is evidence that the youth is on Probation regardless of adjudication status.	**No eligible items for review**		
Data entry into NetMIS and JJIS within (3) business days of intake and discharge	**No eligible items for review**		
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.	**No eligible items for review**		

All case management and counseling needs have been considered and addressed	**No eligible items for review**		
All other services provided to Probation Respite youth are consistent with all other general CINS/FINS program requirements	**No eligible items for review**		
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.*			
Staff Position(s) Interviewed (No Staff Names): Program Director, QI Specialist			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	**Not Applicable**	This program location is not contracted to provide Intensive Case Management services.	
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.	**Not Applicable**		
Services for youth and family include: a. Two (2) direct contacts per month b. Two (2) collateral contacts per week 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.	**Not Applicable**		
Assessments include a. NIRVANA at intake b. NIRVANA Re-Assessment every 90 days c. Post NIRVANA at discharge as aligned with timeframe requirements	**Not Applicable**		
Service/case plan demonstrates a strength-based, trauma-informed focus	**Not Applicable**		
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	**Not Applicable**		
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.*			
Staff Position(s) Interviewed (No Staff Names): Program Director, QI Specialist			

Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	**No eligible items for review**	The program has not served any youth who met the criteria for FYRAC in the last six months or since the last onsite QI 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**		
Agency has evidence that all FYRAC referrals have documented approval from the Florida Network office	**No eligible items for review**		
Intake and initial assessment sessions meets the following criteria: 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. 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. 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**		
Life Management Sessions meets the following criteria: a. Sessions are face-to-face, sixty (60) minutes in length and focus on strengthening the family unit b. 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**		
Individual Sessions: 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. b. Issues to be covered through each session include but are not limited to: 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**		

Group Sessions: 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. 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**		
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**		
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**		
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**		
All data entry in NetMIS is completed within 3 business days as required.	**No eligible items for review**		
Additional Comments: **There are no additional comments for this indicator.**			
2.09- Stop Now and Plan (SNAP)			**Not Applicable**
Provider has a written policy and procedure that meets the requirement for Indicator 2.09		**N/A** If NO, explain here: YFA New Beginnings is not contracted to provide SNAP services	
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): Program Director, QI Specialist			
SNAP Clinical Groups Under 12			
Youth are screened to determine eligibility of services.	**Not Applicable**	YFA New Beginnings is not contracted to provide SNAP services	
The NIRVANA was completed at initial intake, or within two sessions.	**Not Applicable**		
There is evidence of the completed Child Behavior Checklist (CBCL) by the caregiver (pre and post) and is located within the file.	**Not Applicable**		
There is evidence of the completed Teacher Report Form (TRF) is completed by the teacher (pre and post) and is located within the file.	**Not Applicable**		
SNAP Clinical Groups Under 12 - Discharge			
There is evidence of the completed SNAP Discharge Report located within the file for any discharged youth.	**Not Applicable**		

There is evidence of the completed SNAP Discharge Report located within the file for any discharged youth.	Not Applicable		
There is evidence of the SNAP Boys/SNAP Girls Child Group Evaluation Form located in the file.	Not Applicable		
There is evidence of the SNAP Boys/SNAP Girls Parent Group Evaluation Form located in the file.	Not Applicable		
SNAP Clinical Groups for Youth 12-17			
Youth are screened to determine eligibility of services.	Not Applicable		
The Consent to Treatment and Participation in Research Form is completed and located within the file.	Not Applicable		
The NIRVANA was completed at initial intake, or within two sessions.	Not Applicable		
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		
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		

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**		
SNAP for Schools & Communities			
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*)	**Not Applicable**		
The program maintained evidence of a completed "Class Goal" Document for the class reviewed.	**Not Applicable**		
The program maintained evidence of both pre AND post Measure of Classroom Environment (MoCE) completed documents for the class reviewed.	**Not Applicable**		
The program maintained evidence of completed pre and post evaluation documents for the class reviewed.	**Not Applicable**		
There is evidence of the fidelity adherence checklist maintained in the file for each class reviewed.	**Not Applicable**		
Additional Comments: **There are no additional comments for this indicator.**			
3.01 - Shelter Environment			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 3.01	**YES**		
	If NO, explain here:		
	The provider has the required policy and procedure RGC 3.01-Residential Group Care Environment, that was approved on 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.*

Staff Position(s) Interviewed (No Staff Names): Residential Supervisor
Type of Documentation(s) Reviewed: Weekly and perpetual chemical inventory, MSDS, Fire Drills, Emergency Drills, County Fire Inspection, Fire equipment inspection, Department of Health Inspections, activity and program schedule.
Describe any Observations: Tour of facility, postings, inspection of agency vehicle, chemical storage

