Florida Network for Youth and Family Services
Compliance Monitoring Report for

Youth and Family Alternatives, Inc., New Port Richey
RAP House Youth Shelter

7522 Plathe Road
New Port Richey, Florida 34653

March 27-28, 2024

Compliance Monitoring Services Provided by

FOREFRONT

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, RAP House (YFA RAP House) for the FY 2023-2024 at its program office located at 7522 Plathe Road, New Port Richey, 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 RAP House 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): Belinda Ross, CDS Family and Behavioral Central; Mark Shearon, Arnette House; and Kelli Yeazell, Family Resources. Agency representatives from YFA RAP House present for the entrance interview were Toby Fritz, Chief Operating Officer; Amanda Kilian, Vice President of Quality Improvement and Compliance; Ryan Pettit, Program Director; Michele Almand, Quality Improvement Prevention; and Kayla Manning, Team Lead. The last onsite QI visit was conducted April 26-27, 2023.

In general, the Reviewer found that YFA RAP House is in compliance with specific contract requirements. **YFA RAP House received an overall compliance rating of 100% for achieving compliance with all 12 of 12 applicable indicators** of the CINS/FINS Monitoring Tool. There are no corrective actions cited.

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 03-27-2023-2024

Agency Name: YFA- RAP House	**Monitor Name: Marcia Tavares, Lead Reviewer**
Contract Type : CINS/FINS	**Region/Office: 7522 Plathe Road New Port Richey, Florida 34653**
Service Description: Comprehensive Onsite Compliance Monitoring	**Site Visit Date(s): March 27-28, 2024**

Major Programmatic Requirements	Explain Rating: Unacceptable	Conditionally Unacceptable	Fully Met	Exceeded	Not Applicable	Ratings Based Upon: I = Interview O = Observation D = Documentation PTV = Submitted Prior To Visit (List Who and What)	Notes Explain Unacceptable or Conditionally Acceptable:
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 five certified peer reviewers and is required to have a minimum of six for the three locations. Former peer reviewer Alex Pruett who participated on behalf of the RAP House location in a CINS Review during the FY23-24 season, has recently left on 2/3/2024 resulting in a deficit of one peer. The former peer did participate in a CINS review during this current FY to fulfill the contract requirement. The agency will need to send a representative from the RAP House location to the next QI Peer Reviewer training to replace former peer reviewer Alex Pruett.	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	☐	☐	☒	☐	☐	Documentation: The provider submitted a list of three additional funders for FY2023-2024 as follows: DHHS Basic Center Grant, Department of Health, and Kids	No recommendations and/ or corrective actions required.

2023-2024 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
Report Number: CM 03-27-2023-2024

Agency Name: YFA- RAP House	**Monitor Name: Marcia Tavares, Lead Reviewer**
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organizations. Such a listing shall identify the awarding entity and contract start & end dates. **PTV**						Central. The program also maintains interagency agreements and Memorandums of Agreement (MOUs) with schools, mental health, and other local providers.	
Limits of Coverage a. Provider shall provide and maintain during this contract, the following minimum kinds of insurance: Worker's Compensation and Employer's liability insurance as required by Chapter 440, F.S. with a minimum of $100,000 per accident, $100,000 per person and $500,000 policy aggregate. Commercial General Liability with a limit of $500,000 per occurrence, and $1,000,000 policy aggregate. Automobile Liability Insurance shall be required and shall provide bodily injury and property damage liability covering the operation of all vehicles used in conjunction with performance of this contract, with a minimum limit for bodily injury of $250,000 per person; with a minimum limit for bodily injury of $500,000 per accident; with a minimum limit for property damage of $100,000 per accident and with a minimum limit for medical payments or $5,000-$10,000 per person. Florida Network is listed as payee or co-payee. **PTV**	☐	☐	☐	☒	☐	Documentation: A current certificate of insurance coverage from Marsh & McLennan Agency was provided to show evidence of all required coverage with sufficient limits and effective dates within this contract period. 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	No recommendations and/ or corrective actions required.

2023-2024 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
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	Unacceptable	**Conditionally Unacceptable**	**Fully Met**	**Exceeded**	**Not Applicable**		
						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 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	☐	☐	☐	☐	☒	Documentation: The written program update submitted indicated there were	No recommendations and/ or corrective actions required.

2023-2024 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
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a. Provider has corrective action item(s) cited by an external funding source (Fiscal or Non-Fiscal). **ON SITE**						no corrective action items cited by external funding sources.	
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 sound internal controls. Procedures are included for general ledger, payroll, petty cash, computer backup, and other relevant financial processes.	No recommendations and/ or corrective actions required.
b. Agency maintains a general ledger and the corresponding source documents. A general ledger must be set up to track the activity of the grant separately (standard account numbers / separate funds for each revenue source, etc.). **PTV**	☐	☐	☒	☐	☐	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 separately from other funding sources.	No recommendations and/ or corrective actions required.
c. Petty cash ledger system is balanced and all cash disbursements are compliant with financial policies and	☐	☐	☒	☐	☐	Documentation of petty cash policy and procedures FM482 was provided. Policy and procedures indicate use of	No recommendations and/ or corrective actions required.

2023-2024 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
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allowable under the contract. (Disbursements/invoices are approved & monitored by management.) –**ON SITE**						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.	
d. Financial records and reports are current. Includes bank statements reconciled within 6 weeks of receipt. Vendor invoices past 6 months. Invoices are submitted on a monthly basis with supporting documentation. (Disbursements/invoices are approved & monitored by management). **ON SITE**	☐	☐	☒	☐	☐	Documentation and Observation. Reviewed Bank Statements and Bank Reconciliations for August 2023 - February 2024 for operating bank account held with PNC bank. Financial Statements 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. None of the reports show any outstanding unreconciled difference. Invoices are submitted on a monthly basis with supporting documentation.	No recommendations and/ or corrective actions required.
e. Agency maintains inventory in accordance with a written policy and FNYFS contractual requirements. If over $1,000 inventory has DJJ Property Inventory Number/Tag.	☐	☐	☐	☐	☒	A letter dated December 1, 2023 from the VP of Finance was provided as	No recommendations and/ or corrective actions required.

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In the event the provider has purchased computer equipment an Informational Resources Request (IRR) has been submitted to DJJ. **PTV/ON SITE**						documentation that FNYFS funds are not used for asset purchases.	
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 16 bi-weekly payroll tax payments made by Paylocity was provided in compliance with the requirement of submission of employee payroll taxes and total tax deposits made for each period by the service bureau.	No recommendations and/ or corrective actions required.
g. Budget to actual reports prepared and reviewed by appropriate management. Variance from the budget are investigated and explained. **PTV/ON SITE**	☐	☐	☒	☐	☐	Documentation: 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 2/29/2024. Variances in budget are monitored on a regular basis and are discussed with the Board.	No recommendations and/ or corrective actions required.

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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. The audit was due to be finalized no later than March 15, 2024 and the final completed report is currently still pending to be submitted to the agency.	No recommendations and/ or corrective actions required at this time.
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.

