Florida Network for Youth and Family Services
Compliance Monitoring Report for

YOUTH AND FAMILY ALTERNATIVES, INC.
GEORGE W. HARRIS SHELTER

1060 US HWY 17 SOUTH
Bartow, FL 33830

November 6-7, 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, Inc. - GWH Yor the FY 2024-2025 at its program office located at 1060 US Hwy 17 South, Bartow, FL 33830. Forefront LLC (Forefront) is an independent compliance monitoring firm that is contracted by the FNYFS to perform onsite program reviews to assess the agency's adherence to fiscal, programmatic and overall contract requirements. Youth and Family Alternatives, Inc. - Youth and Family Alternatives, Inc. - GWH 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 compliance monitoring review was conducted by Andrea Haugabook, Consultant for Forefront LLC. Agency representatives from Youth and Family Alternatives, Inc. - GWH present for the entrance interview were: Jovia Dukes (Program Director), Michelle Almand (Quality Compliance Coordinator), Shelly Gress (Assistant Program Director), Wayne (Training Coordinator), Kelly Scott (Program Director). The last onsite QI visit was conducted on December 6-7, 2023.

In general, the Reviewer found that Youth and Family Alternatives, Inc. is in compliance with specific contract requirements. **Youth and Family Alternatives, Inc. - GWH received an overall compliance rating of 100% for achieving full compliance with 12 indicators** of the CINS/FINS Monitoring Tool. There were no recommendations or corrective actions 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 11-06-07-2024

Agency Name: Youth & Family Alternatives, George W. Harris Shelter	Monitor Name: Andrea Haugabook, Lead Reviewer
Contract Type: CINS/FINS	Region/Office: 1060 US HWY 17 South, Bartow, FL 33830
Service Description: Comprehensive Onsite Compliance Monitoring	Site Visit Date(s): November 6-7, 2024

Major Programmatic Requirements	Explain Rating: Unacceptable	Conditionally Acceptable	Fully Met	Exceeded	Not Applicable	Ratings Based Upon: I = Interview; O = Observation; D = Documentation; PTV = Submitted Prior To Visit; (List Who and What)	Notes: Explain Unacceptable or Conditionally Acceptable:
I. Administrative and Fiscal							
DJJ Quality Improvement Peer Reviewer a. Provider shall demonstrate that a minimum of two (2) staff members have been trained to be certified as DJJ QI Peer reviewers. Provider shall participate in a minimum of one (1) on-site quality assurance review of a similar type of program in another judicial circuit during each 12-month period of the contract, if requested.	☐	☐	☒	☐	☐	The agency has three peer reviewers for this location: Jovia Dukes (Program Director), Shelly Gress (Assistant Program Director) and Michelle Almand (Quality Improvement Coordinator).	
Additional Contracts a. Provider shall provide a listing of all current federal, state, or local government contracts, as well as other contracts entered into with for profit and not-for-profit organizations. Such a listing shall identify the awarding entity and contract start & end dates. **PTV**	☐	☐	☒	☐	☐	The following is a list of additional contracts and funders awarded to this agency: Basic Centers Grant (10/01/2024-09/30-2025), Department of Health (10/01/2024-09/30/2025), Heartland for Children (07/01/2023-06/30/2024 FY 24-25 funding pending approval), and United Way of Central Florida (07/01/2024-09/30/2025).	
Limits of Coverage a. Provider shall provide and maintain during this contract, the following minimum kinds of insurance: Worker's Compensation and Employer's liability insurance as required by Chapter 440, F.S. with a minimum of $100,000 per accident, $100,000 per person and $500,000 policy aggregate. Commercial General Liability	☐	☐	☒	☐	☐	Documentation of certificate of insurance for 07/0/2024 - 07/01/2025 from insurance agent, March and McLeannan, was reviewed. Benchmark Insurance is the company listed as providing coverage. The certificate listed the following minimum	

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Major Programmatic Requirements	**Unacceptable**	**Conditionally Acceptable**	**Fully Met**	**Exceeded**	**Not Applicable**	**Ratings Based Upon:** **I = Interview** **O = Observation** **D = Documentation** **PTV = Submitted Prior To Visit** **(List Who and What)**	**Notes** **Explain Unacceptable or Conditionally Acceptable:**
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**						kinds of insurance: Worker's Compensation and Employer's liability insurance as required by Chapter 440, F.S. with a limit of $1,000,000 per accident, $1,000,000 per person and $1,000,000 policy aggregate. Commercial General Liability with a limit of $1,000,000 per occurrence, $500,000 damage to rented premises, $20,000 med exp., $1,000,000 personal and adv injury, $3,000,000 policy aggregate, and $3,000,000 products – comp/op agg. Automobile Liability Insurance with a combined single limit of $1,000,000. The certificate does list the Florida Network of Youth and Family Services as an additional certificate holder.	
External/Outside Contract Compliance a. Provider has corrective action item(s) cited by an external funding source (Fiscal or Non-Fiscal). **ON SITE**	☐	☐	☐	☐	☒	The vice president of finance reported there are no corrective action items cited by any external funders.	
Fiscal Practice a. Agency must have employee and fiscal policy/procedures manuals that are in compliance with	☐	☐	☒	☐	☐	The agency has written employee and fiscal policies that are in compliance with GAAP and provide sound internal	

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GAAP and provide sound internal controls. Agency maintains fiscal files that are audit ready. **PTV**						controls. Additionally, the agency maintains files that are audit ready.	
b. Agency maintains a general ledger and the corresponding source documents. A general ledger must be set up to track the activity of the grant separately (standard account numbers / separate funds for each revenue source, etc.). **PTV**	☐	☐	☒	☐	☐	The agency maintains a general ledger and the corresponding source documents. The general ledger was reviewed from July 2024 – September 2024. The general ledger is set up to track the activities of this grant separately.	
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**	☐	☐	☒	☐	☐	The agency maintains a written policy and procedure for petty cash. Interview with the vice-president of finance stated that the petty cash custodian maintains the petty cash with a limit of $500. Checks may be submitted weekly, if needed to reimburse petty cash. The most recent petty cash reimbursement was reviewed. The program director is the custodian and the current petty cash fund is in balance,	
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.	☐	☐	☒	☐	☐	Bank statements and reconciliations from April 2024 through September 2024 were reviewed. Interview with the vice-president of finance reports that the Accountant 1 performs the	

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(Disbursements/invoices are approved & monitored by management). **ON SITE**						bank reconciliations monthly followed by a review of the bank reconciliation by the accountant manager, then vice-president of finance. Invoices are submitted and paid on an ongoing basis and monitored by the fiscal coordinator and vice-president of finance.	
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**	☐	☐	☐	☐	☒	The agency has no inventory valued over $1000 purchased with funds from the Florida Network of Youth and Family Services, Inc.	
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**	☐	☐	☒	☐	☐	The agency uses Paylocity, a third-party payroll company that prepares all quarterly tax returns and payments. Documentation of payroll tax payments and 941 quarterly filings were observed from the quarter ending March 30, 2024 and June 30, 2024.	

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g. Budget to actual reports prepared and reviewed by appropriate management. Variance from the budget are investigated and explained. **PTV/ON SITE**	☐	☐	☒	☐	☐	The budget to the actual report for this fiscal year to date was reviewed. Interview with the Vice-President of Finance reports the fiscal coordinator develops and monitors program budgets. They are reviewed monthly by the fiscal coordinator, Vice President of Finance and Program Directors, then reported to the CEO (who reports to the board of directors). Additionally, quarterly spend plans are conducted with the program directors and operations. Theres plans are reviewed with the fiscal coordinator and vice president of finance.	
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**	☐	☐	☒	☐	☐	An audit report prepared by Rivero, Gordimer and Company, PA., on March 29, 2024, was reviewed. The audit period reflected in this report was through June 30, 2023. The report stated, " In our opinion, the combined financial statements present fairly, in all material respects, the financial position of the organization as of June 30, 2023, and all the changes in its net assets and its cash flows for the year	

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						then ended in accordance with accounting principles generally accepted in the United States of America. One financial statement finding stated in the audit report indicated, during the audit, it was identified that the workers compensation liability was over accrued by $178, 599. This was addressed in a letter from the agency back to the auditor indicating, “YFA immediately issued a credit that was allocated to each funder in FY24, and significant credits were communicated out to the individual funders. Fiscal has improved their reconciliation process and has dual approvals for general ledger reconciliations.”	
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 of the agency’s written confidentiality policy was observed in addition to policies on personal information which state it is not easily accessible. The agency does maintain a backup system in case of accidental loss of financial information and security measures are in place to	

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						protect all agency laptops. The agency shreds obsolete documents and computer hard drives are wiped prior to discarding.	
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**	☐	☐	☒	☐	☐	The documentation provided by the Senior Human Resources Generalist stated that all direct care workers within the shelter and community counseling program received a wage increase on 07/29/2023. The first payout was reflected on the paychecks dated 08/18/2023. Following the wage increase, all job postings have been updated to reflect the current rate and communicated to those who were onboarding that the starting salary for the selected positions has been updated.	

CONCLUSION

Youth and Family Alternatives, Inc. - GWH has met the requirements for the CINS/FINS contract as a result of full compliance with twelve applicable indicators of the Administrative and Fiscal Contract Monitoring Tool. Two of the fourteen indicators were not applicable because the program does not have any inventory over $1000 purchased with funds from the Florida Network of Youth and Family Services and the program does not have any corrective actions cited by external funders. Consequently, **the overall compliance rate for this contract monitoring visit is 100%.** There are no recommendations cited, and no corrective action is required 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 that meet 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. - George W. Harris Shelter
CINS/FINS Program

Date: November 6-7, 2024

Compliance Monitoring Services Provided by

FOREFRONT

CINS/FINS Rating Profile

Standard 1: Management Accountability

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

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

Standard 2: Intervention and Case Management

2.01 Screening and Intake	Satisfactory
2.02 Needs Assessment	Limited
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	Limited
2.08 Special Populations	Satisfactory
2.09 Stop Now and Plan (SNAP)	Failed

Percent of indicators rated Satisfactory: 66.67 %
Percent of indicators rated Limited: 22.22 %
Percent of indicators rated Failed: 11.11 %

Standard 3: Shelter Care & Special Populations

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

Percent of indicators rated Satisfactory: 71.43 %
Percent of indicators rated Limited: 28.57 %
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	Failed
4.04 Medical/Mental Health Alert Process	Satisfactory
4.05 Episodic/Emergency Care	Satisfactory

Percent of indicators rated Satisfactory: 80 %
Percent of indicators rated Limited: 0 %
Percent of indicators rated Failed: 20 %

Overall Rating Summary

Percent of indicators rated Satisfactory: 78.57 %
Percent of indicators rated Limited: 14.29 %
Percent of indicators rated Failed: 7.14 %

Rating Definitions

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

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

Reviewers

Members

Andrea Haugabook - Lead Reviewer Consultant-Forefront LLC/Florida Network of Youth and Family Services
Tamara Mahl-Adkins – Regional Monitor, Department of Juvenile Justice
Rochelle Davis – Boys Town
Cinthya Muniz – Children's Home Society - Osceola
Anastasia Rascon – Youth Advocate Program

Methodology

This review was conducted in accordance with FDJJ-2000 (Quality Assurance Policy and Procedures), and focused on the areas of (1) Management Accountability, (2) Intervention and Case Management, (3) Shelter Care/Health Services, and (4) Mental Health/Health Services, which are included in the Children/Families in Need of Services (CINS/FINS) Standards (Effective July 1, 2024).

Persons Interviewed

	Chief Executive Officer		Case Manager		Nurse – Full time
	Chief Financial Officer	X	Counselor Non-Licensed		Nurse – Part time
	Chief Operating Officer		Advocate		# Case Managers
	Executive Director	X	Direct – Care Full time	1	# Program Supervisors
X	Program Director		Direct – Part time		# Food Service Personnel
	Program Manager		Direct – Care On-Call		# Healthcare Staff
	Program Coordinator		Intern		# Maintenance Personnel
	Clinical Director		Volunteer	4	# Other (listed by title): Assistant Program Director Compliance Coordinator, Training Coordinator Finance Director
	Counselor Licensed	X	Human Resources		

Documents Reviewed

	Accreditation Reports	X	Table of Organization	X	Visitation Logs
X	Affidavit of Good Moral Character		Fire Prevention Plan	X	Youth Handbook
X	CCC Reports	X	Grievance Process/Records	5	# Health Records
X	Logbooks	X	Key Control Log	5	# MH/SA Records
	Continuity of Operation Plan	X	Fire Drill Log	8	# Personnel /Volunteer Records
X	Contract Monitoring Reports	X	Medical and Mental Health Alerts	8	# Training Records
	Contract Scope of Services	X	Precautionary Observation Logs	13	# Youth Records (Closed)
X	Egress Plans	X	Program Schedules	10	# 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		Tool Inventory and Storage	X	Facility and Grounds
	Recreation	X	Toxic Item Inventory & Storage	X	First Aid Kit(s)
X	Searches		Discharge		Group
X	Security Video Tapes		Treatment Team Meetings	X	Meals
X	Social Skill Modeling by Staff	X	Youth Movement and Counts	X	Signage that all youth welcome
X	Medication Administration	X	Staff Interactions with Youth	X	Census Board

Surveys

6	# 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, Inc. - George W. Harris (GWH) Youth Shelter is located at 1060 U.S. Highway 17 South Bartow, FL 33830. The program serves runaway, homeless, lockout, truant, and youth in crisis ranging in age from 10 to 17. The George W. Harris Shelter in Bartow serves Polk, Hardee, and Highlands Counties.

The program reports the following staffing updates: A new shelter nurse began in January 2024 and has since exited the agency. A new part-time shelter counselor earned a masters and is working towards licensing as a mental health practitioner. The new position, assistant program director, was added in August 2024. The program director position has remained stable. One residential supervisor position is filled and the second position currently has a staff onboarding. There is a new chief operating officer effective November 1st. Two new leadership positions were created and recently filled, senior vice-president of program development and data analysis. A returning employee rejoined the team in a new role as chief of program and business development.

The Leadership Council has continued soliciting donations through fundraising events and direct contacts. A significant amount of money was raised to create a Pole Barn to cover the basketball court which provides youth more protection from the elements while they have outside activity. The Leadership Council has provided some comfort items such as rugs and wall art to make dorm rooms homier, as well as providing regular deliveries of hygiene products for the youth. The shelter was able to update the dressers, mattresses, and lockers for the youth, providing sturdier and more organized areas for their personal belongings to be held. New cabinetry was added to the conference room, living room and laundry room to provide more storage space for items. The security system for the shelter was updated in July of 2024, and now utilizes 360 cameras providing better coverage within the shelter and on the grounds.

The property at George W. Harris shelter sustained substantial damage from Hurricane Milton at the beginning of October, which is estimated to cost upwards of $4000 for cleanup and repairs. At least two trees were knocked down and need to be removed, as well as large piles of debris from the damage that have been scheduled to be picked up by the city. The surrounding fence is now leaning as well, and one of the barrier doors on the dumpster fence has come off. The building luckily did not sustain any damage. Cleanup efforts are currently pending due to the damage most of Central Florida received, however the program has prioritized the safety of the youth and families served.

In addition to shelter service, the program provides: community counseling, Stop Now And Plan (SNAP), SNAP is Schools and Communities, FYRAC, Domestic Violence Respite, Case Staffing (when applicable) and Intensive Case Management (ICM). The community counseling team works from remote office locations providing services in the community. Community Counseling files are stored at the agency's New Port Ritchey location. The SNAP staff experience major turnover (the entire SNAP team exited the agency at the end of August). This staff turnover severely impacted the programs SNAP service delivery even with assistance from the agency's SNAP Pasco team. The SNAP and ICM programs Polk County. A new team has been on-boarded and currently in-training to resume services.

