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

**Youth and Family Alternatives, Inc.**
New Beginnings Youth Shelter

18377 Sheriff Mylander Way,
Brooksville, FL 34601

**September 18-19, 2024**

**Compliance Monitoring Services Provided by**

## EXECUTIVE SUMMARY

Forefront LLC conducted a Quality Improvement (QI) monitoring visit on behalf of the Florida Network of Youth and Family Services (FNYFS) for the Youth and Family Alternatives, New Beginnings (YFA New Beginnings) for the FY 2024-2025 at its program office located at 18377 Sheriff Mylander Way, Brooksville, Florida. Forefront LLC (Forefront) is an independent compliance monitoring firm that is contracted by FNYFS to perform onsite program reviews to assess the agency's adherence to fiscal, programmatic and overall contract requirements. YFA New Beginnings is contracted with the Florida Network of Youth and Family Services (FNYFS) to provide direct services to Children/Families in Need of Services (CINS/FINS). The services to be provided are identified in Contract Section A - Descriptions and Specifications and Section B - Delivery and Performance, and are funded with General Revenue Funds effective from July 2024 through June 30, 2025.

The review was conducted by Marcia Tavares, Consultant for Forefront LLC and Peer Reviewer(s): Luis Rodriguez, Regional Monitor, Department of Juvenile Justice; Jeffrey Honaker, SMA Healthcare; Nasheika Martin, Hillsborough County Department of Children's Services; and Lisa Nevarez, Orange County Youth and Family Services Division. Agency representatives from YFA New Beginnings present for the entrance interview were Amanda Kilian, Vice President of Quality Improvement and Compliance, Felicia Jones, Residential Program Director; Kelley Scott, Community Counseling Program Director; Daniel Flores, Assistant Program Director; Michele Almand, Quality Improvement Prevention; and Chelsea Messier, Human Resources Director (via phone). The last onsite QI visit was conducted February 7, 2024.

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

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

# 2024-2025 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
# Report Number: CM 09-18-2024-2025

| | |
|---|---|
| **Agency Name: YFA- New Beginnings** | **Monitor Name: Marcia Tavares, Lead Reviewer** |
| **Contract Type : CINS/FINS** | **Region/Office: 18377 Sheriff Mylander Way, Brooksville, FL 34601** |
| **Service Description: Comprehensive Onsite Compliance Monitoring** | **Site Visit Date(s): September 18-19, 2024** |

| **Major Programmatic Requirements** | **Explain Rating** | | | | | **Ratings Based Upon:**<br>**I = Interview**<br>**O = Observation**<br>**D = Documentation**<br>**PTV = Submitted Prior To Visit**<br>**(List Who and What)** | **Notes**<br>**Explain Unacceptable or Conditionally Acceptable:** |
|---|---|---|---|---|---|---|---|
| | **Unacceptable** | **Conditionally Unacceptable** | **Fully Met** | **Exceeded** | **Not Applicable** | | |
| **I. Administrative and Fiscal** | | | | | | | |
| **DJJ Quality Improvement Peer Reviewer**<br>a. Provider shall demonstrate that a minimum of two (2) staff members have been trained to be certified as DJJ QI Peer reviewers. Provider shall participate in a minimum of one (1) on-site quality assurance review of a similar type of program in another judicial circuit during each 12-month period of the contract, if requested. | ☐ | ☐ | ☒ | ☐ | ☐ | The provider currently has two certified peer reviewers namely: Felicia Jones and Elizabeth Erickson. Both are scheduled to participate in a QI review for the current FY. | No recommendations and/ or corrective actions required. |
| **Additional Contracts**<br>a. Provider shall provide a listing of all current federal, state, or local government contracts, as well as other contracts entered into with for profit and not-for-profit organizations. Such a listing shall identify the awarding entity and contract start & end dates. **PTV** | ☐ | ☐ | ☒ | ☐ | ☐ | Documentation: The provider submitted a list of three additional funders for follows: DHHS Basic Center Grant, Department of Health, and Kids Central. The program also maintains interagency agreements and Memorandums of Agreement (MOUs) with schools, mental health, and other local providers. | No recommendations and/ or corrective actions required. |
| **Limits of Coverage**<br>a. Provider shall provide and maintain during this contract, the following minimum kinds of insurance: Worker's Compensation and Employer's liability insurance as required by Chapter 440, F.S. with a minimum of | ☐ | ☐ | ☐ | ☒ | ☐ | 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 | No recommendations and/ or corrective actions required. |

# 2024-2025 CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
# Report Number: CM 09-18-2024-2025

| | |
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|---|---|---|---|---|---|---|---|
| | **Unacceptable** | **Conditionally Unacceptable** | **Fully Met** | **Exceeded** | **Not Applicable** | | |
| \$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** | | | | | | period. Insurers listed: Alliance of Nonprofits for Insurance for commercial, umbrella, auto, and professional liability insurance. Commercial General liability coverage from 07/01/2024 - 07/01/2025 includes limits of \$1,000,000 per occurrence, \$3,000,000 general aggregate, \$500,000 damage to rented premises, \$20, 000 medical expense, \$1,000,000 personal and adv injury, \$3,000,000 products. Automobile Liability coverage from 07/01/2024 - 07/01/2025 has limits of \$1,000,000 combined single limit (each Accident). Umbrella liability from 07/01/2024 - 07/01/2025 has limits of \$3,000,000 for each occurrence and \$3,000,000 aggregate. Professional Liability 07/01/2024 - 07/01/2025 includes \$1,000,000/ \$3,000,000 and Abuse /Molestation \$1,000,000/ \$2,000,000. Worker's Compensation is covered with Benchmark Insurance Company from 07/01/2024 - 07/01/2025 with | |

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| **Service Description: Comprehensive Onsite Compliance Monitoring** | | | | | | **Site Visit Date(s): September 18-19, 2024** | |
| | **Explain Rating** | | | | | | |
| **Major Programmatic Requirements** | **Unacceptable** | **Conditionally Unacceptable** | **Fully Met** | **Exceeded** | **Not Applicable** | **Ratings Based Upon:**<br>**I = Interview**<br>**O = Observation**<br>**D = Documentation**<br>**PTV = Submitted Prior To Visit**<br>**(List Who and What)** | **Notes**<br>**Explain Unacceptable or Conditionally Acceptable:** |
| | | | | | | limits of $1,000,000 each accident, $1,000,000 each employee, and $1,000,000 disease.<br><br>The Florida Network is listed as certificate holder. | |
| **External/Outside Contract Compliance**<br>a. Provider has corrective action item(s) cited by an external funding source (Fiscal or Non-Fiscal). **ON SITE** | ☐ | ☐ | ☐ | ☐ | ☒ | Documentation: The written program update submitted indicated there were no corrective action items cited by external funding sources. | No recommendations and/ or corrective actions required. |
| **Fiscal Practice**<br>a. Agency must have employee and fiscal policy/procedures manuals that are in compliance with GAAP and provide sound internal controls. Agency maintains fiscal files that are audit ready. **PTV** | ☐ | ☐ | ☒ | ☐ | ☐ | Documentation: 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 | ☐ | ☐ | ☒ | ☐ | ☐ | YFA provided a General Ledger for the current FY. The agency maintains a detailed general ledger that is | No recommendations and/ or corrective actions required. |

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|---|---|---|---|---|---|---|---|
| | **Unacceptable** | **Conditionally Unacceptable** | **Fully Met** | **Exceeded** | **Not Applicable** | | |
| (standard account numbers / separate funds for each revenue source, etc.). **PTV** | | | | | | structured to track all funding sources as well as activities for the CINS/FINS program. | |
| c. Petty cash ledger system is balanced and all cash disbursements are compliant with financial policies and allowable under the contract. (Disbursements/invoices are approved & monitored by management.) –**ON SITE** | ☐ | ☐ | ☒ | ☐ | ☐ | Documentation of petty cash policy and procedures FM482 was provided. Per the policy and procedures and interview with the program director, use of petty for occasional purchase is limited to $25 or less. Policy and procedure addresses custodian responsible, how it is maintained, where it is kept and how it is to be reconciled. | No recommendations and/ or corrective actions required. |
| d. Financial records and reports are current. Includes bank statements reconciled within 6 weeks of receipt. Vendor invoices past 6 months. Invoices are submitted on a monthly basis with supporting documentation and documentation provided contained 2 signatures. (Disbursements/invoices are approved & monitored by management). **ON SITE** | ☐ | ☐ | ☒ | ☐ | ☐ | Documentation and Observation. Reviewed electronic bank Statements and bank reconciliations for March-August 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. Reconciliations are conducted by the accountant and | No recommendations and/ or corrective actions required. |

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| | **Explain Rating** | | | | | | |
| **Major Programmatic Requirements** | **Unacceptable** | **Conditionally Unacceptable** | **Fully Met** | **Exceeded** | **Not Applicable** | **Ratings Based Upon:**<br>**I = Interview**<br>**O = Observation**<br>**D = Documentation**<br>**PTV = Submitted Prior To Visit**<br>**(List Who and What)** | **Notes**<br>**Explain Unacceptable or Conditionally Acceptable:** |
| | | | | | | signed by both the accountant and accounting manager. Invoices are submitted on a monthly basis by the shelter designee. Billing deliverables are verified by the end of the 3rd business day of the month. | |
| e. Agency maintains inventory in accordance with a written policy and FNYFS contractual requirements. If over $1,000 inventory has DJJ Property Inventory Number/Tag. In the event the provider has purchased computer equipment an Informational Resources Request (IRR) has been submitted to DJJ. **PTV/ON SITE** | ☐ | ☐ | ☐ | ☐ | ☒ | A letter dated September 6, 2024, from the VP of Finance was provided as documentation that FNYFS funds are not used for asset purchases. | No recommendations and/ or corrective actions required. |
| f. Agency submits payroll taxes and deposits (and retirement deposits as applicable), Employee IRS Form W-2 and Independent Contractors IRS Form 1099 forms prior to federal requirements. **ON SITE** | ☐ | ☐ | ☒ | ☐ | ☐ | Documentation: The provider contracts with Paylocity for payroll services. Proof of bi-weekly payroll tax payments made by Paylocity was provided in compliance with the requirement of submission of employee payroll taxes and deposits. Documentation for each submission includes pay period, payroll totals, tax liability, total payroll liability, and total transfer. | No recommendations and/ or corrective actions required. |

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|---|---|---|---|---|---|---|---|
| | **Unacceptable** | **Conditionally Unacceptable** | **Fully Met** | **Exceeded** | **Not Applicable** | | |
| 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 Budget to Actual report for FY24-25, year-to-date for the CINS/FINS program. Variances in budget are monitored on a regular basis and are discussed with the Board. | No recommendations and/ or corrective actions required. |
| h. A Single Audit is performed as part of the annual audit if expenses are greater than $750,000. The agency must submit a Corrective Action Plan for findings cited in the management letter and single audit. An annual financial audit was completed within 120 days after the previous fiscal year/calendar year and that a copy was provided to the Network unless and extension has been requested and approved in writing. Copy of Audit is submitted to the FNYFS by December 31st. **Can obtain from FNYFS** | ☐ | ☐ | ☒ | ☐ | ☐ | Documentation: The agency provided the most recent audit report completed by Rivero, Gordimer, and Company, P.A. for period ending June 30, 2023. Per the auditors, a management letter was not required because there were no findings required to be reported in the management letter. | No recommendations and/ or corrective actions required. |
| 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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|---|---|---|---|---|---|---|---|
| | **Unacceptable** | **Conditionally Unacceptable** | **Fully Met** | **Exceeded** | **Not Applicable** | | |
| j. Agency provided evidence that every direct care staff employee, as of October 1, 2023, is being paid at least $19.00 per hour. This also includes funding for additional staff as approved by the Department. **ON SITE** | ☐ | ☐ | ☒ | ☐ | ☐ | Documentation: Agency provided list of all direct care staff positions for YFA – New Beginnings, which included current salaries. Documentation indicated salary changes for all direct care staff (Shelter only) was a minimum $19/hour effective July 29, 2023. A letter from the HR manager, dated 3/26/24, indicated that following the wage increase, all job postings have been updated to reflect the current rate and communicated to those who are onboarding. | No recommendations and/ or corrective actions required. |

## CONCLUSION

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

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

# Florida Network of Youth and Family Services Quality Improvement Program Report

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

September 18-19, 2024

**Compliance Monitoring Services Provided by**

FOREFRONT

New Beginnings

September 18-19, 2024

# CINS/FINS Rating Profile

Standard 1: Management Accountability

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

**Percent of indicators rated Satisfactory: 71.43 %**
**Percent of indicators rated Limited: 28.57 %**
**Percent of indicators rated Failed: 0 %**

Standard 2: Intervention and Case Management

| | |
|---|---|
| 2.01 Screening and Intake | Satisfactory |
| 2.02 Needs Assessment | Satisfactory |
| 2.03 Case/Service Plan | Satisfactory |
| 2.04 Case Management & Service Delivery | Satisfactory |
| 2.05 Counseling Services | Satisfactory |
| 2.06 Adjudication/Petition Process | Satisfactory |
| 2.07 Youth Records | Satisfactory |
| 2.08 Special Populations | Satisfactory |
| 2.09 Stop Now and Plan (SNAP) | Not Applicable |