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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 – RAP House, which included current salaries. Reviewer verified via letter received and salary worksheet that all direct care workers within the shelter and community counseling program received a wage increase on 7/29/2023, which was the beginning of the pay period for all YFA employees. That rate was applied to all employees with a pay increase dependent on their tenure and position within the program.	No recommendations and/ or corrective actions required.

CONCLUSION

YFA RAP House has met the requirements for the CINS/FINS contract as a result of compliance with 12 of 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; however, one recommendation was 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. - RAP House
New Port Richey
CINS/FINS Program

March 27-28, 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	Limited

Percent of Indicators rated Satisfactory: 85.71 %
Percent of Indicators rated Limited: 14.29 %
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	Limited
2.06 Adjudication/Petition Process	Satisfactory
2.07 Youth Records	Satisfactory
2.08 Special Populations	Satisfactory
2.09 Stop Now and Plan (SNAP)	Satisfactory

Percent of Indicators rated Satisfactory: 88.89 %
Percent of Indicators rated Limited: 11.11 %
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: 92.86 %

Percent of indicators rated Limited: 7.14 %

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
Belinda Ross - CDS Interface Central
Mark Shearon - Arnette House
Kelli Yeazell- Family Resources

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	X	Nurse – Full time
	Chief Financial Officer		Counselor Non-Licensed		Nurse – Part time
	Chief Operating Officer		Advocate	1	# Case Managers
	Executive Director	X	Direct – Care Full time	2	# Program Supervisors
X	Program Director		Direct – Part time		# Food Service Personnel
	Program Manager		Direct – Care On-Call		# Healthcare Staff
	Program Coordinator		Intern		# Maintenance Personnel
	Clinical Director		Volunteer	2	# Other (listed by title): ___ VP QI & QI Specialist
	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	5	# Health Records
X	Logbooks		Key Control Log	4	# MH/SA Records
	Continuity of Operation Plan	X	Fire Drill Log	18	# Personnel /Volunteer Records
X	Contract Monitoring Reports	X	Medical and Mental Health Alerts	8	# Training Records
	Contract Scope of Services	X	Precautionary Observation Logs	12	# Youth Records (Closed)
X	Egress Plans	X	Program Schedules	8	# 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
X	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	6	# 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. RAP House, located in New Port Richey, Florida serves judicial circuit 6, which includes Pasco County. The YFA agency as a whole serves additional Counties including Citrus, Hernando, Sumter, Hardee, Highlands and Polk. The RAP House youth shelter is licensed by the Department of Children and Families for 26 beds, effective through April 23, 2024, 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 team for CINS/FINS also serves youth and families in the same County and coordinates 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. This agency location 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 agency is also contracted to provide Stop Now and Plan (SNAP) services to youth under 12 years of age and SNAP in School. 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

At the time of the onsite QI review, the program reported six vacant positions for one Community Counseling case manager, three part time youth care staff, one residential Shift Lead, and one outreach coordinator. Residential Program Director Ryan Pettit is transitioning to the outreach coordinator position effective date 4/30/2024.

Program Updates

The program offers groups services 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. 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

A large pole barn was added to the exterior of the facility and now provides a shaded area for the youth to play.

Funding/Finance

RAP House has continued to operate in a surplus this fiscal year. With the majority of its direct care staff positions filled, the program has been staying at or above the goal for contracted bed days, and has kept the CINS/FINS census between 13-16 youth per day. RAP house had an amazing Christmas, thanks to community partners who provided wrap around support for the youth and were there during the holidays providing food and gifts.

Governance and Community

The program is continuing to increase its local collaboration and engagement with community organizations. Mental Health agreements in place include Baycare Behavioral Health; and Pasco Kids First. Recent Board of Directors changes include the addition of Melanie Waxler (Pasco County Schools) and Amanda Hart 12/2023 (Blackjack Media Group).

Major Challenges

RAP House has had challenges with keeping our nurse position filled. During the last year the program had four nurses come and go. The nurse position was recently filled in January 2024.

Narrative Summary

The management structure for RAP House includes a Sr Director of Residential Services, a Residential Program Director, and a Community Counseling Program Director. In addition to the direct services managers, the program also employs a Quality Improvement Prevention Specialist, a Training Specialist, a Registered Nurse, and two Office Specialists. The residential program is also staffed by six Shift Leads and 14 Youth Development Staff, eight fulltime and 6 part time. The nurse's position was recently filled on 1/22/24. In addition to the Program Director, the community counseling program is staffed by three Pasco County case managers and one Office Specialist. The agency has not reported any critical incidents, administrative review, or current external investigation.

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

Standard 1: There are seven indicators for Standard 1. Indicator 1.01 Background Screening of Employees/Volunteers was rated **Satisfactory with Exception**, Indicator 1.02 Provision of an Abuse Free Environment was rated **Satisfactory with Exception**, 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 with Exception**, and Indicator 1.07 Outreach Services was rated **Limited.**

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**, 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 **Limited**, Indicator 2.06 Adjudication/Petition Process was rated **Satisfactory**, Indicator 2.07 Youth Records was rated **Satisfactory with Exception**, Indicator 2.08 Specialized Additional Program Services was rated **Satisfactory,** and Indicator 2.09 Stop Now and Plan (SNAP) was rated **Satisfactory with Exception.**

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 with Exception**, Indicator 3.03 Youth Room Assignment was rated **Satisfactory**, Indicator 3.04 Log Books was rated **Satisfactory**, Indicator 3.05 Behavior Management Strategies was rated **Satisfactory**, Indicator 3.06 Staffing and Youth Supervision was rated **Satisfactory with Exception**, and Indicator 3.07 Video Surveillance System was rated **Satisfactory.**

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

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

Standard 1:

Indicator 1.07 - Limited

No evidence of attendance was provided to support the program attended any of the two meetings held for the review period.

Standard 2:

Indicator 2.05 - Limited

In the month of September, there was a gap between 9/6-9/16/2023 of no group sessions conducted. In the months of December and January, there were gaps between 12/3-12/8/2023 and 1/1-1/9/2024 of no group sessions conducted. In addition, there was no documentation that group counseling was provided 5 days/week for four of the five residential youth. There were some sessions that did not have their names on the sign-in sheet or documentation as to why they did not participate.

Some group sessions were documented to be less than 30 minutes long such as some were 15, 20, or 25 minutes long. Some group notes did not have a time started and ended or duration documented and was left blank.

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: 17
Total number of 5 Year Re-screen Employee Files: 1
Staff Position(s) Interviewed *(No Staff Names)* **: Program Directors for shelter and community counseling, Shelter Counselor**
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 17 applicable new hires. All 17 new staff successfully passed the CBST. Fifteen of the 17 staff completed the pre-employment assessment tool prior to hire.	Two new staff hired did not complete the CBST pre-assessment tool prior to hire as required. One of the staff was hired 7/17/2023 but completed the CBST on 7/25/23. The second staff was hired 5/15/2023 and completed the CBST on 7/19/23.
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 17 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**	DJJ background screenings were initiated prior to hire dates for all 17 staff and eligibility was 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 the last screening or prior to retained fingerprints expiration date.	**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 15 of the 17 new staff, verifying authorization to work. Per Human Resources, the E-Verifies were manually completed by Paylocity; however, the evidence is not available. A copy of Form I-9 verifying identity and eligible work documents was maintained in the two staff files.	The program did not have the required proof of E-Verify for two new staff hired.
Additional Comments: **There are no additional comments for this indicator.**			
1.02: Provision of an Abuse Free Environment			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 1.02		**YES**	
		If NO, explain here:	
		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 **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 the Employee Handbook. The code of conduct requires employees to conduct themselves in a manner that protects the safety of youth and maintain respectful conduct.	