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

Standard 1: There are seven indicators for Standard 1.
Indicator 1.01 Background Screening of Employees/Volunteers was rated **Satisfactory with Exception.**
Indicator 1.02 Provision of an Abuse Free Environment was rated **Satisfactory**.
Indicator 1.03 Incident Reporting was rated **Satisfactory with Exception**.
Indicator 1.04 Training Requirements was rated **Satisfactory**.
Indicator 1.05 Analyzing and Reporting Information was rated **Satisfactory with Exception**.
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 **Limited.**
Indicator 2.03 Case/Service Plan was rated **Satisfactory with Exception**.
Indicator 2.04 Case Management and Service Delivery was rated **Satisfactory.**
Indicator 2.05 Counseling Services was rated **Satisfactory with Exception.**
Indicator 2.06 Adjudication/Petition Process was rated **Satisfactory.**
Indicator 2.07 Youth Records was rated **Limited**.
Indicator 2.08 Specialized Additional Program Services was rated **Satisfactory with Exception**.
Indicator 2.09 Stop Now and Plan (SNAP) was rated **Failed**.

Standard 3: There are seven indicators for Standard 3.
Indicator 3.01 Shelter Environment was rated **Limited.**
Indicator 3.02 Program Orientation was rated **Satisfactory.**
Indicator 3.03 Youth Room Assignment was rated **Satisfactory with Exception.**
Indicator 3.04 Log Books was rated **Limited.**
Indicator 3.05 Behavior Management Strategies was rated **Satisfactory with Exception.**
Indicator 3.06 Staffing and Youth Supervision was rated **Satisfactory with Exception.**
Indicator 3.07 Video Surveillance System was rated **Satisfactory with Exception.**

Standard 4: There are five indicators for Standard 4.
Indicator 4.01 Healthcare Admission Screening was rated **Satisfactory.**
Indicator 4.02 Suicide Prevention was rated **Satisfactory.**
Indicator 4.03 Medications was rated **Failed.**
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 2: Indicator 2.02 Needs Assessment was rated limited due to two of five NIRVANA assessments for youth in shelter were completed outside the required 72-hour time-frame for initiation. According to the program director, the shelter staff responsible for completing NIRVANA assessments does not work Friday-Sunday, leaving opportunities for intakes occurring on Thursdays to be out of compliance with the 72-hour initiation requirement. Additionally, one of the ten NIRVANA assessments did not have a supervisor's signature.

Indicator 2.07 Youth Records was rated Limited due to ten of twenty-four youth records not being marked confidential. The files were not well organized and all residential files lacked a table of contents.

Indicator 2.09 SNAP was rated Failed due to four out of four files for SNAP under 12 had exceptions for the presence of community counseling intake form. Three out of the four files had significant expectations in regards to the presence of intake documentation and discharge. The site expressed that during the time the files were pulled there was a significant loss of SNAP staff. The site voluntarily provided an additional open SNAP file to demonstrate improvements with the new staff. Only one exception, the presence of the community counseling intake form, was present in the current file. Three of the four files were SNAP in schools and community files had exceptions with the presence of post teacher feedback. The feedback was not present in either of the two files pulled or present in OneDrive/ NetMIS.

Standard 3: Indicator 3.01 Shelter Environment was rated Limited due to a broken white pipe with sharp edges protruding from the ground observed during the review, a heavy metal door for the outdoor dumpster is broken and leaning against the exterior of the dumpster wall. This is a safety concern due to the possibility of the door falling on youth. There is low lighting in the youth bathrooms, as noted in the health inspection report. The assistant program director reported that a repair work order had been submitted to correct this issue. Boys bathroom behind the door in the general area has graffiti. One van had two non-working flashlights. However, batteries were replaced onsite for one flashlight. MSDS sheets are missing for 9 chemicals. Perpetual forms document the time chemicals are removed and returned, date, and the staff name. However, many entries do not have the end balance or inventory changes documented. Kitchen perpetual sheets are not completed at all. Several chemicals are missing on the weekly count sheets and several chemicals are missing perpetual count sheets.

Indicator 3.04 Logbooks was rated limited due to some highlights missing or marked with the incorrect color. This may impacts staff attention to critical issues, as the highlighting system is designed to draw attention to important tasks and incidents. Inconsistent or incorrect highlighting could lead to oversight or delays in addressing key safety and operational concerns. Observation of entries being written over instead of following the correct void procedures for errors, observation of a voided entry with no initials, date, or time. Staff entries indicating a review of the logbook were inconsistent and the following dates with discrepancies were observed: on 10/27/2024, there were three staff members on shift, and two signed reviews were completed; on 11/1/2024, there were four staff members on shift, and three reviews were completed, though one entry needed to be voided for the staff name, who did not work the shift due to attending the agency's annual meeting; on 11/7/2024, there were two staff members on shift, and one review was completed; and on 11/5/2024, there were three staff members on shift, and one review was completed. On 8/6/2024 the review date has a slight gap of one day, as the review was noted as having been done from 8/3/2024, but the last documented review was actually on 8/1/2024. Additionally, the previous supervisor left the company on 10/6/2024, and a new supervisor was hired on 10/30/2024. The Assistant Program Director indicated that the new supervisor is still in training and has not yet begun reviewing logs, resulting in a gap in supervisory reviews of the program's logbook during this period.

Standard 4: Indicator 4.03 Medications was rated Failed due to the the following reasons: 1. Quarterly meetings missing the role playing aspect of the medication errors. 2. One staff did not have the required re-training for doing med pass errors on two occasions. 3. One youth's daily count sheet of a controlled substance was not completed in its entirety (missing information on eight days). 4. Three over-the-counter meds missing various weekly checks. 5. One youth's shift to shift count of a controlled substance was missing information on three occasions. 6. One youth's shift to shift count of a controlled substance was missing information of six days. 7. The monthly Pyxis report did not show anything for September and October 2024 due to the machine not working. 8. One youth who had a CCC due to missed medication pass in July 2024 did not show up on the monthly Pyxis report.

CINS/FINS QUALITY IMPROVEMENT TOOL

Quality Improvement Indicators and Results: Please select the appropriate outcome for each indicator for each item within the indicator.		**Summary/Narrative Findings:** The narrative write-up is a thorough summary of each assigned QI indicator, explaining how finding(s) are determined.	**Deficiencies/Exceptions:** Please add additional detailed explanations for any items that have any deficiencies or exceptions.
Standard One – Management Accountability			
1.01: Background Screening of Employees, Contractors and Volunteers			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 1.01		**YES** If NO, explain here: The agency has a written policy, #RGC 1.01 Background screening of Employees/ Volunteers/ Interns/ Contracted Providers, HR 230 Recruitment and Hiring signed by the CEO 10/13/2023.	
All positions providing direct services to youth has successfully passed pre-employment suitability assessment on the initial attempt prior to an offer of employment.	**Exception**	Eight of eight employee files reviewed contained evidence all positions providing direct services to youth successfully passed the pre-employment suitability assessment on the initial attempt. Five of eight employees completed the suitability assessment prior to an offer of employment as evidenced in their offer/ welcome letters.	Three of eight employees completed the suitability assessment after an offer of employment as evidenced in their offer/ welcome letters.
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**	The agency has a written policy which is in alignment with the Florida Networks standards, pertaining to applicants that do not pass the suitability assessment on the initial attempt. There were no applicants who did not pass the assessment on the initial attempt.	
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.	**Not Applicable**	The agency had no employees who had a break in service for 18 months or more and no change in the suitability assessment.	
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**	Eight of eight employee files reviewed showed evidence of background screening completed prior to hire/ start date. Validation of start dates through the agency's payroll system confirm each employee did not start prior to the date of eligibility on the DJJ background screening result. Initially, five of eight employee names reviewed in the DJJ's staff verification system (SVS) roster showed earlier hire dates, however, interview with HR department staff confirmed the correct hire dates within the agency's payroll system.	

Five-year re-screening is completed every 5 years from the date of the last screening for all applicable employees and volunteers.	**No eligible items for review**	Based on observation of employee hire dates and expiration of retained fingerprints, the program had no employees requiring a five year re-screening during this review period.	
Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st?	**Compliance**	The agency provided a completed Annual Affidavit of Compliance with Level 2 Screening Standards completed and sent to BSU 12/27/2023.	
Proof of E-Verify for all new employees obtained from the Department of Homeland Security	**Compliance**	Eight of eight employee files reviewed contained proof of E-Verify obtained from the Department of Homeland Security.	
Additional Comments: **Three of eight employees did not take the suitability assessment prior to hire.**			
1.02: Provision of an Abuse Free Environment			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 1.02		**YES** If NO, explain here: The agency has a policy, #RGC 1.02 Provision of an Abuse Free Environment approved by CEO on 10/13/23.	
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 of policy in their handbook which is reviewed by the staff during their 72-hour orientation training when hired. There is a checklist signed by the staff as evidence which is found in each staff member's file.	
The agency has a process in place for reporting and documenting child abuse hotline calls.	**Compliance**	The agency's practice is aligned to the requirements. The youth can request to make a call at any time, to any of the staff, or if preferred, they can inform the staff of the situation for them to make the call. In the last six months there has been ten calls documented in the log and all of them were made by the staff member. There is evidence in the file that the call took place with a confirmation email from the abuse line. Seven of those reports were accepted. None of the reports were on the shelter.	
Youth were informed of the Abuse and Contact Number	**Compliance**	Postings of the Abuse Hotline contact number were observed in all the common areas that the kids use and dorm areas.	
Grievance			
The program(s) have an accessible and responsive grievance process for youth to provide feedback and address complaints. Program director/ supervisor has access to and can manage grievances unless it is towards themselves.	**Compliance**	The agency has a grievance process for the youth. They have access to forms and boxes to write feedback or a complaint. The form shows the date of the complaint, the staff who received it and the resolution offered. The complaints are resolved within 72 hours and youth and program director sign the form that the process is completed.	
<u>Shelter only:</u> Grievances are maintained on file at minimum for 1 year.	**Compliance**	After reviewing the binder provided for evidence, it was observed that all the grievances in the binder are for the last eight months. However, staff provided the other grievances from previous months up to a year. They have them in a separate filing location.	

Shelter only: There are formal grievance procedures for youth, including grievance forms, and a locked box which are easily accessible to youth in a common area.	**Compliance**	It was observed that there is a locked box on each side of the dorms that is accessible to the youth. The forms are right above the box for the youth to fill out at any moment.	
Shelter only: 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.	**Compliance**	After reviewing the logbook and comparing the dates of the grievances received in the last eight months, it was evidenced that the boxes are being checked daily. Staff are documenting in the logbook stating the time and the number of grievances found if there were any.	
Shelter only: Grievances are resolved within 72 hours of being submitted or there was documentation explaining the cause for the delay in providing a resolution.	**Compliance**	It was observed in the forms, that the grievances were resolved within 72 hours of being submitted. Youth and program director sign and date the forms.	
1.03: Incident Reporting			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 1.03		**YES** If NO, explain here: The agency has a policy #RM760, Incident Reporting, last reviewed by the CEO 09/01/2023.	
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**	There were eighteen of twenty-two incidents between 05/06/2024 and 11/06/2024 reported to the Department's Central Communication Center (CCC) within the two hour required time-frame.	Four of twenty-two incidents were reported late.
The program completes follow-up communication tasks/special instructions as required by the CCC	**Compliance**	Evidence of completion of follow-up communication was observed in the documentation of all applicable CCC reports requiring follow-up.	
Agency internal incidents are documented on incident reporting forms and all CCC reportable incidents were consistently reported to CCC as required.	**Compliance**	All agency internal incidents were documented on incident reporting forms and each applicable CCC reportable incident was consistently reported as required.	
Incidents are documented in the program logs and on incident reporting forms	**Compliance**	The program's incidents were observed documented in the program log books and on internal incident reporting forms. All entries pertaining to incidents are highlighted in the program's logbook.	
All incident reports are reviewed and signed by program supervisors/ directors	**Compliance**	There were twenty-two total incidents reported from 05/06/2024 - 11/06/2024. The incidents by type for this review period were as follows: Program Disruption - Nine, Medical - Seven, Substance Abuse/ Mental Health - Six.	

1.04: Training Requirements (*Staff receives training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions*)			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 1.04		**YES** If NO, explain here: The agency has policy, #RGC 1.04, Training last reviewed on 9/15/23. Approved by CEO on 10/13/23.	
First Year Direct Care Staff			
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: • Agency policies and procedures • Behavior Management (Shelter Only) • Building/Facility layout • File Documentation/development of paperwork requirements and confidentiality • CCC & Incident Reporting • Child Abuse Reporting • Client Intake & Screening • Client Orientation (direct care staff training on delivering new client orientation) • Fire Equipment Safety • Medical and Mental Health Alert System (Shelter) • Risk Management--Including but not limited to the following: - Disaster Preparedness and Emergency Response - First Aid/CPR - Universal Precautions • Video Camera Surveillance & Equipment • All other necessary information to orient a new hire to perform their job role and duties.	**Compliance**	Five out of the eight files reviewed were new hire. All five of them have documentation of the orientation process completed as a pre-service training. One of the five files was for a community counseling team member and the other four for shelter. The four files for shelter had the documentation of the in-person training and orientation at the facility including all the items requested in this indicator. The checklist was signed by the new hire and program director.	
All staff completed the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days from date of hire.	**Compliance**	All files reviewed had the documentation confirming that the training was completed within the first 30 dates of hire.	
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**	Three out of the eight files reviewed were direct care staff. All three files have documentation verifying more than 80 hours of training within the first full year of employment.	
All staff receives all mandatory training during the first 90 days of employment from date of hire.	**Compliance**	All files reviewed have documentation verifying the completion of all or most of the training that are mandatory within 90 days of hire. Two of the staff were hired within the last two months, therefore, they are still in the process of completing all the training within this window.	

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**	Six out of the eight files reviewed are shelter staff member. All six of them received the training by the registered nurse prior to administering medication to a shelter youth.	
Staff that are Utilizing NETMIS			
Any staff that is utilizing NETMIS has evidence of completing NetMIS Training in their training file.	**Compliance**	One of five staff files reviewed utilizes NetMIS. Documentation of completion of NetMIS training was contained in the one applicable staff's training file. Four other staff files reviewed do not use NetMIS and training is not required.	
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**	Two out of the eight files reviewed required this training. One of the two had the documentation of completion within the first year of employment. The other one is a new hire and still is within the window to complete it.	
Non-licensed Mental Health Clinical Shelter Staff (within first year of employment)			
Documentation of non-licensed mental health clinical staff person's training in Assessment of Suicide Risk form or written confirmation by a licensed mental health professional of training (includes date, signature and license number of the licensed mental health professional supervisor).	**No eligible items for review**	None of the files reviewed included a non-licensed mental health clinical staff person.	
In-Service Direct Care Staff			
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.	**Compliance**	Three out of the eight files reviewed are required to complete annual or two year refresher trainings. There is documentation in all three files of completion of these annual trainings.	
Community Counseling Direct Care staff completes 24 hours of mandatory refresher Florida Network, SkillPro, and job-related training annually.	**Compliance**	There is only one file out of the eight reviewed that needs to complete the 24 hours of mandatory refresher. The file has the documentation verifying the completion of these 24 hours of training.	
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**	Two out of the six shelter files reviewed are required to the 40 hours refreshers. Both files completed the 40 hours refresher and there is documentation of completion in the files.	
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**	Every file has a checklist with the training plan required for each position.	
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 staff member designated responsible to manage all employees' individual training files and complete tracking and reviews of staff files for compliance is the training coordinator.	