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

Standard 3: Shelter Care & Special Populations

| | |
|---|---|
| 3.01 Shelter Environment | Satisfactory |
| 3.02 Program Orientation | Satisfactory |
| 3.03 Youth Room Assignment | Satisfactory |
| 3.04 Log Books | Satisfactory |
| 3.05 Behavior Management Strategies | Satisfactory |
| 3.06 Staffing and Youth Supervision | Satisfactory |
| 3.07 Video Surveillance System | Satisfactory |

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

Standard 4: Mental Health/Health Services

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

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

## Overall Rating Summary

**Percent of indicators rated Satisfactory: 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
Luis Rodriguez – Regional Monitor, Department of Juvenile Justice
Jeffrey Honaker – SMA Healthcare
Nasheika Martin - Hillsborough County Department of Children's Services
Lisa Nevarez – Orange County Youth and Family Services Division

# 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, 2024).

## Persons Interviewed

| | | | | | |
|---|---|---|---|---|---|
| | Chief Executive Officer | X | Case Manager | | Nurse – Full time |
| | Chief Financial Officer | | Counselor Non-Licensed | X | Nurse – Part time |
| | Chief Operating Officer | | Advocate | 1 | # Case Managers |
| | Executive Director | X | Direct – Care Full time | X | # Program Supervisors |
| X | Program Director | | Direct – Part time | | # Food Service Personnel |
| X | Program Manager | | Direct – Care On-Call | | # Healthcare Staff |
| | Program Coordinator | | Intern | | # Maintenance Personnel |
| | Clinical Director | | Volunteer | 2 | # Other (listed by title): QIS, Outreach Coordinator |
| | 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 | 5 | # MH/SA Records |
| | Continuity of Operation Plan | X | Fire Drill Log | 10 | # Personnel /Volunteer Records |
| X | Contract Monitoring Reports | X | Medical and Mental Health Alerts | 8 | # Training Records |
| | Contract Scope of Services | X | Precautionary Observation Logs | 10 | # Youth Records (Closed) |
| X | Egress Plans | X | Program Schedules | 4 | # Youth Records (Open) |
| X | Fire Inspection Report | X | List of Supplemental Contracts | | # Other: |
| | Exposure Control Plan | X | Vehicle Inspection Reports | | |

## Observations During Review

| | | | | | |
|---|---|---|---|---|---|
| | Intake | X | Posting of Abuse Hotline | X | Staff Supervision of Youth |
| X | Program Activities | X | 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 | X | Staff Interactions with Youth | X | Census Board |

## Surveys

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 14 | # of Youth | 9 | # of Direct Staff | | # of Other | | |

# Comments

A Quality Improvement Program Review was conducted for FY 2024-2025

**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.

**Narrative Summary**

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

**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 **Limited**.
Indicator 1.03 Incident Reporting was rated **Satisfactory with Exception.**
Indicator 1.04 Training Requirements was rated **Limited**.
Indicator 1.05 Analyzing and Reporting Information was rated **Satisfactory.**
Indicator 1.06 Client Transportation was rated **Satisfactory.**
Indicator 1.07 Outreach Services was rated **Satisfactory with Exception.**

**Standard 2: There are nine indicators for Standard 2.**

Indicator 2.01 Screening and Intake was rated **Satisfactory.**
Indicator 2.02 Needs Assessment was rated **Satisfactory.**
Indicator 2.03 Case/Service Plan was rated **Satisfactory.**
Indicator 2.04 Case Management and Service Delivery was rated **Satisfactory**.
Indicator 2.05 Counseling Services was rated **Satisfactory**.
Indicator 2.06 Adjudication/Petition Process was rated **Satisfactory**.
Indicator 2.07 Youth Records was rated **Satisfactory.**
Indicator 2.08 Specialized Additional Program Services was rated **Satisfactory**.
Indicator 2.09 Stop Now and Plan (SNAP) was rated **Not Applicable**.

**Standard 3: There are seven indicators for Standard 3.**

Indicator 3.01 Shelter Environment was rated **Satisfactory.**
Indicator 3.02 Program Orientation was rated **Satisfactory**.
Indicator 3.03 Youth Room Assignment was rated **Satisfactory**.
Indicator 3.04 Log Books was rated **Satisfactory with Exception**.
Indicator 3.05 Behavior Management Strategies was rated **Satisfactory**.
Indicator 3.06 Staffing and Youth Supervision was rated **Satisfactory**.
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**.
Indicator 4.05 Episodic/Emergency Care was rated **Satisfactory.**

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

**Standard 1:**

**Indicator 1.02 - Limited**

It was observed that shelter grievance box checks were not consistently conducted and documented in the logbook. On the following dates, there was no evidence supporting that grievance boxes were checked daily per logbook notation.

- 3/25-3/29, 5 of 5 days grievance box checks were not noted.
- 5/2--5/24, 2 of 5 days grievance box checks were not noted.
- 5/27 - 5/31, 2 of 4 days grievance box checks were not noted.
- 6/10-14, only 4 of 5 days grievance box checks were not noted.
- 6/17-20, 2 of 5 days grievance box checks were not noted.
- 7/8-7/12, 4 of 5 days grievance box checks were not noted.
- 7/15-7/19, 4 of 5 days grievance box checks were not noted.
- 8/5-8/9, 3 of 5 days grievance box checks were not noted.
- 8/12-8/16, 2 of 5 days grievance box checks were not noted.

Of the 68 grievances reviewed for the last six months, 17 were not resolved within 72 hours of them being submitted. There was no documentation explaining the cause for the delay in providing a resolution besides the implication that agency did not receive the grievance on the date it was submitted. However, there were also eight instances where the grievances were not resolved within the 72 hours of the "date received by agency" date.

**Indicator 1.04 - Limited**

Two of the four new hire staff did not complete United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days of date of hire. One of the staff was hired 6/10/24 and completed the Civil Rights training on 7/23/24. The second staff was hired 9/25/23 and did not complete the Civil Rights training until 11/10/23.

One new staff, hired 9/25/23, completed all required trainings; however, ten of those were completed outside the required 90-day timeframe as follows:

- DJJ Skill Pro - #316 Human Trafficking Intervention- completed on 1/8/2024
- CPR was completed on 2/7/2024
- First Aid was completed on 2/7/2024
- CINS/FINS Core Training was completed on 1/8/2024
- Florida Network Youth Suicide Prevention was completed on 1/8/2024
- Crisis intervention training was completed on 10/13/2023
- Adverse Childhood Experiences (ACE) was completed on 1/8/2024
- Signs and Symptoms of Mental Health and Substance Abuse was completed on 1/8/2024
- Universal Precautions was completed on 1/8/2024
- Adolescent Development was completed on 1/8/2024

Two in-service staff did not complete the required annual trainings prior to June 30th, the end of their annual training year. Staff hired on 4/19/2022 did not complete eight required trainings within the required timeframe as follows: Florida Network Youth Suicide Prevention was last completed on 7/25/2024; Fire Safety Equipment training was last completed on 7/20/2024 (previously completed 5/14/2022); DJJ SkillPro #316 Human Trafficking 101 training was last completed on 7/23/2024 (last completed was 5/4/2022); and DJJ SkillPro Information Security Awareness, PREA 1, PREA 2, Sexual Harassment, and Trauma Informed Care trainings were last completed on 7/24/2024 (last completed in May 2022).

Staff hired on 6/5/2017 did not complete one required training within the required timeframe. An additional four were not documented as completed at all.

- Florida Network Youth Suicide Prevention was not completed during the annual FY23-24 training period. The completion date of this training was on 7/18/2024.
- There is no evidence that the DJJ SkillPro Information Security Awareness, PREA 1, PREA 2, and Sexual Harassment trainings were completed during the annual FY23-24 training period.

# 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. |
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| **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**<br>If NO, explain here:<br>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). | |
| All positions providing direct services to youth has successfully passed pre-employment suitability assessment on the initial attempt. | **Compliance** | The agency uses the Criteria Basic Skills Test (CBST) pre-assessment tool to screen candidates and determine suitability for employment. The CBST was implemented December 19, 2019 and has an established pass rate of a minimum raw score of 25. The tool was utilized to screen eight applicable new hires and all eight new staff successfully passed the CBST. | |
| 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 eight new staff received passing scores on the initial CBST. | |
| 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 previously employed by the agency. | |
| 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** | The agency initiated the background screenings prior to hire for all eight new hires. Proof of eligibility was documented on the Clearinghouse results for each employee. 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 for all applicable employees and volunteers. | **Exception** | The program had two staff who met the criteria for 5-year re-screening. One of the two staff was re-screened on time and had valid retained prints in the clearinghouse. | There was a lapse with the background re-screening for one of the two re-screened staff during the annual review. Hire date for said staff is 8/15/16 and the original prints expired 10/15/23; however, the re-screening was not completed until 9/17/24. |

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| Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st? | **Compliance** | 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 | **Compliance** | The program provided E-Verify documentation from the Department of Homeland Security for all eight new staff, verifying authorization to work. | |
| ***Additional Comments:*** **There are no additional comments for this indicator.** | | | |
| **1.02: Provision of an Abuse Free Environment** | | | **Limited** |
| **Provider has a written policy and procedure that meets the requirement for Indicator 1.02** | | **YES**<br>If NO, explain here:<br>The provider has the required policy and procedure RGC 1.02 - Provision of an Abuse Free Environment, that was last reviewed 9/15/2023 and approved by the CEO on 10/12/23. | |
| Agency has a code of conduct of policy and there is evidence that staff are aware of agency's code of conduct. | **Compliance** | The agency has a code of conduct listed within their policy. The code of conduct is included in the employee orientation training. It is also posted in multiple common areas. | |
| The agency has a process in place for reporting and documenting child abuse hotline calls. | **Compliance** | Employees are required to report all known or suspected cases of abuse and/or neglect and youth have unimpeded access to self-report. The program documents child abuse hotline calls on a report form which is maintained in a binder to track agency-wide reports. A total of four non-institutional abuse calls were reported during the review period. | |
| Youth were informed of the Abuse and Contact Number | **Compliance** | The Abuse Hotline number is posted throughout the facility in common areas. Youth are informed of their rights to report through program orientation. | |
| **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 grievance process for youth to provide feedback and address complaints. The residential program director has access to and manage grievances unless it is towards themselves. There were no reported grievances towards the program director during the review period. There were 68 grievances submitted within the last six months. | |
| <u>Shelter only:</u><br>Grievances are maintained on file at minimum for 1 year. | **Compliance** | The program director maintains a record of grievances for a minimum of one year. | |
| <u>Shelter only:</u><br>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** | It was observed that the agency has formal grievance procedures for youth including grievance forms, and a locked box which is accessible to youth in multiple common areas throughout the facility. | |

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| Shelter only:<br>There is evidence that grievance boxes are checked by management or a designated supervisor at least daily (excluding weekends and holidays) and documented in the program logbook. | **Exception** | Shelter youth grievances are well organized and tracked in a binder. Grievance boxes are checked regularly as evidenced by the "date received" on the forms. There were 68 grievances submitted within the last six months. Many appear to be a complaint or client request.<br><br>Program director for community counseling was interviewed regarding their grievance process and no grievances were reported.<br><br>Nine random 1-week periods in the logbooks were reviewed from March to August 2024 for evidence of grievance box checks by management daily, excluding weekends and holidays. A total of 44 days were reviewed. Grievance box checks were observed to be documented in the logbook for only 17 of the 44 days reviewed. | It was observed that shelter grievance box checks were not consistently conducted and documented in the logbook.<br><br>On the following dates, there was no evidence supporting that grievance boxes were checked daily per logbook notation.<br>• 3/25-3/29, 5 of 5 days grievance box checks were not noted.<br>• 5/2--5/24, 2 of 5 days grievance box checks were not noted.<br>• 5/28 - 5/31, 2 of 4 days grievance box checks were not noted.<br>• 6/10-14, only 4 of 5 days grievance box checks were not noted.<br>• 6/17-20, 2 of 5 days grievance box checks were not noted.<br>• 7/8-7/12, 4 of 5 days grievance box checks were not noted.<br>• 7/15-7/19, 4 of 5 days grievance box checks were not noted.<br>• 8/5-8/9, 3 of 5 days grievance box checks were not noted.<br>• 8/12-8/16, 2 of 5 days grievance box checks were not noted. |
| Shelter only:<br>Grievances are resolved within 72 hours of being submitted or there was documentation explaining the cause for the delay in providing a resolution. | **Exception** | Grievance forms document when grievances are submitted by youth and when the program receives the filing. Sometimes these dates differ. Grievances are generally resolved within 72 hours of being submitted as evidenced by program director signature. | Of the 68 grievances reviewed for the last six months, 17 were not resolved within 72 hours of them being submitted. There was no documentation explaining the cause for the delay in providing a resolution besides the implication that agency did not receive the grievance on the date it was submitted. However, there were also eight instances where the grievances were not resolved within the 72 hours of the "date received by agency" date. |
| **1.03: Incident Reporting** | | | **Satisfactory with Exception** |
| **Provider has a written policy and procedure that meets the requirement for Indicator 1.03** | | **YES**<br>If NO, explain here:<br>The provider has the required policy and procedure RM760 - Incident Reporting, that was last reviewed 9/1/2023 and approved by the CEO on 9/25/23. This is an agency-wide policy that does not require an annual update. | |
| 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** | A total of 30 DJJ Department CCC Reports for the last six months were reviewed. The program notified the CCC no later than two hours after any reportable incident occurred or within two hours of the program learning of the incident for all but one incident. | One incident on 6/5/2024 was noted by the Department's Central Communications Center (CCC) to be reported later than the required 2-hour timeframe. |