Facility Inspection: a. Furnishings are in good repair. b. The program is free of insect infestation. c. Bathrooms and shower areas are clean and functional, free of foul odors, leaks, dust, and mildew and in good working order. d. There is no graffiti on walls, doors, or windows. e. Lighting is adequate for tasks performed there. f. Exterior areas are free of debris; grounds are free of hazards. g. Dumpster and garbage can(s) are covered. h. All doors are secure, in and out access is limited to staff members and key control is in compliance. 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. j. Interior areas (bedrooms, bathrooms, common areas) do not contain contraband and are free from hazardous unauthorized metal/foreign objects.	**Compliance**	All furniture (foyer, common area, bedrooms, etc.) are in good condition. Throughout the shelter there were no visible signs of distress on the furniture, nor any present signs of graffiti or stains. There were no signs of infestation nor any signs of insects. There was a total of seven bathrooms throughout the facility. Of the seven, three are located in the common area and four are full bathrooms within the shelter. Two bathrooms are located on each side of the dorm sleeping areas. There are no visible signs of graffiti on neither wall, door, nor window. All lighting is adequate in every room. There was a slight glitch in the laundry room once the light switch was activated. The exterior is free of any debris. There are no signs of hazards on the grounds of the facility. The exterior dumpster is covered and placed behind a gate, which is without any debris on the ground. All doors, whether exterior or interior are secured and are accessed by a key fob. The agency utilizes a key control system for all direct care staff which requires the use of keys to be transferred to the oncoming shift. The agency has posted egress plans next to each door throughout the facility. Each egress plan is posted behind a plastic covering. Within the common area the facility has posted rules, incident abuse reporting information, along with additional prevalent numbers. The daily itinerary is posted along with additional shelter information. There are three grievance boxes posted with numerous grievance forms. One grievance box is located inside the shelter, the second is located in the common area, and the third is for staff which is located in the copy room.	
Facility Inspection: a. All agency and staff vehicles are locked. 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.	**Compliance**	There was currently one van in use during the visit as the second van was recently in a car accident. The present van is a White 2022 Chrysler Voyager. Their source of transportation was equipped with current first-aid items. All necessary emergency/safety items were present and functioned properly. The van was equipped with two glass breakers/seat belt cutters. All vehicles on the premises were locked and secured.	

Facility Inspection: 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). A perpetual inventory will be the primary means of maintaining a current and real-time inventory. 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.	**Compliance**	There were three locations in the facility that housed chemicals: one in the kitchen, the cleaning closet, and the laundry room. Each location housed a binder that was comprised of perpetuals and weekly chemical inventories. There are a total of four binders that houses MSDS forms and they are located in the laundry room, the cleaning closet, the kitchen, and within the shelter. The binder in the shelter houses all of the chemicals whereas those in the designated locations only house those chemicals that are located in that area.	
Facility Inspection: Washer/dryer are operational & general area/lint collectors are clean. Agency has a current DCF Child Care License which is displayed in the facility. Each youth has own individual bed with clean covered mattress, pillow, sufficient linens and blanket. Youth have a safe, lockable place to keep personal belongings, if requested.	**Compliance**	The current license was issued on August 10th, 2023 and posted at the entry of the facility. There are two functioning washers/dryers in the laundry room. The lint collectors are clean and free of any debris. Each youth bedding is furnished with a clean mattress pad, fitted flat sheets, comforter, and a pillow. The only youth that have items locked away are those that arrive by DCF. CINS/FINS youth are not allowed to enter with items that need to be locked away.	
Additional Facility Inspection Narrative (if applicable)			

Fire and Safety Health Hazards: a. Annual facility fire inspection was conducted, and the facility is in compliance with local fire marshal and fire safety code within jurisdiction. b. Agency completes a minimum of 1 fire drill on each shift monthly (within 2 minutes or less). c. Completes 1 mock emergency drill per shift per quarter. 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).	**Exception**	The current Fire Inspection was conducted on July 11th, 2023. It is posted next to the entry door behind the receptionist desk. First shift conducted their fire drill August 2nd, September 18th, October 21st, November 1st, December 4th, 2023, and January 3rd, 2024. Second shift conducted their scheduled fire drills on September 10th, October 16th, November 13th, December 18th, 2023, and January 1st, 2024. As applicable 3rd shift conducted fire drills on August 21st, September 7th, September 22nd, October 20th, November 20th, 2023, December 26th, 2023, and January 17th, 2024. First shift conducted a emergency drill on September 28th, October 24th, 2023, and January 25th, 2024. Second shift conducted emergency drills August 1st, and November 5th, 2023. As applicable 3rd shift completed on August 31st, December 28th, 2023, and January 26th, 2024. Piper Fire Protection performed the inspections on the agency's equipment. The agency's sprinkler, hydrant, rapid, and alarm system was inspected on January 25th, 2024. The kitchen suppression inspection was conducted on June 5th, 2023. The fire extinguisher Inspection was conducted on July 19th, 2023.	There was no fire drill conducted on the second shift in the month of August 2023.
Fire and Safety Health Hazards: a. Agency has a current Satisfactory Residential Group Care inspection report from the Department of Health. 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. c. All cold food is properly stored, marked and labeled and dry storage/pantry area is clean and food is properly stored. 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**	Florida Department of Health performed both inspections for Residential Group Care and the Food Service on October 5th, 2023. Food menus approved by a licensed dietician are posted in the kitchen. All items in the refrigerator are labeled with the date the items were purchased along with the open and discard date. Each label also contains an initial. The temperature of the fridge was viewed at 36, while the freezer was -06. Each row was neatly organized and very clean.	
Additional Fire and Safety Health Hazards Narrative (if applicable)	**N/A**		