The program maintains an individual training file or employee file AND a FLN Training Log (or similar document that includes all requirements) for each staff, which includes an annual employee training hours tracking form and related documentation, such as electronic record/transcript, training certificates, sign-in sheets, and agendas for each training attended.	**Compliance**	All eight files reviewed are in compliance. Each file contains the training files and FLN training log including all the details required in this indicator.	
All Staff have completed the Naloxone Training as required within 90 days of hire or 1 year from the policy effective date 7/1/24:		Six out of the eight files reviewed have documentation of completion of this training. The other two are new hires and are still within the window of the 90 days of hire.	
Additional Comments: **There are no additional comments for this indicator.**			
1.05 - Analyzing and Reporting Information			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 1.05		**YES** If NO, explain here: The agency has a policy, #QI300 Continuous Quality Improvement Process/CQI Teams 10/13/22; #QI310 Data Collection and Evaluation 10/13/22; #QI320 Quality Improvement Review of Agency Files 10/13/22; #QI330 CQI Worksheet 10/13/22; #QI340 Stakeholder Feedback 10/13/22.	
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**	There is a quarterly report review in the quality improvement binder provided by the agency that identified compliance with CINS/FINS requirements. It was reviewed and signed by QI Coordinator and program director. We were also provided with the monthly staff meeting minutes and signature sheets were the staff was informed of the summary report from the review.	
The program conducts reviews of incidents, accidents, and grievances quarterly, at a minimum	**Compliance**	There is evidence in the QI binder that the Risk prevention and management team-CQI committee meet quarterly to review incidents, accidents and grievances. The meeting minutes and actions can be found in the binder providing date of meeting, attendees, time, objective and agenda.	
The program conducts an annual review of customer satisfaction data	**Compliance**	There is evidence in the stakeholder committee section in the QI binder that during their meetings, they reviewed the program surveys at least once a year.	
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**	There are "EOM" reports in the QI binder in the Monthly data section. It is also combined with all the other monthly reports and the contract progress report.	

The program has a process in place to review and improve accuracy of data entry & collection	**Compliance**	QI Coordinator provided a summary of their process: 1. Weekly Huddle by Program Director/Assistant Program Director/ Residential Supervisor every Monday at 8am. 2. Shelter meeting every second Friday of the month. 3. Census distributed every weekday to all non-YDS staff and Sr. PD, as well as placed on shift lead clipboard for YDS staff to have. 4. Whiteboard goals established and updated as needed. 5. Senior Program Director sends a current goal for each shelter bi-weekly.	
There is documentation that findings are regularly reviewed by management and communicated to staff and stakeholders.	**Compliance**	Evidence was observed that the findings are communicated to staff on monthly staff meeting minutes and sign-in sheets as well as for the stakeholders during their quarterly meeting minutes.	
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.	**Exception**	Interview with the QI Coordinator indicates the program's leadership provides an oral report of all program performance to the Board of Directors.	The program recently put a process in place to email all final reports with limited or failed scores to 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**	The program identifies strengths and weaknesses and addresses them in staff meetings along with implementation of improvements and modifications. These activities were observed in: staff meeting minutes, quality improvement trainings and sign-in sheets, showing that the staff are informed and involved in the process.	
Additional Comments: **There are no additional comments for this indicator.**			
1.06: Client Transportation			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 1.06		**YES** If NO, explain here: The agency has written policy RGC 1.06 Client Transportation last reviewed by the CEO on 10/13/2023.	
Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle	**Compliance**	All agency staff are approved to drive clients in agency vehicles.	
Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy	**Compliance**	Administrative staff conduct annual motor vehicle checks to ensure staff driver licenses are valid and in in good standing. Evidence of current motor vehicle checks was observed for each approved agency driver. The agency's insurance policy covers all drivers.	
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 has written policy prohibiting transportation of a client without maintaining at least one other passenger in the vehicle. The policy does include an exception in the event a third party is not present in the vehicle.	

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 policy states, in the event a third party cannot be obtained for transport, the client's history, evaluation and recent behavior are considered by the agency's supervisor or managerial personnel.	
The 3rd party is an approved volunteer, intern, agency staff, or other youth	**Compliance**	The agency's written policy states, the third party is an approved volunteer, inter, agency staff or other youth. Program practice observed in the agency's transportation logs from April 2024 to November 2024, show agency staff and other youth as third parties in transportation events.	
The agency demonstrated evidence via logbook or other written verification that supervisor approval was obtained prior to all single youth transports.	**Compliance**	From April 2024 to November 2024, one single transport event was observed in the logbook with prior supervisor approval.	
When transporting a single client in a vehicle, there was documentation of the following: a. the transporting employee completed check-in by phone at agreed-upon intervals with the senior program leader, or designee, upon departure and arrival. b. the employee check-ins were documented by the manager or designee receiving the call.	**Compliance**	Evidence of one single transport was observed from April 2024 to November 2024. Prior approval from the supervisor was observed on the program's transportation log and check-ins documented by the program director.	
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**	Documentation of use of vehicle is captured on program's vehicle log which includes: the name of the driver, date, time, mileage, number of passengers, purpose of travel and location.	
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** If NO, explain here: The agency has a written policy #CS580 Community Outreach and Education last reviewed by the CEO on 9/19/22.	
The program has a lead staff member designated to participate in local DJJ board, Circuit and Council meetings with evidence that includes minutes of the event or other verification of staff participation.	**Compliance**	The program's Assistant Director participates in the local DJJ board, circuit and council meetings. Evidence of meeting attendance was verified through meeting minutes maintained by the program.	
The program maintains written agreements with other community partners which include services provided and a comprehensive referral process.	**Compliance**	Evidence of several written agreements with local community partners were observed for fiscal year 24-25. Each agreement outlines services and referral processes agreed upon between both parties.	

The program will maintain documentation of outreach activities and enter into NetMIS the title, date, duration (hours), zip code, location description, estimated number of people reached, modality, target audience and topic.	**Compliance**	The program maintains documentation of outreach activities. All activities observed from May 2024 - November 2024 were entered into NetMIS and contained the title, date, duration, zip code, location, description, estimated number of people reached, modality, target audience and topic.	
The program has designated staff that conducts outreach which is defined in their job description.	**Compliance**	The program has an Outreach Coordination job position. The outreach coordinator would be the designated staff member that conducts outreach as a dedicated role according to their job description. The program's Outreach Coordinator stepped down in October 2024 and the new hire for the position of Outreach Coordinator is currently in the onboarding process. The Program Director and Assistant Program Director have continued to maintain outreach efforts and events through this transition.	
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** If NO, explain here: The agency has a written policy and procedure number RGC 2.01 Screening and Intake last signed d by the Chief Executive Officer on September 15, 2023.	
Shelter youth: Eligibility screening form is completed immediately for all shelter placement inquiries.	**Compliance**	Five of the five shelter files reviewed had eligibility screenings completed immediately.	
Community counseling: Eligibility screening form is completed within 3 business days of referral by a trained staff using the Florida Network screening form.	**Compliance**	Five of the five community counseling files had eligibility screenings completed within three days of referral.	
There is evidence all referrals for service is screened for eligibility and is logged in NetMIS within 72 hours of screening completion.	**Compliance**	Four of four files sampled were entered within the 72 hours.	
Youth and parents/guardians receive the following in writing: a. Available service options b. Rights and responsibilities of youth and parents/guardians	**Compliance**	All ten of ten files reviewed had documentation of receival each sheet. Agency provided the pamphlets that are given at intake. The treatment consents also provide signatures acknowledging the receival of rights, grievances and CIN/FINS petition information.	
The following is also available to the youth and parents/guardians: a. Possible actions occurring through involvement with CINS/FINS services (case staffing committee, CINS petition, CINS adjudication) b. Grievance procedures	**Compliance**	All ten files reviewed contained evidence of receiving the agency pamphlets that are given at intake which discuss possible actions occurring through involvement with CINS/FINS services. The treatment consents also provide signatures acknowledging the receipt of rights, grievances and CIN/FINS petition information.	

During intake, all youth were screened for suicidality and correctly assessed as required if needed.	**Compliance**	Of the ten files reviewed, all ten were screened for suicidality. Of the ten, three had hits on the assessments. There was proper documentation in the files that additional screenings were preformed and approved by a licensed mental health professional.	
Additional Comments: **There are no additional comments for this indicator.**			
2.02 - Needs Assessment			**Limited**
Provider has a written policy and procedure that meets the requirement for Indicator 2.02		**YES** If NO, explain here: The agency has a written policy and procedures number RGC 2.02, Needs Assessment last signed by the Chief Executive Officer on September 15th, 2023.	
Shelter Youth: NIRVANA is initiated within 72 hours of admission	**Exception**	Three of the five files reviewed had a NIRVANA initiated within 72-hours of admission.	Two of the five files reviewed had NIRVANAs completed outside of the 72-hour period. Both of these intakes occurred over the weekend. The program director reported the shelter staff who completes the NIRVANA does not work Friday, Saturday and Sunday, therefore any intakes on Thursday do not get an assessment until Monday.
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 of the five files reviewed had NIRVANAS initiated on intake.	
Supervisor signatures is documented for all completed NIRVANA assessments and/or the chronological note and/or interview guide that is located in the youths' file.	**Exception**	Nine of the ten NIRVANAs reviewed had a supervisors signature. Ten of the ten NIRVANAs were present in the files with a chronological note.	One of the ten NIRVANAs did not have a supervisors signature.
(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**	Of the five shelter files reviewed, all five had the NIRVANA Self-report assessment completed within 24 hours of the youth being admitted.	
A NIRVANA Post-Assessment is completed at discharge for all youth who have a length of stay that is greater than 30 days.	**Compliance**	Of the two files reviewed that were eligible for a Post-Assessment, both files had a NIRVANA Post-Assessment completed.	
A NIRVANA Re-Assessment is completed every 90 days excluding files for youth receiving SNAP services.	**Not Applicable**	None of the ten files reviewed required a 90 days NIRVANA Re-assessment.	

All files include the interview guide and/or printed NIRVANA.	**Compliance**	All ten of the files reviewed contained a printed NIRVANA.	
Additional Comments: **There are no additional comments for this indicator.**			
2.03 - Case/Service Plan			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 2.03		**YES** If NO, explain here: The agency has a policy and procedures including the policy number RGC 2.03, which was last authorized, approved and signed by the Chief Executive Officer on September 15th, 2023.	
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**	A case plan was created for all of the ten files reviewed using a case plan form in the organization's MindShare system. The case plan form contained all the necessary information for a Florida Network approved plan.	
Case/Service plan is developed within 7 working days of NIRVANA	**Compliance**	For all ten of the files reviewed, a case plan was developed within seven days of the NIRVANA.	
Case plan/service plan includes: 1. Individualized and prioritized need(s) and goal(s) identified by the NIRVANA 2. Service type, frequency, location 3. Person(s) responsible 4. Target date(s) for completion and actual completion date(s) 5. Signature of youth, parent/guardian, counselor, and supervisor 6. Date the plan was initiated	**Compliance**	All ten of the files reviewed had a case plan that included goals identified by NIRVANA, service types, frequency, location and person responsible. Of the ten files reviewed, all ten files contained a target date. Only seven of the ten files were closed files and in need of a completion date. All of these files included a completion date. All of the ten files included a date of when the plan was initiated/developed. All ten of the files included the signature of the youth, counselor and supervisor. Nine of the ten files included signatures from the parent/guardian. One of the file files contained a case plan that did not include a parent signature. There was documentation in the case notes stating that the parent/guardian was unable to come in person for the plan development. The plan was scheduled to be signed by the parent/ guardian on November 13th during the youth's family session.	

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	**Exception**	Of the ten files reviewed, only four were applicable for case plan review. A review of four files applicable for 30/ 60/ or 90-day reviews was conducted. One file contained documentation that a 30-day review occurred timely. One file due for a 30-day review was required on or near 5/30/2024 and completed on 05/24/2024. Based on an interview with the community counseling program director, the organization is conducting the reviews more frequently than required by the Network's QI standard, however, this appears to disrupt the frequency of reviews being completed consistently as required.	It showed three files did not have a review that occurred on either the 30/ 60/ or 90-day mark. One file showed evidence of a 60-day review required on 6/30/2024, completed on 06/06/2024, additionally, a 90-day review was required on 07/30/2024 but there was no 90-day review completed. A second file was due for a 30-day review on or near 10/23/2024, the review was completed on 10/16/2024 and the next review date was dated 11/4/2024. A third file showed evidence the 60-day review was not completed. The FNYFS policy and procedure requires service plan reviews to be conducted every 30 days over the first 3 months and every 6 months thereafter. The program conducting reviews early resulted in the reviews not being completed per the aforementioned time periods (30, 60, and 90 days). The internal policy does not speak to any allowable contrary or variance to the 30-day review period. There was inconsistency in the reported 2-week service plan intervals being consistent and the shortened and extended periods of review are being conducted haphazardly without justification for the practice being done outside of the FN requirement. A review of the practice and client progress notes did not indicate any explanation of earlier reviews such as early completion of goals, schedule conflicts for the client or assigned staff, or other personal matters for the client to justify the inconsistency in assessing client progress.
Additional Comments: **There are no additional comments for this indicator.**			

2.04 - Case Management and Service Delivery			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.04		**YES** If NO, explain here: The agency has a policy and procedures including the policy number RGC 2.04, which was last authorized, approved and signed by the Chief Executive Officer on September 16th, 2023.	
Counselor/Case Manager is assigned	**Compliance**	All of the ten files reviewed had a case manager or counselor assigned. This was evident in that each case had a signed case plan designating a case manager/counselor. Each file also contained contact notes reflecting that the assigned case manager/ counselor was working with the youth.	
The Counselor/Case Manager completes the following as applicable: 1. Establishes referral needs and coordinates referrals to services based upon the on-going assessment of the youth's/family's problems and needs 2. Coordinates service plan implementation 3. Monitors youth's/family's progress in services 4. Provides support for families 5. Monitoring progress of court ordered youth in shelter 6. Makes referrals to the case staffing to address problems and needs of the youth/family 7. Accompanies youth and parent/guardian to court hearings and related appointments 8. Refers the youth/family for additional services when appropriate 9. Provides case monitoring and reviews court orders 10. Provides case termination notes 11. Provides follow-up after 30 days post discharge 12. Provides follow-up after 60 days post discharge	**Compliance**	Of the ten files reviewed, two of the community counseling files were identified with needs for referrals. Based on interviews with several staff, and program directors, it was identified that all families receive a referral sheet at several points, intake and discharge, for community services. A sample of the form was reviewed and found sufficient to cover various areas of need for families. Case notes revealed that for all ten files, the counselor/case manager ensured delivery of service and monitored the progress of the service plan frequently. None of the files reviewed for this indicator were court ordered. This agency had no requests for case staffing for the period under review. Six of the ten files were closed and applicable for review of termination reports. All six of these files contained a discharge report. Four of the six closed files were discharged more than 30 days from the time of review and were applicable for a 30 day follow-up. All four of these files had evidence that a 30 day follow-up did occur on time. Two of the six closed files were discharged more than 60 days from the time of review and applicable for a 60 day follow-up. Both of these files contained evidence that a 60 day follow-up call occurred.	
The program maintains written agreements with other community partners that include services provided and a comprehensive referral process	**Compliance**	A binder of signed Memorandum of Understandings (MOUs) was provided to review. The signed MOUs included schools, law enforcement offices, mental health services, and other community programs. Active dates for the MOUs were also observed.	
Additional Comments: **There are no additional comments for this indicator.**			
2.05 - Counseling Services			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 2.05		**YES** If NO, explain here: The agency has a policy and procedures including the policy number RGC 2.05, which was last authorized, approved and signed by the Chief Executive Officer on September 15th, 2023.	

Shelter Program			
Shelter programs provides individual and family counseling	**Compliance**	Five of the five files reviewed provided family and individual counseling. The service notes documented when the counseling occurred for each individual youth. If family interactions were a concern, the case manager would be in contact with and work with both the youth and family individually. If there was no concern/ resistance to joint family counselling then a family session was completed.	
Group counseling sessions held a minimum of five days per week	**Compliance**	A binder of attendance sheets was provided for group sessions. It was observed that there was a minimum of five group sessions being held a week.	
Groups are conducted by staff, youth, or guests and group counseling sessions consist of : 1. A clear leader or facilitator 2.Relevant topic - educational/informational or developmental 3. Opportunity for youth to participate 4. 30 minutes or longer	**Compliance**	All of the attendance sheets observed in the group sessions binder had a written facilitator, topic, and type of interactive activity provided. The topics included things such as anger, aggression and coping. The activities provided included worksheets, games and group discussions. The length of groups ranged from 30 minutes to 2 hours in length.	
Documentation of groups must include date and time, a list of participants, length of time, and topic.	**Exception**	The binder of attendance sheets provided a list of the youth that attended, the topic of discussion, as well as the date and time that the group started.	Several of the sheets observed did not include the length of time for the group. These dates included but were not limited to 4/24/2024, 7/9/2024, 7/8/2024 and, 7/3/2024.
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**	Five of five of the community counselling files reviewed included contact notes that documented services being provided at the schools, home or other community locations. The services also included emails and phone calls but the virtual contacts were not used in lieu of in person services.	
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**	Ten of the ten files contained evidence/ documentation that services are reviewed with supervisors to coordinate case management and delivery. The process was confirmed through interviews with program coordinators.	
Maintain individual case files on all youth and adhere to all laws regarding confidentiality.	**Compliance**	Ten of the ten files were kept in a secure area and maintained requirements for confidentiality.	
Case notes maintained for all counseling services provided and documents youth's progress.	**Compliance**	Ten of the ten files reviewed contained case notes and contacts.	