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| The program completes follow-up communication tasks/special instructions as required by the CCC | **Compliance** | The program completes follow-up communication tasks/special instructions as required by the CCC. None of the incidents reviewed had outstanding tasks to be completed. | |
| Agency internal incidents are documented on incident reporting forms and all CCC reportable incidents were consistently reported to CCC as required. | **Compliance** | Agency maintains incident reporting forms and all CCC reportable incidents in a binder. All incidents were consistently reported to CCC as required. | |
| Incidents are documented in the program logs and on incident reporting forms | **Exception** | All incidents were reported on the agency's internal Incident/Complaint Report Form, but not all were documented in the program logs. Five randomly selected CCC incidents during the last six months were reviewed to determine if they were documented in the logbook. Evidence supported one of the five CCC incidents was recorded in the program logbook. On 5/29/24 the incident was documented in the logbook and indicated that it was reported to CCC. | Of the remaining four CCC incidents reviewed for documentation in the program logs, three had a note of an incident and one had no mention of an incident at all. None of the four were recorded in the program logbook as reported to CCC.<br>• 3/8/2024: No documentation of the incident in logbook or report to CCC.<br>• 6/19/24, 7/17/24, and 8/16/24, there was notation of the incidents in the logbook, but no indication they were reported to CCC. |
| All incident reports are reviewed and signed by program supervisors/ directors | **Compliance** | For the 30 CCC reportable incidents reviewed, all internal incident reports were reviewed and signed by the program director. Reportable incidents by type are as follows.<br>2 - Program Disruptions<br>0 - Escape/Absconds<br>17 - Medical<br>4 - Mental Health and Substance Abuse<br>6 - Complaints Against Staff<br>1 - Youth Behavior Incident | |
| **1.04: Training Requirements** (*Staff receives training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions*) | | | **Limited** |
| **Provider has a written policy and procedure that meets the requirement for Indicator 1.04** | | **YES**<br>If NO, explain here:<br>The program has the required policy and procedure RGC 1.04 - Training, that was last reviewed 9/15/2023 and approved by the CEO on 10/13/23. | |

| First Year Direct Care Staff | | | |
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| All direct care staff have completed a new hire pre-service training provider orientation before they work independently. At a minimum, the orientation included the following:<br>• Agency policies and procedures<br>• Behavior Management (Shelter Only)<br>• Building/Facility layout<br>• File Documentation/development of paperwork requirements and confidentiality<br>• CCC & Incident Reporting<br>• Child Abuse Reporting<br>• Client Intake & Screening<br>• Client Orientation (direct care staff training on delivering new client orientation)<br>• Fire Equipment Safety<br>• Medical and Mental Health Alert System (Shelter)<br>• Risk Management--Including but not limited to the following:<br>- Disaster Preparedness and Emergency Response<br>- First Aid/CPR<br>- Universal Precautions<br>• Video Camera Surveillance & Equipment<br>• All other necessary information to orient a new hire to perform their job role and duties. | **Compliance** | A total of four first year direct care staff training records were reviewed. All four direct care staff have completed the required new hire pre-service trainings provided at orientation before they worked independently with youth. | |
| All staff completed the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days from date of hire. | **Exception** | All four new hire direct care staff training files reviewed have completed the United States Department of Justice (DOJ) Civil Rights & Federal Funds training. | Two of the four new hire staff did not complete United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days of date of hire. One of the staff was hired 6/10/24 and completed the Civil Rights training on 7/23/24. The second staff was hired 9/25/23 and did not complete the Civil Rights training until 11/10/23. |
| All direct care CINS/FINS staff for shelter and community counseling services, including independent contractors (full-time, part-time, and on-call) and interns met the minimum requirement of 80 hours of training for the first full year of employment. | **Compliance** | A full year of employment does not apply for all four new hire direct care CINS/FINS staff training files reviewed. One staff, hired on 9/25/23, has already met the 80-hour training requirement. The remaining staff completed over 70 hours each with adequate time remaining to complete the 80 hours required. | |

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| All staff receives all mandatory training during the first 90 days of employment from date of hire. | **Exception** | Of the four new hire direct care staff training files reviewed, three of the four contained trainings that were completed within the required 90-day timeframe. | One new staff, hired 9/25/23, completed all required trainings; however, ten of those were completed outside the required 90-day timeframe as follows:<br>• DJJ Skill Pro - #316 Human Trafficking Intervention-completed on 1/8/2024<br>• CPR was completed on 2/7/2024<br>• First Aid was completed on 2/7/2024<br>• CINS/FINS Core Training was completed on 1/8/2024<br>• Florida Network Youth Suicide Prevention was completed on 1/8/2024<br>• Crisis intervention training was completed on 10/13/2023<br>• Adverse Childhood Experiences (ACE) was completed on 1/8/2024<br>• Signs and Symptoms of Mental Health and Substance Abuse was completed on 1/8/2024<br>• Universal Precautions was completed on 1/8/2024<br>• Adolescent Development was completed on 1/8/2024 |
| **Non Licensed Staff Assisting with Medication Distribution** | | | |
| Any staff without a medical license that assists with Medication Distribution received in-person training from a Registered Nurse prior to administering medication to a shelter youth. | **Compliance** | Of the four new hire direct care staff training files reviewed, two eligible staff that are able to assist with Medication Distribution have completed the required training prior to administering medication to shelter youth. The remaining two staff are awaiting medication and are not yet approved to administer medication. | |
| **Staff that are Utilizing NETMIS** | | | |
| Any staff that is utilizing NETMIS has evidence of completing NetMIS Training in their training file. | **Compliance** | Of the four new hire direct care CINS/FINS staff training files reviewed, the one staff that uses NetMIS completed the required training on 5/7/2024. | |
| **Staff Participating in Case Staffing & CINS Petitions (within the first year of employment BUT no later 7/1/24 for previous staff)** | | | |
| Documentation of instructor-led FL Statute 984 CINS Petition Training by a local DJJ Attorney within 1 year of employment or no later than 7/1/24 if hired before 7/1/23. (*Policy went into effect 7/1/23).* | **Compliance** | Of the four new hire direct care CINS/FINS staff training files reviewed, the one staff that participates in CINS Petitions completed the required training on 3/21/2024. | |
| **Non-licensed Mental Health Clinical Shelter Staff (within first year of employment)** | | | |
| Documentation of non-licensed mental health clinical staff person's training in Assessment of Suicide Risk form or written confirmation by a licensed mental health professional of training (includes date, signature and license number of the licensed mental health professional supervisor). | **No eligible items for review** | The program has not hired any new non-licensed mental health clinical shelter staff person during the review period. | |
| **In-Service Direct Care Staff** | | | |

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| In-service staff completes all of the required annual or 2-year mandatory refresher Florida Network, SkillPro, or other job-related trainings within the required timeframe. | **Exception** | Four in-service staff training files were reviewed. Two staff completed all of their required annual trainings within the required timeframe. After the first year, all in-service staff are required to complete their annual trainings by June 30th, the end of the fiscal year. | Two in-service staff did not complete the required annual trainings prior to June 30th, the end of their annual training year.<br>Staff hired on 4/19/2022 did not complete eight required trainings within the required timeframe as follows: Florida Network Youth Suicide Prevention was last completed on 7/25/2024; Fire Safety Equipment training was last completed on 7/20/2024 (previously completed 5/14/2022); DJJ SkillPro #316 Human Trafficking 101 training was last completed on 7/23/2024 (last completed was 5/4/2022); and DJJ SkillPro Information Security Awareness, PREA 1, PREA 2, Sexual Harassment, and Trauma Informed Care trainings were last completed on 7/24/2024 (last completed in May 2022).<br><br>Staff hired on 6/5/2017 did not complete one required training within the required timeframe. An additional four were not documented as completed at all.<br>• Florida Network Youth Suicide Prevention was not completed during the annual FY23-24 training period. The completion date of this training was on 7/18/2024.<br>• There is no evidence that the DJJ SkillPro Information Security Awareness, PREA 1, PREA 2, and Sexual Harassment trainings were completed during the annual FY23-24 training period. |

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| Community Counseling Direct Care staff completes 24 hours of mandatory refresher Florida Network, SkillPro, and job-related training annually. | **Compliance** | Of the four in-service staff training files reviewed, two are Community Counseling Direct Care staff. Both staff completed an excess of 24 annual training hours | |
| Shelter Program Direct Care staff completes 40 hours of mandatory refresher Florida Network, SkillPro, and job-related training annually *(E.g. the program has a DCF child caring license).* | **Compliance** | Of the four in-service staff training files reviewed, two are shelter program direct care staff. Both staff completed an excess of 40 annual training hours. | |
| **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** | Each staff member has an individualized training plan within their training file. It includes all of the required training topics including the pre-service and in-service. | |
| 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 to manage all employee's individual 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 training files reviewed were in a maintained, individual training file 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. | |
| ***Additional Comments:*** **There are no additional comments for this indicator.** | | | |
| **1.05 - Analyzing and Reporting Information** | | | **Satisfactory** |
| **Provider has a written policy and procedure that meets the requirement for Indicator 1.05** | | **YES**<br>If NO, explain here:<br>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. The agency also has a Continuous Quality Improvement Plan for the fiscal year 2024-2025. | |

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| Case record review reports demonstrate reviews are conducted quarterly, at a minimum. *(A summary report of case record reviews, identifying compliance with the CINS/FINS requirements, which is reviewed by management and communicated with staff on a quarterly basis at minimum.)* | **Compliance** | The Vice President of Quality Improvement and Compliance (VPQI), Quality Improvement Specialist (QIS) were interviewed to assess compliance with the Indicator. Quarterly prevention reviews are conducted by the QIS to review youth files for shelter and community counseling (CINS FINS) program. Case record reviews are documented on the Residential/Community Counseling Scoring Tool and reported on the consolidated tool that highlights corrective actions to be followed up. The QIS reviews five residential and five community counseling records quarterly. Additionally, as a practice, residential staff reviews files as a team on a weekly basis and discuss file requirement content as well as service delivery. Community counseling supervisors review files monthly and documents the record review on a form that is maintained in the youth's record. Annual record reviews are also conducted by the QIS in the last quarter of the year. The 2023 annual review included 20 youth records. The QIS conducted residential record reviews April 16th and September 11, 2024 for a total of 14 youth records. A total of 11 community counseling records were reviewed in March and June 2024.The reviews are documented on a CQI Worksheet that summarizes the findings and outlines the areas identified for improvement, action steps, parties responsible and timeframes for completion. | |
| The program conducts reviews of incidents, accidents, and grievances quarterly, at a minimum | **Compliance** | The agency's Risk Prevention and Management Team - CQI Committee convenes quarterly to aggregate data that is collected monthly and assess for any trends. Data reviewed by the committee is documented on score cards including facility safety issues, types of incidents, medication errors, transportation incidents, contraband, restrictive behavior management, service modalities, workers compensation, legal issues, and grievances. Evidence of quarterly data collected and reviews were observed for March and July 2024. The VPQI prepares an Incident Report Data document quarterly and year end that is emailed to leadership. The report provides graphical data for several types of incidents including abuse calls, altercation, runaways, deaths, medication errors, suicide/attempts, accidents, and illnesses. The VPQI also does a report quarterly and year end that is emailed to leadership. Reports for April 2024 and the end of FY report, completed in August, were reviewed. | |
| The program conducts an annual review of customer satisfaction data | **Compliance** | The Stakeholder Involvement Team (SIT) reviews consumer satisfaction surveys received from YFA programs, including from youth and their families served by Prevention programs and caregivers of CBC children. The SIT Team Lead compiles surveys for review and discussion at the SIT quarterly meeting. Results of these surveys are evaluated for trends and patterns and recommendations are made to strengthen practices if needed. The most recent committee meeting was held April 2024 and next meeting is scheduled for September. Shelter staff meetings also include reviews of satisfaction surveys monthly to review the NetMIS surveys results. | |

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| 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 sent to the leadership staff and emailed by the QIS to program supervisors to share with staff. Monthly data reports using power BI) examine program outcomes. The reports include a link to share with leadership, managers/supervisors 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. | |
| The program has a process in place to review and improve accuracy of data entry & collection | **Compliance** | The YFA shelter designee is responsible for verifying timely submission and accuracy of program data that is captured in NetMIS. The shelter designee 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. The most recent mock reviews were conducted by the QIS for New Beginnings on 6/5/24 and 7/31/24. | |
| 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** | | **NO**<br>If NO, explain here: "Purpose of travel" transportation requirement is not documented in policy and procedure RGC 1.06 – Client Transportation<br>The provider has a policy and procedure RGC 1.06 – Client Transportation that was approved by the CEO on 10/13/23. | |
| Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle | **Compliance** | The provider maintains a list of 29 approved agency drivers to drive clients in agency or agency-approved private vehicles. The program has two vans used to transport youth. | |