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. Staff documents child abuse calls directly on the abuse hotline's website and maintain a copy of the printed report in a binder as well as emails from the hotline indicating acceptance status of the calls. A total of 24 non-institutional abuse calls were reported during the review period. Nineteen of the calls were accepted by the hotline.	
Youth were informed of the Abuse and Contact Number	**Compliance**	Youth are informed about the abuse hotline and contact number and have full access to that information. Three youth records reviewed demonstrated youth are informed during orientation and it's documented on the Client Orientation checklist. The abuse hotline telephone number is posted throughout the facility and is visible in the dayroom as well as on each wing in the dorm area.	
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. Three youth records reviewed demonstrated youth are informed about the grievance procedure during orientation and it's on the Client Orientation checklist as well as in the client handbook provided to youth. Agency supervisors have access to and manage 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. During the past six months a total of 83 grievances were reported by youth.	
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 two locked boxes including forms which are accessible to youth on each wing of the dormitory.	
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.	**Exception**	Logbook review of grievance box checks was conducted for the following two-week periods each month: October 8th -21st, November 5th-18th, December 17th-30th, January 14th-27th, February 4th-17th, and March 10th-23rd. Grievance box checks and documentation in the program logbook was not evident daily for the dates reviewed.	No grievance box checks were documented for 12 of the 39 days reviewed on the following dates: 10/9, 10/16, 10/18, 11/10, 11/15, 11/17, 12/18, 12/26, 12/28, 1/15, 1/17, and 1/22.
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.	**Exception**	The residential supervisor responded to and resolved 80 of the 83 grievances reviewed within the 72 hours required.	Three grievances reviewed were not resolved within 72 hours as required. One grievance submitted 10/8/23 was reviewed on 10/12/23 after the youth was discharged. Another grievance was submitted on 1/9/24 but not resolved until 1/16/24. A third grievance was reported on 1/1/24. It appears the supervisor's date was a typo, indicating it was resolved 1/7/23; however, the program director verified the date should be 1/7/24.

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 33 incidents between 8/7/2023 and 2/7/2024 was reviewed and compared to the agency's CCC report submission. Twenty-seven of the 33 CCC incidents were reported within the required 2- hour timeline.	Six of the 33 incidents reported to CCC were not reported within the 2 hour timeframe required. Dates for the late CCC reports are 9/16/23, 11/8/23, 1/12/24, 1/21/24. 2/24/24, and 3/7/24.
The program completes follow-up communication tasks/special instructions as required by the CCC	**Compliance**	All applicable follow up tasks were completed as requested with the email communication with DJJ documented.	
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 ten randomly selected CCC incidents to determine if incidents are documented in the program log. Evidence supported eight of the ten CCC incidents were recorded in the program logbook.	Two of 10 randomly selected incidents reported to CCC were not logged in the program logbook.
All incident reports are reviewed and signed by program supervisors/ directors	**Compliance**	All 33 incidents were reviewed and signed by the program director. The reportable incidents were classified as follows: six mental health; nine medical; thirteen program disruption; two complaint against staff; and three youth behavior.	

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.	
All staff completed the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days from date of hire.	**Compliance**	All four first year staff completed new the Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days from date of hire.	
All direct care CINS/FINS staff (full time, part time, or on-call) demonstrated a minimum of 80 hours of training or more for the first full year of employment.	**Compliance**	One of the four staff completed an excess of 80 hours of annual training. Three of the four records show training hours between 52-60 hours completed with adequate time remaining to complete the 80 hours required.	
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.	One staff was late completing three trainings - motivational interviewing, cultural diversity, and adolescent behavior. The second staff was also late completing cultural diversity and Adolescent Development and there's no documentation of completion of behavior management training.

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 training.	
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*	**Compliance**	One applicable staff member participating in Case Staffing completed the FL Statute 984 CINS Petition Training by a local DJJ Attorney.	
Documentation of non-licensed mental health clinical staff person's training in Assessment of Suicide Risk form or written confirmation by a licensed mental health professional of training (includes date, signature and license number of the licensed mental health professional supervisor).	**Compliance**	The program had one new non-licensed mental health clinical shelter staff person hired during the review period. Documentation supported the staff completed the required Assessment of Suicide training.	
In-Service Direct Care Staff			
Direct care staff completes 24 hours of mandatory refresher Florida Network, SkillPro, and job-related training annually *(40 hours if the program has a DCF child caring license).*	**Exception**	Three of the four 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.	One in-service staff missed two annual trainings for FY22-23 (human trafficking and information security awareness, last done June 2022 for FY21-22).
Required Training Documentation			
The agency has a training plan that includes all of the required training topics including the pre-service and in-service.	**Compliance**	The agency has a 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 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.	**Compliance**	All 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.	
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 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 (RPMT) - 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 for the period July 2023-January 2024 of the current FY were observed to be discussed at RPMT meetings held 12/5/23 and 3/15/24.	

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 community based 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 with Exception**
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-March 2024 **Staff Position(s) Interviewed (No Staff Names): QIS** **Type of Documentation(s) Reviewed: transportation logs, eligible drivers DMV Check, auto insurance policy**			
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 24 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.	**Exception**	During the review period, it was observed the program made significant effort to avoid single transport. A total of four transport events included a single youth. Three of the four single youth transports evidenced prior approval by the supervisor.	One single transport on 9/1/2023 did not document proof of supervisor's approval.
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 used to transport youth, a 2023 Chrysler Pacifica, and a 2022 Chrysler voyager. Each van uses a separate transportation log that 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			**Limited**
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, Program Director/Outreach Coordinator **Type of Documentation(s) Reviewed: DJJ Board Meeting Schedule, 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.	**Exception**	The provider has a designated staff defined by title and job description to conduct outreach activities. The community counseling program director is designated to participate in the Pasco County Circuit 6 DJJ Circuit meetings. Circuit 6 held two meetings, January 9th and March 7th, in the past 6 months.	No evidence of attendance was provided to support the program attended any of the two meetings held for the review period.
The program maintains written agreements with other community partners which include services provided and a comprehensive referral process.	**Compliance**	The program has written agreements with community partners which include services provided and a comprehensive referral process. Current agreements include: National Safe Place; Pasco Juvenile Assessment Center; District School Board of Pasco County (truancy and diversion) ; United Way Pasco; Baycare Behavioral Health; and Pasco Kids First. All of the agreements were found to have effective dates.	