Youth Engagement			
a. Youth are engaged in meaningful, structured activities (e.g., education, recreation, counseling services, life and social skill training) seven days a week during awake hours. Idle time is minimal. b. At least one hour of physical activity is provided daily. c. Youth are provided the opportunity to participate in a variety of faith-based activities. Non-punitive structured activities are offered to youth who do not choose to participate in faith-based activities. d. Daily programming includes opportunities for youth to complete homework and access a variety of age appropriate, program approved books for reading. Youth are allowed quiet time to read. e. Daily programming schedule is publicly posted and accessible to both staff and youth.	**Compliance**	The agency has a structured scheduled posted in the common area stating that all youth will have access to educational, recreational, and counseling services daily. Faith-based activities are throughout the week for those youth that are interested. Youth who are not interested may take advantage of other activities. The agency offers youth the opportunity for quite time to complete homework and/or read a book. The schedule shows that youth have two 15-minute physical activity breaks; however, youth have access to over an hour of physical activity outside. This is documented in the logbook.	
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**	
	If NO, explain here:	
	The provider has the required policy and procedure RGC 3.02 - Program Orientation, that was 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: 1 open residential record
Total number of Closed Files: 2 closed residential records
Type of Documentation(s) Reviewed: Orientation checklist and youth handbook

Youth received a comprehensive orientation and handbook provided within 24 hours	**Compliance**	All three youth records reviewed had documentation to support the youth received a comprehensive orientation within the first twenty-four hours of admission.	

Orientation includes the following: a. Youth is given a list of contraband items b. Disciplinary action is explained c. Dress code explained d. Review of access to medical and mental health services e. Procedures for visitation, mail and telephone f. Grievance procedure g. Disaster preparedness instructions h. Physical layout of the facility i. Sleeping room assignment and introductions j. Suicide prevention- alerting staff of feelings or awareness of others having suicidal thoughts	**Compliance**	All three youth records reviewed had documentation to support the orientation addressed all required topics. Many of the topics were addressed in the youth handbook and the remaining topics were discussed verbally and documented on the admission documentation.	
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**	All three reviewed youth records contained the dates the information was provided to the youth. Each youth signed the orientation documentation along with the staff who provided the orientation.	
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** If NO, explain here: The provider has the required policy and procedure RGC 3.03 - Youth Room Assignment, that was 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: 1 open residential record **Total number of Closed Files: 2 closed residential records** **Type of Documentation(s) Reviewed: Youth assessments completed at intake** **Staff Position(s) Interviewed** *(No Staff Names)* **: Program Director and Residential Supervisor**			
A process is in place that includes an initial classification of the youths, to include:			

a. Review of available information about the youth's history, status and exposure to trauma b. Initial collateral contacts, c. Initial interactions with and observations or the youth d. Separation of younger youth from older youth, e. Separation of violent youth from non-violent youth f. Identification of youth susceptible to victimization g. Presence of medical, mental or physical disabilities h. Suicide risk i. Sexual aggression and predatory behavior j. Acute health symptoms requiring quarantine or isolation	**Compliance**	All three reviewed youth records contained completed assessments addressing all required information needed to make an appropriate room assignment. Information found in the electronic system also supported information was obtained and considered when making the youth's room assignment.	
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**	The program has several systems in place to document alerts. The program uses a letter system where each letter stands for a specific alert. Each record had a sticker on the front of the record with the alert letters. There is a white board maintained in the residential area of the facility. The white board also contains each youth's alert. The medical room also has an alert board documenting medical alerts. The kitchen also has a list of individual youth who are allergic to certain food items. A comparison of the information within the record to the alert system confirmed the alerts were correct for all three youth.	
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** If NO, explain here: The provider has the required policy and procedures RGC 3.04-Logbook Requirements, that was 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.*			
Dates or Timeframe Reviewed: Two consecutive weeks selected each month during the review period: August 1st-15th, September 14th-28th, October 10th-24th, November 13th-27th, December 17th-31st, and January 1st-15th. **Staff Position(s) Interviewed** *(No Staff Names)* **: Residential Supervisor, Counselor, and Program Director** **Type of Documentation(s) Reviewed: Logbook Entries**			
Log book entries that could impact the security and safety of the youth and/or program are highlighted	**Compliance**	The program uses a hardcover logbook. All entries that are vital to youth were highlighted to communicate with oncoming staff so they're informed.	
All entries are brief, legibly written in ink and include: • Date and time of the incident, event or activity • Names of youth and staff involved • Brief statement providing pertinent information • Name and signature of person making the entry	**Compliance**	All reviewed entries were legible and descriptive. Dates, times, activities and other pertinent information along with the name/signature of the staff and all others involved are evidenced in the logbook.	
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**	A review of the program logbook for the weeks selected revealed use of correcting errors, as required with staffs' use of the strike through method, initials, and date was not observed to be conducted consistently.	Entries that consisted of errors were witnessed with writing over the word/number, multiple lines through a word, and bubbling out word. There was no notation of the name/initials of person who made the correction nor a date that the error occurred.
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**	The director assigned the Residential Supervisor authorization to complete the weekly documentation. For the random 2-week periods reviewed, the supervisor documented review of the logbook ten (10) days in August, eight (8) days in September, nine (9) days in October, ten (10) days in November, eleven (11) days in December, and eight (8) days in January. Review of the logbook was only noted by a signature at each corner of the page. There was no dedicated weekly entry in the logbook notating of the dates that were observed, any corrections, recommendations, or new information.	The Residential Supervisor, reviewed the logbook frequently when on duty; however, a specific chronological note for supervisory review of the logbook, indicating the dates that were reviewed, any corrections, recommendations, or new information was not observed.