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| Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy | **Exception** | There is evidence from review of DMV documentation that the 29 approved drivers for the agency all have valid drivers' licenses and per agency policy, all approved drivers are covered under company's insurance policy. A copy of the current automobile policy was verified. | One of the YDS staff has a valid Oklahoma driver's license which needs to be updated to a Florida driver's license as the staff has been a resident of Florida beyond 30 days of establishing residency. |
| Agency's Transportation policy prohibit transporting a client without maintaining at least one other passenger in the vehicle during the trip and include exceptions in the event that a 3rd party is NOT present in the vehicle while transporting | **Compliance** | The agency'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 agency'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 agency 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. | **No eligible items for review** | No evidence to review as agency states that they do not do single youth transport. Single Transport Log reviewed supported no single transports were documented. | |
| 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's Monthly Trip and Mileage Log contains all required documentation for use of vehicles including the names/initials of the driver, date and time of the trip, odometer start and end, number of passengers, passenger initials, and purpose of travel along with the destination. | |
| ***Additional Comments:*** **There are no additional comments for this indicator.** | | | |
| **1.07 - Outreach Services** | | | **Satisfactory with Exception** |
| **Provider has a written policy and procedure that meets the requirement for Indicator 1.07** | | **YES**<br>If NO, explain here:<br>Policy and Procedure CS580 – Community Outreach and Education was last reviewed 9/19/2022 and approved by the CEO and on 9/30/22 and Board Chair on 10/4/22. This is an agency-wide policy that per the provider, does not require an annual update. | |
| 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 agency has a designated outreach coordinator who is responsible for conducting outreach activities and attending circuit advisory board (CAB) meetings. Three CAB meetings were held during the review period. Two of the three meetings held were attended by the outreach coordinator. | There was no agency representative at the 8/22/24 CAB meeting. |
| The program maintains written agreements with other community partners which include services provided and a comprehensive referral process. | **Compliance** | The Outreach Coordinator has written agreements for each community partner which include services provided to support referral process. All agreements reviewed were current. | |

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| The program will maintain documentation of outreach activities and enter into NetMIS the title, date, duration (hours), zip code, location description, estimated number of people reached, modality, target audience and topic. | **Compliance** | The Outreach Coordinator maintains documentation of outreach activities and enters them into NetMIS. NetMIS entries capture the title, date, duration, zip code, location description, estimated number of people reached, modality, target audience and topic. A random sample of five outreach activities were reviewed that showed participation at a variety of events such as school, community safety event, youth summit, street outreach, and nonprofit expo. Documentation was provided for each. | |
| The program has designated staff that conducts outreach which is defined in their job description. | **Compliance** | The Outreach Coordinator is the designated staff defined by title and job description to conduct outreach activities. | |
| ***Additional Comments:*** **There are no additional comments for this indicator.** | | | |
| **2.01 - Screening and Intake** | | | **Satisfactory** |
| **Provider has a written policy and procedure that meets the requirement for Indicator 2.01** | | **YES**<br>If NO, explain here:<br>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. | |
| **Shelter youth:** Eligibility screening form is completed immediately for all shelter placement inquiries. | **Compliance** | A total of five residential records, two open and three closed, were reviewed. All five residential records reviewed demonstrated eligibility screenings were completed immediately for all shelter placement inquires. | |
| **Community counseling:** Eligibility screening form is completed within 3 business days of referral by a trained staff using the Florida Network screening form. | **Compliance** | A total of five community counseling records, two open and three closed, were reviewed. All five community counseling records reviewed demonstrated screening forms were completed within three business days of receiving the referral. A detailed excel sheet provided information regarding referral date (date received), school, client name, and screening date. | |
| There is evidence all referrals for service is screened for eligibility and is logged in NetMIS within 72 hours of screening completion. | **Compliance** | All ten records reviewed indicated referrals were screened for eligibility, then logged into NETMIS within 72 hrs. | |
| Youth and parents/guardians receive the following in writing:<br>a. Available service options<br>b. Rights and responsibilities of youth and parents/guardians | **Compliance** | All ten records reviewed included a document signed by the parent/guardian and youth verifying they received the information regarding available service options and their rights and responsibilities. | |

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| The following is also available to the youth and parents/guardians:<br>a. Possible actions occurring through involvement with CINS/FINS services (case staffing committee, CINS petition, CINS adjudication)<br>b. Grievance procedures | **Compliance** | All ten records reviewed include a document signed at intake, that youth and parents/guardians are informed about the program's grievance procedure and possible actions which could occur through involvement with CINS/FINS. The community counseling staff also provide additional information during intake about possible actions such as case staffing. | |
| During intake, all youth were screened for suicidality and correctly assessed as required if needed. | **Compliance** | All ten records reviewed included a suicide risk screening. Additional assessments were completed as needed by a licensed mental health professional (LMHC). | |
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| **2.02 - Needs Assessment** | | | **Satisfactory** |
| **Provider has a written policy and procedure that meets the requirement for Indicator 2.02** | | **YES**<br>If NO, explain here:<br>The provider has the required policy and procedure RGC 2.02 / NIRVANA that was approved on 10/13/2023 by the CEO. | |
| Shelter Youth: NIRVANA is initiated within 72 hours of admission | **Compliance** | All five residential records reviewed had a NIRVANA Assessment completed 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 records reviewed included NIRVANA assessments completed within two to three face-to-face contacts after the initial intake. | |
| Supervisor signatures is documented for all completed NIRVANA assessments and/or the chronological note and/or interview guide that is located in the youths' file. | **Compliance** | All ten records reviewed included a supervisor's signature for all completed NIRVANA Assessments. All ten records reviewed included a printed NIRVANA. | |
| (Shelter Only) NIRVANA Self-Assessment (NSR) is completed within 24 hours of youth being admitted into shelter. If unable to complete, there must be documentation in NetMIS and the youth's file explaining the barriers to completion. | **Compliance** | All five residential records reviewed contained a printed NIRVANA Self-Assessment that was completed by the youth. | |
| A NIRVANA Post-Assessment is completed at discharge for all youth who have a length of stay that is greater than 30 days. | **Compliance** | There were three applicable closed community counseling records with length of stay greater than 30 days. All three records reviewed included a post NIRVANA Assessment. | |
| A NIRVANA Re-Assessment is completed every 90 days excluding files for youth receiving SNAP services. | **Compliance** | One applicable active community counseling youth record had a completed 90-day NIRVANA Re-Assessment. | |

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| All files include the interview guide and/or printed NIRVANA. | **Compliance** | All ten records reviewed included a printed NIRVANA in the file. | |
| ***Additional Comments:*** **There are no additional comments for this indicator.** | | | |
| **2.03 - Case/Service Plan** | | | **Satisfactory** |
| **Provider has a written policy and procedure that meets the requirement for Indicator 2.03** | | **YES**<br>If NO, explain here:<br>The provider has the required policy and procedure RGC 2.03/Service Plan Development and Service Monitoring, that was approved on 10/13/2023 by the CEO. | |
| 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 ten records reviewed included a case/service plan which was developed on New Beginnings approved form. It was evident the case/service plans are based on information gathered during the initial screening, intake and NIRVANA. | |
| Case/Service plan is developed within 7 working days of NIRVANA | **Compliance** | All ten records reviewed included a case/service plan which was developed within seven working days of the NIRVANA. | |
| **Case plan/service plan includes:**<br>1. Individualized and prioritized need(s) and goal(s) identified by the NIRVANA<br>2. Service type, frequency, location<br>3. Person(s) responsible<br>4. Target date(s) for completion and actual completion date(s)<br>5. Signature of youth, parent/guardian, counselor, and supervisor<br>6. Date the plan was initiated | **Compliance** | All ten records reviewed included the following: individualized and prioritized needs and goals identified by the NIRVANA, service type, frequency, location; person(s) responsible, target dates for completion and actual completion dates, signature of youth, parent/guardian, counselor signature, supervisor signatures, and the date the plan was initiated. | |
| 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** | All five applicable records reviewed (community counseling records) included case plans which were reviewed by the counselor and parent in a timely manner, every 30 days. | |
| ***Additional Comments:*** **There are no additional comments for this indicator.** | | | |

| 2.04 - Case Management and Service Delivery | | | Satisfactory |
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| **Provider has a written policy and procedure that meets the requirement for Indicator 2.04** | | **YES**<br>If NO, explain here:<br>The provider has the required policy and procedure RGC 2.04 Traditional and Intensive Case Management and Service Delivery, that was approved on 10/13/23 by the CEO. | |
| Counselor/Case Manager is assigned | **Compliance** | All ten records reviewed included an assigned counselor or case manager. | |
| The Counselor/Case Manager completes the following as applicable:<br>1. Establishes referral needs and coordinates referrals to services based upon the on-going assessment of the youth's/family's problems and needs<br>2. Coordinates service plan implementation<br>3. Monitors youth's/family's progress in services<br>4. Provides support for families<br>5. Monitoring progress of court ordered youth in shelter<br>6. Makes referrals to the case staffing to address problems and needs of the youth/family<br>7. Accompanies youth and parent/guardian to court hearings and related appointments<br>8. Refers the youth/family for additional services when appropriate<br>9. Provides case monitoring and reviews court orders<br>10. Provides case termination notes<br>11. Provides follow-up after 30 days post discharge<br>12. Provides follow-up after 60 days post discharge | **Compliance** | All ten records reviewed included documentation of services that were being offered and provided. All records included the following: applicable referrals based on the on-going needs of the family, coordination of service plan implementation, monitoring of the youth's/family's progress, applicable supports provided to the families, termination notes, and follow ups completed 30 and 60 days post discharge where applicable.<br><br>None of the records reviewed required a referral for case staffing or required the counselor/case manager to accompany the youth/parent to court. | |
| The program maintains written agreements with other community partners that include services provided and a comprehensive referral process | **Compliance** | The program provided verification of written agreements with other community partners that included services provided and a comprehensive referral process. | |
| ***Additional Comments:*** **There are no additional comments for this indicator.** | | | |

| 2.05 - Counseling Services | | | Satisfactory |
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| **Provider has a written policy and procedure that meets the requirement for Indicator 2.05** | | **YES**<br>If NO, explain here:<br>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. | |
| **Shelter Program** | | | |
| Shelter programs provides individual and family counseling | **Compliance** | All five residential records reviewed included documentation that the program provided individual and family counseling. | |
| Group counseling sessions held a minimum of five days per week | **Compliance** | Documentation was provided that group counseling sessions were held a minimum of five days per week as evidenced by group sessions logged in the group log book. | |
| Groups are conducted by staff, youth, or guests and group counseling sessions consist of :<br>1. A clear leader or facilitator<br>2.Relevant topic - educational/informational or developmental<br>3. Opportunity for youth to participate<br>4. 30 minutes or longer | **Compliance** | Group session logs included information to support groups were conducted by staff, youth, or guests. Documentation also indicated that the following requirements of the group were being completed: a clear leader/facilitator, relevant topic, opportunities for the youth to participate and were help for at least 30 minutes. | |
| Documentation of groups must include date and time, a list of participants, length of time, and topic. | **Compliance** | The documentation that was reviewed included verification of the following: the date and time of the group, the list of participants, the length of time the group was held for and the topic which was discussed. | |
| **Community Counseling** | | | |
| Community counseling programs provide therapeutic community-based services designed to provide the intervention necessary to stabilize the family. Services are provided in the youth's home, a community location, the local provider's counseling office or virtually if written documentation is provided in the youth's file for reasons why it is in the best interest of the youth and family. | **Compliance** | All five of the residential records reviewed included documentation that the community counseling program provided therapeutic community based services. All five files reviewed indicated the location where the services were provided (either in the youth's home, counseling office, community location or virtual).<br><br>None of the records reviewed included virtual sessions. | |

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| **Counseling Services** | | | |
| There is evidence the program completes review of all case files for coordination between presenting problem(s), psychosocial assessment, case/service plan, case/service plan reviews, case management, and follow-up. | **Compliance** | All ten records reviewed provided documentation that the program reviews of all case files for coordination between the presenting problem(s), psychosocial assessments, case/service plan, case/service plan implementation, case management and follow ups. | |
| Maintain individual case files on all youth and adhere to all laws regarding confidentiality. | **Compliance** | All ten records reviewed were maintained individually, and followed all laws regarding confidentiality. | |
| Case notes maintained for all counseling services provided and documents youth's progress. | **Compliance** | All ten records reviewed included case notes for all counseling services provided as well as documentation of the youth's progress. | |
| On-going internal process that ensures clinical reviews of case records and staff performance. | **Compliance** | Verification was provided that the agency has an on-going internal process which ensures clinical reviews of the case records and staff performances are being completed. The QIS also completes case record reviews and provide feedback to program managers. | |
| 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** | Of the ten records reviewed, no documentation indicated any of the intakes were completed through virtual means. | |
| ***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**<br>If NO, explain here:<br>The provider has the required policy and procedure RGC 2.06 - Adjudication/Petition Process, that was approved on 10/13/2023 by the CEO. | |
| Must include:<br>a. DJJ rep. or CINS/FINS provider<br>b. Local school district representative | **Compliance** | Per interview with the community counseling Program Director, there were no case staffing requests since the last QI review. Per the policy and procedure, and emails sent to the case staffing committee, committee members include a DJJ Representative, the CINS/FINS provider, and a school district representative. | |
| Other members may include:<br>a. State Attorney's Office<br>b. Others requested by youth/ family<br>c. Substance abuse representative<br>d. Law enforcement representative<br>e. DCF representative<br>f. Mental health representative | **Compliance** | Per the program's policy and procedure, other members of the committee may include: State Attorney's Office; others requested by youth/ family; substance abuse representative; law enforcement representative; DCF representative; and mental health representative. They are not standing members but are invited as needed. | |
| The program has an established case staffing committee, and has regular communication with committee members | **Compliance** | Per interview with the community counseling Program Director and email correspondence, the program has an established case staffing committee and scheduled meeting dates for the remainder of the year. There were no case staffing requests since the last QI review. | |
| The program has an internal procedure for the case staffing process, including a schedule for committee meetings | **Compliance** | Internal procedures for the case staffing are outlined in the provider's policy and procedures reviewed. | |