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 program 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 program has an Outreach Coordinator who is the designated staff defined by title and job description to conduct outreach activities. Outreach activities are documented on the Outreach Events Form and supporting documentation of the event is attached and maintained in a binder.	
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)* **: Residential and Community Counseling Program Directors** **Type of Documentation(s) Reviewed: Youth records, electronic record system, and NETMIS system.** **Describe any Observations: Half of the documentation for each residential youth file was electronic and half paper copy. All of community counseling youth files were paper files.**			
Shelter youth: Eligibility screening form is completed immediately for all shelter placement inquiries.	**Compliance**	Five residential youth records were reviewed in total for two open and three closed files. All screening forms were completed immediately during time of call for shelter placement.	
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 within three business days of the referral by a trained staff.	
There is evidence all referrals for service is screened for eligibility and is logged in NetMIS within 72 hours of screening completion.	**Exception**	Six of the ten screenings reviewed were logged into NetMIS within 72 hours of screening completion.	One residential and three community counseling youth screenings reviewed were not logged into NetMIS within the 72 hours required. The delays for data entry ranged from six to eleven days across the four records.
Youth and parents/guardians receive the following in writing: a. Available service options b. Rights and responsibilities of youth and parents/guardians	**Compliance**	Each youth record reviewed had evidence youth and parents/guardians were given verbal or written review of available service options, rights and responsibilities, and are provided a copy of the program brochure during the intake process.	

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	**Compliance**	Each youth record reviewed had evidence youth and parents/guardians were given verbal or written review of grievance procedures and/or any possible actions that may occur through involvement with CINS/FINS services during the intake process..	
During intake, all youth were screened for suicidality and correctly assessed as required if needed.	**Compliance**	All ten youth were screened for suicidality during the intake process and a full suicide assessment was completed for four applicable youth by either a licensed mental health professional or an unlicensed mental health professional under the supervision of a licensed mental health professional.	
Additional Comments: **There are no additional comments for this indicator.**			
2.02 - Needs Assessment			**Satisfactory**
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)* **: Residential and Community Counseling Program Directors** **Type of Documentation(s) Reviewed: Youth records, electronic record system, and NETMIS system.** **Describe any Observations: Half of the documentation for each residential youth file was electronic and half paper copy. All of community counseling youth files were paper files.**			
Shelter Youth: NIRVANA is initiated within 72 hours of admission	**Compliance**	All five shelter youth had a NIRVANA assessment initiated within 72 hours of admission.	
Non-Residential youth: NIRVANA is initiated at intake and completed within 2 to 3 face-to-face contacts after the initial intake **OR** updated, if most recent assessment is over 6 months old	**Compliance**	All five community counseling youth records reviewed had a NIRVANA assessment initiated and completed at time of intake.	
Supervisor signatures is documented for all completed NIRVANA assessments and/or the chronological note and/or interview guide that is located in the youths' file.	**Compliance**	All youth records reviewed had a NIRVANA assessment signed by a supervisor.	
(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**	The five shelter youth completed a NIRVANA self-assessment at intake and within 24 hours of admission.	
A NIRVANA Post-Assessment is completed at discharge for all youth who have a length of stay that is greater than 30 days.	**Compliance**	Six of the ten records were closed. Out of the six closed youth records, four youth had a length of stay greater than 30 days and a NIRVANA post-assessment was completed at discharge.	

A NIRVANA Re-Assessment is completed every 90 days excluding files for youth receiving SNAP services.	**Compliance**	The five community counseling youth were the only youth that received services for more than 90 days and a NIRVANA re-assessment was completed and filed in each record.	
All files include the interview guide and/or printed NIRVANA.	**Compliance**	All ten youth records reviewed had a NIRVANA assessment printed and filed for each youth.	
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)* **: Residential and Community Counseling Program Directors** **Type of Documentation(s) Reviewed: Youth records, electronic record system, and NETMIS system.** **Describe any Observations: Half of the documentation for each residential youth file was electronic and half paper copy. All of community counseling youth files were paper files.**			
The case/service plan is developed on a local provider-approved form or through NETMIS and is based on information gathered during the initial screening, intake, and NIRVANA.	**Compliance**	All youth had a case/service plan developed on a local provider-approved form and were based on information gathered during the initial screening, intake, and NIRVANA.	
Case/Service plan is developed within 7 working days of NIRVANA	**Compliance**	All youth had a case/service plan developed within 7 working days of NIRVANA.	
Case plan/service plan includes: 1. Individualized and prioritized need(s) and goal(s) identified by the NIRVANA 2. Service type, frequency, location 3. Person(s) responsible 4. Target date(s) for completion and actual completion date(s) 5. Signature of youth, parent/guardian, counselor, and supervisor 6. Date the plan was initiated	**Exception**	All ten service plans reviewed included individualized and prioritized needs and goals identified by the Nirvana and listed the date the plan was initiated. Nine of the ten youth case/service plans included type, frequency, and location of services documented on the case/service plan. All case plans were signed by the youth, counselor, and supervisor. There were parent/guardian signatures on six of the ten case/service plans reviewed; however, there was written documentation on the case/service plans of verbal consent via phone with the parent/guardian or attempts to contact parent for three additional youth records that did not have a parent/guardian signature on the case/service plan. There were actual completion dates documented on four of the six applicable closed case/service plans.	One of the case plans was missing service type, frequency, and location. There were no parent/guardian signatures on one case/service plan for a residential youth. There were also missing actual completion dates on the case/service plans for two closed community counseling youth records reviewed.

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**	Out of the 10 youth records that were reviewed, only the 5 CC youth received services longer than 30 days and their case/service plans were reviewed for progress timely every 30 days.	
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)* **: Residential and Community Counseling Program Directors** **Type of Documentation(s) Reviewed: Youth records, electronic record system, and NETMIS system.** **Describe any Observations: Half of the documentation for each residential youth file was electronic and half paper copy. All of community counseling youth files were paper files.**			
Counselor/Case Manager is assigned	**Compliance**	All ten youth records have a counselor/case manager assigned.	
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. Two of the youth were referred to case staffing. Five records were applicable for 30 day review post discharge and four for 60 day post discharge review. Thirty and/or 60-day post discharge reviews were conducted for four of the five youth.	One of five applicable records was missing the 30 day and 60 day post discharge follow-ups.
The program maintains written agreements with other community partners that include services provided and a comprehensive referral process	**Compliance**	The agency has written agreements with community partners which include services provided and a comprehensive referral process. Current agreements include: National Safe Place; Pasco Juvenile Assessment Center; District School Board of Pasco County (truancy and diversion) ; United Way Pasco; Baycare Behavioral Health; and Pasco Kids First.	
Additional Comments: **There are no additional comments for this indicator.**			