On-going internal process that ensures clinical reviews of case records and staff performance.	**Compliance**	Service plans are reviewed by case manager and progress on plans is noted on a progress document. That document is then reviewed by a supervisor, these documents were present in ten of ten files reviewed. Service plans are updates/ revised if needed according to interview with program coordinator.	
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.	**Compliance**	Of the ten files reviewed, one file had an intake conducted virtually. It was documented in the case notes that the intake was done virtually with parent due to guardian being unable to take time off of work as the sole family provider. Intake was signed off by a supervisor and a supervision meeting took place to review the case.	
Additional Comments: **There are no additional comments for this indicator.**			
2.06 - Adjudication/Petition Process			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.06		**YES** If NO, explain here: The agency has a policy and procedures including the policy number RGC 2.06, Adjudication/ Petition Process, last signed by the Chief Executive Officer on September 15th, 2023.	
Must include: a. DJJ rep. or CINS/FINS provider b. Local school district representative	**Compliance**	The agency had 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: a. State Attorney's Office b. Others requested by youth/ family c. Substance abuse representative d. Law enforcement representative e. DCF representative f. Mental health representative	**Compliance**	The program has a written policy and procedure that states other invited members of the committee may include: State Attorney's Office; others requested by youth/ family; substance abuse representative; law enforcement representative; DCF representative; and mental health representative.	
The program has an established case staffing committee, and has regular communication with committee members	**Compliance**	The program has an established case staffing committee and scheduled meeting dates for the remainder of the year as evidenced through email correspondence. The program had 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.	
The youth and family are provided a new or revised plan for services	**No eligible items for review**	Since the last QI review the agency had no CINS petition case requests to 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**	Since the last QI review the agency had no CINS petition case requests to review.	

If applicable, the program works with the circuit court for judicial intervention for the youth/family	**No eligible items for review**	Since the last QI review the agency had no CINS petition case requests to review.	
Case Manager/Counselor completes a review summary prior to the court hearing	**No eligible items for review**	Since the last QI review the agency had no CINS petition case requests to review.	
Additional Comments: **There are no additional comments for this indicator.**			
2.07 - Youth Records			**Limited**
Provider has a written policy and procedure that meets the requirement for Indicator 2.07		**YES** If NO, explain here: The agency has a policy and procedures including the policy number RGC 2.07, Youth Records, last signed by the Chief Executive Officer on September 15th, 2023.	
All records are clearly marked 'confidential'.	**Exception**	Fourteen of the twenty-four files reviewed onsite had a visible confidential marking.	Ten files did not have a visible confidential marking.
All records are kept in a secure room or locked in a file cabinet that is marked "confidential"	**Compliance**	All records observed were kept in a locked room. No files have been observed left out unattended.	
When in transport, all records are locked in an opaque container marked "confidential"	**Compliance**	On interviews with multiple staff it was confirmed that only community counseling transports files. Lock box used to transport the files was observed on site	
All records are maintained in a neat and orderly manner	**Exception**	Each youth had an individual file created. The files contained sections and tabbing to help distinguish where some of the paperwork would be.	Based on observations of files, file reviews, and discussions with other reviewers, the records were deemed unorganized.
SHELTER FILES contain the following: Table of Contents that outlines documents in each section: •Screening •Informed Consent • Photograph of the youth • Shelter Intake Form • Suicide Assessment (if needed) • NIRVANA Self Report (NSR) • NIRVANA full Assessment • Plan of Service • Chronological Notes • Medication Inventory Form • Approved contact list • Copies of referrals made & Follow-Up (if needed) • Discharge summary once case is closed	**Exception**	Five of the five shelter files reviewed utilized tabs to distinguish sections such as intake, discharge, case notes and medications.	No table of contents was provided in any of the five shelter files reviewed.

COMMUNITY COUNSELING FILES contain the following: Table of Contents that outlines documents in each section: • Screening • Informed Consent • Community Counseling Intake Form • Suicide Assessment (if needed) • NIRVANA full Assessment • Plan of Service • Chronological case notes • Copies of referrals made & Follow-Up (if needed) • Discharge summary once the case is closed	**Compliance**	Five of the five community counselling files reviewed contained a table of contents that included screening forms, informed consents, community counselling intake form, NIRVANA, plan of service, case notes, and referrals/ follow ups.	
All records kept electronically, are maintained securely and can be made immediately available upon request for audit purposes.	**Compliance**	Based on interview with QI Coordinator and Program Coordinator, it was identified that the agency is beginning to move files to electronic methods. The agency utilizes a programing called Mindshare. Each staff has an individual logging that is separate from their computer login. Staff stated that computers are not left unattended or opened on mindshare. This was confirmed by observations made while on site. Any files requested were able to be immediately pulled up on Mindshare while onsite.	
Records are retained for the duration of the time specified by the contract.	**Compliance**	Based on interview with QI Coordinator, it was confirmed that files are kept offsite at a secured storage facility for a minimum of ten years.	
Additional Comments: **Two of the files reviewed contained documents for youth who were enrolled into two separate programs.**			
2.08 - Specialized Additional Program Services			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 2.08		**YES** If NO, explain here: The agency has written policy and procedures including the policy number RGC 2.08, Specialized Additional Program Services, which was last signed by the Chief Executive Officer on September 15th, 2023.	
Staff Secure			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? **(If no, select rating "No eligible items for review")**	**No eligible items for review**	The agency had no Staff Secure cases in the past six months or back to the date of the last review.	
Staff Secure policy and procedure outlines the following: a. In-depth orientation on admission b. Assessment and service planning c. Enhanced supervision and security with emphasis on control and appropriate level of physical intervention d. Parental involvement e. Collaborative aftercare	**No eligible items for review**	The agency has a written policy which addresses Staff Secure cases and outlines all the required components of this indicator.	
Program only accept youth that meet legal requirements of F.S. 984 for being formally court ordered in to Staff Secure Services	**No eligible items for review**	The agency had no Staff Secure cases in the past six months or back to the date of the last review.	

Staff Assigned: a. One staff secure bed and assigned staff supervision to one staff secure youth at any given time b. Program assign specific staff during each shift to monitor location/ movement of staff secure youth c. Agency clearly documents the specific staff person assigned to the staff secure youth in the logbook or any other means on each shift	**No eligible items for review**	The agency had no Staff Secure cases in the past six months or back to the date of the last review.	
Agency provides a written report for any court proceedings regarding the youth's progress	**No eligible items for review**	The agency had no Staff Secure cases in the past six months or back to the date of the last 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? (If no, select rating "No eligible items for review")	**No eligible items for review**	The agency had no Domestic Minor Sex Trafficking cases in the past six months or back to the date of the last review.	
Agency has evidence that the FNYFS was contacted for approval prior to admission for all Domestic Minor Sex Trafficking (DMST) placements.	**No eligible items for review**	The agency had no Domestic Minor Sex Trafficking cases in the past six months or back to the date of the last review.	
There is evidence the youth was entered into NetMIS as a Special Populations youth at admission and a Human Trafficking Screening Tool (HTST) was completed.	**No eligible items for review**	The agency had no Domestic Minor Sex Trafficking cases in the past six months or back to the date of the last review.	
Services provided to these youth specifically designated services designed to serve DMST youth	**No eligible items for review**	The agency had no Domestic Minor Sex Trafficking cases in the past six months or back to the date of the last review.	
Did the placement of DMST youth require additional supervision for the safety of the youth or the program? If so, did the agency provide the appropriate level of supervision and safety measures?	**No eligible items for review**	The agency had no Domestic Minor Sex Trafficking cases in the past six months or back to the date of the last review.	
Length of Stay: a. Youth in program do not have length of stay in DMST placement that exceeds seven (7) days b. Agency has approval for stays and support beyond seven (7) days for DMST placements that are obtained on a case-by-case basis? (If applicable.)	**No eligible items for review**	The agency had no Domestic Minor Sex Trafficking cases in the past six months or back to the date of the last review.	
Agency has evidence that staff assigned to DMST youth under this provision are to enhance the regular services available through direct engagement in positive activities designed to encourage the youth to remain in shelter	**No eligible items for review**	The agency had no Domestic Minor Sex Trafficking cases in the past six months or back to the date of the last review.	
All other services provided to DMST youth are consistent with all other general CINS/FINS program requirements	**No eligible items for review**	The agency had no Domestic Minor Sex Trafficking cases in the past six months or back to the date of the last review.	
Domestic Violence			
Does the agency have any cases in the last 6 months or since the last onsite QI review was conducted? (If no, select rating "No eligible items for review")	**Yes**	Two case files were pulled for review of this indicator.	
Youth admitted to DV Respite placement have evidence in the file of a pending DV charge	**Compliance**	A referral form and charges from the Department of Juvenile Justice (DJJ) was present in both of the files reviewed.	

Data entry into NetMIS within (3) business days of intake and discharge	**Compliance**	Both of the files reviewed had NIRVANAs entered into NetMIS within three business days of intake. Length of stay for both files were under 30 days that would be necessary for a post-NIRVANA assessment,	
Youth length of stay in DV Respite placement does not exceed 21 days. If more than 21 days, documentation exists in youth file of transition to CINS/FINS or Probation Respite placement, if applicable.	**Compliance**	The files documented discharge reports that occurred prior to the 21st day of intake.	
Case plan in file reflects goals for aggression management, family coping skills, or other intervention designed to reduce propensity for violence in the home	**Compliance**	Both files contained service plans that reflected goals of aggression management and improvement in familiar relationships.	
All other services provided to Domestic Violence Respite youth are consistent with all other general CINS/FINS program requirements	**Compliance**	Both files contained case notes, service plans and reviews that were consistent with other CINS/FINS requirements.	
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")	**Yes**	Two case files were pulled for review of this indicator.	
All probation respite referrals are submitted to the Florida Network.	**Compliance**	Three of the three files had referrals submitted to the Florida Network.	
All Probation Respite Referral come from DJJ Probation and there is evidence that the youth is on Probation regardless of adjudication status.	**Compliance**	Three of the three files had evidence that the referrals come from the DJJ and contained supporting evidence that the youth was on probation.	
Data entry into NetMIS and JJIS within (3) business days of intake and discharge	**Compliance**	Youth information and screenings were entered into NetMIS within three business days.	
Length of stay is no more than fourteen (14) to thirty (30) days. Any placement beyond thirty (30) days contains evidence in the file that the JPO was contacted in writing to request the need of an extension no later than the 25th day the youth was admitted into the program.	**Compliance**	All three files had lengths of stays that were less than 30 days.	
All case management and counseling needs have been considered and addressed	**Compliance**	Three of the three files contained evidence of continuous case management through case notes and evidence that needs were being met throughout the stay.	
All other services provided to Probation Respite youth are consistent with all other general CINS/FINS program requirements	**Compliance**	Three of the three files contained service plans, case management, screening and a level of care consistent with other CINS/FINS services.	

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")	**Yes**	Three intensive case management files were pulled to review.	
Youth receiving services were deemed chronically truant and/or runaway and require more intensive and lengthy services. The youth was determined to be eligible because they have gone through petition and/or case staffing and was in need of case management services.	**Compliance**	Interview with the program coordinator indicated that clients who are not eligible for shelter are moved into Intensive Case Management (ICM). Supervision is done monthly to address eligibility. School records are reviewed and in files to support truancy issues. The county uses a truancy court system for youth with identified issues and does not have case staffing, so this process was developed to identify youth eligible for intensive case management.	
Services for youth and family include: a. Two (2) direct contacts per month b. Two (2) collateral contacts per week c. Direct and collateral contacts not obtained must have documentation to support attempts made to obtain them. All reasonable attempts (at minimum of three) must be made to reach all contacts (direct and collateral) and documented in the case file and NetMIS.	**Compliance**	Three of the three files reviewed had case notes that documented two direct contacts per month. Two of the three files had a minimum of two collateral contacts per week. One of the three files review did not have the required two collateral contacts for the week of October 14th. One of the three attempts was made to make contact. It was documented that due to the hurricane there was a loss of power and that both the school and agency would be closed.	
Assessments include a. NIRVANA at intake b. NIRVANA Re-Assessment every 90 days c. Post NIRVANA at discharge as aligned with timeframe requirements	**Compliance**	All three of the files reviewed contained a NIRVANA completed at intake. All three files were recent open cases and as such did not require a NIRVANA re-assessment or Post-NIRVANA.	
Service/case plan demonstrates a strength-based, trauma-informed focus	**Compliance**	Three of the three service plans contained goals that were trauma/ DV oriented as well as plans to implement services that were trauma-informed.	
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**	Zero of the three files contained virtual services. The program does not provide virtual services.	
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? (If no, select rating "No eligible items for review")	**No eligible items for review**	The agency had no Family and Youth Respite Aftercare cases in the past six months or back to the date of the last review.	
Youth is referred by DJJ for a domestic violence arrest on a household member, and/or the youth is on probation regardless of adjudication status and at risk of violating.	**No eligible items for review**	The agency had no Family and Youth Respite Aftercare cases in the past six months or back to the date of the last review.	
Agency has evidence that all FYRAC referrals have documented approval from the Florida Network office	**No eligible items for review**	The agency had no Family and Youth Respite Aftercare cases in the past six months or back to the date of the last review.	

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

All data entry in NetMIS is completed within 3 business days as required.	**No eligible items for review**	The agency had no Family and Youth Respite Aftercare cases in the past six months or back to the date of the last review.	
Additional Comments: **There are no additional comments for this indicator.**			
2.09- Stop Now and Plan (SNAP)			**Failed**
Provider has a written policy and procedure that meets the requirement for Indicator 2.09		**YES** If NO, explain here: The agency has a policy and procedures including the policy number RGC 2.09, which was last authorized, approved and signed by the Chief Executive Officer on September 15th, 2023.	
SNAP Clinical Groups Under 12			
Youth are screened to determine eligibility of services with the required documents: a. Florida Network Youth Screening Form b. SNAP® Brief Intake Screening Checklist	**Exception**	Three of the four files reviewed contained a completed Florida Network Youth Screening Form. Four of the four files reviewed contained a completed SNAP Brief Intake Screening Checklist.	One of the four files did not contain a completed Florida Network Youth Screening Form.
All files contain **each** of the required documents below: a. SNAP Child Screening Interview Report b. Florida Network Community Counseling Intake Form c. Reinforcement Trap/Coercive Cycle Diagram d. Consent to Treatment and Participation in Research Form	**Exception**	Two of the four files reviewed contained a completed SNAP Child Screening Interview Report. All four of the files reviewed contained a completed Reinforcement Trap/ Coercive Cycle Diagram. All four of the files reviewed contained signed and completed Consent to Treatment and Participation in Research Forms.	Two of the four files did not have a completed SNAP Child Screening Interview Report. Zero of the four files reviewed contained a completed Florida Network Community Counseling Intake Form, neither was record of a completed form available upon request.
The NIRVANA was completed at initial intake, or within two sessions.	**Compliance**	All four of the files reviewed contained NIRVANAs completed at intake.	
There is evidence of the completed the Pre - Child Behavior Checklist (CBCL) by the caregiver and is located within the file.	**Exception**	Three of the four files reviewed contained a completed and printed Pre-Child Behavior Checklist form that was completed by the caregiver.	One of the four files did not contain evidence of a Pre- Child behavior Checklist being completed by the caregiver.
There is evidence of the completed Pre - TOPSE is completed by the caregiver and is located within the file.	**Compliance**	Four of the four files reviewed contained a completed Pre-TOPSE.	
There is evidence of the following documents located within the file: a. SNAP® Parent Goal Sheet b. Child Way To Go Goal Sheet (*This may be in progress for open files but is required for all closed files.*)	**Exception**	One of the four files reviewed contained a completed Child Way To Go Goal Sheet. Two of the four files had completed SNAP Parenting Goal Sheet.	Three closed files did not have a completed Child Way to Go Goal Sheet. One closed file had no SNAP Parenting Goal Sheet in the file and one closed file had an incomplete SNAP Parenting Goal Sheet.