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| The youth and family are provided a new or revised plan for services | **No eligible items for review** | | |
| Written report is provided to the parent/guardian within 7 days of the case staffing meeting, outlining recommendations and reasons behind the recommendations | **No eligible items for review** | | |
| If applicable, the program works with the circuit court for judicial intervention for the youth/family | **No eligible items for review** | | |
| Case Manager/Counselor completes a review summary prior to the court hearing | **No eligible items for review** | | |
| ***Additional Comments:*** **There are no additional comments for this indicator.** | | | |
| **2.07 - Youth Records** | | | **Satisfactory** |
| **Provider has a written policy and procedure that meets the requirement for Indicator 2.07** | | **YES**<br>If NO, explain here:<br>The provider has the required policy and procedure RGC 2.07/Youth Records, that was approved on 10/13/23 by the CEO. | |
| All records are clearly marked 'confidential'. | **Compliance** | Client files are maintained in Mindshare, an electronic platform but hard copies of some documents are kept until the transition is complete. Hard copy of files for all ten records reviewed were clearly marked 'confidential'. | |
| All records are kept in a secure room or locked in a file cabinet that is marked "confidential" | **Compliance** | The reviewer examined the area where the records are kept. All records were stored in a secure locked room, in a locked file cabinet. The cabinet was marked "confidential". | |
| When in transport, all records are locked in an opaque container marked "confidential" | **Compliance** | The reviewer was shown an opaque locked container marked "confidential" which is used when any records are transported. | |
| All records are maintained in a neat and orderly manner | **Compliance** | The agency maintains all records in a neat and orderly manner with easy to follow organization of documents. | |
| SHELTER FILES contain the following:<br>Table of Contents that outlines documents in each section:<br>•Screening<br>•Informed Consent<br>• Photograph of the youth<br>• Shelter Intake Form<br>• Suicide Assessment (if needed)<br>• NIRVANA Self Report (NSR)<br>• NIRVANA full Assessment<br>• Plan of Service<br>• Chronological Notes<br>• Medication Inventory Form<br>• Approved contact list<br>• Copies of referrals made & Follow-Up (if needed)<br>• Discharge summary once case is closed | **Compliance** | All five residential records reviewed included a Table of Contents sections which outlines the documents in each section. The Table of Contents included the following: screening, informed consent, photograph of the youth, the shelter intake form, suicide assessment (if applicable), NIRVANA self-report (NSR), NIRVANA full assessment, plan of service, chronological notes, medication inventory form, approved contact list, copies of referrals made, follow ups as needed, and discharge summary. | |

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| COMMUNITY COUNSELING FILES contain the following:<br>Table of Contents that outlines documents in each section:<br>• Screening<br>• Informed Consent<br>• Community Counseling Intake Form<br>• Suicide Assessment (if needed)<br>• NIRVANA full Assessment<br>• Plan of Service<br>• Chronological case notes<br>• Copies of referrals made & Follow-Up (if needed)<br>• Discharge summary once the case is closed | **Compliance** | All five community counseling records reviewed included a Table of Contents which included the following: screening, informed consent, community counseling intake form, suicide assessment (if applicable), NIRVANA full assessment, plan of service/case plan, chronological case notes, and copies of referrals made and follow ups (if needed). | |
| All records kept electronically, are maintained securely and can be made immediately available upon request for audit purposes. | **Compliance** | Reviewer examined records which were kept electronically, all records are maintained securely and were made available immediately upon request during the audit. Files can only be accessed through secure passwords individually assigned to each staff. | |
| Records are retained for the duration of the time specified by the contract. | **Compliance** | All records reviewed onsite were within the six months review period; however, the agency's policy requires records to be retained for the duration of the time specified by the contract. | |
| ***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**<br>If NO, explain here:<br>The provider has the required policy and procedure RGC 2.08/ Specialized Additional Program Services that was approved on 10/13/2023 by the CEO. | |
| **Staff Secure** | | | |
| Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted?<br>**(If no, select rating "No eligible items for review")** | **No eligible items for review** | The provider has not served any youth who meet the criteria for Staff Secure services since the last QI review. | |
| Staff Secure policy and procedure outlines the following:<br>a. In-depth orientation on admission<br>b. Assessment and service planning<br>c. Enhanced supervision and security with emphasis on control and appropriate level of physical intervention<br>d. Parental involvement<br>e. Collaborative aftercare | **No eligible items for review** | | |
| 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** | | |

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| Staff Assigned:<br>a. One staff secure bed and assigned staff supervision to one staff secure youth at any given time<br>b. Program assign specific staff during each shift to monitor location/ movement of staff secure youth<br>c. Agency clearly documents the specific staff person assigned to the staff secure youth in the logbook or any other means on each shift | **No eligible items for review** | | |
| Agency provides a written report for any court proceedings regarding the youth's progress | **No eligible items for review** | | |
| **Domestic Minor Sex Trafficking (DMST)** | | | |
| Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted?<br>(If no, select rating "No eligible items for review") | **No eligible items for review** | The provider has not served any youth who meet the criteria for Domestic Minor Sex Trafficking (DMST) services since the last QI review. | |
| Agency has evidence that the FNYFS was contacted for approval prior to admission for all Domestic Minor Sex Trafficking (DMST) placements. | **No eligible items for review** | | |
| There is evidence the youth was entered into NetMIS as a Special Populations youth at admission and a Human Trafficking Screening Tool (HTST) was completed. | **No eligible items for review** | | |
| Services provided to these youth specifically designated services designed to serve DMST youth | **No eligible items for review** | | |
| Did the placement of DMST youth require additional supervision for the safety of the youth or the program? If so, did the agency provide the appropriate level of supervision and safety measures? | **No eligible items for review** | | |
| Length of Stay:<br>a. Youth in program do not have length of stay in DMST placement that exceeds seven (7) days<br>b. Agency has approval for stays and support beyond seven (7) days for DMST placements that are obtained on a case-by-case basis? (If applicable.) | **No eligible items for review** | | |
| 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** | | | |
| Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted?<br>(If no, select rating "No eligible items for review") | **No eligible items for review** | The provider has not served any youth who meet the criteria for Domestic Violence Respite services since the last QI review. | |
| Youth admitted to DV Respite placement have evidence in the file of a pending DV charge | **No eligible items for review** | | |

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| Data entry into NetMIS within (3) business days of intake and discharge | **No eligible items for review** | | |
| 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. | **No eligible items for review** | | |
| Case plan in file reflects goals for aggression management, family coping skills, or other intervention designed to reduce propensity for violence in the home | **No eligible items for review** | | |
| All other services provided to Domestic Violence Respite youth are consistent with all other general CINS/FINS program requirements | **No eligible items for review** | | |
| **Probation Respite** | | | |
| Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review") | **No eligible items for review** | The provider has not served any youth who meet the criteria for Probation Respite since the last QI review. | |
| All probation respite referrals are submitted to the Florida Network. | **No eligible items for review** | | |
| All Probation Respite Referral come from DJJ Probation and there is evidence that the youth is on Probation regardless of adjudication status. | **No eligible items for review** | | |
| Data entry into NetMIS and JJIS within (3) business days of intake and discharge | **No eligible items for review** | | |
| Length of stay is no more than fourteen (14) to thirty (30) days. Any placement beyond thirty (30) days contains evidence in the file that the JPO was contacted in writing to request the need of an extension no later than the 25th day the youth was admitted into the program. | **No eligible items for review** | | |
| All case management and counseling needs have been considered and addressed | **No eligible items for review** | | |
| All other services provided to Probation Respite youth are consistent with all other general CINS/FINS program requirements | **No eligible items for review** | | |
| **Intensive Case Management (ICM)** | | | |
| 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** | | |

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| Services for youth and family include:<br>a. Two (2) direct contacts per month<br>b. Two (2) collateral contacts per week<br>c. Direct and collateral contacts not obtained must have documentation to support attempts made to obtain them. All reasonable attempts (at minimum of three) must be made to reach all contacts (direct and collateral) and documented in the case file and NetMIS. | **Not Applicable** | | |
| Assessments include<br>a. NIRVANA at intake<br>b. NIRVANA Re-Assessment every 90 days<br>c. Post NIRVANA at discharge as aligned with timeframe requirements | **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)** | | | |
| Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted?<br>(If no, select rating "No eligible items for review") | **No eligible items for review** | The 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:<br>a. Services shall be documented through the signature of the youth and his/her parent/guardian as well as orientation to the program which is kept in the youths file.<br>b. The initial assessment shall be face-to-face, in person or through virtual means, to include a gathering of all family history and demographic information, as well as the development of the service plan.<br>c. For youth on probation, a copy of the youths Community Assessment Tool (CAT) to assist with development of the family service plan. | **No eligible items for review** | | |
| Life Management Sessions meets the following criteria:<br>a. Sessions are face-to-face, sixty (60) minutes in length and focus on strengthening the family unit<br>b. Services are highly supportive, individualized, and flexible and require a "whole family" approach to dealing with the problems affecting the youth and family. | **No eligible items for review** | | |

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| Individual Sessions:<br>a. The program conducted sessions with the youth and family to focus on work to engage the parties and identify strengths and needs of each member that help to improve family functioning.<br>b. Issues to be covered through each session include but are not limited to:<br>Identifying emotional triggers; body cues; healthy coping strategies through individual, group and family counseling; understanding the cycle of violence and the physical and emotional symptoms of anger; developing safety plans; and educating families on the legal process and rights. | **No eligible items for review** | | |
| Group Sessions:<br>a. Focus on the same issues as individual/family sessions with application to youth pulling on similar experiences with other group members with the overall goal of strengthening relationships and prevention of domestic violence.<br>b. Shall be no more than eight (8) youth at one (1) time and shall be for a minimum of sixty (60) minutes per session | **No eligible items for review** | | |
| There is evidence of completed 30 and/or 60 day follow-ups and is documented in NetMIS following case discharge. | **No eligible items for review** | | |
| Youth and family participate in services for thirteen (13) sessions or ninety (90) consecutive days of services, or there is evidence in the youth's file that an extension is granted by DJJ circuit Probation staff | **No eligible items for review** | | |
| Any service that is offered virtually, is documented in the youth's file why it was in the youth and families best interest. | **No eligible items for review** | | |
| All data entry in NetMIS is completed within 3 business days as required. | **No eligible items for review** | | |
| ***Additional Comments:*** **There are no additional comments for this indicator.** | | | |

| 2.09- Stop Now and Plan (SNAP) | | | Not Applicable |
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| **Provider has a written policy and procedure that meets the requirement for Indicator 2.09** | | **YES**<br>If NO, explain here:<br>The provider a policy and procedure RGC 2.09/SNAP- Stop Now and Plan, approved on 10/13/2023 by the CEO. YFA New Beginnings is not contracted to provide SNAP services | |
| **SNAP Clinical Groups Under 12** | | | |
| Youth are screened to determine eligibility of services with the (Florida Network Youth Screening Form and SNAP Child Screening Interview Report). | **Not Applicable** | | |
| The file contains the following required documents:<br>a. SNAP® Brief Intake Screening Checklist (BISC)<br>b. Florida Network Community Counseling Intake Form<br>c. Reinforcement Trap/Coercive Cycle Diagram<br>d. SNAP® Parent Goal Sheet<br>e. Child Way To Go Goal Sheet<br>f. Consent to Treatment and Participation in Research Form | **Not Applicable** | | |
| The NIRVANA was completed at initial intake, or within two sessions. | **Not Applicable** | | |
| There is evidence of the completed the Pre - Child Behavior Checklist (CBCL) by the caregiver and is located within the file. | **Not Applicable** | | |
| There is evidence of the completed Pre - TOPSE is completed by the caregiver and is located within the file. | **Not Applicable** | | |
| **SNAP Clinical Groups Under 12 - Discharge** | | | |
| There is evidence of the completed the Post - Child Behavior Checklist (CBCL) by the caregiver and is located within the file. | **Not Applicable** | | |
| There is evidence of the completed Post - TOPSE is completed by the caregiver and is located within the file. | **Not Applicable** | | |
| There is evidence of the completed SNAP Discharge Report located within the file for any discharged youth. | **Not Applicable** | | |
| There is evidence of the SNAP Boys/SNAP Girls Child Group Evaluation Form located in the file. | **Not Applicable** | | |
| There is evidence of the SNAP Boys/SNAP Girls Parent Group Evaluation Form located in the file. | **Not Applicable** | | |
| **SNAP Clinical Groups for Youth 12-17** | | | |
| Youth are screened to determine eligibility of services. | **Not Applicable** | | |