2.05 - Counseling Services			Limited
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)* **: Residential and Community Counseling Program Directors** **Type of Documentation(s) Reviewed: Youth records, electronic record system, and NETMIS system.** **Describe any Observations: Half of the documentation for each residential youth file was electronic and half paper copy. All of community counseling youth files were paper files.**			
Shelter Program			
Shelter programs provides individual and family counseling	**Compliance**	Documentation in each youth record supported individual and family counseling sessions were conducted for shelter youth.	
Group counseling sessions held a minimum of five days per week	**Exception**	The group binder with sign-in sheets was reviewed for group counseling services. There was no documentation in the group binder that showed that group sessions were conducted five days per week and there were gaps in some months where some days and/or weeks no group sessions were conducted.	In the month of September, there was a gap between 9/6-9/16/2023 of no group sessions conducted. In the months of December and January, there were gaps between 12/3-12/8/2023 and 1/1-1/9/2024 of no group sessions conducted. In addition, there was no documentation that group counseling was provided 5 days/week for four of the five residential youth. There were some sessions that did not have their names on the sign-in sheet or documentation as to why they did not participate.
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	**Exception**	The group binder was reviewed for group counseling services. There was documentation indicating that groups were conducted by a leader/facilitator, had a relevant topic, and had sign-in sheets to show which youth participated; however, not all group sessions were conducted for 30 minutes or longer.	Some group sessions were documented to be less than 30 minutes long such as some were 15, 20, or 25 minutes long.
Documentation of groups must include date and time, a list of participants, length of time, and topic.	**Exception**	The group binder was reviewed for group counseling services. There was documentation that included the date, a list of participants (sign-in sheets) and topic; however, some group notes did not have a time or duration documented.	Some group notes did not have a time started and ended or duration documented and was left blank.
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**	There was written documentation that counseling services were being provided on a weekly basis with the youth and family as needed and were provided primarily in the school setting.	
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**	There was written documentation that showed clinical meetings being held between counselor/case manager and supervisor to review and discuss case files such as monitoring notes, progress notes, and case/service plan reviews.	
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.	
Case notes maintained for all counseling services provided and documents youth's progress.	**Compliance**	Youth's progress was documented on monitoring notes, progress notes and case/service plan reviews.	
On-going internal process that ensures clinical reviews of case records and staff performance.	**Compliance**	There was written documentation that showed clinical meetings being held between counselor/case manager and supervisor to review and discuss case files.	
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**	The Residential and Community Counseling Program Directors both reported that they do not conduct intakes or counseling sessions virtually.	
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: 2 Community counseling
Total number of Closed (Residential & Community) Files: 1 Community counseling
Staff Position(s) Interviewed *(No Staff Names)* **: Community Counseling Program Director**
Type of Documentation(s) Reviewed: Community counseling youth records that were petitioned for case staffing and emails to show where the program director sent notifications to the committee for case staffing.

Must include: a. DJJ rep. or CINS/FINS provider b. Local school district representative	**Compliance**	Three community counseling youth records were reviewed, 2 open and 1 closed. Each case staffing included a DJJ representative or CINS/FINS provider and a local school 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**	One case staffing included a law enforcement representative. All other members are not applicable as the program director reported they were not required to attend.	
The program has an established case staffing committee, and has regular communication with committee members	**Compliance**	The community counseling program director reported the program has a case staffing committee and communicates regularly via email or phone when there is a petition for case staffing.	
The program has an internal procedure for the case staffing process, including a schedule for committee meetings	**Compliance**	Per the program director, the internal procedure for the case staffing process is to notify the committee via email and parents/guardians via mail, email, or phone when there is a petition for case staffing. There is not a set schedule for committee meetings, but a schedule is created for case staffing.	
The youth and family are provided a new or revised plan for services	**Compliance**	Each youth record had written documentation to show that a copy of the new/revised case plan was provided to parents/guardians on the day of the case staffing or reviewed with them if they attended by phone and via mail or email if the parent/guardian was not in attendance.	
Written report is provided to the parent/guardian within 7 days of the case staffing meeting, outlining recommendations and reasons behind the recommendations	**Compliance**	Each youth record had written documentation to show that a written report was provided to the parent/guardian within 7 days of the case staffing meeting, outlining recommendations and reasons behind the recommendations either in person or reviewed by phone on the day of the case staffing or via mail or email if the parent/guardian was not in attendance.	
If applicable, the program works with the circuit court for judicial intervention for the youth/family	**No eligible items for review**	None of the three records were referred to court for judicial interventions.	
Case Manager/Counselor completes a review summary prior to the court hearing	**No eligible items for review**	None of the three records were referred to court for judicial interventions.	
Additional Comments: **There are no additional comments for this indicator.**			
2.07 - Youth Records			**Satisfactory with Exception**
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.*			

Staff Position(s) Interviewed *(No Staff Names)* **: Residential Program Director and Nurse**
Type of Documentation(s) Reviewed: Youth records, nurse's office, travel bag w/lock and lock box where records are stored while in transport.
Describe any Observations: All youth records are kept in a file cabinet in the nurse's office which is secured and locked.

All records are clearly marked 'confidential'.	**Exception**	Eight of the ten youth records reviewed were marked/stamped "confidential."	Two youth records (one residential and one community counseling) were not marked "confidential."
All records are kept in a secure room or locked in a file cabinet that is marked "confidential"	**Exception**	All youth records are kept in a file cabinet in the nurse's office which is secured and locked.	There is no signage of the word "confidential" on the nurse's office door or on the file cabinet.
When in transport, all records are locked in an opaque container marked "confidential"	**Compliance**	When in transport, youth records are locked in a black metal box or a black travel bag that are both marked "confidential."	
All records are maintained in a neat and orderly manner so that staff can quickly and easily access information	**Compliance**	All youth records are maintained neat and orderly in color coded folders that are easy to access for information.	

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.*

Total number of Open Files: 0
Total number of Closed Files:0
Staff Position(s) Interviewed *(No Staff Names)* **: Residential program director**

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 agency has not served any staff-secure cases 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	**Compliance**	Policy and procedure RGC 2.08 - Specialized Additional Program Service includes the procedures for the required items for staff secure services.	
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.*			
Total number of Open Files: 0 **Total number of Closed Files:0** **Staff Position(s) Interviewed** *(No Staff Names)* **: Residential program director**			
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 agency has not had domestic minor sex trafficking cases 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 Closed Files: 3 **Staff Position(s) Interviewed** *(No Staff Names)* **: Program Director** **Type of Documentation(s) Reviewed: Closed 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**	The agency had three cases open in the last 6 months all of which are currently closed.	
Youth admitted to DV Respite placement have evidence in the file of a pending DV charge	**Compliance**	All three youth residential files were admitted to DV respite placement as 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 exceeded 21 days of stay in the DV program.	
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**	One of the three residential files included a case plan. After speaking with the program director two of the three files did not include a case plan because they were discharged from shelter within 4-5 days. This information was confirmed by the discharge report.	
All other services provided to Domestic Violence Respite youth are consistent with all other general CINS/FINS program requirements	**Compliance**	All three residential files were in compliance with services following CINS/FINS program requirements.	
Probation Respite			
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: 1 **Staff Position(s) Interviewed** *(No Staff Names)* **: Program Director** **Type of Documentation(s) Reviewed: Open file**			