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.	**Exception**	One of the four files reviewed was an open file and as such does not yet require the completion of the post-Child Behavior Checklist (post-CBCL).	Three of the four files were closed and did require a completed post-CBCL. Zero of the three files had evidence of a completed post-CBCL. It was noted by program coordinator during an interview that the site had a major loss in SNAP employment around the time of file discharge.
There is evidence of the completed Post - TOPSE is completed by the caregiver and is located within the file.	**Exception**	Of the four files reviewed, only three were closed files requiring the completion of the post-TOPSE. One of the three closed files contained a completed post-TOPSE.	Two of the three closed files did not have evidence in the file that a post-TOPSE was completed.
There is evidence of the completed SNAP Discharge Report located within the file for any discharged youth.	**Exception**	One of the four files was an open file and as such was not applicable for review for a SNAP Discharge Report.	Of the three closed files, zero had evidence of a completed SNAP Discharge Report.
There is evidence of the SNAP Boys/SNAP Girls Child Group Evaluation Form located in the file.	**Exception**	One of the four files was an open file and as such was not applicable for review of the Child Group Evaluation Forms.	Zero of the three closed files contained evidence of a completed Child Group Evaluation form.
There is evidence of the SNAP Boys/SNAP Girls Parent Group Evaluation Form located in the file.	**Exception**	One of the four files was an open file and as such was not applicable for review of the Parent Group Evaluation Forms.	Zero of the three closed files contained evidence of a completed Parent Group Evaluation form.
SNAP Clinical Groups for Youth 12-17			
Youth are screened to determine eligibility of services using the Florida Network Youth Screening Form.	**No eligible items for review**	The program does not conduct SNAP Clinical Groups of Youth ages 12-17.	
The file contains the completed Florida Network Community Counseling Intake Form and is located within the file.	**No eligible items for review**	The program does not conduct SNAP Clinical Groups of Youth ages 12-17.	
The Consent to Treatment and Participation in Research Form is completed, signed by the parent/guardian before receiving services, and located within the file.	**No eligible items for review**	The program does not conduct SNAP Clinical Groups of Youth ages 12-17.	
The NIRVANA was completed at initial intake, or within two sessions.	**No eligible items for review**	The program does not conduct SNAP Clinical Groups of Youth ages 12-17.	
There is evidence of the completed 'How I Think Questionnaire' (HIT) form located within the file or evidence of at least three (3) documented attempts in the youths' file to obtain this information.	**No eligible items for review**	The program does not conduct SNAP Clinical Groups of Youth ages 12-17.	
There is evidence of the completed Social Skills Improvement System (SSIS) Student form located within the file or evidence of at least three (3) documented attempts in the youths' file to obtain this information.	**No eligible items for review**	The program does not conduct SNAP Clinical Groups of Youth ages 12-17.	

There is evidence of the completed Social Skills Improvement System (SSIS) Teacher/Adult form located within the file or evidence of at least three (3) documented attempts in the youths' file to obtain this information.	**No eligible items for review**	The program does not conduct SNAP Clinical Groups of Youth ages 12-17.	
All closed files contained evidence in the file a NIRVANA was completed at discharge.	**No eligible items for review**	The program does not conduct SNAP Clinical Groups of Youth ages 12-17.	
SNAP for Schools & Communities			
The program demonstrated all of the required weekly attendance sheets that included youth names and/or identifying numbers completed with the teacher and trained SNAP Facilitator signatures. (*This must include a total of 13 attendance sheets for a full cycle*)	**Compliance**	Both of the files reviewed contained 13 attendance sheets that provided the names of the youth in attendance, teacher and facilitator.	
The program maintained evidence of a completed 'Way to Go Goal' Sheet within the file.	**Compliance**	Both of the files reviewed contained a completed way to go goal sheet completed for each class.	
The program maintained evidence of both pre AND post Measure of Classroom Environment (MoCE) completed documents for the class reviewed.	**Compliance**	Both of the files reviewed contained completed pre-Measure of Classroom Environment. Both of the files also contained completed post Measure of Classroom Environment.	
The program maintained evidence of completed pre and post evaluation documents for the class reviewed.	**Compliance**	Both files reviewed had evidence of pre and post youth evaluations completed. The number of post-evaluations matched the number of youth present in the 13th attendance sheet.	
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.	**Exception**	Two completed SNAP in schools sessions were reviewed for evidence of completed SNAP for Schools & Communities Feedback Forms by the supervisory adult responsible for the support of the youth receiving services and entered into NetMIS.	Neither of the two files reviewed contained the feedback form completed by a supervisory adult. Interview with program director confirmed these documents were not completed and there was no proof of entry into NetMIS presented during the time of the review.
There is evidence of one (1) Fidelity Adherence Checklist completed per classroom for the 13-week classroom sessions which is located in the file.	**Compliance**	Two completed SNAP in Schools sessions were reviewed for the Fidelity Adherence Checklist completed per classroom for the 13-week classroom sessions. Fidelity Adherence was not present physically in either of the two files, but upon immediate request, the Fidelity adherence checklist was able to be printed from OneDrive for both of the files.	
Additional Comments: **There are no additional comments for this indicator.**			

3.01 - Shelter Environment			Limited
Provider has a written policy and procedure that meets the requirement for Indicator 3.01		**YES** If NO, explain here: The agency has written policy and procedures including the policy number of RGC 3.01 Shelter Environment, which was reviewed and signed last by the Chief Executive Officer on October 13, 2023.	
Facility Inspection: a. Furnishings are in good repair. b. The program is free of insect infestation. c. Bathrooms and shower areas are clean and functional, free of foul odors, leaks, dust, and mildew and in good working order. d. There is no graffiti on walls, doors, or windows. e. Lighting is adequate for tasks performed there. f. Exterior areas are free of debris; grounds are free of hazards. g. Dumpster and garbage can(s) are covered. h. All doors are secure, in and out access is limited to staff members and key control is in compliance. i. Detailed map and egress plans of the facility, general client rules, grievance forms, abuse hotline information, DJJ Incident Reporting Number and other related notices are posted. j. Interior areas (bedrooms, bathrooms, common areas) do not contain contraband and are free from hazardous unauthorized metal/foreign objects.	**Exception**	Youth and Family Alternatives has the current Department of Children and Families license, effective through December 18, 2024, posted in the main reception area. The Assistant Program Director reports the agency has completed the annual DCF relicensing process and is awaiting the updated license. The agency provides a clean and welcoming family-style environment, well-suited to the needs of the youth residents. The common areas are furnished with wood tables and chairs with cushions, all of which are in good repair and well-maintained. The furniture is appropriate for the spaces they occupy, creating a comfortable and functional living environment. The youth dorm rooms are spacious, neatly arranged, and personalized with individual decorations, reflecting a homelike atmosphere. Beds are made, and rooms are free of clutter and hazards, promoting a sense of order and responsibility. No insect infestations were observed during the audit. Documentation from the Assistant Program Director confirmed regular pest control services, with reports from April, August, September, and October 2024 provided for review. There are four bathrooms available to youth—two in the boys' dorm, two in the girls' dorm—as well as two additional bathrooms in the common area. Staff have separate bathroom facilities, ensuring privacy and maintaining boundaries between staff and youth spaces. The youth bathrooms are clean, well-maintained, and adequately stocked with supplies, including toilet paper and clean shower curtains. Anti-slip rubber mats are provided in the showers for safety. Adequate lighting is maintained throughout the facility, except where noted. The exterior property is generally clean, and the lawn is well-maintained. However, two trees have fallen, and there are piles of brush from hurricanes in September and October 2024.	During the inspection, a broken white pipe with sharp edges protruding from the ground was found, which maintenance promptly fixed on-site. The heavy metal door for the outdoor dumpster is broken and leaning against the dumpster wall, posing a safety concern due to the risk of it falling on youth. The Assistant Program Director confirmed that a request for removal was submitted to the county on October 14th.

Facility Inspection: a. All agency and staff vehicles are locked. b. Agency vehicles are equipped with major safety equipment including first aid kit, (all items in the first aid kit are current and do not have expired items; all expired items should be replaced regularly), fire extinguisher, flashlight, glass breaker and, seat belt cutter.	**Compliance**	Vehicle #1, a white Dodge Chrysler minivan (Plate X6605E), has a fire extinguisher inspected in July 2024. The registration expires 6/30/2025, and insurance is valid through 7/1/2024. The first aid kit is stocked, with unexpired items, but the flashlight is inoperable. The vehicle has an all-in-one glass breaker, seat belt cutter, and flashlight multitool. Seat belts are operable. Vehicle #2, another white Dodge Chrysler minivan (Plate X6620E), has insurance effective 7/1/2024, and registration expiring 6/30/2025. The first aid kit is stocked with unexpired items, but the flashlight is inoperable. The fire extinguisher was inspected in July 2024. The vehicle is equipped with the same all-in-one glass breaker, seat belt cutter, and flashlight multitool. No flash lights had working batteries. Working batteries were added to the multitool flashlights on site. Seat belts are operable. Four vehicles were randomly checked and all doors were locked.	
Facility Inspection: All chemicals are listed, approved for use, inventoried weekly and perpetually, stored securely and Material Safety Data Sheets (MSDS) are maintained on each item (minimum 1 time per week or per agency policy). A perpetual inventory will be the primary means of maintaining a current and real-time inventory. The weekly inventory will be conducted weekly at a minimum to ensure that a perpetual inventory is being maintained consistently and accurately. If more than one location is used to store chemicals, there is an inventory wherever chemicals are stored that is current and well maintained unless previously approved by the Network.	**Exception**	During the audit, it was observed that chemicals were stored in three places; the kitchen pantry, laundry room, and a hallway closet. All chemical storage is behind locked doors accessible only to staff. A full inventory of chemicals was conducted, and the Material Safety Data Sheets (MSDS) for the chemicals provided by the program were reviewed. Weekly inventory lists were inspected for the last six months.	Nine chemicals in the inventory were missing corresponding MSDS sheets. The weekly inventory did not match the supplies in stock. The inventory log in the chemical closet indicated that Lysol was last logged on 10/27/2024: count (0) zero, however, the actual count on-site was (7) seven. The inventory log in the laundry room listed Clorox on the weekly log dated 10/27/2024, but it was not in stock and was not listed on the perpetual log. The agency has a perpetual inventory form that has the name of the chemical, date, and time the chemical was removed and returned with staff initials for both entries and chemical balances which document what was discarded, added, and end balance. Lists from the chemical closet and laundry room, dating back to July were inspected and it was noted that most lists were missing chemicals when added or discarded, and the end balance was inconsistent. Weekly inventory log in the kitchen, last count dated 10/27/24 recorded: (4) four Santimine documented, but there were (5) five in stock, (1) Odor ban, but none could be located and (6) six oven grill cleaners, but only (2) two in kitchen. The perpetual inventory lists for the kitchen were blank and the program was not able to provide completed documentation.

Facility Inspection: Washer/dryer are operational & general area/lint collectors are clean. Agency has a current DCF Child Care License which is displayed in the facility. Each youth has own individual bed with clean covered mattress, pillow, sufficient linens and blanket. Youth have a safe, lockable place to keep personal belongings, if requested.	**Compliance**	The Department of Children and Families license effective December 19, 2023 and expiring December 18, 2024 was posted in the main reception area. The Assistant Program Director reports that the agency has completed the annual DCF relicensing process and is awaiting the updated license. Washer and dryer were observed and reported to be in good working order by the Assistant Program director. Lint screens were checked were observed to be free from lint. Each room in the facility had beds that were assigned to each youth in the program. Beds were clean and clean linen was observed in the laundry rooms. Bed were well made and included sheets, blankets and pillows that were in good repair.	
Additional Facility Inspection Narrative (if applicable)	The dumpster was covered and, throughout the facility, garbage cans were observed to be covered. There are a total of nine exterior doors, with badge access for four doors and key entry for five doors. Four of the five key-entry doors lead to the dorm rooms and are equipped with active alarms. Staff checks out keys from the med room, and the shift supervisor oversees the transfer of keys between shifts, ensuring keys remain with staff at all times. Three sets of keys are maintained. Interior badge access is used for the dorm room entrance, laundry room, kitchen, and the door between the boys' and girls' wings. Several exterior doors were tested, and all were found to be locked and free from obstruction. Two doors were tested from the interior and both were properly alarmed. Evacuation plans are posted throughout the facility, including in each youth room and bathroom, conference rooms, offices, hallways, kitchen, dining area, and recreational rooms. Client rules are posted at the entrance to the boys' dorm, in the recreational room, and at the entrance to the dorm rooms, but were not posted in the girls' dorm. Grievance rules were posted in the recreational room and dorms, with grievance forms located above the grievance boxes in both the boys' and girls' wings. The abuse hotline was posted in the recreational room, dining room, conference room, and dorms. The Department of Juvenile Justice (DJJ) Incident Reporting Number was located on the staff clipboard. Notices regarding staff-to-youth ratio were posted in the recreational room, conference room, dining room, and dorms, while the file room contained an authorized personnel list. Additionally, Department of Children and Families (DCF) Human Trafficking (HT) Forms were posted in the dorm rooms, dining room, and conference room. The common areas also feature important information posted for both staff and youth, including notices, schedules, and resources. Vibrant murals and artwork completed by the youth decorate the walls, fostering a sense of ownership and pride in their environment. A notable feature in the common area is the "Birthday Wall," which displays the birthdays of all youth residing in the home. The Program Director shared that every youth's birthday is celebrated, contributing to a supportive atmosphere. During the on-site review, two air-fresheners were observed on a shelf in the main hallway, traversed by youth (under the supervision of staff). The Assistant Program Director explained this shelf, along with the air fresheners and other chemicals, was temporarily placed in the hallway while the staff bathroom was under repair, and it was observed that the shelf was returned to the bathroom once repairs were completed in a matter of hours that same day. It was noted that the lighting in the bathrooms is low, which was cited in the agency's recent annual health inspection. The Assistant Program Director provided an agency newsletter and email correspondence confirming that repairs are scheduled to address the lighting issues. Otherwise, lighting in the remainder of the facility is suitable to perform tasks in designated areas. The facility was mostly free of graffiti, with some observed behind the door in the boys' bathroom, though efforts to manage or cover graffiti were evident. Chalk writing was also noted on a door in the girls' dorm (outside of the designated space in each room for chalk writing). The Assistant Program Director explained that this is allowed as long as it is done with chalk, as it helps minimize permanent damage to walls while encouraging creative expression. Overall, the facility demonstrates a commitment to creating a safe, clean, and comfortable environment for the youth in its care. The staff's attention to detail, the meaningful decorations, and the regular maintenance of the home contribute to the positive living conditions observed during the audit.	