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| The file contains the Florida Network Community Counseling Intake Form is completed and located within the file. | **Not Applicable** | | |
| The Consent to Treatment and Participation in Research Form is completed and located within the file. | **Not Applicable** | | |
| The NIRVANA was completed at initial intake, or within two sessions. | **Not Applicable** | | |
| There is evidence of the completed 'How I Think Questionnaire' (HIT) form located within the file or evidence of at least three (3) documented attempts in the youths' file to obtain this information. | **Not Applicable** | | |
| There is evidence of the completed Social Skills Improvement System (SSIS) Student form located within the file or evidence of at least three (3) documented attempts in the youths' file to obtain this information. | **Not Applicable** | | |
| There is evidence of the completed Social Skills Improvement System (SSIS) Teacher/Adult form located within the file or evidence of at least three (3) documented attempts in the youths' file to obtain this information. | **Not Applicable** | | |
| **SNAP for Schools & Communities** | | | |
| The program demonstrated all of the required weekly attendance sheets that included youth names and/or identifying numbers completed with the teacher and trained SNAP Facilitator signatures. (*This must include a total of 13 attendance sheets for a full cycle* ) | **Not Applicable** | | |
| The program maintained evidence of a completed 'Way to Go Goal Sheet' within the file. | **Not Applicable** | | |
| The program maintained evidence of both pre AND post Measure of Classroom Environment (MoCE) completed documents for the class reviewed. | **Not Applicable** | | |
| The program maintained evidence of completed pre and post evaluation documents for the class reviewed. | **Not Applicable** | | |
| There is evidence of the SNAP® for Schools & Communities Feedback Form completed by the supervisory adult responsible for the support of the youth receiving services and entered into NetMIS. | **Not Applicable** | | |
| ***Additional Comments:*** **There are no additional comments for this indicator.** | | | |
| **3.01 - Shelter Environment** | | | **Satisfactory** |
| **Provider has a written policy and procedure that meets the requirement for Indicator 3.01** | | **YES**<br>If NO, explain here:<br>The provider has the required policy and procedure # 3.01 Approved by CEO on 10/13/2023. | |

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| **Facility Inspection:**<br>a. Furnishings are in good repair.<br>b. The program is free of insect infestation.<br>c. Bathrooms and shower areas are clean and functional, free of foul odors, leaks, dust, and mildew and in good working order.<br>d. There is no graffiti on walls, doors, or windows.<br>e. Lighting is adequate for tasks performed there.<br>f. Exterior areas are free of debris; grounds are free of hazards.<br>g. Dumpster and garbage can(s) are covered.<br>h. All doors are secure, in and out access is limited to staff members and key control is in compliance.<br>i. Detailed map and egress plans of the facility, general client rules, grievance forms, abuse hotline information, DJJ Incident Reporting Number and other related notices are posted.<br>j. Interior areas (bedrooms, bathrooms, common areas) do not contain contraband and are free from hazardous unauthorized metal/foreign objects. | **Compliance** | Upon direct inspection and observation of all items in this indicator, it was found that the shelter's furnishings, lighting, and all mechanicals in bathrooms were in good working order. No graffiti or defacement of walls, doors, or any other structural items were observed. No foul odors, mildew, or rust was observed in any of the bathrooms. Dumpsters and interior trash receptables were covered appropriately as well. Interior and exterior doors were found to be secure and egress maps were posted in every bedroom, hallway and common area should an emergency evacuation be required. Interior rooms were adequately lit and well suited to tasks that would be performed in each area. All interior areas were found to be free of contraband and hazards. The Abuse Hotline number was prominently posted along with DJJ incident reporting number. Grievance forms and boxes were readily available for youth to utilize/access at will. | |
| **Facility Inspection:**<br>a. All agency and staff vehicles are locked.<br>b. Agency vehicles are equipped with major safety equipment including first aid kit, (all items in the first aid kit are current and do not have expired items; all expired items should be replaced regularly), fire extinguisher, flashlight, glass breaker and, seat belt cutter. | **Compliance** | The shelter operates two mini-vans which are as follows: (1) 2024 Chrysler Pacifica and, (2) 2022 Chrysler Voyager. Each was equipped with the necessary items noted in this indicator. First aid kits were current with no expired items. Fire extinguishers, flashlight, glass breaker, and belt cutters were present in each vehicle. Both vehicles were locked at the time of observation. | |
| **Facility Inspection:**<br><br>All chemicals are listed, approved for use, inventoried weekly and perpetually, stored securely and Material Safety Data Sheets (MSDS) are maintained on each item (minimum 1 time per week or per agency policy).<br><br>A perpetual inventory will be the primary means of maintaining a current and real-time inventory.<br><br>The weekly inventory will be conducted weekly at a minimum to ensure that a perpetual inventory is being maintained consistently and accurately. If more than one location is used to store chemicals, there is an inventory wherever chemicals are stored that is current and well maintained unless previously approved by the Network. | **Compliance** | As evidenced by review of chemical inventories and MSDS logs, all chemicals were observed to be accurately stored and inventoried. The shelter has three locations where chemicals are stored and all locations had MSDS binders which contained inventory logs that evidenced a perpetual inventory being maintained and reviewed consistently every week. | |

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| **Facility Inspection:**<br><br>Washer/dryer are operational & general area/lint collectors are clean.<br>Agency has a current DCF Child Care License which is displayed in the facility.<br>Each youth has own individual bed with clean covered mattress, pillow, sufficient linens and blanket.<br>Youth have a safe, lockable place to keep personal belongings, if requested. | **Compliance** | Based on interview and upon direct inspection of two dryers, one was cleaned and free of lint. The second dryer was currently in use during the inspection. Given observations during tour and subsequent access to these areas and visits to the dorm area, each youth had an assigned bed with all appropriate items, to include mattress (covered), pillow, blanket and additional linens should they be required. Additionally, youth belongings not readily accessible to the youth in the shelter are securely stored behind a locked door and cabinet. Staff members only have access to these areas. | |
| **Additional Facility Inspection Narrative (if applicable)** | | | |
| **Fire and Safety Health Hazards:**<br>a. Annual facility fire inspection was conducted, and the facility is in compliance with local fire marshal and fire safety code within jurisdiction.<br>b. Agency completes a minimum of 1 fire drill on each shift monthly (within 2 minutes or less).<br>c. Completes 1 mock emergency drill per shift per quarter.<br>d. All annual fire safety equipment inspections are valid and up to date (extinguishers, sprinklers, alarm system and kitchen overhead hood, including fire extinguishers in all vehicles). | **Compliance** | Current annual fire inspection was conducted by Brooksville Fire Department on 7/8/24, which is valid for one year. Upon review, fire drills had been conducted monthly for each shift. 1st shift fire drill dates include 9/6/24, 8/10/24, 7/8/24, 6/13/24, 5/31/24, 4/2/24, 3/4/24. Second shift dates include: 8/23/24, 7/19/24, 6/18/24, 5/15/24, 4/10/24, 3/28/24. Third shift dates include: 8/28/24, 7/23/24, 6/26/24 5/29/24, 4/22/24, 3/20/24. Likewise, the shelter conducted quarterly mock drills during the review period on all shifts as well. Date of fire safety equipment inspection is 7/8/24 with the result of "satisfactory" and inspection is valid for one year. Regarding all fire extinguishers, a current inspection date of 9/3/24 was completed and all extinguishers are easily accessible. Both of the shelter's vehicles had fire extinguishers with up-to-date inspections of 9/3/24. | |

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| **Fire and Safety Health Hazards:**<br>a. Agency has a current Satisfactory Residential Group Care inspection report from the Department of Health.<br>b. Agency has a current Satisfactory Food Service inspection report from the Department of Health and food menus are posted, current and signed by Licensed Dietician annually.<br>c. All cold food is properly stored, marked and labeled and dry storage/pantry area is clean and food is properly stored.<br>d. Refrigerators/Freezers are clean and maintained at required temperatures and all small and medium sized appliances are operable and clean for use as needed. | **Compliance** | The department of health completed its annual health inspection on 6/28/24 and is valid for one year. Food handling certificates are current and valid until 2029. Both the refrigerator and freezer, upon inspection, were clean and well maintained with the temperatures as follows: Refrigerator: 36 degrees and, (2) Freezer: -7 degrees. Additionally, upon inspection, all cold food is properly labeled and stored. Menus are posted and approved by Licensed Dietician (current/valid for year). | |
| **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.<br>b. At least one hour of physical activity is provided daily.<br>c. Youth are provided the opportunity to participate in a variety of faith-based activities. Non-punitive structured activities are offered to youth who do not choose to participate in faith-based activities.<br>d. Daily programming includes opportunities for youth to complete homework and access a variety of age appropriate, program approved books for reading. Youth are allowed quiet time to read.<br>e. Daily programming schedule is publicly posted and accessible to both staff and youth. | **Compliance** | As evidenced by direct observation of youth in the shelter and observation of shelter's activity schedule, all youth are engaged throughout the day in meaningful/structured activities. Activities include recreation, counseling, therapeutic group, and structured individual/group time. Appropriate daily physical activity is allotted as well in the schedule. Additional time is allotted daily for completion of school work, such as homework or projects. Per Policy 3.01 of the organization's policy and procedure manual, youth are provided the opportunity to participate in faith-based activities according to their liking/beliefs. Youth are permitted to decline such activities without fear of punitive measures and alternative programming is offered. The activities schedule is posted in all youth occupied areas and easily accessible to both staff members and youth at all times. | |
| ***Additional Comments:*** **There are no additional comments for this indicator.** | | | |
| **3.02 - Program Orientation** | | | **Satisfactory** |
| **Provider has a written policy and procedure that meets the requirement for Indicator 3.02** | | **YES**<br>If NO, explain here:<br>The provider has the required policy and procedure RGC 3.02 - Program Orientation, that was approved 10/13/23 by the CEO. | |
| Youth received a comprehensive orientation and handbook provided within 24 hours | **Compliance** | A total of five youth records (two open and three closed) were reviewed for this indicator. All five youth records reviewed had documentation to support the youth received a comprehensive orientation within the first twenty-four hours of admission. | |

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| Orientation includes the following:<br>a. Youth is given a list of contraband items<br>b. Disciplinary action is explained<br>c. Dress code explained<br>d. Review of access to medical and mental health services<br>e. Procedures for visitation, mail and telephone<br>f. Grievance procedure<br>g. Disaster preparedness instructions<br>h. Physical layout of the facility<br>i. Sleeping room assignment and introductions<br>j. Suicide prevention- alerting staff of feelings or awareness of others having suicidal thoughts | **Compliance** | Documentation reviewed supported youth receive a resident packet/handbook that includes information about orientation, house rules, contraband, grievance procedures, point store, and the six pillar behavior management and level system with worksheets, and education services provided. Additionally, the program has an orientation checklist utilized during the orientation that covers all required topics. All five youth records maintained evidence of receiving orientation. | |
| Documentation of each component of orientation, including orientation topics and dates of presentation, as well as signatures of the youth and staff involved is maintained in the individual youth record | **Compliance** | All five records reviewed supported each contained the dates orientation was conducted along with information that was provided to the youth. Each youth signed the orientation documentation along with the staff who provided the orientation. | |
| ***Additional Comments:*** **There are no additional comments for this indicator.** | | | |
| **3.03 - Youth Room Assignment** | | | **Satisfactory** |
| **Provider has a written policy and procedure that meets the requirement for Indicator 3.03** | | **YES**<br>If NO, explain here:<br>The provider has the required policy and procedure RGC 3.03 - Youth Room Assignment, that was approved 10/13/23 by the CEO. | |
| **A process is in place that includes an initial classification of the youths, to include:** | | | |
| a. Review of available information about the youth's history, status and exposure to trauma<br>b. Initial collateral contacts,<br>c. Initial interactions with and observations or the youth<br>d. Separation of younger youth from older youth,<br>e. Separation of violent youth from non-violent youth<br>f. Identification of youth susceptible to victimization<br>g. Presence of medical, mental or physical disabilities<br>h. Suicide risk<br>i. Sexual aggression and predatory behavior<br>j. Acute health symptoms requiring quarantine or isolation | **Compliance** | During intake, youth are evaluated to determine appropriate classification and need for immediate services. All five youth records reviewed contained completed assessments addressing all required information needed to make an appropriate room assignment. Information found in the electronic system also supported information was obtained and considered when making the youth's room assignment. | |
| An alert is immediately entered into the program's alert system when a youth is admitted with special needs and risks such as risk of suicide, mental health, substance abuse, physical health or security risk factors | **Compliance** | The program has an alert system in place with a variety of protocols to identify and document alerts. The program uses a letter system where each letter stands for a specific alert. Each record is labeled with a sticker on the front of the record representing the relevant alert letters. There is a white board maintained in the residential area of the facility. The white board also contains each youth's alert. The medical room also has an alert board documenting medical alerts. The kitchen also has a list of individual youth who are allergic to certain food items. A comparison of the information within the record to the alert system confirmed the alerts were correct for all five youth. | |
| ***Additional Comments: There are no additional comments for this indicator.*** | | | |