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**	The agency has one open applicable youth record in the last six months which was reviewed.	
All probation respite referrals are submitted to the Florida Network.	**Compliance**	The one open youth residential file was in compliance for a respite referral being submitted to the Florida Network for approval.	
All Probation Respite Referral come from DJJ Probation and there is evidence that the youth is on Probation regardless of adjudication status.	**Compliance**	The one open youth residential file provided evidence of probation as observed on the client's face sheet in the case file.	
Data entry into NetMIS and JJIS within (3) business days of intake and discharge	**Compliance**	The case was entered into NetMIS within 3 business days of intake.	
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**	Case was opened on 3/14/2024, less than 14 days.	
All case management and counseling needs have been considered and addressed	**Compliance**	The residential youth file contains case management and counseling services identified from the assessments.	
All other services provided to Probation Respite youth are consistent with all other general CINS/FINS program requirements	**Compliance**	Probation respite services are in compliance with standards and similar to services provided to general CINS/FINS youth.	
Intensive Case Management (ICM)			
Document Source: Please provide a detailed explanation of any sources used to complete this indicator. *e.g. Indicate the type of file reviewed or the total number of records reviewed (e.g. 3 new hire staff/employee records or 2 closed youth residential files 2 open community counseling files), type of documents reviewed (e.g. logbooks, drills, inspections, emails, training certificates, meeting minutes, grievances, groups meeting, etc.), describe observations (e.g. signage/postings or staff interactions with youth), document interviews with any staff members, and any other information used to gather evidence to substantiate findings for the indicator.*			
Total number of Open Files: 0 **Total number of Closed Files:0** **Staff Position(s) Interviewed** *(No Staff Names)* **: Residential program director**			
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.*			
Total number of Open Files: 0 **Total number of Closed Files:0** **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)			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 2.09		**YES** If NO, explain here: The provider has the required policy and procedure RGC 2.09 SNAP-Stop Now And Plan that was approved 10/13/2023 by the CEO,	
Total number of Open Files: 1 **Total number of Closed Files: 2** **Staff Position(s) Interviewed** *(No Staff Names)* **: SNAP Coordinator/Supervisor** **Type of Documentation(s) Reviewed: youth files**			
SNAP Clinical Groups Under 12			
Youth are screened to determine eligibility of services.	**Compliance**	All three youth files were screened for eligibility.	
The NIRVANA was completed at initial intake, or within two sessions.	**Compliance**	All three records were observed to have the printed NIRVANA completed during intake.	
There is evidence of the completed Child Behavior Checklist (CBCL) by the caregiver (pre and post) and is located within the file.	**Compliance**	One open file contained the pre CBCL. Two closed files contained the pre-CBCL and post -CBCL.	
There is evidence of the completed Teacher Report Form (TRF) is completed by the teacher (pre and post) and is located within the file.	**Exception**	Of the three files observed, only one contained pre-TRF proof. No post-TRF proof was found in one applicable file; one of the three files was currently open and not needing the post-TRF. TRF proof was not obtained in the third file because the child was removed from school prior to completing the program.	Two files were missing pre-TRF proof and one was missing the post-TRF proof.
There is evidence of the completed TOPSE is completed by the caregiver (pre and post) and is located within the file.	**Compliance**	All three files were observed to have the pre TOPSE. The two closed files were observed to have the post TOPSE.	
SNAP Clinical Groups Under 12 - Discharge			
There is evidence of the completed SNAP Discharge Report located within the file for any discharged youth.	**Exception**	Two SNAP U12 closed files were reviewed. Both closed files did not contain a discharge summary report.	Two of two closed files did not have a discharge summary report.
There is evidence of the SNAP Boys/SNAP Girls Child Group Evaluation Form located in the file.	**Compliance**	Three of the three files contained the child evaluation form completed.	
There is evidence of the SNAP Boys/SNAP Girls Parent Group Evaluation Form located in the file.	**Compliance**	Three of the three files contained the parents evaluation form completed.	

SNAP Clinical Groups for Youth 12-17			
Youth are screened to determine eligibility of services.	**Not Applicable**	The agency does not have a SNAP for Youth 12-17 program.	
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*)	**Compliance**	Two SNAP in Schools classes were observed, one closed and one open. Both classes contained 13 attendance sheets with signatures and names of the students.	
The program maintained evidence of a completed "Class Goal" Document for the class reviewed.	**Exception**	Out of the two SNAP in Schools classes observed only one class had a goal sheet in the file.	The goal sheet for Mrs. M's class was located in her classroom and unavailable for review.
The program maintained evidence of both pre AND post Measure of Classroom Environment (MoCE) completed documents for the class reviewed.	**Compliance**	Both SNAP in Schools class contained completed MoCE's.	
The program maintained evidence of completed pre and post evaluation documents for the class reviewed.	**Exception**	Both SNAP in Schools class contained pre evaluations for the class. However, the closed class was missing the students post evaluations.	Post evaluations were missing for the closed class students.
There is evidence of the fidelity adherence checklist maintained in the file for each class reviewed.	**Compliance**	Both SNAP in Schools class were observed to have completed fidelities.	
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.	**Exception**	All the furnishings throughout the facility are in good repairs and appropriate for the setting. No insects were spotted during the facility tour. There are two bathrooms on each wing of the living areas, one is regular bathroom and one is handicap accessible bathroom. Agency has a chalk board wall in each youth room which has cut down on graffiti. Agency grounds are very clean and landscaped. Lighting appears adequate. Dumpster is enclosed in a fenced area. Doors are secured with magnet locks and require a key fob to enter or you can use a key as well. Egress maps are posted in all the youth rooms at the door and also posted at the exit doors. Grievance boxes are at the end of each hall and in the dayroom. Abuse hotline numbers are on a board in the hallways and in the dayroom.	Upon touring the facility it was observed that three of the four bathrooms had metal rings on the shower curtain rode. Program Director was made aware of the findings and is currently get them changed out.
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.	**Exception**	The program has two vehicles used to transport youth, a 2023 Chrysler Pacifica and a 2022 Chrysler Voyager. Upon checking one of the vehicles, the Chrysler Pacifica was left unlocked. Both vehicles are equipped with all contractual safety equipment. Vehicle keys are kept in the nurse's office in a key cabinet.	One of the agency vehicles was left unlocked but the youth had just returned from an outing and it was raining at the time.

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**	Inventory is completed on all chemicals weekly and it is separated by utility closest, kitchen, and laundry room. In addition, the program maintains a perpetual inventory for chemicals frequently used. MSDS books are in each area as well and accounts for each chemical used in the facility. There is one in the kitchen, one in the utility room and one in the laundry room.	
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 agency has three washers and three dryers that are operational and free of lint. Each youth is provided with age appropriate bed linens that are clean and sufficient. Agency has invested in lockers that are at the top of each hallway that allows youth to lock away any personnel items they wants.	
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**	Pasco County Fire Marshall conducted the annual fire inspection on 2/7/24. Fire drills were conducted on each shift as follows: 1st Shift: 3/8, 2/6, 1/27, 12/6, 11/6, 10/4, 9/8 2nd Shift: 3/26, 2/20, 2/15, 1/26, 11/20, 10/8, 9/12 3rd Shift: 3/21, 2/18, 2/16, 1/18, 11/25, 10/19, 9/19 Mock emergency drills were completed as follows: 1st Shift:1/27/24,10/19/23, 9/8/23 2nd Shift: 1/27/24, 9/24/23 3rd Shift: 1/27/24,10/20/23,9/27/23 Piper Fire Protection Company conducted the Fire Suppression System inspection on 2/21/24 and the same company conducted the Sprinkler and Backflow Inspection on 2/14/24. Fire Master conducted the Fire Extinguisher inspection on 1/10/24.	For the Months of December and November of 2023 there were only two fire drills conducted during those months. After speaking with the Program Director, it was reported disciplinary actions were taken for the staff responsible for not completing those drills.