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**	All direct care staff members documented within their entries that they had reviewed the logbook from the previous two shifts.	
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**	As noted above, the reviewer observed the supervisor's signature at the top of each page that was reviewed for several days during the random 2-week periods reviewed but not consistently for all days on duty. It was observed that the counselor's entry was also not consistently completed for each shift worked. Counselor stated "Reviewed previous shift" six (6) days in August, nine (9) days in September, five (5) days in October, and four(4) days in November. December started the entries that included the dates reviewed for four (4) days in December, and six (6) days in January.	Reviews of the logbook are conducted by the supervisor and counselor; however, they are not consistently done on each work day with a dedicated log entry indicating the dates reviewed.
Logbook entries include: a. Supervision and resident counts b. Visitation and home visits	**Compliance**	Supervisions, resident counts, and home visit were well documented by staff throughout the logbook.	
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** If NO, explain here: The provider has the required policy and procedures RGC 3.05-Behavior Management Strategies, that was 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.*			
Staff Position(s) Interviewed (No Staff Names): Residential Supervisor **Type of Documentation(s) Reviewed: Program Youth Handbook**			
The program has a detailed written description of the BMS and it is explained during program orientation	**Compliance**	The Behavior Management Strategies are discussed during the initial intake process.	
Behavior Management Strategies must include:			

a.BMS is designed to teach youth new behaviors and help youth understand the natural consequences for their actions b.Behavioral interventions are applied immediately, with certainty, and reflect the severity of the behavior c.BMS uses a wide variety of awards/incentives to encourage participation and completion of the program d.Appropriate consequences and sanctions are used by the program and consequences for behavior are logical and designed to promote skill-building for the youth e.Counseling, verbal intervention and de-escalation techniques are used prior to physical intervention (Only techniques approved by the Florida Network and DJJ are used if physical intervention is required) f.Only staff discipline youth. Group discipline is not imposed g.Room restriction is not used as part of the system or for youth who are physically and/or emotionally out of control h.Youth should never be denied basic rights such as meals, clothing, sleep, services, exercise, or correspondence privileges	**Compliance**	The Behavior Management Strategies discussed during the initial intake process include a detailed description of each level. Awards, incentives, sanctions, and steps for direct care staff are notated on the agencies forms. The program's Behavior Management System consists of four different phases. (Orientation, Education, Graduation and Collegiate). Youth are placed on Orientation level for the first 72 hours after being admitted to the program. While in the Orientation level, the emphasis is to become oriented to the program's core values (six pillars of character) and youth development strategies (twelve developmental outcomes). After completion of the Orientation level (which requires setting a weekly goal), the youth will advance to the Education Level. The Education level's emphasis is placed on the youth's ability to demonstrate what they have learned while on the Orientation level as well as actively participate in educational activities, groups, outings etc. At completion of the Education level, youth achieve the Graduate level. At the Graduate level, the expectation is to demonstrate an enhanced understanding of the skills learned while on the previous levels. Youth must exemplify the characteristics of a role model. The highest level of the program is the Collegiate level. At this level, youth are expected to be role models and serve as peer leaders. Only staff discipline youth. Room restriction is not used as part of the BMS and youth are never denied basic rights.	
Program's use of the BMS			
All staff are trained in the theory and practice of administering BMS rewards and consequences	**Compliance**	Each direct care staff member is trained on the BMS system during the orientation period.	
There is a protocol for providing feedback and evaluation of staff regarding their use of BMS rewards and consequences	**Compliance**	There is policy in place explaining program protocol for feedback and evaluation of staff regarding their use of the Behavior Management System. The program discusses use of the BMS during staff meetings occasionally.	
Supervisors are trained to monitor the use of rewards and consequences by their staff	**Compliance**	Supervisors are trained to monitor interventions implemented by staff to ensure that there is no misuse of the strategies and that interventions are appropriate and consistent with the program's behavioral management structure.	
Additional Comments: **There are no additional comments for this indicator.**			

3.06 - Staffing and Youth Supervision			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 3.06		**YES** If NO, explain here: The provider has the required policy and procedures 3.06-Staffing and Youth Supervision, that was 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.*			
Dates or Timeframe Reviewed: August 1st-15th; September 14th-28th; October 10th-24th; November 13th-27th; December 17th-31st; and January 1st-15th. **Staff Position(s) Interviewed** *(No Staff Names)* **: Residential Supervisor** **Type of Documentation(s) Reviewed: Monthly Schedules, logbook** **Describe any Observations: Video surveillance**			
The program maintains minimum staffing ratios as required by Florida Administrative Code and contract. • 1 staff to 6 youth during awake hours and community activities • 1 staff to 12 youth during the sleep period	**Compliance**	The program has maintained adequate staffing ratios as required, maintaining at minimum two staff on first shift, three on second shift and two on the over nights. Evidence of staff to youth ratios during the day was observed to be at least 1:6 ratio and the overnight ratio is 3:18 which is also equivalent to 1:6.	
All shifts must always provide a minimum of two direct care staff present that have met the minimum training requirements	**Compliance**	Staffing schedules reviewed show at least 2 staff are scheduled on each shift.	
Program staff included in staff-to-youth ratio includes only staff that are background screened and properly trained youth care workers, supervision staff, and treatment staff	**Compliance**	Shelter staff included in the staff-to-youth ratio included only properly trained youth care workers.	
The staff schedule is provided to staff or posted in a place visible to staff	**Compliance**	A monthly schedule is posted in the staff area and the front office.	
There is a holdover or overtime rotation roster which includes the telephone numbers of staff who may be accessed when additional coverage is needed	**Compliance**	The staff list, with staff phone numbers, is posted in the staff work area in the event additional coverage is needed.	