| 3.04 - Log Books | | | Satisfactory with Exception |
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| **Provider has a written policy and procedure that meets the requirement for Indicator 3.04** | | **YES**<br>If NO, explain here:<br>The provider has the required policy and procedure RGC #3.04 which was approved by the CEO on 10/13/23. | |
| Log book entries that could impact the security and safety of the youth and/or program are highlighted | **Compliance** | A random selection of two consecutive weeks for each month, March – August, was reviewed to assess compliance with the indicator. Based on this sample, a review of logbook entries evidenced staff members noted necessary items that could impact safety and security of youth. One such occurrence noted and highlighted, was the calling of EMS for a resident who had fallen ill. | |
| All entries are brief, legibly written in ink and include:<br>• Date and time of the incident, event or activity<br>• Names of youth and staff involved<br>• Brief statement providing pertinent information<br>• Name and signature of person making the entry | **Compliance** | Given review of logbooks, all reviewed entries were legible and descriptive and included date, time, activity or event as well as the names of the staff and youth involved. Informational notes were generally brief and to the point along with the signature of the staff member making the entry. | |
| Recording errors are struck through with a single line. The staff person must initial and date the correction. The use of whiteout and erasures is prohibited. | **Exception** | A review of the program logbook for the weeks selected revealed use of correcting errors, as required with staffs' use of the strike through method, initials, and date was not observed to be conducted consistently. | Two corrections were observed to have been made in the review sample without noting the date of the correction. In both instances, the error was properly marked through and initialed; however, the correction was not dated accordingly. |
| 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** | It was determined through the review of the logbook sample, the program director and/or designee reviewed the logbooks on a weekly basis. Notations were in purple ink and/or purple highlight. All notations were dated and signed at the time of entry. | |
| 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** | Throughout the review of the sample it was observed that direct care staff consistently reviewed their prior two shifts in the logbook, and signed, and dated the review entries. | |
| 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** | Throughout the review of the logbook sample, it was observed that the oncoming supervisor/counselor reviewed all entries since their last shift. All reviews were dated and signed consistently throughout the sample. | |
| Logbook entries include:<br>a. Supervision and resident counts<br>b. Visitation and home visits | **Compliance** | Throughout the logbook review, staff supervision of youth and headcounts were consistently noted, dated, and signed. On-site visitation and home visitation are also noted and entered throughout the sample. | |
| ***Additional Comments:*** **There are no additional comments for this indicator.** | | | |
| **3.05 - Behavior Management Strategies** | | | **Satisfactory** |
| **Provider has a written policy and procedure that meets the requirement for Indicator 3.05** | | **YES**<br>If NO, explain here:<br>The provider has the required policy and procedure RGC #3.05 Approved by CEO on 10/13/2023. | |

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| The program has a detailed written description of the BMS and it is explained during program orientation | **Compliance** | Per the shelter's policy, the program has a detailed description of their behavioral management strategy that is maintained in a binder for staff reference. Training and familiarization to BMS also occurs during initial program orientation with new staff and residents | |
| **Behavior Management Strategies must include:** | | | |
| a. BMS is designed to teach youth new behaviors and help youth understand the natural consequences for their actions<br>b. Behavioral interventions are applied immediately, with certainty, and reflect the severity of the behavior<br>c. BMS uses a wide variety of awards/incentives to encourage participation and completion of the program<br>d. Appropriate consequences and sanctions are used by the program and consequences for behavior are logical and designed to promote skill-building for the youth<br>e. Counseling, verbal intervention and de-escalation techniques are used prior to physical intervention (Only techniques approved by the Florida Network and DJJ are used if physical intervention is required)<br>f. Only staff discipline youth. Group discipline is not imposed<br>g. Room restriction is not used as part of the system or for youth who are physically and/or emotionally out of control<br>h. Youth should never be denied basic rights such as meals, clothing, sleep, services, exercise, or correspondence privileges | **Compliance** | As evidenced by interview with the team lead and review of the written BMS strategy, it was determined that the propose of the BMS is to teach youth new behaviors and provide an opportunity for skill-building. Central to the work with youth in the shelter is that interventions are immediate and appropriate (logical & natural). Verbal de-escalation is a focus of the BMS as well. Physical restraint is not utilized. Consequences for non-prosocial behavior are reasonable and there are also a variety of positive rewards based on point attainment and level achieved. Extended bedtimes and other privileges which are incorporated into each youth's level in the program. Given review of the BMS and interview with team lead, it was determined that only staff discipline the youth, and room restriction or group punishment is not practiced. Regardless of level and/or disciplinary sanction, youth are not denied any basic rights such as food/meals/snacks, sleep, services, or correspondence privileges. | |
| **Program's use of the BMS** | | | |
| All staff are trained in the theory and practice of administering BMS rewards and consequences | **Compliance** | Each direct care staff member is trained on the BMS system in the application of the BMS including rewards and consequences during the orientation period. This was demonstrated during the review of training records for four direct care staff hired in the past year. | |
| There is a protocol for providing feedback and evaluation of staff regarding their use of BMS rewards and consequences | **Compliance** | Given interview with the team lead, it was determined that frequent feedback and communication occurs with direct care staff regarding the application of the shelter's BMS system, including rewards and consequences. The program director also discusses use of the BMS during staff meetings occasionally. | |
| Supervisors are trained to monitor the use of rewards and consequences by their staff | **Compliance** | Per interview with the team lead, it was determined that supervisors & team leads are actively monitoring staff members application of rewards and consequences of the BMS to ensure that there is no misuse of the strategies and that interventions are appropriate and consistent with the program's behavioral management structure. | |
| ***Additional Comments:*** **There are no additional comments for this indicator.** | | | |
| **3.06 - Staffing and Youth Supervision** | | | **Satisfactory** |
| **Provider has a written policy and procedure that meets the requirement for Indicator 3.06** | | **YES**<br>If NO, explain here:<br>The provider has the required policy and procedures RGC #3.06 approved by CEO on 10/13/2023. | |

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| The program maintains minimum staffing ratios as required by Florida Administrative Code and contract.<br>• 1 staff to 6 youth during awake hours and community activities<br>• 1 staff to 12 youth during the sleep period | **Compliance** | A review of the staff schedules for the review period was conducted. It is evidenced by review of the schedules that staffing ratios are maintained by the shelter with a minimum ratio being 1:6 at all times. Additionally, there is signage throughout the shelter that serves as a reminder to staff of the mandated staff to resident ratio. | |
| All shifts must always provide a minimum of two direct care staff present that have met the minimum training requirements | **Compliance** | Given direct observation and review of staff schedules, all shifts have a minimum of two direct care staff members on duty at all times. All staff included in the ratio have met minimum training requirements. | |
| 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** | After review of new staff hired and new hire training files reviewed, all staff that are included in the minimum staffing ratio have been properly trained and screened, including supervisory and administrative staff. | |
| The staff schedule is provided to staff or posted in a place visible to staff | **Compliance** | The staff schedule is posted on the "Communication Board", which is located in a centralized staff area within the shelter. | |
| 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** | A holdover roster exists with employee names and contact information, should a shortage with the oncoming shift be experienced. | |
| Staff observe youth at least every 15 minutes while they are in their sleeping room, either during the sleep period or at other times, such as during illness or room restriction | **Compliance** | Video and logbook entries were checked and matched for the following dates and times randomly selected: 9/4- 12am-2am; 9/6 – 2am-4am; 9/8 –4am-6am; 9/9 - 1am-3am; and 9/14-3am-5am. No inconsistencies were noted on the video surveillance review during the sleeping hours. Although the Florida Network's policy is 15 minute bed checks, the shelter's practice is a completed check every 10 minutes. Checks were observed to occur at the 10 minute mark. Bedroom doors on both the boys and girls dorm remain open and staff conducting the checks look into each room to monitor youth, thus conducting a quality check. | |
| ***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 RGC #3.07 that was approved by the CEO on 10/13/23. | |

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| **Surveillance System** | | | |
| The agency, at a minimum, shall demonstrate:<br>a. A written notice that is conspicuously posted on the premises for the purpose of security<br>b. System can capture and retain video photographic images which must be stored for a minimum of 30 days<br>c. System can record date, time, and location; maintain resolution that enables facial recognition<br>d. Back-up capabilities consist of cameras' ability to operate during a power outage<br>e. Have cameras placed in interior (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.<br>f. All cameras are visible | **Compliance** | The shelter operates a video surveillance system with cameras located throughout the public areas of the shelter's interior and the exterior. Upon inspection, all cameras are visible and their presence in the shelter's interior and exterior is conspicuously posted. Cameras also monitor the entrance and exit areas for anyone who may be entering or leaving the shelter. The video surveillance system clearly captures images including staff and is time stamped with camera location noted. The surveillance system can retrieve video footage of all areas within the shelter's interior and exterior within the last 60 days. The system is backed up by the standby generator to allow for continued operation during power outages. Camera coverage is complete throughout the public areas within the shelter that youth and staff congregate. Key areas include the intake area, cafeteria, group room, staff area, and the exterior areas to include parking lot, recreation area, entrance and exit points. Cameras were found to not be placed in youth bedrooms or bathrooms. | |
| A list of designated personnel who can access the video surveillance system is maintained (includes off-site capability per personnel)? | **Compliance** | Camera access/review whether onsite or off-site is restricted to supervisory and QIS staff only. | |
| Supervisory review of video is conducted a minimum of once every 14 days and timeframes reviewed are noted in the logbook. | **Compliance** | Given review of logbooks and via policy, supervisory review of video(s) is conducted at a minimum of every 14 days and reviews are documented in the program's logbook. | |
| The reviews assess the activities of the facility and include a review of random sample of overnight shifts | **Compliance** | The supervisory reviews of video surveillances were observed to consist of random periods during the overnight shifts. | |
| Grant the requesting of video recordings to yield a result within 24-72 hours from program quality improvement visits and when an investigation is pursued after an allegation of an incident | **Compliance** | The shelter has the appropriate policy that facilitates releasing video footage from appropriate agencies (e.g. QI or investigatory) within 24-48 hours of request. During this review period, no evidence was found related to barriers that existed. | |
| 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** | Per interview with the program director, any issues regarding the surveillance systems functioning is reported immediately to IT well within the 24 hour time tolerance. Service requests are documented an maintained. This was also incidentally observed during the review upon the request of videos prior to 9/4/24. IT was called responded within a couple of hours. | |
| ***Additional Comments:*** **There are no additional comments for this indicator.** | | | |
| **4.01 - Healthcare Admission Screening** | | | **Satisfactory** |
| **Provider has a written policy and procedure that meets the requirement for Indicator 4.01** | | **YES**<br>If NO, explain here:<br>The provider has the required policy and procedure RGC 4.01-Healthcare Admission Screening that was approved by the President/CEO on 10/13/2024. | |
| **Preliminary Healthcare Screening** | | | |

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| Screening includes :<br>a. Current medications<br>b. Existing (acute and chronic) medical conditions<br>c. Allergies<br>d. Recent injuries or illnesses<br>e. Presence of pain or other physical distress<br>f. Observation for evidence of illness, injury, physical distress, difficulty moving, etc.<br>g. Observation for presence of scars, tattoos, or other skin markings<br>h. Acute health symptoms requiring quarantine or isolation | **Compliance** | All five youth records reviewed contained all required information during the healthcare screenings process. Each healthcare screening was completed within a 24 hour time frame with no issues. No youth had acute health symptoms requiring quarantine or isolation during this review period. | |
| **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** | The program has a policy and procedures in place to have thorough process and mechanisms for necessary follow-up medical care for youth admitted with chronic medical conditions. None of the five youths required a medical referral for any chronic conditions. | |
| When needed, the parent is involved with the coordination and scheduling of follow-up medical appointments | **No eligible items for review** | A follow-up medical appointment was not required for the five youth. | |
| All medical referrals are documented on a daily log. | **No eligible items for review** | A medical referral was not required for any of the five youths. | |
| The program has a thorough referral process and a mechanism for necessary follow-up medical care as required and/or needed | **Compliance** | The facility's licensed practical nurse explained the referral process and mechanism for follow-up care. The process includes updating information on the white board located in the medical room, so staff are updated as needed. | |
| ***Additional Comments:*** **There are no additional comments for this indicator.** | | | |
| **4.02 - Suicide Prevention** | | | **Satisfactory** |
| **Provider has a written policy and procedure that meets the requirement for Indicator 4.02** | | **YES**<br>If NO, explain here:<br>The provider has the required policy and procedure RGC 4.02/Healthcare Admission Screening that was approved by the President/CEO on 10/13/23. | |
| **Suicide Risk Screening and Approval (*Residential and Community Counseling*)** | | | |
| Suicide risk screening occurred during the initial intake and screening process. Suicide screening results reviewed and signed by the supervisor and documented in the youth's case file. | **Compliance** | Six youth records were reviewed. All six were screened for suicide risk at the time of intake, with screening results reviewed by the supervisor and documented in the youth's case record. | |
| The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services | **Compliance** | The program's suicide risk assessment was previously approved by the Florida Network and has not changed since the last QI review. | |
| **Supervision of Youth with Suicide Risk *(Shelter Only)*** | | | |