Fire and Safety Health Hazards: a. Annual facility fire inspection was conducted, and the facility is in compliance with local fire marshal and fire safety code within jurisdiction. b. Agency completes a minimum of 1 fire drill on each shift monthly (within 2 minutes or less). c. Completes 1 mock emergency drill per shift per quarter. d. All annual fire safety equipment inspections are valid and up to date (extinguishers, sprinklers, alarm system and kitchen overhead hood, including fire extinguishers in all vehicles).	**Compliance**	All shifts from April 2024 to October 2024 were reviewed. All drills were under two minutes and there was one drill completed for each shift. Staff complete a fire drill document that includes the shift, drill start time, duration, return time to the building, evacuation area, and number of clients and staff evacuated. Staff signatures are on the forms. The program completes one mock drill per shift monthly. Fire extinguishers were observed in the vehicles and throughout the facility. Fire extinguisher report is dated 6/28/2024. The report notes that there was no access to one vehicle. However, reviewer observed inspected and tagged extinguishers in both vehicles. Reviewer randomly looked at five extinguishers throughout the building and they were all tagged and current. Some were dated 9/2024 due to tag being lost and a new tagging being completed. Sprinkler inspection report is noted as annual and dated 3/21/2024. Semi-annual hood cleaning report is dated 4/23/2024. Kitchen suppression inspection dated 6/6/2024. All shifts for the review period were reviewed. All drills were under two minutes and there was one drill completed for each shift. Staff complete a fire drill document that includes the shift, drill start time, duration, return time to the building, evacuation area, and number of clients and staff evacuated. Mock drills were completed as required by the Florida Network. Staff signatures are on the forms.	
Fire and Safety Health Hazards: a. Agency has a current Satisfactory Residential Group Care inspection report from the Department of Health. b. Agency has a current Satisfactory Food Service inspection report from the Department of Health and food menus are posted, current and signed by Licensed Dietician annually. c. All cold food is properly stored, marked and labeled and dry storage/pantry area is clean and food is properly stored. d. Refrigerators/Freezers are clean and maintained at required temperatures and all small and medium sized appliances are operable and clean for use as needed.	**Compliance**	The most recent Health Department inspection, dated 9/24/2024, was satisfactory. The following violations were noted: 14 - Ware Washing/Cleaning, 17 - Maintenance, 21 - Lighting/Ft. Candles, and 38 - Storage/Container. The program is actively working on addressing the lighting issue. According to the program, the drain plug issue was repaired by the city, though no documentation was provided. The reviewer confirmed that the repair was completed. The pantry storage was observed to be clean and organized, with no expired items. Cold food was properly stored, and all items not in their original containers were labeled and dated, including the stored date and the last date of usage. Fridge temperatures were recorded as Fridge #1 at 29°F and Fridge #2 at 37°F. One freezer was down, while the second freezer was at 7°F. All appliances were clean, and food was properly stored.	
Additional Fire and Safety Health Hazards Narrative (if applicable)			

Youth Engagement			
a. Youth are engaged in meaningful, structured activities (e.g., education, recreation, counseling services, life and social skill training) seven days a week during awake hours. Idle time is minimal. b. At least one hour of physical activity is provided daily. c. Youth are provided the opportunity to participate in a variety of faith-based activities. Non-punitive structured activities are offered to youth who do not choose to participate in faith-based activities. d. Daily programming includes opportunities for youth to complete homework and access a variety of age appropriate, program approved books for reading. Youth are allowed quiet time to read. e. Daily programming schedule is publicly posted and accessible to both staff and youth.	**Compliance**	The facility offers a range of activities that support the holistic development of youth, including skill-building, educational support, counseling, and recreational opportunities. A key aspect of the program is the emphasis on the "Six Pillars of Character"—trustworthiness, respect, responsibility, fairness, caring, and citizenship—which are integrated into daily activities. Youth are also introduced to the "12 Developmental Outcomes" focusing on areas such as employability, mental health, physical health, mastery & future planning, cultural ability, safety & structure, intellectual ability, self-worth, civic & social ability, belonging & membership, self-awareness, spirituality, and autonomy & responsibility. Religious engagement is also an important component of the program. A pastor visits the facility every Wednesday, and church services are held on Sundays and every other Tuesday, with occasional visits on Fridays. These sessions include games, biblical studies, and opportunities for spiritual growth. The facility is supportive of youth with different religious preferences and makes accommodations to ensure their spiritual needs are met. Participation in religious activities is voluntary, and youth who prefer not to participate are not required to do so. This is clearly outlined in the program handbook, which is provided to both parents and youth, ensuring transparency and informed consent. Additionally, during intake, youth undergo a screening process that includes questions about their religious preferences, as well as a health and residential intake form to better understand their needs and ensure the appropriate support is provided. In terms of daily activities, youth gather in the common area for group activities, counseling, and skill-building sessions. Daily outdoor time is integrated into the schedule, allowing youth to engage in sports and other recreational activities. Homework is completed in the dining area, and youth who request quiet time are provided with a space for reflection. Schedules are posted in the dorms and common areas, helping youth manage their time and stay informed about their daily routines. Overall, the program provides a supportive environment where youth can grow emotionally, intellectually, and spiritually, with a focus on individualized needs and preferences.	
Additional Comments: During the onsite visit, a search was performed on three youth returning from school on 11/7/2024. The search procedure included the removal of shoes and socks, having the youth shake out their shirts and, for the female youth, her bra. Youth were also asked to empty all pockets, and the perimeter of the waistband was expanded. A starfish wand technique was used to scan the youth from head to toe, front and back, side to side. Jackets were removed at the start of the process, and staff checked the jackets thoroughly. The youth did not have any bags. The search was conducted in the front lobby prior to entering the shelter environment, with two staff members present—one conducting the search and the other observing. The time of the search was documented in the master log. No contraband or issues were identified during the search.			

3.02 - Program Orientation			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 3.02		**YES** If NO, explain here: The agency has written policy and procedures including the policy number of RGC 3.02, Program Orientation, which was reviewed and signed last by the Chief Executive Officer on October 13, 2023.	
Youth received a comprehensive orientation and handbook provided within 24 hours	**Compliance**	Six files were reviewed and all youth received a Welcome Packet and program orientation within 24 hours of admission.	
Orientation includes the following: a. Youth is given a list of contraband items b. Disciplinary action is explained c. Dress code explained d. Review of access to medical and mental health services e. Procedures for visitation, mail and telephone f. Grievance procedure g. Disaster preparedness instructions h. Physical layout of the facility i. Sleeping room assignment and introductions j. Suicide prevention- alerting staff of feelings or awareness of others having suicidal thoughts	**Compliance**	Six files were reviewed and all youth received a complete orientation that meet the guidelines provided by the FL Network which includes: a list of contraband items, dress code, review of access to medical and mental health services, procedures for visitation, mail and telephone, grievance procedures, disaster preparedness instructions, suicide prevention - alerting staff of feelings or awareness of others having suicidal thoughts. Youth are given a tour of the facility and shown building layout/evacuation maps (observed) posted in the facility, location of grievance boxes and forms (observed), and sleeping room assignment and introductions. Disciplinary actions is briefly cited in the GWH Level System and is verbally explained in detail along with the review of the house rules.	
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**	Assistant Program Director was interviewed and shared that both the parent(s) and youth sign intake and orientation forms during intake. Youth signs a facilities orientation checklist confirms all parts of orientation completed and welcome packet form acknowledging receipt of welcome packet. All content is reviewed with parent and youth at time of intake. The orientation paperwork is online and electronically signed. Parent receives and emailed copy and youth receives a printed copy. Forms are maintained in youth file and the programs Mindshare Electronic Database. It was observed that the Abuse Hotline number is not provided in writing, but it is posted in various locations throughout the facility.	
Additional Comments: **There are no additional comments for this indicator.**			
3.03 - Youth Room Assignment			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 3.03		**YES** If NO, explain here: The agency has written policy and procedures including the policy number of RGC 3.03, Youth Room Assignment, which was reviewed and signed last by the Chief Executive Officer on October 13, 2023.	

A process is in place that includes an initial classification of the youths, to include:			
a. Review of available information about the youth's history, status and exposure to trauma b. Initial collateral contacts, c. Initial interactions with and observations or the youth d. Separation of younger youth from older youth, e. Separation of violent youth from non-violent youth f. Identification of youth susceptible to victimization g. Presence of medical, mental or physical disabilities h. Suicide risk i. Sexual aggression and predatory behavior j. Acute health symptoms requiring quarantine or isolation	**Compliance**	An interview was completed with the Assistant Program Director and documentation was observed during the review. Residential supervisors, assist program director and program director are the only staff allowed to do room assignment. During screening and admission, questions related to the safety and security concerns listed in indicator 3.03 are explored with the youth and parent. The youth's Mindshare (Electronic File) shows various categories in the screening tab. The detailed questions and information was observed on the printed youth screening form which is used to generate the information transferring into Mindshare. In some instances if the paper form is used and the staff files this in the youth record. This was observed for one of the six files observed. The completion and filing of the paper format is not required. Five of the six files had the information electronically stored in Mindshare. It was observed that the questions are also in Mindshare even those cannot be seen after the completion of the file. Residential intake form housed in Mindshare was observed. Mindshare updates for recent admissions override the prior admission alerts however information observed in June 2024 Census Roster, physical file and intake email that included the alerts and Alert Codes. Census Roster had an alert key with letters representing various alert concerns and the staff have these on them at all time.	
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	**Exception**	In five of the six file reviewed alerts information was observed on the youth physical file, Mindshare Electronic Database, Census Reports and the intake email sent out to staff.	One of the six files reviewed was missing the alert notification on both the youth file and census report. Parent started the intake on the day before and the alert was not updated the next day after youth arrival to the facility and assessment after release from DJJ custody.
Additional Comments: **There are no additional comments for this indicator.**			
3.04 - Log Books			**Limited**
Provider has a written policy and procedure that meets the requirement for Indicator 3.04		**YES** If NO, explain here: The agency has written policy and procedures including the policy number of RGC 3.04, Log Books, which was reviewed and signed last by the Chief Executive Officer on October 13, 2023.	

Log book entries that could impact the security and safety of the youth and/or program are highlighted	**Exception**	The program uses a system to highlight key information related to safety, visitors, medication, transportation, and incidents. Staff are trained on this system during orientation. Several dates and incidents were reviewed, including: 4/14/2024: Med pass, transport, heat index, outing 6/5/2024: Perimeter checks, shift change info, heat index 10/3/2024: Altercation, perimeter check, med pass, discharge, head counts, transport 7/23/2024: Key exchange, perimeter check, CCC updates, med count, med pass, grievance box check, intakes	It was noted that some highlights were either missing or marked with the incorrect color. This may impact staff attention to critical issues, as the highlighting system is designed to draw attention to important tasks and incidents. Inconsistent or incorrect highlighting could lead to oversight or delays in addressing key safety and operational concerns.
All entries are brief, legibly written in ink and include: • Date and time of the incident, event or activity • Names of youth and staff involved • Brief statement providing pertinent information • Name and signature of person making the entry	**Compliance**	All log book entries reviewed meet the required standards, including the names of youth and staff, date and time of incidents or activities, concise details of the events, and the name and signature of the person making the entry. The following dates were observed for these entries: 4/15/2024, 6/5/2024, 10/3/2024, and 7/23/2024. The entries were properly documented, ensuring clear and accurate records of incidents and activities.	
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**	No whiteout was observed in the logbooks. Assistant Program Director shared that whiteout is not allowed in the building. During the review of log book entries, several issues were identified with the recording of errors and void procedures. On 4/14/2024, five errors were properly documented with a single line through them, along with staff initials and the date. On 10/3/2024, two entries adhered to proper void procedures, On 7/24/2024, four voids were correctly documented.	However, on 6/4/2024, one staff member wrote over errors instead of following the correct void procedures. On 7/23/2024, two improper voids were observed, with letters written over and times altered. The void procedure was updated in October 2024 to include time documentation on entries, which was observed on 10/28/2024. However, discrepancies were still found on 11/7/2024, where a voided entry had no initials, date, or time, and on 11/4/2024, where a void was recorded without time.

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**	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, recommendation and follow-up are required and sign and date the entry. Observations were made regarding such reviews as follows: in June, the review was conducted on 6/23/2024 for the period 5/21/2024 - 6/23/2024, and again on 6/25/2024 for 6/24/2024 - 6/25/2024 (highlighted yellow instead of purple). In July, the Program Director review was done on 7/28/2024 for the period 6/28/2024 - 7/28/2024. In September, Program Director reviews were conducted on 9/1/2024 for 8/31/2024 - 9/1/2024, 9/2/2024 for 8/27/2024 - 9/2/2024, and 8/27/2024 for 8/25/2024 - 8/27/2024. Additional reviews took place on 9/3/2024, 9/4/2024, 9/5/2024, 9/8/2024, 9/9/2024, and 9/17/2024. The final review observed was on 11/3/2024. There was no Program Director review for the month of April 2024. Interviews with the Program Director and Assistant Program Director revealed that both perform similar tasks, although the Program Director may designate a supervisor to complete the weekly log book checks. The reviewer was unable to distinguish when a supervisor was acting as the Program Director's designee during the log book review. The Assistant Program Director position was created in August 2024, and since then, the Assistant Program Director has been conducting daily reviews. Starting in August, overlapping reviews by both the Assistant Program Director and the Program Director have been occurring, meeting the weekly requirement for the Program Director review. This change represents a significant improvement, and the concern regarding review consistency has been resolved.	

All staff review the logbook of the previous two shifts and makes an entry signed and dated into the logbook indicating the dates reviewed	**Exception**	In June 2024, the process was updated to include documenting start and end times for reviews, with staff required to review the log from the last time they worked. The lead staff writes the review verbiage and dates, and staff are required to sign. Documentation shows that the Assistant Program Director has been prompting staff to sign the shift reviews. The following staff reviews were observed in the program's logbook on the dates listed: On 4/14/2024, there were two staff members on shift, and two reviews were completed; on 6/5/2024, there were three staff members on shift, and three reviews were completed; on 11/4/2024, there were seven staff members on shift, and seven reviews were completed; on 10/19/2024, there were three staff members on shift, and three reviews were completed.	There are notable inconsistencies, such as missing signatures, voided entries not being properly corrected, and discrepancies between the number of staff on shift and the number of reviews completed. The following dates with discrepancies were observed in the program's logbook: on 10/27/2024, there were three staff members on shift, and two signed reviews were completed; on 11/1/2024, there were four staff members on shift, and three reviews were completed, though one entry needed to be voided for the staff name, who did not work the shift due to attending the agency's annual meeting; on 11/7/2024, there were two staff members on shift, and one review was completed; and on 11/5/2024, there were three staff members on shift, and one review was completed.
At the beginning of their shift, oncoming supervisor and shelter counselor reviews the logbook of all shifts since their last log entry and makes a signed and dated entry and into log book indicating the dates reviewed.	**Exception**	At the beginning of their shift, the oncoming supervisor and shelter counselor reviews the logbook of all shifts since their last log entry. Supervisor reviews are documented in purple pen or highlight, with the following review dates observed: 4/15/2024, 6/6/2024, 9/19/2024, and 8/6/2024.	On 8/6/2024 the review date has a slight gap of one day, as the review was noted as having been done from 8/3/2024, but the last documented review was actually on 8/1/2024. Additionally, the previous supervisor left the company on 10/6/2024, and a new supervisor was hired on 10/30/2024. The Assistant Program Director indicated that the new supervisor is still in training and has not yet begun reviewing logs, resulting in a gap in documentation during this period.
Logbook entries include: a. Supervision and resident counts b. Visitation and home visits	**Compliance**	Logbook entries outlining supervision, resident counts, and visitation were observed and reviewed. The dates for supervision and resident counts included 4/15/2024, 6/5/2024, 5/9/2024, 10/3/2024, and 11/3/2024. Visitation and home visits were properly documented with entries on 4/15/2024, 6/5/2024, 6/26/2024, 10/15/2024, 8/31/2024, and 11/3/2024.	
Additional Comments: **There are no additional comments for this indicator.**			

3.05 - Behavior Management Strategies			Satisfactory with Exception
Provider has a written policy and procedure that meets the requirement for Indicator 3.05		**YES** If NO, explain here: The agency has written policy and procedures including the policy number of RGC 3.05, Behavior Management, which was reviewed and signed last by the Chief Executive Officer on October 13, 2023.	
The program has a detailed written description of the BMS and it is explained during program orientation	**Compliance**	Program's Welcome Packet included a detailed four page explanation of the George W. Harris Jr. Level System. House Rules and Level Privileges form also contain detailed behavior management system information.	
Behavior Management Strategies must include:			
a. BMS is designed to teach youth new behaviors and help youth understand the natural consequences for their actions b. Behavioral interventions are applied immediately, with certainty, and reflect the severity of the behavior c. BMS uses a wide variety of awards/incentives to encourage participation and completion of the program d. Appropriate consequences and sanctions are used by the program and consequences for behavior are logical and designed to promote skill-building for the youth e. Counseling, verbal intervention and de-escalation techniques are used prior to physical intervention (Only techniques approved by the Florida Network and DJJ are used if physical intervention is required) f. Only staff discipline youth. Group discipline is not imposed g. Room restriction is not used as part of the system or for youth who are physically and/or emotionally out of control h. Youth should never be denied basic rights such as meals, clothing, sleep, services, exercise, or correspondence privileges	**Compliance**	The behavior management system was reviewed and meets the FL Network guideline. The Behavior Management System has 4 levels - Orientation/Education/Graduation/Collegiate. Incentives are used to progress forward through each level system. After orientation each additional level incorporate a variety of privileges that range from extra hour for video games, dollar store trips for purchases, staying up late, control of tv remote and more. The level system describes the teaching youth using 6 Pillars of Character and 12 Developmental Outcomes which included but are not limited to subject mattes on employability, mental health, self-worth, Civic and Social Ability and Autonomy and Responsibility. Consequences were observed on the house rules form demonstrating that youth are placed on reflection based on severity of the infraction. This system issued consistently. Reflection - Lose privileges. They must complete a reinstatement form explaining the infraction and how it ties into the 6 pillar or 12 developmental outcomes are impacted by the violation in addition to what they would do differently. This is a 40 word document. Interview with Asst. Program Director yielded that they partner with youth who may have a difficult time preparing the document. Based on interviews with the Assistant Program Director and documentation review the program does not use group discipline, room restrictions, or denial of basic rights as methods for discipline.	
Program's use of the BMS			
All staff are trained in the theory and practice of administering BMS rewards and consequences	**Compliance**	Assistant Program Director and Training Coordinator were interviewed and reported the program utilizes a reward and consequences system of behavior management. Training of the theory and practice of administering awards and consequences is conducted by the Program Director or Assistant Program Director. Evidence of training was observed in all staff files reviewed.	