Staff observe youth at least every 15 minutes while they are in their sleeping room, either during the sleep period or at other times, such as during illness or room restriction	**Compliance**	Video and logbook entries were checked and matched for the following dates and times randomly selected: January 14th from 12am-2am; January 19th from 2am-4am; January 24th from 4am-6am; January 27th from 1am-3am; and February 5th from 3am-5am. During review of the video surveillance system it was observed staff bed checks were being completed at least every five to fifteen minutes as required and the exact times were documented within the logbook in real time. There is a male's hall and a girl's hall identified as sleeping quarters for youth. Each bedroom is equipped to have two youth assigned if necessary. There is an identified area by the staff office for youth who are required to be placed on Sight & Sound for observation.	
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: The provider has the required policy and procedure 3.07-Video Surveillance System that was 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.*			
Staff Position(s) Interviewed (No Staff Names): Residential Supervisor **Type of Documentation(s) Reviewed: Surveillance Logs, policy** **Describe any Observations: Video surveillance system, cameras**			
Surveillance System			

The agency, at a minimum, shall demonstrate: a. A written notice that is conspicuously posted on the premises for the purpose of security b. System can capture and retain video photographic images which must be stored for a minimum of 30 days c. System can record date, time, and location; maintain resolution that enables facial recognition d. Back-up capabilities consist of cameras' ability to operate during a power outage e. Have cameras placed in interior (e.g. intake office, counseling office, cafeteria, day room) and exterior (e.g. entrance/exit, recreation area, parking lot) general locations of the shelter where youth and staff congregate and where visitors enter and exit; to include locations where youth searches are conducted. Cameras are never placed in bathrooms or sleeping quarters. f. All cameras are visible	**Compliance**	The shelter has a video surveillance system that is operational twenty-four hours a day, seven days a week. There were written notices posted around the grounds of the program indicating there is recording in progress. Cameras were located in the interior and exterior of the shelter where youth and staff congregate and where visitors enter and exit. All cameras were visible. There were no cameras in the sleeping quarters or the bathrooms. The video surveillance system can retain video and photographic images for up to thirty days. The system captures date, time, location and maintains resolution for facial recognition. The cameras do have the ability to operate during a power outage.	
A list of designated personnel who can access the video surveillance system is maintained (includes off-site capability per personnel)?	**Compliance**	Camera review ability is limited to supervisory staff only.	
Supervisory review of video is conducted a minimum of once every 14 days and timeframes reviewed are noted in the logbook.	**Compliance**	A supervisory surveillance review of video was observed to be conducted at least every fourteen days and documented in the program's logbook.	
The reviews assess the activities of the facility and include a review of random sample of overnight shifts	**Compliance**	The review consists of random sample of overnight shifts.	
Grant the requesting of video recordings to yield a result within 24-72 hours from program quality improvement visits and when an investigation is pursued after an allegation of an incident	**Exception**	The shelter has a policy in place that grants the requesting party video recordings within twenty-four to seventy-two hours from the time of the request. However, in practice, there appears to be a delay in providing the requested video footage within the required timeframe.	On two occasions, CCC has requested video footage of a situation that transpired at the facility. The transfer of evidence has surpassed its 24-72 hour deadline. There has been ongoing correspondence with CCC and IT regarding the issues with downloading of the evidence.
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**	The shelter has a policy in place that states camera service orders will be made within twenty-four hours of discovery of malfunction or being inoperable. All efforts to obtain repairs are documented and maintained.	
Additional Comments: **There are no additional comments for this indicator.**			

4.01 - Healthcare Admission Screening			Satisfactory with Exception
Provider has a written policy and procedure that meets the requirement for Indicator 4.01		**YES** If NO, explain here: The provider has the required policy and procedures RGC 4.01-Healthcare Admission Screening, that was 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: 2 open residential youth records **Total number of Closed Files: 3 closed residential youth records** **Staff Position(s) Interviewed** *(No Staff Names)* **: Program Nurse** **Type of Documentation(s) Reviewed: Youth Records and Admission Documentation**			
Preliminary Healthcare Screening			
Screening includes : a. Current medications b. Existing (acute and chronic) medical conditions c. Allergies d. Recent injuries or illnesses e. Presence of pain or other physical distress f. Observation for evidence of illness, injury, physical distress, difficulty moving, etc. g. Observation for presence of scars, tattoos, or other skin markings h. Acute health symptoms requiring quarantine or isolation	**Exception**	All five reviewed youth records and the electronic system contained all required information needed to complete a thorough healthcare screening. The healthcare screening was completed for each youth; however, only three of the five were completed upon admission. Three of the youth were taking medications upon arrival to the program and there was documentation of the nurse or staff completing verification of the prescription. None of the youth required quarantine or isolation when they were first admitted to the program.	One youth's Health Screening Form was completed the day after the youth's day of admission. Another youth had the Health Screening form completed; however, there was no date documented by the staff who completed the form. The screening was reviewed by the nurse on September 9, 2023. When the exception was brought to the attention of the program, the nurse indicated the form was completed as part of the admission process so the date completed would be September 1, 2023.
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.)	**No eligible items for review**	None of the youth reviewed had any chronic medical conditions.	
When needed, the parent is involved with the coordination and scheduling of follow-up medical appointments	**No eligible items for review**	None of the youth reviewed needed a follow-up medical appointment.	
All medical referrals are documented on a daily log.	**No eligible items for review**	None of the youth reviewed required a medical referral.	