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**	The agency's last combined Group Care and Food Inspection was conducted January 18th, 2024 with no corrections needed. Program Director and kitchen staff stated that the County Health Department does not require a Quarterly Inspection per the policy of the Health Department. Four weeks of menus are posted in day room and dining room. Menus are signed by a registered dietician on 9/23/23 and dietician's license is good through 5-21-25. Upon observing the freezers and refrigerator , everything is stored appropriately and they were clean. Fridge Temperature: 40 degrees Freezer Temperature: -42, 0, 4	
Additional Fire and Safety Health Hazards Narrative (if applicable)			
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 has 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 with Exception**
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
Total number of Closed Files: 2
Staff Position(s) Interviewed *(No Staff Names)* **: Program Director and Team Leader**
Type of Documentation(s) Reviewed: Youth intake files
Describe any Observations: Youth files are stored on an electronic tracking program.

Youth received a comprehensive orientation and handbook provided within 24 hours	**Exception**	Agency has a very comprehensive orientation process and youth handbook that is provided to each youth during their intake process. Two of three records reviewed demonstrated orientation is completed within 24 hours of admission.	One youth was Baker Acted during his intake and returned to the facility the same day. The youth's orientation was not completed until five days later after a supervisor was completing a chart review.
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**	Agency has a very comprehensive form that captures all contractual required information which is stored on an electronic platform. 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**	Agency has a form that captures the signature of the youth and staff that is working with the youth at the time of intake.	

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
Total number of Closed Files: 2
Staff Position(s) Interviewed *(No Staff Names)* **: Program Director and Team Leader**
Type of Documentation(s) Reviewed: Youth's intake documents
Describe any Observations: Documents are stored on electronic platform

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 Agency has a comprehensive Alert System that shows up when a youth present signs during their intake that requires an alert. The Agency places a sticker on the front of the youth's chart. It is then posted on the alert boards in the nurse's office as well as on the census board in the hallway outside of the laundry room. Also, the alerts pop up on the electronic tracking system. 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**
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: March fourth thru the fifteenth of 2024 and October ninth thru the tenth of 2023. **Staff Position(s) Interviewed (No Staff Names): Program Director** **Type of Documentation(s) Reviewed: Physical log books.** **Describe any Observations: Log books are standard green log books and the pages are numbered.**			
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. Four random weeks of logbook entries from March 4th through the 15th of 2024 and October 9th through the 20th of 2023 were reviewed. 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.	**Compliance**	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 observed to be conducted consistently.	
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	**Compliance**	Evidence of supervisory reviews of the logbooks bi-weekly was observed. Entries are made in purple when the program director or designee reviews the log book.	
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.	**Compliance**	The Shift Supervisor make the original entry in the log book to start the shift and then the other employees on shift take the log book and makes entries that they read missed shifts.	
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)* **: Program Director and Team Leader** **Type of Documentation(s) Reviewed: Policies and Procedures and Behavior Management Program, Youth Handbook**			
The program has a detailed written description of the BMS and it is explained during program orientation	**Compliance**	Each youth is given a handbook at intake that clearly explains the behavior management system.	
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**	Supervisors monitor the behavior management program and discuss it at monthly staff meetings and weekly at the treatment teams. The supervisor posts the levels that each youth is on in the day room on the board so that all staff and youth know their level status. Program director states that the agency trains staff on the BMS during the MAB training. The training coordinator provided an outline showing a description of the training covered during MAB.	
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 and via email.	
Supervisors are trained to monitor the use of rewards and consequences by their staff	**Compliance**	The Program Director and Team Leader monitor the BMS and the use of rewards and consequences and discuss it with the staff during monthly staff meetings and during the weekly Treatment Team meeting.	
Additional Comments: **There are no additional comments for this indicator.**			

3.06 - Staffing and Youth Supervision			Satisfactory with Exception
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: The last 6 months of staff schedules were reviewed **Staff Position(s) Interviewed Program Director and Team Leader** **Type of Documentation(s) Reviewed: Staff Schedules**			
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 at least 1:12 on the overnight.	
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 two 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**	All employees must pass background screening and be properly trained prior to working on the floor with the youth. Shelter staff included in the staff-to-youth ratio were verified to be properly trained and background screened.	
The staff schedule is provided to staff or posted in a place visible to staff	**Compliance**	A monthly schedule is posted in the copy room and sent out via email.	
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 program maintains a list of all employees and if someone calls out they start at the bottom of the list with the YDS staff and continue up the list all the way up to the Program Director until they get someone to fill the shift.	
Staff observe youth at least every 15 minutes while they are in their sleeping room, either during the sleep period or at other times, such as during illness or room restriction	**Exception**	Bed Check Dates/Times reviewed: •March 3rd , 2am-4am (During observation the employees missed two checks on 2:40am and 3:00am) •March 8th, 4am-6am (All checks were completed in accordance to standard) •March 16th, 1am-3am (Employees missed the 1:10am check) •March 25th, 3am-5am (Employees missed the 4:20am check)	After reviewing the camera system with the Program Director and observing the program logbooks, it was observed that on March 3, 2024 the bed check for 2:40am and the bed check for 3:00am were missed all together, as well as the 1:10am bed check on March 16, 2024. Finally, the bed check on March 25, 2024 at 4:20am was missed.
Additional Comments: **There are no additional comments for this indicator.**			

3.07 - Video Surveillance System			Satisfactory
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.*			
Dates or Timeframe Reviewed: Cameras were reviewed for March 4th from 2 to 4am, March 8th from 4 to 6am, March 16th from1 to 3 am, and March 25th 3 to 5am. **Staff Position(s) Interviewed: Program Director** **Type of Documentation(s) Reviewed: Actual camera system**			
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**	Signs are posted on the exterior of the building stating cameras are in use. Cameras are placed in all contractual areas. All cameras are visible. There are no cameras in any bathrooms or sleeping areas. Agency is in the middle of an upgrade to a new cloud based camera system which will give them more cameras and longer storage time. Camera system is equipped to do all the required task but the system is slow and grainy so the agency has opted to upgrade their system. Agency is equipped with an emergency generator that keeps the camera system running if power goes out.	
A list of designated personnel who can access the video surveillance system is maintained (includes off-site capability per personnel)?	**Compliance**	The video can be accessed off-site by the Program Director, Residential Supervisor, Team Leader, Senior Program Director of Residential and School Programs, and COO.	
Supervisory review of video is conducted a minimum of once every 14 days and timeframes reviewed are noted in the logbook.	**Compliance**	Program Director has a separate log that is kept in his office where he document his checks that are conducted according to standards.	
The reviews assess the activities of the facility and include a review of random sample of overnight shifts	**Compliance**	Program Director does a very good job at doing random reviews covering all 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	**Compliance**	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.	

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**	Program Director submits a work order to the facility manager and they take care of any of the issues or gets outside agency to come in and fix it.	
Additional Comments: **There are no additional comments for this indicator.**			
4.01 - Healthcare Admission Screening			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 4.01		**YES** 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 **Total number of Closed Files:3** **Staff Position(s) Interviewed** *(No Staff Names)* **: Residential Program Director** **Type of Documentation(s) Reviewed: Youth's File Records HealthCare Screening Admission**			
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	**Compliance**	Two open and three closed youth residential files were reviewed for the preliminary healthcare screening. In all five files reviewed, a preliminary healthcare screening was completed for each including current medication; medical conditions (if applicable); allergies; recent injuries - including a description of the injuries and locations; and tattoos, scars, and other skin markings. In the five files reviewed none required quarantine or isolation for health symptoms.	
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**	After review of two open and three closed residential files, none of the youth were found to have 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**	Medical referrals were not applicable for the two open youth residential files reviewed and three closed residential files reviewed.	