There is a protocol for providing feedback and evaluation of staff regarding their use of BMS rewards and consequences	**Compliance**	Assistant Program Director was interviewed regarding protocols for providing feedback on their behavior management system. Program leaders provide staff with feedback regarding appropriate tolerances and utilizing the program's behavior management system. Documentation of staff feedback was observed.	
Supervisors are trained to monitor the use of rewards and consequences by their staff	**Exception**	The program provided a staff consultation note dated July18, 2024 that demonstrated that the supervisor addressed proper use of the behavior management system when managing youth behaviors.	Based on interviews with the program Assistant Program Directors, Training Coordinator, and Quality Improvement Staff there is no specific training for supervisor educating them on how to monitor youth care worker's use of rewards and consequences. The program did provide a staff consultation note dates July 18, 2024 that demonstrated that the supervisor addressed proper use of the behavior management system when managing youth behaviors.
Additional Comments: **There are no additional comments for this indicator.**			
3.06 - Staffing and Youth Supervision			**Satisfactory with Exception**
Provider has a written policy and procedure that meets the requirement for Indicator 3.06		**YES** If NO, explain here: The agency has written policy and procedures including the policy number of RGC 3.06, Staffing and Youth Supervision, which was reviewed and signed last by the Chief Executive Officer on October 13, 2023.	
The program maintains minimum staffing ratios as required by Florida Administrative Code and contract. • 1 staff to 6 youth during awake hours and community activities • 1 staff to 12 youth during the sleep period	**Compliance**	The program maintains minimum staff ratios. The following dates for each shift were selected for review, and all shifts reviewed met the required staff-to-youth ratio. For Shift Three: (12:00 AM - 8:00 AM), on 3/30/2024, there were 2 staff members for 18 youth, and on 9/9/2024, there were 3 staff members for 17 youth. For Shift Two (4:00 PM - 12:00 AM), on 4/13/2024, there were 4 staff members for 16 youth, and on 7/11/2024, there were 3 staff members for 16 youth. For Shift One (8:00 AM - 4:00 PM), on 6/19/2024, there were 3 staff members for 14 youth, and on 10/12/2024, there were 2 staff members for 9 youth.	

All shifts must always provide a minimum of two direct care staff present that have met the minimum training requirements	**Compliance**	Staff schedules from March 30, 2024, to November 1, 2024, were observed, and it was noted that all shifts had at least two staff members scheduled. According to the interview with the Assistant Program Director, changes to the schedule are made through formalized requests for time off. However, if there is a staff call-out, the schedule is not always updated to reflect the change.	
Program staff included in staff-to-youth ratio includes only staff that are background screened and properly trained youth care workers, supervision staff, and treatment staff	**Compliance**	All program staff included in staff-to-youth ratios have been properly background screened as evidenced in the personnel records reviewed and properly trained according to the training files reviewed.	
The staff schedule is provided to staff or posted in a place visible to staff	**Compliance**	The reviewer observed the staff schedule posted in the copy room, as well as maintained on the staff clipboard, which is utilized by staff throughout the day. The schedule is also emailed weekly to staff. Several weekly staff schedule emails were observed for the following dates: 11/2/2024, 10/19/2024, and 9/7/2024. Additionally, the monthly schedule was available on the agency's SharePoint site, which allows access to all employees. This system ensures that staff have multiple points of access to the schedule and are kept informed of shift assignments.	
There is a holdover or overtime rotation roster which includes the telephone numbers of staff who may be accessed when additional coverage is needed	**Compliance**	The reviewer observed the holdover overtime rotation roster, which includes the cell phone numbers of staff available to provide coverage. This roster is located on the staff shift clipboard, ensuring that staff can easily access contact information for colleagues who may be needed for overtime shifts or coverage.	
Staff observe youth at least every 15 minutes while they are in their sleeping room, either during the sleep period or at other times, such as during illness or room restriction	**Exception**	An interview was conducted with the Assistant Program Director, who explained the process for overnight bed checks. Bed checks are initiated Sunday through Thursday at 8:30 PM, with the end time varying based on the youth's location. On Fridays and Saturdays, bed checks are initiated between 8:30 PM and 10:30 PM, with the end time typically between 9:00 AM and 10:00 AM. Bed checks are conducted once all youth are in the dorms, and the checks are done approximately every 10 minutes. This practice has been in place for about four months. The dates for bed checks for girls were 4/19/2024, 5/21/2024, 8/10/2024, and 10/23/2024, and all checks were completed within the required timeframes. For the boys, the dates for bed checks were 4/10/2024 and 5/7/2024.	The review of boys' bed checks revealed that on the following dates, checks exceeded the 15-minute time frame: 5/8/2024, where the morning check was missing; 7/11/2024, where the check exceeded 15 minutes; and 9/16/2024.
Additional Comments: **There are no additional comments for this indicator.**			

3.07 - Video Surveillance System			Satisfactory with Exception
Provider has a written policy and procedure that meets the requirement for Indicator 3.07		**YES** If NO, explain here: The agency has written policy and procedures including the policy number of RGC 3.07, Video Surveillance, which was reviewed and signed last by the Chief Executive Officer on October 13, 2023.	
Surveillance System			
The agency, at a minimum, shall demonstrate: a. A written notice that is conspicuously posted on the premises for the purpose of security b. System can capture and retain video photographic images which must be stored for a minimum of 30 days c. System can record date, time, and location; maintain resolution that enables facial recognition d. Back-up capabilities consist of cameras' ability to operate during a power outage e. Have cameras placed in interior (e.g. intake office, counseling office, cafeteria, day room) and exterior (e.g. entrance/exit, recreation area, parking lot) general locations of the shelter where youth and staff congregate and where visitors enter and exit; to include locations where youth searches are conducted. Cameras are never placed in bathrooms or sleeping quarters. f. All cameras are visible	**Compliance**	A written notice is posted on the main entrance door notifying visitors that the location is being monitored by cameras. Additionally, there is a large canvas hand-painted sign in the lobby also informing visitors about the presence of cameras. The camera system was observed, and images dating back 30 days to October 6th were reviewed. During an interview with the Assistant Program Director, she demonstrated the camera system and was able to show and upload recordings, which included the video date, time, location, and clear resolution that allows for facial recognition. Several different dates, cameras, and angles were reviewed, confirming that the system is functional and provides detailed coverage. The Assistant Program Director also confirmed that a backup generator is in place to power the cameras, refrigerators/freezers, and some air conditioning units during power outages. The cameras provide a 360-degree view and can be adjusted to capture various angles. Cameras are strategically located at entrance and exit points, along the building perimeter, and in general areas within the shelter and dorm halls. Importantly, no cameras were observed in youth personal spaces or bathrooms, ensuring privacy. All cameras are visible, and proper signage is posted throughout the facility to inform staff, visitors, and youth of the monitoring system.	
A list of designated personnel who can access the video surveillance system is maintained (includes off-site capability per personnel)?	**Compliance**	The reviewer observed a list of designated personnel authorized to access the video system, which was located in a binder in the Assistant Program Director's office. The individuals with permission to access the video footage include the Program Director, Residential Supervisor, Assistant Program Director, Senior Program Director of Residential and School Programs, Chief of Program and Business Development, and the President and CEO. Additionally, all staff members with proper permissions have the ability to access the video system remotely, off-site.	

Supervisory review of video is conducted a minimum of once every 14 days and timeframes reviewed are noted in the logbook.	**Exception**	The Assistant Program Director and Residential Supervisors are responsible for reviewing the camera footage and notating their observations in a log housed in a binder. This information is also documented in the master program log book. The reviewer examined log entries spanning from 4/3/2024 to 11/3/2024.	Notable gaps in the log were observed during the following review periods: 5/30/2024 to 6/18/2024, 6/18/2024 to 7/7/2024, and 7/7/2024 to 7/22/2024, where no camera reviews were documented for over 14 days. The camera checks varied on different dates and times throughout the day. Some gaps in the consistency and documentation of the reviews were noted.
The reviews assess the activities of the facility and include a review of random sample of overnight shifts	**Compliance**	Supervisory reviews observed on the following dates and times showed a review of shelter activities and overnight shifts; 4/19/2024 at 9:45 PM, 5/16/2024 at 10:00 PM, 7/27/2024 to 8/3/2024 between 12:00 AM and 6:00 AM, 9/18/2024 from 3:00 AM to 5:00 AM, and 10/24/2024 from 8:30 PM to 10:30 PM.	
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 video system includes an export feature that allows footage to be uploaded to the CCC shared drive or a law enforcement jump drive. During an interview with the Assistant Program Director, it was confirmed that videos are retained for 30 days and can be accessed or exported upon request within the 24-72 hour timeframe of a quality improvement visit and when and investigation is pursued after an allegation of an incident. Additionally, the system is equipped to operate during power outages, ensuring continuous monitoring and video retention even during disruptions in power. This provides an added layer of security and ensures that important footage is preserved for the required period.	
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**	Observation of the program's policy indicates a camera service order/ request will be made within 24 hours of discovery of camera malfunctioning or being inoperable. Per policy, all efforts made to obtain repairs will be documented and maintained. In an interview with the Assistant Program Director, it was noted that the camera system went down in June 2024, and a new camera system was subsequently installed. The old camera system remains in place and could be used as a backup if necessary, although it is not being utilized at this time. This ensures that there is an alternative system available should any issues arise with the current setup.	
Additional Comments: **There are no additional comments for this indicator.**			

4.01 - Healthcare Admission Screening			Satisfactory
Provider has a written policy and procedure that meets the requirement for Indicator 4.01		**YES** If NO, explain here: The agency has written policy and procedures including the policy number of RGC 4.01, Healthcare Admission Screening, which was reviewed and signed last by the Chief Executive Officer on October 13, 2023.	
Preliminary Healthcare Screening			
Screening includes : a. Current medications b. Existing (acute and chronic) medical conditions c. Allergies d. Recent injuries or illnesses e. Presence of pain or other physical distress f. Observation for evidence of illness, injury, physical distress, difficulty moving, etc. g. Observation for presence of scars, tattoos, or other skin markings h. Acute health symptoms requiring quarantine or isolation	**Compliance**	Four closed and one open residential record were reviewed. In all five records the primary healthcare screening and observations included current medications, existing medical conditions, allergies, recent injuries or illnesses, presence of pain or other physical distress, observation for evidence of illness, injury, physical distress, difficulty moving, presence of scars, tattoos, other skin markings, as well as acute health symptoms requiring quarantine or isolation.	
Referral and Follow-Up			
Youth with chronic medical conditions have a referral to ensure medical care (e.g. diabetes, pregnancy, seizure disorder, cardiac disorders, asthma, tuberculosis, hemophilia, head injuries, etc.)	**No eligible items for review**	None of the five records reviewed had any chronic medical conditions requiring a referral to ensure medical care, such as diabetes, pregnancy, seizure disorder, cardiac disorder, asthma, tuberculosis, hemophilia, or head injury. The program director reported there were no youth in the past six months with chronic medical conditions requiring a referral.	
When needed, the parent is involved with the coordination and scheduling of follow-up medical appointments	**No eligible items for review**	In none of the five records reviewed was it required for the parent/guardian to be involved to coordinate and schedule follow-up medical appointments. In the event of follow-up medical appointments, the program director reported, parents are involved with coordination and scheduling of said appointments.	
All medical referrals are documented on a daily log.	**No eligible items for review**	The five youth did not have any medical referrals. The program director indicated that all medical referrals would be documented in the program's daily log.	

The program has a thorough referral process and a mechanism for necessary follow-up medical care as required and/or needed	**Compliance**	The program has a thorough referral process and a mechanism for necessary follow-up medical care as required and/or needed. All youth requiring a medical appointment are documented in the communication log, as well as in the individual youth record. If the youth is in acute medical distress the staff will call 9-1-1 and the Central Communications Center, which is also documented in the youth's record.	
Additional Comments: **There are no additional comments for this indicator.**			
4.02 - Suicide Prevention			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 4.02		**YES** If NO, explain here: The agency has a written policy and procedures including the policy number RGC 4.02, Suicide Prevention, which was last approved and signed by the Chief Executive Officer on October 13, 2023.	
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**	Four closed and one open residential youth record reviewed included a suicide risk screening during the initial intake and screening process. The suicide screening results were reviewed and signed by the supervisor and this was documented in each youth's 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 has been approved by the Florida Network of Youth and Family Services and includes the necessary information.	
Supervision of Youth with Suicide Risk *(Shelter Only)*			
Youth are placed on the appropriate level of supervision based on the results of the suicide risk assessment.	**Compliance**	Two of the five shelter youth records reviewed were applicable for suicide risk. The two youth were placed on the appropriate level of supervision based on the results of the suicide risk assessment.	
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**	In the two youth records the staff person assigned to monitor each youth maintained one-to-one supervision or constant supervision and documented the observations of each youth's behavior at thirty minute or less intervals.	
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**	In the two applicable youth records the observation logs included the time of day, behavioral observation, any warning signs observed, and the observer's initials.	

Supervision level was not changed/reduced until a licensed professional or a non-licensed mental health professional under the supervision of a licensed professional completed a further assessment OR Baker Act by local law enforcement	**Compliance**	In the two applicable youth records reviewed the supervision level was not changed/reduced until a licensed professional or non-licensed mental health professional completed a suicide risk assessment. One of the two applicable youth was assessed by a licensed professional or a non-licensed professional under the supervision of the licensed professional within the twenty-four hours from the suicide risk screening results or morning of the next business day. One of the two applicable youth was assessed by a licensed professional or a non-licensed professional under the supervision of the licensed professional one business day late. The youth file reflected an intake and risk screening being completed on Thursday and the assessment completed on Monday. The program director reported that the clinician does not work on Fridays. This caused the assessment to be completed outside of the 24-hour period. Supervision level had not been changed until such time the youth was fully assessed.	
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**	In the two applicable records there was evidence documentation was reviewed by the supervisory staff each shift. The observation logs were completed and maintained in each youth record.	
Youth with Suicide Risk *(Community Counseling Only)*			
Youth identified for suicide risk during intake was immediately assessed by a licensed professional or non-licensed professional (under the direct supervision of a licensed mental health professional) and the parents and supervisor were both notified of the results.	**No eligible items for review**	None of five community counseling youth records reviewed had an indication of suicide risk, requiring a full assessment. No suicide risk identified in any community counseling youth in the past six months or back to the date of the last review.	
During the intake, if the appropriate staff is unavailable, youth identified for suicide risk was immediately referred by the provider and the parent/guardian is notified of the suicide risk findings disclosed and advised that an Assessment of Suicide Risk should be completed ASAP by a licensed professional.	**No eligible items for review**	None of five community counseling youth records reviewed had an indication of suicide risk, requiring a full assessment. No suicide risk identified in any community counseling youth in the past six months or back to the date of the last review.	
Information on resources available in the community for further assessment was provided to the parent/guardian and is documented in the youth's file and signed by the parent/guardian OR a written follow-up notification was sent by certified mail if the parent/guardian was not present during the screening and was notified by telephone.	**No eligible items for review**	None of five community counseling youth records reviewed had an indication of suicide risk, requiring a full assessment. No suicide risk identified in any community counseling youth in the past six months or back to the date of the last review.	
If the parent/guardian cannot be contacted, all efforts to contact them are documented in the case file.	**No eligible items for review**	None of five community counseling youth records reviewed had an indication of suicide risk, requiring a full assessment. No suicide risk identified in any community counseling youth in the past six months or back to the date of the last review.	