The program has a thorough referral process and a mechanism for necessary follow-up medical care as required and/or needed	**Compliance**	The nurse explained the referral process and mechanism for follow-up care. The process includes updating information on the white board located in the medical room so staff are updated as needed.	
Additional Comments: **There are no additional comments for this indicator.**			
4.02 - Suicide Prevention			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 4.02		**YES** If NO, explain here: RGC 4.02/Healthcare Admission Screening 9/15/23 & 10/13/23. Approved by: President/CEO Mark Wickham and COO Toby Fritz.	
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: 1 residential and 2 community counseling youth record **Total number of Closed (Residential & Community) Files: 2 residential and 1 community counseling youth record** **Staff Position(s) Interviewed (No Staff Names): Residential supervisor, Program Director Community Counseling** **Type of Documentation(s) Reviewed: Youth records, 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**	Six youth records were reviewed. All six were screened for suicide risk at the time of intake, with screening results reviewed by the supervisor and documented in the youth's case record.	
The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services	**Compliance**	The program's suicide risk assessment was previously approved by the Florida Network and has not changed since the last QI review.	
Supervision of Youth with Suicide Risk *(Shelter Only)*			
Youth are placed on the appropriate level of supervision based on the results of the suicide risk assessment.	**Compliance**	All three residential youth were placed on sight-and-sound supervision until assessed by a non-licensed professional working under the supervision of the licensed professional.	
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**	Staff monitored each youth's behavior on the observation log at least every thirty minutes or less and documented their observation of the youth's behavior.	
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 was maintained for the duration of time each youth was placed on sight and sound. The observation log includes the observer's initial, time of day, and behavioral observations.	

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	**Compliance**	Supervision level was not changed/reduced for any of the three youth until the non-licensed staff, under supervision of a licensed clinician, completed a further assessment.	
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**	Documentation of supervisory staff signature was observed on the observation logs, on each shift, for each youth of the three residential youth. The observation logs were kept in the youth's case file.	
Youth with Suicide Risk *(Community Counseling Only)*			
Youth identified for suicide risk during intake was immediately assessed by a licensed professional or non-licensed professional (under the direct supervision of a licensed mental health professional) and the parents and supervisor were both notified of the results.	**Compliance**	All three community counseling youth identified for suicide risk during intake were immediately assessed by non-licensed professional (under the direct supervision of a licensed mental health professional) and the parents and 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**	The three youth were immediately referred and advised that an assessment of suicide risk should be completed as soon as possible and the parent/guardian were notified.	
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 program provided information on available resources in the community to the youth and parent/guardian on the referral form maintained in the youth's record.	
If the parent/guardian cannot be contacted, all efforts to contact them are documented in the case file.	**Not Applicable**	The parent/guardians were contacted during the intake.	
When the screening was completed during school hours on school property, the appropriate school authorities were notified.	**Not Applicable**	None of the three suicide screenings were conducted on school property.	
Additional Comments: **There are no additional comments for this indicator.**			

4.03 - Medications			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 4.03		**YES** If NO, explain here: The provider has the required policy and procedures RGC 4.03 - Medication Control and Management, 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: 2 open residential youth records **Total number of Closed Files: 1 closed residential youth record** **Staff Position(s) Interviewed** *(No Staff Names)***: Program nurse** **Type of Documentation(s) Reviewed: Staff Training, Medical Distribution forms** **Describe any Observations: Pyxis Medication Cabinet**			
The agency has a Registered Nurse (RN) and/or a Licensed Practical Nurse (LPN) that is being supervised by RN and all of their credentials have been verified.	**Compliance**	The program's registered nurse holds an active and clear license.	
The agency has evidence of the following for all non-nursing shelter staff designated to assist with the self-administration of medication: a. Documentation of in-person self-administration of medication distribution training provided by a Registered Nurse b. Evidence demonstrating their competency to assist with self-administration of medication distribution c. Maintenance of their annual medication training re-certification	**Compliance**	All staff permitted to assist in distributing medication receives training on using an EpiPen, medication training, and medication distribution record training using tic-tacs in a prescription bottle. The staff must pass a test and job shadow another staff for a shift. The staff distribute the medication with a second experienced staff providing oversight.	
The agency held at least quarterly staff meetings conducted by RN and/or Shelter Manager to review and assess: a. strategies implemented to reduce medication errors shelter wide b. analyze factors that contributed to medication errors c. allow staff the opportunity to practice and role-play solutions	**Compliance**	The program's registered nurse indicated there is a standing topic on the monthly staff meeting agenda called Med Minute. During that time she provides training on topics relevant to observations she has made in the program.	
The agency has strategies implemented to ensure medications are provided within the 2-hour time frame.	**Compliance**	The staff lead carries the program phone and the program phone is set with an alarm to sound when it is time for med pass. The times of med pass are also documented on the white board in the medical room. There is an alarm in the medical room that has to be shut off manually. This alarm is set to sound at med pass time as well.	