The program has a thorough referral process and a mechanism for necessary follow-up medical care as required and/or needed	**Compliance**	The program has documented policy and procedures with a thorough referral process and follow-up medical care located under Youth and Family Alternatives Policies and Procedures RCG 4.01.	
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: The provider has the required policy and procedure RGC 4.02/Healthcare Admission Screening approved 10/13/23by 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: 1 residential, 1 community counseling **Total number of Closed (Residential & Community) Files: 2 residential** **Staff Position(s) Interviewed** *(No Staff Names)* **: Community Counseling Program Director, Residential Program Director** **Type of Documentation(s) Reviewed: Youth File Records Suicide Risk Screening**			
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**	All four youth records were observed to include suicide risk screenings and the screening results were reviewed and signed by a supervisor.	
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 the appropriate level of 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**	Three residential youth files were observed for one-to-one constant supervision. In the youth residential files, 15 to 30 minutes documented observations were recorded for each youth.	
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**	Three residential youth files were observed to have documentation of time of day, behaviors, and initials in the observation log.	

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**	One community counseling file was observed as having a completed suicide risk assessment completed by a licensed staff. Parent and supervisor signature were observed on the assessment.	
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.	**Not Applicable**	Referral was not made because program staff was available to complete a suicide assessment and notified parents.	
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 and noted it 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/guardian was contacted and notified.	
When the screening was completed during school hours on school property, the appropriate school authorities were notified.	**Not Applicable**	The suicide screening was not 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 Closed Files: 2 **Staff Position(s) Interviewed** *(No Staff Names)* **: Nurse, Program Director** **Type of Documentation(s) Reviewed: Program policy, Files, Sharps Binder** **Describe any Observations: Pyxis machine, nursing station, med books, medical 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 (RN) holds an active and clear license valid through 4/30/25.	
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**	The agency provided a list of trained staff who had completed the in-person self-administration medication training by the RN with the "Medication Assistance Program" handbook detailing evidence of competency requirements.	
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 has documentation to support the RN provided a review of medication practices at the staff meeting held 11/30/23- During the meeting medication training was completed by Tina Stone. On 2/29/24, the agenda included a review of medication errors and practice, monthly review of Pyxis and medical room procedures.	
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 agency has a board of each youths medication, times, and dosages as well as a binder. If there are any medication updates each shift is notified by email at the beginning of the shift.	
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 agency uses the Pyxis machine and physical binders to ensure appropriate medication management. The RN monitors and tracks medication. The delivery process of medication follows agency policy and Florida Network policy of only being accepted from a licensed pharmacy, only accepting medication in the appropriate container labeled, interviewed by youth and parent about medication, and having all medication reviewed by the RN or Program Director/Supervisor.	
Admission/Intake of Youth			
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**	According to agency policy RGC 4.03 Medication Control and Management, when the RN is on duty she meets with the youth and guardian. When the RN is not duty the youth's medical records are reviewed by the RN within three business days. In the two residential files reviewed, the supervisor reviewed all medication forms the day of intake.	
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 agency has four site-specific System Managers for the Pyxis ES Station. Only trained staff have access to the Pyxis machine and medical room. The medical distribution log is updated weekly. The agency follows the Florida Network medication methods by Pharmacy Contact, Lexi Comp, or Physician Desk Reference. RN Carolyn Palmer distributes medication when on duty. The agency does have or accept youth who are prescribed injectable medication.	
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**	Of the two youth residential files reviewed the prescription medication log provides the time of medication administration, youth's initials and dosage provided, staff initials and dosage provided.	

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**	Of the two youth residential files reviewed medication was given within the one hour scheduled time of ordered medication located in the youth's prescription medication log.	
During the review period, there were no instances where youth missed their medication due to failure to open the pyxis machine.	**Compliance**	The Pyxis machine was disabled due to a connection issue from 9/15/23-10/11/23. However, no medication errors occurred in this time period according to CCC reports.	
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.	**Compliance**	Staff who were responsible for medication errors were re-trained by DJJ nurse Katheryn Egan or Kelley Ansel before January when nurse Carolyn Palmer came on board.	
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**	Controlled substances and over the counter medication is stored in the Pyxis machine. When the Pyxis machine is out of order the medical cabinet is utilized. All inventory counts are kept in the Pyxis and binder. Syringes are not used and are not kept on site. A "sharps" binder logs any sharp objects including scissors in the facility.	

There are monthly reviews of the Pyxis reports to monitor medication management practice.	**Compliance**	RN Carolyn Palmer reviews Pyxis discrepancy reports weekly and full Pyxis reports monthly.	
Medication discrepancies are cleared after each shift.	**Compliance**	Medication discrepancies are cleared through Pyxis during each shift. RN Carolyn Palmer teaches staff how to clear medical discrepancies once they are fixed. All medication discrepancies are documented through email for staff to be aware of at the start of each shift.	
Additional Comments: **There are no additional comments for this indicator.**			
4.04 - Medical/Mental Health Alert Process			**Satisfactory**
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 **Total number of Closed Files: 3** **Staff Position(s) Interviewed** *(No Staff Names)* **: Program Director** **Type of Documentation(s) Reviewed: Youth Residential Files**			
Youth with a medical, mental health, or food allergy was appropriately placed on the program's alert system	**Compliance**	All five residential youth were appropriately placed on the program's alert system which consists of marking the youth's file, documenting on the board in the lobby of the shelter and sending out in the shift email.	
Alert system includes precautions concerning prescribed medications, medical/mental health conditions	**Compliance**	The Agency's alert system includes medication and health conditions.	
Staff are provided sufficient training, information and instructions to recognize/respond to the need for emergency care for medical/mental health problems	**Compliance**	The Agency provides a policy and training for staff to recognize medical/mental health problems.	

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**	Five of the five youth residential files were appropriately placed on the program's alert system which consists of marking the youth's file, documenting on the board in the lobby of the shelter and sending out in the shift email.	
Additional Comments: **There are no additional comments for this indicator.**			
4.05 - Episodic/Emergency Care			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 4.05		**YES** 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)* **: Program Director** **Type of Documentation(s) Reviewed: Youth Residential Files**			
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	**Compliance**	Three closed youth residential files were reviewed. Incident reports were documented and submitted to CCC for the three off site medical incidents. Two of the three youth files show youth verification of medical clearance and discharge instructions. The youth file that did not show verification was discharged due to an arrest during the medical incident. Proof of parent/guardian notification was shown in all three youth files and the log was updated for all three youth files.	
All staff are trained on emergency medical procedures	**Compliance**	All staff are appropriately trained in emergency medical procedures during shadowing.	
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 four locations on the premises which are accessible to all staff.	
Additional Comments: **There are no additional comments for this indicator.**			