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| Youth are placed on the appropriate level of supervision based on the results of the suicide risk assessment. | **Compliance** | All five residential youth were placed on sight-and-sound supervision until assessed by a non-licensed professional working under the supervision of the licensed professional. | |
| Staff person assigned to monitor youth maintained one-to-one supervision or constant supervision and documented his/her observations of the youth's behavior at 30 minute or less intervals | **Compliance** | Staff monitored each of the five residential youth's behavior on the observation log at least every thirty minutes or less and documented their observation of the youth's behavior. | |
| Documentation includes the time of day, behavioral observations, any warning signs observed, and the observers' initials and was maintained in either an observation log or in the shelter daily log. | **Compliance** | Documentation was maintained for the duration of time each youth was placed on sight and sound. The observation log includes the observer's initial, time of day, and behavioral observations. | |
| Supervision level was not changed/reduced until a licensed professional or a non-licensed mental health professional under the supervision of a licensed professional completed a further assessment OR Baker Act by local law enforcement | **Compliance** | Supervision level was not changed/reduced for any of the five residential 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 five 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** | The one applicable community counseling youth identified for suicide risk during intake was immediately assessed by non-licensed professional (under the direct supervision of a licensed mental health professional) and the parents and supervisor were notified of the results. | |
| During the intake, if the appropriate staff is unavailable, youth identified for suicide risk was immediately referred by the provider and the parent/guardian is notified of the suicide risk findings disclosed and advised that an Assessment of Suicide Risk should be completed ASAP by a licensed professional. | **Compliance** | The youth was immediately referred and advised that an assessment of suicide risk should be completed as soon as possible and the parent/guardian were notified. | |
| Information on resources available in the community for further assessment was provided to the parent/guardian and is documented in the youth's file and signed by the parent/guardian OR a written follow-up notification was sent by certified mail if the parent/guardian was not present during the screening and was notified by telephone. | **Compliance** | The program provided information on available resources in the community to the youth and parent/guardian on the referral form maintained in the youth's record. | |
| If the parent/guardian cannot be contacted, all efforts to contact them are documented in the case file. | **No eligible items for review** | The parent/guardian was contacted during the intake. | |
| When the screening was completed during school hours on school property, the appropriate school authorities were notified. | **Compliance** | The community counseling youth screening was completed during school hours. The counselor, social worker, and school resource officer were notified. | |
| ***Additional Comments:*** **There are no additional comments for this indicator.** | | | |

| 4.03 - Medications | | | Satisfactory |
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| **Provider has a written policy and procedure that meets the requirement for Indicator 4.03** | | **YES**<br>If NO, explain here:<br>The provider has the required policy and procedures RGC 4.03 - Medication Control and Management that was approved on 10/13/23 by the President/CEO. | |
| 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 facility has both a Registered Nurse and Licensed Practical Nurse that is being supervised by the Registered Nurse and both have verified active credentials. | |
| The agency has evidence of the following for all non-nursing shelter staff designated to assist with the self-administration of medication:<br>a. Documentation of in-person self-administration of medication distribution training provided by a Registered Nurse<br>b. Evidence demonstrating their competency to assist with self-administration of medication distribution<br>c. Maintenance of their annual medication training re-certification | **Compliance** | All staff permitted to assist in distributing medication receive training on using an EpiPen, medication training, and medication distribution record training using candy in a prescription bottle. The staff must pass a test and job shadow another staff for a shift. The staff distribute the medication with a second experienced staff providing oversight. | |
| The agency held at least quarterly staff meetings conducted by RN and/or Shelter Manager to review and assess:<br>a. strategies implemented to reduce medication errors shelter wide<br>b. analyze factors that contributed to medication errors<br>c. allow staff the opportunity to practice and role-play solutions | **Compliance** | The facility's licensed practical nurse indicated there is a standing topic on the monthly staff meeting agenda called Med Minute. During that time she provides training on topics relevant to observations she has made in the program. Monthly meetings for this review period were verified. | |
| The agency has strategies implemented to ensure medications are provided within the 2-hour time frame. | **Compliance** | The license practical nurse stated that a two hour time frame is given to ensure medication is being distributed in a timely matter, one hour before and one hour after the set time of the original time of dosage. | |
| 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 facility licensed practical nurse stated the 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** | All youth prescribed medication are documented on the white board in the medical room. The name of the medication, the dose, and the time of dose is included in the information on the white board. | |
| The delivery process of medications is consistent with the FNYFS Medication Management and Distribution Policy and the agency has an internal quality assurance process to include the following:<br>a. to ensure appropriate medication management and distribution methods<br>b. to track medication errors<br>c. to identify systemic issues and implement mitigation strategies, as appropriate. | **Compliance** | The facilities license practical nurse stated the registered nurse reviews all medical documentation each day she works at the facility. The facility has a delivery process for medications that is consistent with the FNYFS Medication Management and Distribution Policy. There is a an internal quality assurance process in place. The facility identifies medication issues and discusses medication management and errors during CINS/FINS meetings. | |

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| **Admission/Intake of Youth** | | | |
| a. Upon admission, the youth and parent/guardian (if available) were interviewed by the Registered Nurse (when on-site) about the youth's current medications as part of the Medical and Mental Health Assessment screening process and/or an interview was conducted by the RN within three (3) business days if the RN was not on the premise at admission. **If the agency does not have a RN, there was a medication review conducted by a certified Leadership position.*<br><br>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** | All five youth were taking medication at the time of admission. The medical information was either documented by a staff member or the registered nurse. Documentation supported the registered nurse reviewed all medical information recorded by staff the next day she was at the program. The review was conducted no more than three days after the youth's admission. There was documentation to support the shift supervisor also reviewed the documentation the day of admission. | |
| **Medication Storage** | | | |
| a. All medications are stored in a Pyxis ES Medication Cabinet that is inaccessible to youth (when unaccompanied by authorized staff)<br>b. Pyxis machine is stored in accordance with guidelines in FS 499.0121 and policy section in Medication Management<br>c. Oral medications are stored separately from injectable epi-pen and topical medications<br>d. Medications requiring refrigeration are stored in a secure refrigerator that is used only for this purpose, at temperature range 2-8 degrees C or 36-46 degrees F. (If the refrigerator is not secure, the room is secure and inaccessible to youth.)<br>e. Narcotics and controlled medications are stored in the Pyxis ES Station<br>f. Pyxis keys with the following labels are accessible to staff in the event they need to access medications if there is a Pyxis malfunction: a TOP COVER b BACK PANEL- LEFT TALL CABINET LOCK- LEFT, c BACK PANEL- RIGHT TALL CABINET LOCK- RIGHT | **Compliance** | The Pyxis machine is located behind a locked door that leads into the medical room. The Pyxis machine is 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 locked refrigerator in the medical room used to store medication that requires refrigeration. During 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 | | | |
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| a. Agency maintains a minimum of 2 site-specific System Managers for the Pyxis ES Station<br>b. Only designated staff delineated in User Permissions have access to secured medications, with limited access to controlled substances (narcotics)<br>c. A Medication Distribution Log shall be used for distribution of medication by non-licensed and licensed staff<br>d. Agency verifies medication using one of three methods listed in the FNYFS Policies & Procedures Manual<br>e. When nurse is on duty, medication processes are 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.<br>f. Agency does not accept youth currently prescribed injectable medications, except for epi-pens<br>h. Non-licensed staff have received training in the use of epinephrine auto-injectors provided by a registered nurse | **Compliance** | The program has a list of authorized staff who are the system managers for the Pyxis machine. Staff who have access to the medication was presented in writing. The reviewed Medication Distribution Logs (MDL) confirmed the registered nurse provides the youth their medication when she is at the program. The program verifies medication using the Five Rights method prior to the delivery of medication. The Medication Distribution Logs also confirmed when the designated staff provided medication. The registered nurse provides constant oversight to staff to ensure there are minimal to no medication errors. All staff permitted to assist in distributing medication received training on using an EpiPen, medical training, and MDL training. | |
| The medication distribution log documentation includes:<br>a. the time of medication administration<br>b. evidence of youth initials that the dosage was given<br>c. evidence of staff initials that the dosage was given | **Compliance** | The Medication Distribution Log was reviewed and confirmed each log contained the time the medication is distributed, and initials of the youth and staff to indicate the dosage was given. | |
| There is evidence that staff provide youth with medications within one hour of the scheduled time of delivery as ordered by the medication. Documentation is provided for instances this does not occur within the required timeframe. | **Compliance** | Documentation stated on the Medication Distribution Log supported the medications were provided to the youth within one hour of the scheduled time of delivery. | |
| During the review period, there were no instances where youth missed their medication due to failure to open the pyxis machine. | **Compliance** | There were no instances where the youth did not receive their medication because the Pyxis machine would not open during the review period. | |
| **If applicable:**<br>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.<br>There is evidence that any staff member deemed responsible for 3 errors within a 1-year time frame, had their certification suspended and was not recertified until the completion of the full **in-person** medication administration training, demonstrating competency and re-certification from an RN. | **No eligible items for review** | There were no medication errors during this review period. | |

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| **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<br>b. Over-the-counter medications that are accessed regularly and inventoried weekly<br>c. Syringes and sharps (needles, scissors, etc.) are secured, and counted and documented weekly | **Compliance** | Documentation supported all controlled medication and over-the-counter medication, as well as other prescription drugs had a perpetual inventory maintained. Observations of four medications confirmed the perpetual inventory was correct. The program does not have any syringes or sharps during the review period. | |
| There are monthly reviews of the Pyxis reports to monitor medication management practice. | **Compliance** | There was documentation to support the Pyxis reports are reviewed monthly. Data graphs are produced based on the findings of the reviews such as dispensed reports, mechanical issues reports, and placed on the scorecard performance indicator. | |
| Medication discrepancies are cleared after each shift. | **Compliance** | The licensed practical nurse confirmed medication discrepancies are cleared after each shift. She stated the registered nurse verifies this by running a report every day she is at the program. | |
| ***Additional Comments:*** **There are no additional comments for this indicator.** | | | |
| **4.04 - Medical/Mental Health Alert Process** | | | **Satisfactory** |
| **Provider has a written policy and procedure that meets the requirement for Indicator 4.04** | | **YES**<br>If NO, explain here:<br>The provider has the required policy and procedures RGC 4.04 - Medical and Mental Health Alert, that was approved 10/13/23 by the President/CEO. | |
| Youth with a medical, mental health, or food allergy was appropriately placed on the program's alert system | **Compliance** | Five youth records were reviewed for medical and mental health alerts. All five youth were placed on their applicable alert in the alert system. | |
| Alert system includes precautions concerning prescribed medications, medical/mental health conditions | **Compliance** | The provider's policy and procedures outlines specific instructions concerning precautions for prescribed medication and medical/mental 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** | All staff were verified to be trained in CPR and First Aid. New staff receive information and instructions during orientation to recognize and respond to any needed emergency care. | |

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| A medical and mental health alert system is in place that ensures information concerning a youth's medical condition, allergies, common side effects of prescribed medications, foods and medications that are contraindicated, or other pertinent mental health treatment information, is communicated to all staff | **Compliance** | The facility has multiple systems in place to document alerts. In addition to using a letter-coded system to communicate alerts on youth records, alerts are also documented on a white board in the residential area of the facility. The medical room also has an alert board documenting medical alerts and the kitchen also contained a list of individual youth who are allergic to certain food items. | |
| ***Additional Comments:*** **There are no additional comments for this indicator.** | | | |
| **4.05 - Episodic/Emergency Care** | | | **Satisfactory** |
| **Provider has a written policy and procedure that meets the requirement for Indicator 4.05** | | **YES**<br>If NO, explain here:<br>The provider has the required policy and procedures RGC 4.05 - Episodic and Emergency Care, that was approved on 10/13/23 by the President/CEO. | |
| **Off Site Emergency Care** | | | |
| a. If off-site emergency medical or dental care was provided, an incident report was submitted for the medical or dental care<br>b. Upon youth return, there is a verification receipt of medical clearance via discharge instructions with follow-up is present in file<br>c. Youth's parent/guardian was notified<br>d. A daily log is maintained for emergency care provided | **Compliance** | Three youth medical records were reviewed for emergency and/or episodic care. There was an incident report completed for all three incidents. Upon each youth's return, documentation confirmed the medical clearance was present in the youth's record. In all three incidents, documentation supported the youth's parent/guardian was notified. The episodic log does not differentiate offsite medical transports from onsite emergency care provided. | |
| All staff are trained on emergency medical procedures | **Compliance** | Eight staff training records were reviewed. Documentation supported all the staff received training on emergency medical procedures. | |
| The program has a Knife-for-life and wire cutters accessible to staff in a secure location(s) | **Compliance** | The Knife for Life and wire cutters are located in the medical room and copier room. First Aid kits are located in the medical room, the kitchen, the storage room, copy room, and one for each van. Naloxone is located in the medical room in a cabinet for all staff access. A monthly inspection of the Naloxone was reviewed which was added to the first aid kit inspection. All new staff were trained in the use of the Naloxone and per the training coordinator, in-service staff are required to complete the training by the end of the calendar year. | |
| ***Additional Comments:*** **There are no additional comments for this indicator.** | | | |