All non-licensed staff members are clearly identified and designated on the staff schedule and shift change report/shift responsibility form for assisting with the self-administration of medications on each shift	**Compliance**	The program's registered nurse maintains an up-to-date list of staff who have completed the required training and are permitted to assist with medication distribution. These staff are also delineated on the staff schedule.	
The agency has clear methods of communicating which youth are on medications with the times and dosage easily discernable by all staff on each shift.	**Compliance**	The youth who take medication are documented on the white board in the medical room. The name of the medication, the dose, and the time of dose is included in the information on the white board.	
The delivery process of medications is consistent with the FNYFS Medication Management and Distribution Policy and the agency has an internal quality assurance process to include the following: a. to ensure appropriate medication management and distribution methods b. to track medication errors c. to identify systemic issues and implement mitigation strategies, as appropriate.	**Compliance**	The program's registered nurse reviews all medical documentation each day she works at the program. The program has a delivery process for medications that is consistent with the FNYFS Medication Management and Distribution Policy. There is a an internal quality assurance process in place. The program identifies medication issues and discusses medication management and errors during CINS/FINS meetings.	
Admission/Intake of Youth			
a. Upon admission, the youth and parent/guardian (if available) were interviewed by the Registered Nurse (when on-site) about the youth's current medications as part of the Medical and Mental Health Assessment screening process and/or an interview was conducted by the RN within three (3) business days if the RN was not on the premise at admission. **If the agency does not have a RN, there was a medication review conducted by a certified Leadership position.* b. Upon intake/admission, there is evidence that the on-shift certified supervisor of higher level staff did review all medication forms by the next business day.	**Compliance**	Three youth who were taking medication at the time of admission were reviewed. The medical information was either documented by a staff member or the registered nurse. Documentation supported the registered nurse reviewed all medical information recorded by staff the next day she was at the program. The review was conducted no more then three days after the youth's admission. There was documentation to support the shift supervisor also reviewed the documentation the day of admission.	

Medication Storage			
a. All medications are stored in a Pyxis ES Medication Cabinet that is inaccessible to youth (when unaccompanied by authorized staff) b. Pyxis machine is stored in accordance with guidelines in FS 499.0121 and policy section in Medication Management c. Oral medications are stored separately from injectable epi-pen and topical medications d. Medications requiring refrigeration are stored in a secure refrigerator that is used only for this purpose, at temperature range 2-8 degrees C or 36-46 degrees F. (If the refrigerator is not secure, the room is secure and inaccessible to youth.) e. Narcotics and controlled medications are stored in the Pyxis ES Station f. Pyxis keys with the following labels are accessible to staff in the event they need to access medications if there is a Pyxis malfunction: a TOP COVER b BACK PANEL- LEFT TALL CABINET LOCK- LEFT, c BACK PANEL- RIGHT TALL CABINET LOCK- RIGHT	**Compliance**	The Pyxis machine is located behind the locked door going into the medical room. The Pyxis machine was stored as required. All medication within the Pyxis machine was stored as required. Observations also confirmed controlled medication was stored as required. There is a refrigerator in the medical room used to store medication that requires refrigeration. At the time of the review there were no medication that needed to be refrigerated. Documentation support the refrigerator temperature is checked on a regular basis. The required Pyxis keys are located in a drawer in the medical room. All keys were accounted for and labeled as required.	
Medication Distribution			
a. Agency maintains a minimum of 2 site-specific System Managers for the Pyxis ES Station b. Only designated staff delineated in User Permissions have access to secured medications, with limited access to controlled substances (narcotics) c. A Medication Distribution Log shall be used for distribution of medication by non-licensed and licensed staff d. Agency verifies medication using one of three methods listed in the FNYFS Policies & Procedures Manual e. When nurse is on duty, medication processes are ALWAYS conducted by the nurse or when the nurse is not onsite, then the designated staff who has been trained by a licensed Registered Nurse provides the medication. f. Agency does not accept youth currently prescribed injectable medications, except for epi-pens h. Non-licensed staff have received training in the use of epinephrine auto-injectors provided by a registered nurse	**Compliance**	The program has designated staff who are the system managers for the Pyxis machine. Staff who have access to the medication was delineated in writing. The reviewed Medication Distribution Logs (MDL) confirmed the registered nurse provides the youth their medication when she is at the program. The program verifies medication using the Five Rights method prior to the delivery of medication. The Medication Distribution Logs also confirmed when the designated staff provided medication. The registered nurse provides constant oversight to staff to ensure there are minimal to no medication errors. All staff permitted to assist in distributing medication received training on using an EpiPen, medical training, and MDL training.	