When the screening was completed during school hours on school property, the appropriate school authorities were notified.	**No eligible items for review**	None of five community counseling youth records reviewed had an indication of suicide risk, requiring a full assessment. No suicide risk identified in any community counseling youth in the past six months or back to the date of the last review.	
Additional Comments: **There are no additional comments for this indicator.**			
4.03 - Medications			**Failed**
Provider has a written policy and procedure that meets the requirement for Indicator 4.03		**YES** If NO, explain here: The agency has a policy and procedures including the policy number RGC 4.03, Medication Control and Management, which was last authorized, approved and signed by the Chief Executive Officer on October 13, 2023.	
The agency has a Registered Nurse (RN) and/or a Licensed Practical Nurse (LPN) that is being supervised by RN and all of their credentials have been verified.	**Exception**	The agency is in the process of hiring a Registered Nurse.	The program currently has a part-time Licensed Practical Nurse (LPN). The last Registered Nurse who supervised the LPN resigned on October 18, 2024.
The agency has evidence of the following for all non-nursing shelter staff designated to assist with the self-administration of medication: a. Documentation of in-person self-administration of medication distribution training provided by a Registered Nurse b. Evidence demonstrating their competency to assist with self-administration of medication distribution c. Maintenance of their annual medication training re-certification	**Compliance**	A review of four pre-service and three in-service staff training records indicated the agency designates non-nursing shelter staff to assist with the self-administration of medication and provides training by a Registered Nurse of in-person self-administration of medication distribution, staff demonstrating competency to assist with self-administration of medication distribution and maintaining annual re-certification.	
The agency held at least quarterly staff meetings conducted by RN and/or Shelter Manager to review and assess: a. strategies implemented to reduce medication errors shelter wide b. analyze factors that contributed to medication errors c. allow staff the opportunity to practice and role-play solutions	**Exception**	The agency holds at least quarterly shelter meetings which includes the Registered Nurse and/or Program Director reviewing and assessing strategies to implement a reduction in medication errors shelter wide and analyzing factors contributing to medication errors. The meetings were held on April 12, 2024, May, 10, 2024, June 7, 2024, July 12, 2024, August 9, 2024, and October 25, 2024.	The staff meetings did not include the staff having the opportunity to practice and role play solutions for medication errors.
The agency has strategies implemented to ensure medications are provided within the 2-hour time frame.	**Compliance**	The agency has implemented strategies to ensure medications are provided within the two-hour time frame. The assigned staff set an alarm on their cellular telephone to remind them to conduct the medication pass on time.	

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 non-licensed staff members identified and designated as responsible for assisting with the self-administration of medications on each shift are the Program Director and Assistant Program Director. The Program Director covers the morining shift and the Assistant Program Director covers the night shift. The program has a process wherein in the absence of the nurse the Program Director and Assistant Program Director conducts medication pass. If neither is on-site the supervisor on duty will conduct medication pass.	
The agency has clear methods of communicating which youth are on medications with the times and dosage easily discernable by all staff on each shift.	**Compliance**	The program had a clear method of communicating which youth are on medications with the times and dosage easily discernable by all staff on each shift. The program posts the name of the youth, a photograph of the youth, the name of the medication, dosage and the time the medication is to be given for staff access in the medication room.	
The delivery process of medications is consistent with the FNYFS Medication Management and Distribution Policy and the agency has an internal quality assurance process to include the following: a. to ensure appropriate medication management and distribution methods b. to track medication errors c. to identify systemic issues and implement mitigation strategies, as appropriate.	**Compliance**	The program has a delivery process of medication consistent with the Florida Network Youth and Families Services Medication Management and Distribution Policy and the agency has an internal quality assurance process to include appropriate medication management and distribution methods are used, tracking medication errors and identifying systemic issues and implementing mitigation strategies, when appropriate. An interview with the Quality Improvement Staff indicated the agency conducts weekly internal audits with the Quality Improvement Staff, the Program Director, the Assistant Program Director and Supervisors. The Quality Improvement Staff reviews the medication administration records and initials the document after each review. A sample of medication administration records was reviewed and the initials were observed.	
Admission/Intake of Youth			
a. Upon admission, the youth and parent/guardian (if available) were interviewed by the Registered Nurse (when on-site) about the youth's current medications as part of the Medical and Mental Health Assessment screening process and/or an interview was conducted by the RN within three (3) business days if the RN was not on the premise at admission. **If the agency does not have a RN, there was a medication review conducted by a certified Leadership position.* b. Upon intake/admission, there is evidence that the on-shift certified supervisor of higher level staff did review all medication forms by the next business day.	**Compliance**	In four closed and one open youth records reviewed upon intake/admission the on-shift certified supervisor of higher level staff did review all medication forms by the next business day. In four closed and one open youth records reviewed upon admission each youth and parent/ guardian were interviewed, by a Licensed Practical Nurse (LPN), about each youth's current medications as part of the Medical and Mental Health Assessment screening processing.	

Medication Storage			
a. All medications are stored in a Pyxis ES Medication Cabinet that is inaccessible to youth (when unaccompanied by authorized staff) b. Pyxis machine is stored in accordance with guidelines in FS 499.0121 and policy section in Medication Management c. Oral medications are stored separately from injectable epi-pen and topical medications d. Medications requiring refrigeration are stored in a secure refrigerator that is used only for this purpose, at temperature range 2-8 degrees C or 36-46 degrees F. (If the refrigerator is not secure, the room is secure and inaccessible to youth.) e. Narcotics and controlled medications are stored in the Pyxis ES Station f. Pyxis keys with the following labels are accessible to staff in the event they need to access medications if there is a Pyxis malfunction: a TOP COVER b BACK PANEL- LEFT TALL CABINET LOCK- LEFT, c BACK PANEL- RIGHT TALL CABINET LOCK- RIGHT	**Exception**	The Pyxis machine is stored in accordance with the guidelines in Florida Statute 499.0121 and policy section in Medication Management. The program only had oral medications on-site during the review which were stored in a lockbox. The program has a medication refrigerator which was locked and maintained in the medication room at a temperature range of 2-8 degree Celsius and 36-46 degrees Fahrenheit. At the time of the review the program did not have any refrigerated medications and the refrigerator was empty. The Pyxis keys with the labels of TOP COVER, BACK PANEL-LEFT TALL CABINET LOCK-LEFT and BACK PANEL-RIGHT TALL CABINET LOCK-RIGHT were maintained accessible to staff in the event they need access to medications if the Pyxis machine is malfunctioning. The keys were in a locked box in the medication room next to the Pyxis machine.	During the on-site review the Pyxis ES Medication Cabinet was not in working order and all medications, including controlled substances were stored in a locked lockbox in the locked medication room. An interview with the Program Director indicated the Pyxis machine had been malfunctioning and was out of order in September, October and November 2024. The Pyxis machine was repaired on the last day of the review, November 7, 2024 and all medications were uploaded into the Pyxis machine, which is inaccessible to youth, and included controlled substances.
Medication Distribution			
a. Agency maintains a minimum of 2 site-specific System Managers for the Pyxis ES Station b. Only designated staff delineated in User Permissions have access to secured medications, with limited access to controlled substances (narcotics) c. A Medication Distribution Log shall be used for distribution of medication by non-licensed and licensed staff d. Agency verifies medication using one of three methods listed in the FNYFS Policies & Procedures Manual e. When nurse is on duty, medication processes are ALWAYS conducted by the nurse or when the nurse is not onsite, then the designated staff who has been trained by a licensed Registered Nurse provides the medication. f. Agency does not accept youth currently prescribed injectable medications, except for epi-pens h. Non-licensed staff have received training in the use of epinephrine auto-injectors provided by a registered nurse	**Compliance**	The program maintains a minimum of two site-specific System Managers/Super Users for the Pyxis ES Station. Only designated staff delineated in User Permissions have access to secured medications, with limited access to controlled substances. In four closed and one open youth records reviewed the program utilized Medication Distribution Logs for the distribution of medication by non-licensed and licensed staff. The agency verifies medication using at least one of the three methods listed in the Florida Network Youth and Family Services Policies and Procedures Manual. An interview with the Assistant Program Director indicated when the nurse is not on duty the medication processes are always conducted by the nurse or when the nurse is not on-site, then the designated staff who has been trained by a licensed Registered Nurse provides the medication. All program staff are trained to provide medication. The program does not accept youth currently prescribed injectable medications, except for epinephrine auto-injector. A review of four pre-service and three in-service staff training records indicated all non-licensed staff had received training in the use of the epinephrine auto-injector provided by a Registered Nurse.	

The medication distribution log documentation includes: a. the time of medication administration b. evidence of youth initials that the dosage was given c. evidence of staff initials that the dosage was given	**Compliance**	In four closed and one open youth records reviewed the medication distribution log documentation included the time of medication administration, evidence of youth initialing the dosage given and evidence of staff initialing the dosage provided.	
There is evidence that staff provide youth with medications within one hour of the scheduled time of delivery as ordered by the medication. Documentation is provided for instances this does not occur within the required timeframe.	**Compliance**	In four closed and one open youth record reviewed there is evidence the staff provided youth with medications within one hour of the scheduled time of delivery as ordered by the medication label. There were no instances in the records reviewed which included out of time frame medication administration.	
During the review period, there were no instances where youth missed their medication due to failure to open the pyxis machine.	**Compliance**	The program director was interviewed and indicated during the review period there were no instances where youth missed their medications due to failure to open the Pyxis machine.	
If applicable: Any staff member deemed responsible for a medication error, there was evidence that the staff member received refresher training from an RN and demonstrated competency prior to being assigned future medication administration responsibilities. There is evidence that any staff member deemed responsible for 3 errors within a 1-year time frame, had their certification suspended and was not recertified until the completion of the full **in-person** medication administration training, demonstrating competency and re-certification from an RN.	**Exception**	The program did not have any staff deemed responsible for three errors within a one year time frame.	The program had one staff which was deemed responsible on two different occasions for medication error, July 2024 and October 2024. The staff did not receive a refresher training from a Registered Nurse. The staff was removed from being eligible to conduct medication administration after the second medication error.
Medication Inventory			
a. For controlled substances, a perpetual inventory with running balances is maintained as well as a shift-to shift count verified by a witness and documented b. Over-the-counter medications that are accessed regularly and inventoried weekly c. Syringes and sharps (needles, scissors, etc.) are secured, and counted and documented weekly	**Exception**	A review of four closed and one open record was conducted. Three of the five records had youth with one controlled substance each. In all three records the controlled substance had a perpetual inventory with running balances. A review of eight over-the-counter medication inventories indicated five were completed weekly for the review period. The program did not have any sharps on-site during the review period to conduct weekly inventories.	A review of four closed and one open record was conducted. Three of the five records had youth with one controlled substance each. In all three records there was missing shift-to-shift counts. A review of eight over-the-counter medication inventories indicated three did not have all weekly inventories. The Acetaminophen was missing weekly inventories from May 6, 2024 to July 5, 2024, Benadryl was missing from June 1, 2024 to July 5, 2024, Advil was missing from May 6, 2024 to July 4, 2024, and August 1, 2024 to August 31, 2024.

There are monthly reviews of the Pyxis reports to monitor medication management practice.	**Exception**	A review of the Pyxis reports for April to October 2024 indicated the program completed monthly Pyxis reports from April to August 2024.	A review of Pyxis reports for the review period indicated September and October 2024 did not have any information on the report due to the Pyxis machine being out of order.
Medication discrepancies are cleared after each shift.	**Exception**	An interview with the Assistant Program Director and the Program Director indicated they clear medication discrepancies after each shift Pyxis monthly reports indicated medication discrepancies have been cleared after each shift. A review of the Pyxis monthly reports for April to August 2024 did not show any medication discrepancies needing to be cleared.	A review of the Central Communications Center incident reports indicated a youth had a medication error in July 2024 and October 2024. A review of the July 2024 Pyxis report did not have the youth's name or medication noted on it. An interview with the Assistant Program Director indicated the youth had been at the shelter for one week at the time of the incident. A review of the October 2024 Pyxis report could not be conducted since the Pyxis machine was out of order.
Additional Comments: **There are no additional comments for this indicator.**			
4.04 - Medical/Mental Health Alert Process			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 4.04		**YES** If NO, explain here: The agency has a policy and procedures which included the policy number RCG 4.04 Medical and Mental Health Alert System, signed by the Chief Executive Officer on October 13, 2023.	
Youth with a medical, mental health, or food allergy was appropriately placed on the program's alert system	**Compliance**	In four closed and one open record reviewed each youth with a medical, mental health, or food allergy was appropriately placed on the program's alert system.	
Alert system includes precautions concerning prescribed medications, medical/mental health conditions	**Compliance**	The program has an alert system including precautions concerning prescribed medications, and medical/mental health conditions. The alert system includes posting in the program's logbook, in the kitchen, in the med room and in the staff bubble.	
Staff are provided sufficient training, information and instructions to recognize/respond to the need for emergency care for medical/mental health problems	**Compliance**	The program provides staff sufficient training, information, and instructions to recognize/respond when the need for emergency care for medical/mental health problems arise.	

A medical and mental health alert system is in place that ensures information concerning a youth's medical condition, allergies, common side effects of prescribed medications, foods and medications that are contraindicated, or other pertinent mental health treatment information, is communicated to all staff	**Compliance**	The program has a medical and mental health alert system in place ensuring 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. The program's alert system is noted on each youth's record, Mindshare Electronic Database, Census Reports, and intake emails are sent out to staff. The staff have the census which includes the alerts on their person during each shift.	
Additional Comments: **There are no additional comments for this indicator.**			
4.05 - Episodic/Emergency Care			**Satisfactory**
Provider has a written policy and procedure that meets the requirement for Indicator 4.05		**YES** If NO, explain here: The agency has a policy and procedures including the policy number RGC 4.05, Episodic Emergency Care, signed by the Chief Executive Officer on October 13, 2023.	
Off Site Emergency Care			
a. If off-site emergency medical or dental care was provided, an incident report was submitted for the medical or dental care b. Upon youth return, there is a verification receipt of medical clearance via discharge instructions with follow-up is present in file c. Youth's parent/guardian was notified d. A daily log is maintained for emergency care provided	**Compliance**	A review of four closed records indicated all youth received off-site emergency medical or dental care and an incident report was submitted for the medical or dental care. In three of the four upon the youth's return there was a verification receipt of medical clearance through discharge instructions with follow-up present in each record. In all four the parent/guardian was notified of the off-site emergency care. In all four the daily log was maintained for emergency care provided. In one of the four records the documentation indicated the parent/ guardian did not bring the discharge paperwork to the shelter and the youth was released from the shelter.	
All staff are trained on emergency medical procedures	**Compliance**	A review of four pre-service and three in-service staff training records indicated all of the staff were trained in emergency medical procedures.	
The program has a Knife-for-life and wire cutters accessible to staff in a secure location(s)	**Compliance**	The program has a knife-for-life and wire cutters, as well as first-aid kits in the medication room, staff station, copy room and kitchen for a total of four. The program has two doses of Narcan in each first-aid kit, as well as two doses in the nurse office. All were inaccessible to youth and accessible to staff.	
Additional Comments: **There are no additional comments for this indicator.**			