The medication distribution log documentation includes: a. the time of medication administration b. evidence of youth initials that the dosage was given c. evidence of staff initials that the dosage was given	**Compliance**	A review of the Medication Distribution Log confirmed each log contained the time the medication is distributed, and initials of the youth and staff to indicate the dosage was given.	
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**	Documentation on the Medication Distribution Log supported the medications were provided to the youth within one hour of the scheduled time of delivery.	
During the review period, there were no instances where youth missed their medication due to failure to open the pyxis machine.	**Compliance**	There were no issues where the youth did not receive their medication because the Pyxis machine would not open.	
If applicable: Any staff member deemed responsible for a medication error, there was evidence that the staff member received refresher training from an RN and demonstrated competency prior to being assigned future medication administration responsibilities. There is evidence that any staff member deemed responsible for 3 errors within a 1-year time frame, had their certification suspended and was not recertified until the completion of the full **in-person** medication administration training, demonstrating competency and re-certification from an RN.	**No eligible items for review**	Four staff were responsible for six medication errors that occurred during the annual audit. The errors occurred on 8/25/23, 8/26/23, 9/5 /23, 10/28/23, 12/1/23, and 12/7/23. All errors occurred prior to the effective date of this indicator.	
Medication Inventory			
a. For controlled substances, a perpetual inventory with running balances is maintained as well as a shift-to shift count verified by a witness and documented b. Over-the-counter medications that are accessed regularly and inventoried weekly c. Syringes and sharps (needles, scissors, etc.) are secured, and counted and documented weekly	**Compliance**	Documentation supported all controlled medication and over-the-counter medication, as well as other prescription drugs had a perpetual inventory maintained. Observations of three medications confirmed the perpetual inventory was correct. The program does not have any syringes or sharps.	
There are monthly reviews of the Pyxis reports to monitor medication management practice.	**Compliance**	There was documentation to support the Pyxis reports are reviewed monthly. Data graphs are produced based on the findings of the reviews.	
Medication discrepancies are cleared after each shift.	**Compliance**	The registered nurse confirmed medication discrepancies are cleared after each shift. She verifies this by running a report every day she is at the program.	
Additional Comments: **There are no additional comments for this indicator.**			

4.04 - Medical/Mental Health Alert Process			Satisfactory with Exception
Provider has a written policy and procedure that meets the requirement for Indicator 4.04	**YES**		
	If NO, explain here:		
	The provider has the required policy and procedures RGC 4.04 - Medical and Mental Health Alert, that was 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: 2 residential youth records
Total number of Closed Files: 3 residential youth records
Type of Documentation(s) Reviewed: Youth Records
Describe any Observations: Observed the alert boards and stickers on the cover of each record.

Youth with a medical, mental health, or food allergy was appropriately placed on the program's alert system	**Exception**	Five youth were reviewed for medical and mental health alerts. Four of the five youth were appropriately placed on the alert system.	There was an alert on one youth's record indicating a history of physical/sexual aggression but the intake screening for that information was left blank/not checked.
Alert system includes precautions concerning prescribed medications, medical/mental health conditions	**Compliance**	The program has several systems in place to document alerts. The program uses a letter system where each letter stands for a specific alert. Each record had a sticker on the front of the record with the alert letters. There is a white board maintained in the residential area of the facility. The white board also contains each youth's alert. The medical room also has an alert board documenting medical alerts. The kitchen also has a list of individual youth who are allergic to certain food items. A comparison of the information within the record to the alert system confirmed the alerts were correct for all three youth.	
Staff are provided sufficient training, information and instructions to recognize/respond to the need for emergency care for medical/mental health problems	**Compliance**	All staff were verified to be trained in CPR and First Aid. New staff receive information and instructions during orientation to recognize and respond to any needed emergency care.	
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**	The program has several systems in place to document alerts. The program uses a letter system where each letter stands for a specific alert. Each record had a sticker on the front of the record with the alert letters. There is a white board maintained in the residential area of the facility. The white board also contains each youth's alert. The medical room also has an alert board documenting medical alerts. The kitchen also has a list of individual youth who are allergic to certain food items.	

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

4.05 - Episodic/Emergency Care			Satisfactory with Exception
Provider has a written policy and procedure that meets the requirement for Indicator 4.05		**YES** If NO, explain here: The provider has the required policy and procedures RGC 4.05 - Episodic and Emergency Care, that was 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 Closed Files: 3 **Staff Position(s) Interviewed** *(No Staff Names)* **: Registered Nurse** **Type of Documentation(s) Reviewed: Three youth records and the Episodic/Emergency Care log**			
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 b. Upon youth return, there is a verification receipt of medical clearance via discharge instructions with follow-up is present in file c. Youth's parent/guardian was notified d. A daily log is maintained for emergency care provided	**Exception**	Three youth medical records were reviewed for emergency and/or episodic care. There was an incident report completed for all three incidents. Upon each youth's return, documentation confirmed the medical clearance was present in the youth's record. In all three incidents, documentation supported the youth's parent/guardian was notified. The episodic log does not differentiate offsite medical transports from onsite emergency care provided.	There were two exceptions found. There was a medical transport for one of the youth on December 14, 2023 and another youth on December 10, 2023 that were not noted on the episodic/emergency care log. Both were noted in the logbook.
All staff are trained on emergency medical procedures	**Compliance**	A total of eight staff training records were reviewed. Documentation supported all the staff received 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 Knife for Life and wire cutters are located in the medical room. First Aid kits are located in the medical room, the kitchen, the hurricane box, and the van.	
Additional Comments: **There are no additional comments for this indicator.**			